Section 125 Cafeteria Plan
Summary Plan Description

South San Antonio ISD

5622 Ray Ellison Dr.
San Antonio, TX
210-977-7000
EIN 74-6002335
Plan# 501

Plan Year: November 1, 2016 - October 31, 2017

Health or Dependent Care FSA Plan Year, if Different:

Health FSA n/a

Dependent Care FSA n/a

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

TABLE OF CONTENTS

South San Antonio ISD

Section 125 Cafeteria Plan

SUMMARY PLAN DESCRIPTION

GENERAL INFORMATION ABOUT THE PLAN

South San Antonio ISD (the "Employer") is pleased to sponsor an employee benefit program known as the **Section 125 Cafeteria Plan** (the "Plan") for eligible employees of the Employer. The Plan allows you to choose between taxable compensation and one or more of the non-taxable benefit programs offered under the Plan ("Benefit Options"). In essence, the Plan allows you to reduce your compensation before applicable federal and most state taxes are deducted pursuant to an agreement between you and your Employer ("Salary Reduction Agreement") and have the Employer apply that amount towards your share of the cost of the Benefit Options that you choose. The amount that you elect pursuant to the Salary Reduction Agreement is referred to herein as a "Pre-tax Salary Reduction." You may also choose the reimbursement options offered under this Plan.

This Plan has two components:

(i) ***The Pre-tax Salary Reduction Component.*** The Pre-tax Salary Reduction Component enables you to make Pre-tax Salary Reductions through this Plan for certain Benefits offered through the Plan. To the extent identified as a Benefit Option in the Plan Information Summary, you may be able to make contributions to a Health Savings Account through this Plan.

(ii) ***The Flexible Spending Account Component.*** Two reimbursement options are offered through this Plan: the Health Flexible Spending Account ("Health FSA") and the Dependent Care Flexible Spending Account ("Dependent Care FSA").

Each of the components identified above is summarized in this Summary Plan Description ("SPD"). This SPD describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. There are several appendices attached to this SPD. Each appendix is incorporated into and forms an integral part of this SPD. The Plan is also established pursuant to a plan document into which the SPD has been incorporated. However, if there is a conflict between the official plan document and the SPD, this SPD will govern.

Certain terms in this SPD are capitalized. Capitalized terms reflect important terms that are specifically defined in this SPD or in the Plan Document into which this SPD is incorporated. If a capitalized term is not specifically defined in this SPD, it will have the same meaning given it in the Plan Document. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator (who is identified in the Plan Information Summary).

NOTE: Information pertaining specifically to this Plan, (such as the identity of the Plan Administrator, the Third Party Administrator, the plan number, etc.) is set forth in the Plan Information Summary attached to this SPD.

PRE-TAX SALARY REDUCTION COMPONENT SUMMARY

Q-1. What is the purpose of the Pre-tax Salary Reduction Component of the Plan?

The primary purpose of the Pre-tax Salary Reduction Component of the Plan is to allow eligible Employees to reduce their compensation before applicable federal and most state taxes are deducted pursuant to an agreement between the Employee and Employer ("Salary Reduction Agreement") and have the Employer apply that amount towards the cost of the Benefit Options chosen by the Employee. The amount of compensation reduced pursuant to the Salary Reduction Agreement and applied by the Employer towards the cost of the Benefit Options is referred to herein as "Pre-tax Salary Reductions." The Benefit Options offered through this Plan are identified in the Plan Information Summary. **NOTE: You may use this Plan to pay for Benefit Options covering only yourself and your tax dependents as defined in Code Section 152 (except as otherwise defined in Code Section 105 for health plan purposes, Code Section 21 for Dependent Care FSA purposes-to the extent applicable).**

This Pre-tax Salary Reduction Component Summary describes the rights and obligations of both you and the Employer with regard to the Pre-tax Salary Reductions you choose to make.

Q-2. Who can make Pre-tax Salary Reductions through this Plan?

Each Employee of the Employer who (i) satisfies the Plan's Eligibility Requirements and (ii) is also eligible to participate in at least one of the Benefit Options will be eligible to make Pre-tax Salary Reductions through this Plan no earlier than the Eligibility Date. No Pre-tax Salary Reduction may be made unless a proper election is made in accordance with the terms of this SPD. The Eligibility Requirements and Eligibility Date are described in the Plan Information Summary. If you are eligible to make Pre-tax Salary Reductions under this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options offered under this Plan. For details regarding each Benefit Option's eligibility provisions, please refer to the governing documents of the Benefit Options.

Q-3. When do I cease to be eligible for the Pre-tax Salary Reduction Component of this Plan?

You cease to be eligible for the Pre-tax Salary Reduction Component of this Plan on the earliest of the following to occur:

(i) The date that you no longer satisfy the Eligibility Requirements of this Plan or the eligibility requirements of all of the Benefit Options; or

(ii) The date that the Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If you cease to be eligible during the Plan Year, Pre-tax Salary Reductions made through this Plan will *automatically* cease. If during the same Plan Year you become eligible again more than 30 days after you stopped being eligible, you may make new Pre-tax Salary Reduction elections in accordance with the terms of this SPD (subject to any other limitations on participation imposed by the governing documents of the Benefit Options). If you become eligible within 30 days of the date you stopped being eligible, your Pre-tax Salary Reduction elections that were in effect when you stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4. How do I make Pre-tax Salary Reduction elections?

If you have otherwise satisfied the Eligibility Requirements, you may make Pre-tax Salary Reduction elections by completing an individual Salary Reduction Agreement (sometimes referred to as an "Election Form") most applicable on which you agree with the Employer to reduce your compensation before most applicable taxes are deducted and have the Employer apply that amount towards the cost of the Benefit Options that you choose. You will be provided a Salary Reduction Agreement (or given access to a Salary Reduction Agreement) on or before your Eligibility Date. You must complete the form and submit it in accordance with the instructions provided with your Salary Reduction Agreement during one of the election periods described in **Q-6.** below. The election that you make under this Plan (whether to make Pre-tax Salary Reductions or not) is generally irrevocable during the Plan Year except as set forth in Q-6 below.

In some cases, the Employer may *require* you to pay your share of the cost of the Benefit Options that you choose with Pre-tax Salary Reductions. If that is the case, you agree to make Pre-tax Salary Reductions equal to your share of the cost of the Benefit Options you choose when you properly enroll in the Benefit Options. **NOTE: Although coverage under a Benefit Option may be retroactively effective, the Pre-tax Salary Reduction elections made under this plan are typically effective on a prospective basis only. To the extent set forth in enrollment materials, an exception exists allowing retroactive enrollment for new hires and in the event of HIPAA special enrollment for birth and/or adoption. See Q-6 below for more information.**

You may be required to complete a Salary Reduction Agreement via telephone or voice response technology, electronic communication, or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5. What are tax advantages and disadvantages of participating in the Pre-tax Salary Reduction Component of the Plan?

The Pre-tax Salary Reductions that you elect to make are not subject to federal income and employment taxes and most state taxes. Plan participation will also reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-6. What are the election periods for making a Pre-tax Salary Reduction Election under the Plan?

The Plan basically has three election periods: (i) the "Initial Election Period," (ii) the "Annual Election Period," and (iii) the "Election Change Period." The following is a summary of the Initial Election Period and the Annual Election Period. The Election Change Period is described in Q-8 below.

What is the Initial Election Period?

The Initial Election Period is the period following the date that you first satisfy the Eligibility Requirements. The enrollment material provided to you by the Employer (or its designee) will identify the Initial Election Period. If you make a Pre-tax Salary Reduction election during the Initial Election Period, your election will be effective on the later of your Eligibility Date or the first pay period coinciding with or next following the date that your election is received. The effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options. **NOTE: The election that you make during the Initial Election Period (whether to make Pre-tax Salary Reduction Elections or not) is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you experience one of the enumerated events and provide proper notice in accordance with Q-8 below.**

What is the Annual Election Period?

The Plan also has an "Annual Election Period" during which you may change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election form must be returned to the Plan Administrator on or before the last day of the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you experience one of the enumerated events and you provide proper notice as set forth in Q-8 below. **NOTE: If you fail to make an affirmative election during the Annual Election Period, you may be deemed to have elected to continue your current elections during the next Plan Year. This is called an "Evergreen Election." Alternatively, you may not be permitted to make Pre-tax Salary Reductions during the next Plan Year if you don't make an affirmative election during the Annual Election Period. The consequences of failing to make an election during the Annual Election Period are described in the Plan Information Summary.**

Special Rule for Flexible Spending Account Component elections and Health Savings Account Contribution Component elections: Evergreen Elections do not apply to Flexible Spending Account Component elections and Health Savings Account Contribution Component elections. Consequently, you must make an election each Annual Election Period in order to participate in the Flexible Spending Account Component and/or to contribute to a Health Savings Account offered under the Plan during the next Plan Year.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. How are Pre-tax Salary Reductions applied by the Employer towards the cost of the Benefit Options I choose?

When you elect to make Pre-tax Salary Reductions through this Plan, an amount equal to your share of the annual cost of the Benefit Options that you choose divided by the applicable number of pay periods through the end of the Plan Year is deducted from each paycheck during the Plan Year. If, as of the date that any elected coverage under this Plan terminates, your year-to-date Pre-tax Salary Reductions exceed or are less than your required Contributions for the coverage, the Employer will, as applicable, return the excess to you as additional taxable wages or recoup the due Pre-tax Salary amounts from any remaining Compensation.

An Employer may choose to pay for a share of the cost of the Benefit Options you choose with non-elective employer contributions ("Employer Contributions"). The amount of Employer Contributions that is applied by the Employer towards the cost of the Benefit Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion at any time. The Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Employer Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in the Plan Information Summary.

The Employer may provide you with Employer Contributions over which you have discretion to allocate to one or more Benefit Options available under the Plan. These elective employer contributions are called "Flexible Credits" or "Benefit Credits." The Flexible or Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

If you elect to pay your share of the Contributions for medical insurance benefits with After-tax Contributions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

Q-8. Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Plan during the Plan Year. There are, however, a few exceptions.

First, your Pre-tax Salary Reduction elections will automatically terminate if you cease to be eligible for this Plan. Moreover, if coverage under a Benefit Option ends, the corresponding Pre-tax Salary Reductions for that coverage will automatically end.

Second, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

(a) You experience a "Change in Status Event" or "Cost or Coverage Change" described below; and

(b) You provide appropriate notice of the event within the Election Change period described in the Plan Information Summary.

Change in Status Events and Cost or Coverage Changes recognized by this particular Plan, and the rules surrounding election changes are described in the Election Change (Appendix II) attached to this SPD.

Third, an election under this Plan may be unilaterally modified by the Employer during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) as necessary to prevent the Plan from failing the applicable non-discrimination rules set forth in the Code**.**

Generally, the Plan Years for the Health FSA and Dependent Care FSA (if chosen by the Employer) will be the same. However, in some cases, the Health FSA and Dependent Care FSA Plan Years will be different; they may also be different from the medical option. In this situation, because the Plan Years are different, the periods during which you may not make election changes (unless certain exceptions apply) will also be different. See the Plan Information Summary to determine if this applies to you.

Q-9. What happens to my Pre-tax Salary Reduction elections if I take a leave of absence?

Your Employer may elect to continue coverage under one or more of the Benefit Options that you chose while you are absent on a paid leave. If so, you will pay your share of the cost of such coverage that you are required to pay during such a leave by the method normally used during any paid leave (for example, with Pre-tax Salary Reductions).

In the event of unpaid leave (or paid leave where coverage is not required to be continued), you will be permitted to pay your share of the cost of any such Benefit Options that you are permitted to continue during the leave in accordance with policies adopted by your Employer. The payment options offered by the Employer in accordance with such policies will be established in accordance with Code Section 125, FMLA (to the extent applicable), any other applicable federal or state law(s), and any applicable regulations issued thereunder.

Q-10. How long will the Pre-tax Salary Reduction Component of this Plan remain in effect?

The Plan Administrator has the right to modify or terminate the Pre-tax Salary Reduction Component of this Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Q-11. What happens if I have a dispute about my rights under the Pre-tax Salary Reduction Component of this Plan (e.g. an election change or other issue germane to Pre-tax Contributions?

You have the right to a full and fair review process. If you are denied a claim related to Pre-tax Salary Reductions under this Plan, your claim will be reviewed in accordance with the Employer's internal policies and procedures.

FLEXIBLE SPENDING ACCOUNT COMPONENT

Q-12. What is the Flexible Spending Account Component of the Plan?

The Plan offers two different reimbursement options: a Health Flexible Spending Account ("Health FSA") option and a Dependent Care Flexible Spending Account ("Dependent Care FSA") option. The Health FSA reimburses Eligible Medical Expenses and the Dependent Care FSA reimburses Eligible Day Care Expenses in accordance with the terms of the SPD. Collectively Eligible Medical Expenses and Eligible Day Care Expenses are referred to as "Eligible Expenses." The Health FSA is intended to qualify as a self-insured medical reimbursement plan subject to Code Section 105 and the regulations issued thereunder and the Dependent Care FSA is intended to qualify as a dependent care assistance plan subject to Code Section 129 and the regulations issued thereunder.

Q-13. Who can participate in the Flexible Spending Account Component of the Plan?

Each Employee who satisfies the Eligibility Requirements identified in the Plan Information Summary is eligible to participate in the Flexible Spending Account Component no earlier than the Eligibility Date identified in the Plan Information Summary. Participation does not begin unless a proper election is made in accordance with Q-14 below. The effective date of coverage is also identified in Q-14 below.

[For Health FSA only] If you are a participant in the Health FSA option, your Eligible Dependents are also covered. Your Eligible Dependents, for purposes of the Health FSA option, are your Spouse (determined in accordance with the federal Defense of Marriage Act), any of your children (until the child attains age 26), and any other person who qualifies as your dependent under Code Section 105(b).

In general, your children include your:

- Daughter or step daughter
- Son or stepson
- legally adopted child; or
- eligible foster child.

Your child is eligible for coverage under the Health FSA regardless of marital status, tax dependency, employment status, or residency, so long as the child has not yet attained age 26.

An individual is a "dependent" for purposes of Code Section 105(b) if the individual is a dependent for income tax purposes under Code Section 152 or would qualify as your dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount (applicable to "Qualifying Relatives" as defined in Code Section 152); (ii) you are a dependent of another taxpayer, or (iii) the individual is married and files a joint return with his or her spouse.

NOTE: A domestic partner's expenses are not eligible for reimbursement under the Health FSA unless the domestic partner qualifies as your dependent under Code Section 105(b).

Q-14. How do I make an election to participate in the Flexible Spending Account Component?

You become a participant in Flexible Spending Account Component of this Plan by electing the Health FSA option and/or Dependent Care FSA Option during the election periods described in Q-6 of this SPD. Your participation in the Flexible Spending Account Component of this Plan will be effective on the date that you make a timely election or your Eligibility Date, whichever is later. If you wish to participate in either of the options during the next Plan Year, you must make an election to participate in the desired option(s) during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Flexible Spending Account component elections.

If you elect to participate in the Health FSA option, the Employer will establish a notional "Health Care Account." If you elect to participate in the Dependent Care FSA option, the Employer will establish a notional "Dependent Care Account." Collectively, the Health Care Account and the Dependent Care Account are referred to as "Account(s)." Each Account is established to keep a record of the Pre-tax Salary Reductions (and Employer Contributions, if any) applied towards the cost of your coverage under each option that you elect as well as the reimbursements of Eligible Expenses to which you are entitled during the Plan Year. No actual account is established; the Accounts are merely bookkeeping accounts. Benefits under the Health FSA and Dependent Care FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-15. When does coverage under a Flexible Spending Account Component option that I elect end?

Coverage under a Flexible Spending Account Component option ends on the earlier of the following to occur:

(a) The date that you revoke your election to participate in an option;
(b) The last day of the Plan Year unless you make an election during the Annual Election Period to continue participation in the option;
(c) The date that you no longer satisfy the Eligibility Requirements; or
(d) The date that the Flexible Spending Account Component option is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

Coverage for your Eligible Dependents ends on earliest of the following to occur:

(a) The date your coverage ends;
(b) The date that your dependents cease to be Eligible Dependents (e.g. you and your spouse divorce);
(c) The date the Flexible Spending Account Component option is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Flexible Spending Account Component option.

You (and your covered spouse and/or dependent children) may be entitled to elect COBRA Continuation Coverage under the Health FSA if coverage ends because of a Qualifying Event (as set forth in more detail in Q-27 below).

Q-16. Can I ever change my Flexible Spending Account Component elections?

You can change your Flexible Spending Account Component elections in accordance with Q-8 of this SPD.

Q-17. What happens to my Flexible Spending Account Component coverage if I take an approved leave of absence?

(a) Health FSA Option:

(i) Your Employer may elect to continue all health coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(ii) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the Employer will continue to maintain your Benefit Options that provide health coverage, including the Health FSA option, on the same terms and conditions as though you were still active to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage). Alternatively, the Employer may *require* all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator. The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer. If you elect to continue coverage while on FMLA leave, you may pay your share of contributions in one of the following ways:

- with After-tax Contributions, by sending monthly payments to the Employer by the due date established by the Employer;

- with Pre-tax Contributions, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the contributions for the expected duration of the leave on a Pre-tax Contribution basis out of pre-leave Compensation. To pre-pay the contributions, you must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

- under another arrangement agreed upon between you and the Plan Administrator (e.g., the Plan Administrator may fund coverage

during the leave and withhold "catch-up" amounts from your Compensation on a pre-tax or after-tax basis) upon your return.

(iii) If your Health FSA coverage ceases while on FMLA leave (e.g., for non-payment of require contributions), you will be permitted to re-enter the Health FSA option upon return from such leave on the same basis as you were participating prior to the leave, or as otherwise required by the FMLA. Your coverage under the Health FSA may be automatically reinstated provided that Health FSA coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(iv) You will have two reinstatement options upon return from FMLA leave:

- Reinstate the maximum reimbursement amount available prior to the leave (reduced by any reimbursements for expenses incurred prior to the leave) reduced by the contributions you fail to make while out on leave. Your pre-leave contribution amount will remain the same. For example: Assume Bob takes a leave of absence on April 1 and his Health FSA balance is $1200 ($100 per month). His coverage ceased during the leave, which lasts 3 months (through June 30). If Bob elects this option upon return, his maximum annual reimbursement amount will be $900 [$1200 pre-leave reimbursement maximum reduced by $300 ($100 for each month he was out on leave)] and his monthly contribution will be $100.

- Reinstate the maximum reimbursement amount available prior to the leave. The contributions that you fail to make during your leave will be pro-rated over the remaining months in the Plan Year and added to the original monthly contribution amount. For example, assume Bob elects this option upon return from leave. Bob will have a $1200 maximum reimbursement amount available but his monthly contribution amount will be $150 ($300 pro-rated over the remaining 6 months).

(b) Dependent Care FSA Option: Your Dependent Care FSA election under this Plan shall be treated in the same manner that the Employer treats elections for non-health benefits with respect to Participants commencing and returning from unpaid non-FMLA leave.

Non-FMLA Leave of Absence: If you go on an unpaid leave of absence that does not affect eligibility, you will continue to participate and the contributions due for you will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, then the election change rules in Appendix II will apply.

Q-18. What is an "Eligible Medical Expense?"

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your Eligible Dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d) that is incurred by you or your Eligible Dependents;
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Through the end of 2010, this includes, but is not limited to, both prescription and over-the-counter drugs (and over-the-counter products and devices). Over-the-counter drugs and medicines (other than insulin) that are for "medical care" will not constitute an Eligible Medical Expense unless you or your eligible dependents have obtained a prescription from a provider authorized by state law (e.g., a physician). Insulin and over-the-counter products and devices other than drugs or medicines will still constitute an Eligible Medical Expense even if not prescribed by a physician to the extent that they are for medical care. The Health FSA may reimburse no more than two over-the-counter (OTC) drugs or medicines of the same kind purchased in a single calendar month (even assuming the drug otherwise meets applicable requirements set forth in Q-18, including that it is for medical care under Code Section 213(d)). Not every health related expense you or your Eligible Dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. "Stockpiling" of over the counter drugs (even with a prescription) and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

Special Items for Health FSAs:

Orthodontia Claims: Orthodontia expenses can be prepaid, up to the elected amount, as long as the services are rendered in the same plan year.

Maternity Claims: Maternity claims be reimbursed on an incurred basis. Therefore, reimbursement cannot occur until services are rendered.

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA participant (and any covered dependents) will not be able to make/receive tax favored contributions to a Code Section 223 HSA unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (to the extent such expenses constitute "medical care" as defined in Code Section 213(d)):

(i) Services or treatments for dental care (excluding premiums)
(ii) Services or treatments for vision care (excluding premiums)
(iii) Services or treatments that are preventive care (as described in IRS Notice 2004-23).

You will be able to elect the limited purpose reimbursement option under the plan during the Initial Election Period and/or the Annual Election Period.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers 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).

Q-19. What is an "Eligible Day Care Expense?"

You may be reimbursed for work-related dependent care expenses ("Eligible Day Care Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care Expense:

1. The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A Qualifying Individual is:

(i) An individual age 12 or under who is a "Qualifying Child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child as defined in Code Section 152 (including a brother, sister, step sibling, niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her own support; or

(ii) A Spouse or other tax "dependent" (as defined generally in Code Section 21) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this Dependent Care FSA only, a "Dependent" under Code Section 21 means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d) (applicable to "Qualifying Relatives" as defined in Code Section 152); (ii) the individual is a child of a Participant who is a tax dependent of another taxpayer under Code Section 152 or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (i.e. a child of divorced or separated parents) may only be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child on his or her tax return.

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your Spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your Spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight camp are not Eligible Day Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, day camps are considered to be for custodial care even if they also provide educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The care is not provided by a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent. Moreover, the care cannot be provided by a parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 503 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Day Care Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-20. What is the maximum annual reimbursement amount under the Health FSA option?

Effective the first Plan Year on or after January 1, 2013, the maximum Salary Reduction contribution that can be made to a Participant's Health Care Account for any Plan Year shall be $2,500 (as indexed for inflation for future years) or such lesser amount as is communicated in enrollment materials.

You will be reimbursed up to the annual reimbursement amount you elect plus any Employer Contributions (if any) allocated to your Health Care Account, not to exceed the Maximum Annual Health Care Reimbursement identified in the Plan Information Summary. If the Employer has elected the Health FSA carryover, your annual reimbursement amount will also include any rollover amounts from the previous Plan Year (up to $500). You may also be required to elect a reimbursement equal to or greater than the Minimum Health Care Reimbursement in the Plan Information Summary. You will be required to pay the full cost of coverage (reduced by any Employer Contributions applied to your Health Care Account by the Employer, if any) with Pre-tax Salary Reductions. Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change. So long as coverage is effective, the full, annual reimbursement applicable to you, reduced by the amount of previous Health FSA reimbursements received during the Year, will be available at any time during the Plan Year, without regard to the amount of Pre-tax Salary Reductions that have been applied towards the cost of your Health FSA coverage.

Q-21. What is the maximum annual reimbursement of Eligible Day Care Expenses available under the Dependent Care FSA?

The annual reimbursement amount you elect cannot exceed the Maximum Annual Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The Maximum Annual Dependent Care Reimbursement amount is currently $5,000 per Plan Year if:

- You are married and file a joint return;
- You are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or

- You are single.

If you are married and reside together, but file a separate federal income tax return, the Maximum Annual Dependent Care Reimbursement amount that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the Plan Year cannot exceed the lesser of your Earned Income (as defined in Code Section 32) or your spouse's Earned Income.

Your Spouse will be deemed to have Earned Income of $200 if you have one Qualifying Individual and $400 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is:

(i) Physically or mentally incapable of caring for himself or herself, or

(ii) A full-time student (as defined by Code Section 21).

You will be reimbursed up to the annual reimbursement amount you elect plus any Employer Contributions (if any) allocated to your Dependent Care Account, not to exceed the maximum annual reimbursement identified above. You will be required to pay the full cost of coverage (reduced by any non-elective Employer Contributions applied to your Dependent Care Account by the Employer) with Pre-tax Salary Reductions. **Unlike the Health FSA, you are only entitled to receive reimbursement under a Dependent Care FSA up to Dependent Care Account balance at the time the request for reimbursement is made.**

Q-22. How do I receive reimbursement under the Flexible Spending Account Component?

When you incur an Eligible Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. 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:

1. Name of person receiving service
2. Name and address of service provider
3. 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
4. Amount of reimbursable expense under the plan
5. Date(s) of service (i.e., the substantiation for Eligible Day Care Expenses provided over more than 1 day should identify the beginning and end dates of the service)

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Expense, you will receive notification of this determination. You must submit all claims for reimbursement during the Plan Year in which they were incurred or during the Run Out Period. The Run Out Period is described in the Plan Information Summary.

NOTE: You cannot use the Health Care Account to reimburse Eligible Day Care Expenses and you cannot use the Dependent Care Account to reimburse Eligible Medical Expenses.

Electronic Payment Card: If your employer offers this option, the Electronic Payment Card (the "Card") allows you to pay for Eligible Expenses and Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works. **NOTE: The Plan Administrator reserves the right to offer the Card for use under one option or the other but not both.**

(a) *You must make an election to use the card.* In order to be eligible for the Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Cardholder Agreement issued in conjunction with the Card, including any fees applicable to participate in the Program, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program when you first enroll and during each Annual Election Period. The Card will not be activated if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period.

(b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable election period that the Card will only be used Eligible Expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) *Reimbursement under the Card is limited to certain merchants.* Use of the Card is limited to merchants identified by the Plan Administrator or its designee as an eligible merchant. In addition, the Card will be administered in accordance with applicable IRS guidance.

(e) *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 or day care 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 under the Health Care Account or Dependent Care Account (whichever is applicable). 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.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement 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).

If the expense is for a prescribed over-the-counter drug or medicine, the written statement must indicate the name of the drug or medicine or a copy of the box top must be included

- The date the expense was incurred or the period during which the services were provided (for example, Day Care Expenses should show the period during which the services were provided if payment is made for than one day).
- The amount of the expense.

You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement is generally required to be submitted (except as otherwise provided in the Cardholder Agreement or as otherwise permitted under applicable law and associated guidance). You will receive a notification from the Claims Administrator if a third party statement is needed. You must provide the third party statement to the Claims Administrator within the period identified in the notification from the Claims Administrator. The Card may not be used to purchase over-the-counter drugs or medicines at merchants (e.g., pharmacies and drug stores) utilizing an inventory information approval system (IIAS).

(g) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the Plan for the unsubstantiated expense as set forth below. In addition, your usage of the card may be terminated by the Employer.

(h) If the Plan Administrator decides to offer electronic payment cards as a payment option under the Dependent Care FSA, you may only use the Card to pay for Eligible Day Care Expenses incurred after you have properly substantiated an initial Day Care expense (the "Original Day Care Expense) for which you do not receive reimbursement under the Plan. Once you have "incurred" the Original Day Care Expense at a particular day care provider, you should submit the appropriate substantiation regarding this expense to the Third Party Administrator on or after the period during which the day care provider provided services or treatments (the "Service Duration"). If the Original Day Care Expense is determined to be an Eligible Day Care Expense, the Third Party Administrator will allocate to your Card an amount equal to the lesser of the amount of the Original Day Care Expense or the Dependent Care Account balance. The Third Party Administrator will continue to allocate amounts equal to the lesser of the Original Day Care Expense or your Dependent Care Account balance each time you use the card at the same day care provider, for the same or lesser amount, and during the same Service Duration periods. Any increase in the amount, day care provider and/or service duration period will require you to begin the process over with a new Original Day Care Expense before you can use the Card again.

(i) *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.

Q-23. When must the expenses be incurred in order to receive reimbursement?

Eligible Expenses must be incurred ***during*** the Plan Year and while you are a participant in the applicable Flexible Spending Account option. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are

provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the Flexible Spending Account Component coverage becomes effective or after coverage ends (unless you elect to continue Health FSA coverage in accordance with COBRA).

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the applicable Account that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period," if adopted, will be described in the Plan Information Summary.

Q-24. What if the Eligible Expenses I incur during the Plan Year are less than the annual amount available for reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred and properly submitted for reimbursement and the maximum annual reimbursement available to you under the Applicable Account, unless the Employer has elected to allow carryovers (which are applicable only under the Health FSA). Unless this carryover has been elected, any amount allocated to an Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the Run Out period described in the Plan Information Summary. Amounts so forfeited shall be used in accordance with applicable rules and regulations.

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Account(s) that are unused at the end of the Plan Year may also be used to reimburse eligible expenses incurred during the grace period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year and during the grace period will be forfeited.

If the Employer has elected to allow carryovers under the Health FSA, Health FSA balances that are unused for a Plan Year may be used for reimbursement of eligible Health FSA expenses incurred at any time in the subsequent Plan Year (in addition to the amount that is otherwise available for reimbursement in the subsequent Plan Year). Please keep in mind that the Employer may not implement both a carryover and a grace period under the Health FSA (although the Health FSA carryover would not affect a grace period under the Dependent Care FSA).

Q-25. What happens if a Claim for reimbursement is denied?

You will have the right to a full and fair review process. If you are denied reimbursement under a Flexible Spending Account Component option, your claim will be reviewed in accordance with the claims review procedures set forth in the Claims Review Procedure Appendix ("Appendix I") attached to this SPD.

Q-26. What happens to unclaimed reimbursements?

Any reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Expense was incurred shall be forfeited.

Q-27. What is COBRA continuation coverage?

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the employer is a "small employer" or the Health FSA is a church plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee's Termination of employment or reduction in hours of employment	√	√	√
2. Divorce or Legal Separation		√	
3. Child ceasing to be an eligible dependent			√
4. Death of the covered employee		√	√

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health FSA upon the occurrence of any event that

permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the COBRA Administrator (if a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) date of the event (ii) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g., divorce decree).

An employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be

notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);

- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;

- if you become entitled to Medicare; or

- if the employer no longer provides group health coverage to any of its employees.

Q-28. What happens if I receive erroneous or excess reimbursements?

If it is determined that you have received payments under this Flexible Spending Account Component that exceed the amount of Eligible Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a qualifying dependent), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification. (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Expenses submitted for reimbursement (in accordance with applicable law) or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i) – (iii), the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

Q-29. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies with respect to the Health FSA.

Q-30. How long will the Flexible Spending Account Component of this Plan remain in effect?

Although the Employer expects to maintain the Flexible Spending Account Component indefinitely, it has the right to modify or terminate the Component at any time and for any reason.

Q-31. How does this Health FSA interact with a Health Reimbursement Arrangement (HRA) Sponsored by the Employer? (Only if Applicable)

Typically, a Health FSA is the payor of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an HRA sponsored by the Employer that covers expenses covered by this Health FSA, the employer may require the Health FSA pay first, rather than the HRA. If the Health FSA pays first, you must exhaust your Health Care Account before using funds allocated to your HRA. The Plan Information Summary will indicate whether the Health FSA or HRA must pay first.

MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

ERISA Rights (not applicable to non-ERISA Plans)

The Health FSA Plan may be an ERISA welfare benefit plan if your employer is a private employer. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents will have to pay for such coverage. You should review Q-27 of this Health FSA Summary for more information concerning your COBRA continuation coverage rights.

(To the extent the Health FSA is subject to HIPAA's portability rules) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the 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 from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the 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 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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 Employee Benefits Security Administration.

HEALTH SAVINGS ACCOUNT CONTRIBUTION SUMMARY

This Summary applies only to the extent that health savings accounts are identified in the Plan Information Appendix as a Benefit Option offered through the Plan.

Q-32. 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).

Q-33. 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.

Q-34. 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.

Q-35. 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).

Q-36. 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 Q-2 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.

Q-37. 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.

PLAN INFORMATION SUMMARY

This Appendix provides information specific to the **Section 125 Cafeteria Pl**an**.** The Effective Date of this Plan Information Summary is November 1, 2016 **.** This Plan Information Summary replaces and supersedes any other Plan Information Summary with an earlier effective date.

I. EMPLOYER/PLAN SPONSOR/THIRD PARTY ADMINISTRATOR INFORMATION

A. Name, address, and telephone number of the Employer/Plan Sponsor:	South San Antonio ISD 5622 Ray Ellison Dr. San Antonio, TX 210-977-7000
B. Name, address, and telephone number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan.	**National Plan Administrators** **P.O. Box 161630** **Austin, TX 78716** **(512) 327-6481**
C. Effective Date of the Plan: This is the date that the Plan was first established.	October 1, 2011
D. Effective Date of this SPD	November 1, 2016
E. Plan Year:	November 1, 2016 - October 31, 2017
Health or Dependent Care FSA Plan Year, if Different:	Health FSA: n/a Dependent Care FSA: n/a
F. Third Party Administrator:	**National Plan Administrators**
G. Applicable State Law	**State of Texas**
H. Run-Out Period	90 **days**

II. PLAN INFORMATION

(A) **Eligibility Requirements and Eligibility Date**. Each Employee who work 20 hours per week or 50% of their regular work hours ("Eligibility Requirements") will be eligible to participate in this Plan on first day of the month following date of hire.

The Employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in this SPD. Eligibility for coverage under any given Benefit Option shall be determined not by this Plan but by the terms of that Benefit Option.

(B) **Qualified Reservist Distribution.** The Qualified Reservist Distribution described in the Health FSA component of this SPD **is not** offered under the plan.

If the Employer has adopted the Qualified Reservist Distribution, you must meet the following criteria in order to be eligible to receive such distribution:

- be a member of a "reserve component" (as defined in section 101 of title 37 of the United States Code), which means a member of the Army National Guard; the Reserve for the U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard; Air National Guard of the United States; or the Reserve Corps of the Public Health Service;
- be called or ordered to active military duty for (i) 180 days or more or (ii) for an indefinite period; and
- be a Participant in the Health FSA on the date you are called or ordered to duty.

If the Employer has adopted the Qualified Reservist Distribution and you believe you are eligible for a Qualified Reservist Distribution, you must contact the Plan Administrator to request a distribution request form as soon as possible. A request for a Qualified Reservist Distribution must be made in writing on the form provided by the Plan Administrator. You must submit a copy of your order or call to active duty along with your request. Requests for a Qualified Reservist Distribution must be made on or after the date of the order or call to duty but before the last day of the Plan Year (or grace period, if applicable) during which the order or call to duty occurred. You will receive your Qualified Reservist Distribution within a reasonable period of time, but no later than sixty (60) days after your request has been received.

A Qualified Reservist Distribution will be made based on all salary reduction amounts credited to your Health FSA for the applicable Plan Year that have not been applied to provide Health FSA Reimbursements submitted before the Qualified Reservist Distribution request is submitted. Claims incurred and submitted but not yet reimbursed at the time the Qualified Reservist Distribution Request is received will be treated like any other claim submitted for reimbursement under the Health FSA. The Plan Administrator will determine what this amount is on a uniform basis, consistent with applicable law and IRS interpretations. Notwithstanding any other provision of this Plan, an individual who has selected a Qualified Reservist Distribution shall be considered to have made such election as an alternative to COBRA or USERRA coverage continuation for the Health FSA (except as may otherwise be required by applicable law). If you elect to receive a Qualified Reservist Distribution, you forfeit any right to reimbursement for medical expenses incurred after the date of the Qualified Reservist Distribution request that would otherwise be available under the Plan.

Unlike your reimbursements from your Health FSA for Eligible Medical Expenses, the amount of your Qualified Reservist Distribution is taxed as income and will be reported as income on your W-2.

Qualified Reservist Distributions do not apply to amounts in your Dependent Care FSA.

(C) **Annual Election Rules**. With respect to Pre-tax Salary Reduction elections (other than the Health FSA and Dependent Care FSA and HSA elections), failure to make an election during the Annual Election Period will result in the one of following deemed election(s):

[**X**] The employee will be deemed to have elected not to make Pre-tax Salary Reductions during the subsequent plan year.

[N/A] The employee will be deemed to have elected to continue his or her Benefit Option elections in effect as of the end of the Plan Year in which the Annual Election Period took place. This is called an "Evergreen Election."

(D) **Change of Election Period**: If you experience a Change in Status Event or Cost or Coverage Change as described in the SPD and in the Election Change Chart Appendix, you may make the permitted election changes described in the Election Change Chart Appendix if you complete and submit an election change form within **30 days** after the date of the event. If you are participating in an insured arrangement that provides a longer election change period, the election change period described in the insurance policy will apply.

(E) **Benefit Options**: The Employer elects to offer to eligible Employees the following Benefit Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Options. These Benefit Option(s) are specifically incorporated herein by reference. The maximum Pre-tax Salary Reduction that may be made via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Options selected reduced by any Employer Contributions, if any. It is intended that such Pre-tax Salary Reduction amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

The following Benefit Options are made available under the Plan to all those eligible Employees who make an appropriate election.

1. ☑ Health FSA Option

2. ☑ Dependent Care FSA Option

3. ☐ Health Savings Account Option

4. ☑ Medical Option

5. ☑ Dental Option

6. ☑ Vision Option

7. ☑ Cancer Option

8. ☑ Heart/Stroke Option

9. ☑ Accident Option

FLEXIBLE SPENDING ACCOUNT

(F) **Annual Health Care Reimbursement Amounts**. The Maximum Annual Health Care Reimbursement Amount each year is $2,550 (Participant contribution may not exceed $2,550, as indexed for inflation in future years). The minimum reimbursement amount that may be elected under the Health FSA is $120.

(G) **Run Out Period.** The Run-Out Period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

(i) The Run-Out Period for active employees ends 90 **days**.

(ii) The Run-Out Period for terminated employees ends 30 **days.**

(H) **Interaction with HRA.** See below regarding this Health FSA's rules with respect to coordination with an HRA:

Does the Employer sponsor an HRA?	[**No**]

III. GRACE PERIOD

The Employer has not adopted a Grace Period.

(If indicated above that the Employer has adopted the grace period, the following rules apply) The Employer has established a "grace period" for the Dependent Care FSA/Health FSA that follows the end of the Plan Year during which amounts you have allocated to the applicable spending account(s) that are unused at the end of the Plan Year may be used to reimburse eligible expenses (with respect to the applicable spending account) incurred during the grace period.

The grace period will begin on the first day of the next Plan Year and will end no later than two (2) months and fifteen days after the beginning of the plan year. For example, for a calendar year plan, if the Plan Year ends December 31, 2013, the grace period begins January 1, 2011 and ends March 15, 2014.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available

to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. This may be impact the potential reimbursement of eligible expenses incurred during the Plan Year to which the grace period relates to the extent such expenses have not yet been submitted for reimbursement. Previous claims will not be reprocessed or recharacterized so as to change the order in which they were received.

For example, assume that $200 remains in your Health FSA sub-account at the end of the 2007 Plan Year and further assume that you have elected to allocate $2400 to the Health FSA for the 2008 Plan Year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred on January 15, 2008, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the 2007 Plan Year and the remaining $300 will be paid out of amounts allocated to your Health FSA for 2008.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period described in this SPD. This is the same Run-out Period for expenses incurred during the Plan Year to which the grace period relates. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-out Period.

- You may not use Health FSA amounts to reimburse Eligible Day Care Expenses (and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses).

- There can be no carryover of Health FSA amounts to the next Plan Year if the grace period is elected.

IV. HEALTH FSA CARRYOVER

The Employer ___has___ adopted the Health FSA Carryover. The carryover amount is $ 500.00 (must be $500 or less).

(If indicated above that the Employer has adopted the Health FSA Carryover, the following rules apply):

Health FSA balances that are unused for a Plan Year may be used for reimbursement of eligible Health FSA expenses incurred at any time in the subsequent Plan Year (in addition to the amount that is otherwise available for reimbursement in the subsequent Plan Year), if the following conditions apply:

- No more than $500 of the unused amount for a Plan Year ("Carryover Maximum") may be rolled over for use in the subsequent Plan Year (or any lesser amount selected by the Employer, as indicated above).

- The specific Carryover amount is generally determined at the end of the run out period following such Plan Year ("Carryover").

    - For example, if you have an unused Health FSA balance at the end of the 2013 Plan Year equal to $1000, and you have no other expenses that were incurred in 2013, your 2013 Carryover amount that may be used in the 2014 Plan Year is $500. However, if you have 2013 Plan Year expenses equal to $600 that you timely submit during the run out period for the 2013 Plan Year, then your 2013 Carryover amount that may be used in the 2014 Plan Year will only be $400.

- If you incur an eligible expense during a Plan Year ("Current Year Expense") but before the end of the prior Plan Year's run out period, the plan administrator may, at its discretion, apply up to $500 of the amount unused *at the end of the prior Plan Year* (if any) towards the Current Year Expense. NOTE: This will reduce the amount that is available to reimburse expenses incurred during the prior Plan Year ("Prior Year Expenses") submitted during the prior Plan Year's run out period and it will reduce the Carryover Maximum by the same amount.

    - For example, assume that you have $800 at the end of the 2013 Plan year and you have elected $2500 for the 2014 Plan Year. On February 1, 2014, you incur a $2700 eligible medical expense. The entire $2,700 expense will be reimbursed with the $2,500 elected for 2014 and $200 of the $800 unused at the end of the 2013 Plan Year. However, only $600 will be available for 2013 Plan Year expenses submitted during the run out period for the 2013 Plan year and your 2013 Carryover Maximum is reduced to $300 ($500 maximum minus the $200 already used). Further assume that after reimbursement of the $2,700 expense that was incurred on February 1, 2014 but before the end of the run out period for the 2013 Plan Year, you submit a $750 expense incurred in 2013. Only $600 of that 2013 expense will be reimbursed and you will have no 2013 Carryover for use in the 2014 Plan Year.

- The Carryover does not count against the maximum salary reduction election.

- If you are otherwise eligible for the Health FSA for a Plan Year but you do not make an election to participate, you may still use any Carryover from the prior Plan Year for Current Year Expenses and Prior Year Expenses (in accordance with terms of the Plan and the ordering rules described above).

- Under IRS rules, if you have unused Health FSA amounts on the last day of a Plan Year in a general purpose Health FSA (i.e., anything other than a $0 balance), you (and your spouse, if you are married) cannot contribute to an HSA during the following plan year. For this purpose, whether you have unused Health FSA amounts is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not the claims have been submitted). Unless, based on IRS clarification, the Employer allows you to waive any Carryover eligibility and/or direct such amounts to a limited purpose Health FSA (if offered), you must exhaust your general purpose Health FSA account prior to the last day of the Plan Year to retain HSA eligibility.

- You must be a participant in the Health FSA as of the last day of the Plan Year to benefit from the Carryover. Termination of employment and cessation of eligibility will generally result in a loss of Carryover eligibility unless a COBRA election is made.

- The Employer may not elect both a carryover and a grace period under the Health FSA.

APPENDIX I

CLAIMS REVIEW PROCEDURE APPENDIX

The Effective Date of this Appendix I is November 1, 2016. It should replace and supersede any other Appendix I with an earlier date.

The Plan has established the following claims review procedure in the event you are denied a benefit under the Flexible Spending Account Component of this Plan. The procedure set forth below does not apply to benefit claims filed under the Benefit Options other than the Health FSA and Dependant Care FSA.

Step 1: *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party **Administrator**, review it carefully. The notice will contain:

a. the reason(s) for the denial and the Plan provisions on which the denial is based;
b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Third Party Administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from Third Party Administrator.* If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision and you wish to appeal, you must file a written appeal with the Plan

Administrator within the time period set forth in the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- The Plan Administrator is required to give the Participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- You cannot file suit in federal court until you have exhausted these appeals procedures; however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision; and
- Each Participant has the right to request and obtain documents, records and other information as it pertains to their Benefit Plan(s).

APPENDIX II

ELECTION CHANGE APPENDIX

The Effective Date of this Appendix II is November 1, 2016. It should replace and supersede any other Appendix II with an earlier date.

The following is a summary of the election changes that are permitted under this Plan. Also, election changes that are permitted under this Plan may not be permitted under the Benefit Option (e.g., the insurance carrier may not allow a change). If a change is not permitted under a Benefit Option, no election change is permitted under the Plan. Likewise, a Benefit Option may allow an election change that is not permitted by this Plan. In that case, your pre-tax reduction may not be changed even though a coverage change is permitted. For a description of the election change rules for Health Savings Accounts, see the Health Savings Account Contribution Component Summary above.

1. **Change in Status**. Election changes may be allowed if a Participant or a Participant's Spouse or Dependent experiences one of the Change in Status Events set forth in the chart. The election change must be on account of and correspond with the Change in Status Event as determined by the Plan Administrator (or its designated Third Party Administrator). With the exception of enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective (generally the first of the month following the date you make a new election with the Third Party Administrator but it may be earlier depending on the Employer's internal policies or procedures). As a general rule, a desired election change will be found to be consistent with a Change in Status Event if the Change in Status affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving a divorce, annulment or legal separation, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, an election to cancel accident or health benefits for any individual other than the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent. Contact the Third Party Administrator for more information.

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the

plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Gain of Coverage Eligibility under another Employer's Plan*. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under another employer's cafeteria plan or benefit plan as a result of a change in marital status or a change in the Participant's, the Participant's Spouse's, or the Participant's Dependent's employment status, an election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Dependent Care Reimbursement Plan Benefits.* With respect to the Dependent Care FSA benefit, an election change is permitted only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care FSA expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.
- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Options offered under the Plan.)* For group term life insurance, disability income and accidental death and dismemberment benefits only if a Participant experiences any Change in Status (as described above), an election to either increase or decrease coverage is permitted.

  Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If a Participant, Participant's Spouse and/or Dependent are entitled to special enrollment rights under a Benefit Option that is a group health plan, an election change to correspond with the special enrollment right is permitted. Thus, for example, if an otherwise eligible employee declined enrollment in medical coverage for the employee or the employee's eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal

separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), the employee may be able to elect medical coverage under the Plan for the employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee gains a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may also be able to enroll the employee, the employee's Spouse, and the employee's newly acquired Dependent, provided that a request for enrollment is made within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Effective April 1, 2009, if an un-enrolled but otherwise eligible Employee or such Employee's dependent (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act due to a loss of eligibility for coverage under Medicaid or SCHIP; or (2) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the Employee is entitled to special enrollment rights under a Benefit Plan Option that is a group health plan and an election change to correspond with the special enrollment right is permitted. However, you must request enrollment **within 60 days** after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for premium assistance subsidy, as applicable. Please refer to the group health plan summary description for an explanation of special enrollment rights. Note: This only applies to a Health FSA to the extent that the Health FSA is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires a Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, an election change to provide coverage for the Dependent child identified in the order is permissible. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If a Participant or the Participant's Dependents become entitled to Medicare or Medicaid, an election to cancel that person's accident or health coverage is permitted. Similarly, if a Participant or Participant's Dependents who have been entitled to Medicare or Medicaid loses eligibility for such, you may elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the cost of a Benefit Option significantly increases, a Participant may choose to make an increase in contributions, revoke the election and receive coverage under another Benefit Option that provides similar coverage, or drop coverage altogether *if no similar coverage exists*. If the cost of a Benefit Option significantly decreases, a Participant who elected to participate in another Benefit Option may revoke the election and elect to receive coverage provided under the Benefit Option that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Plan may elect to participate in the Benefit Option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Option options, however, Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Health FSA, to the extent offered under the Plan.)

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If coverage under a Benefit Option is significantly curtailed, a Participant may elect to revoke his or her election and elect coverage under another Benefit Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, a Participant may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, a Participant may revoke his or her election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, a Participant may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, a Participant may change his or her election to add coverage under this Plan for the Participant, the Participant's Spouse or Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Health FSA, to the extent offered under the Plan.)

APPENDIX III TO THE CAFETERIA PLAN SUMMARY PLAN DESCRIPTION

Summary of Health FSA HIPAA Privacy Policies and Procedures

OUR 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 FSA claims reimbursed under the Plan for Plan administration purposes. This summary applies to all of the medical records we maintain with regard to the Health FSA. Your personal doctor or health care provider will have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. During the course of providing you with health coverage under the Health FSA, the Plan will have access to information about you that is deemed to be "protected health information", or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. In accordance with the Plan, the following is a summary of procedures adopted by the Employer to ensure that both Employer and any third party service providers treat your PHI with the level of protection required by HIPAA. You may receive a separate notice that provides more detailed information regarding the procedures adopted by Employer.

This summary will provide you with a general overview of the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. **In the event this summary conflicts with the separate Privacy Notice from Employer, the separate Privacy Notice controls.**

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer. Except as otherwise provided in the separate Privacy Notice that may be provided to you, these employees consist of the members of the Personnel Benefits Department of Employer who assist in administration of Health FSA claims. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action. Employer will establish a mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

By adoption of the SPD, Employer has certified that it will comply with the privacy procedures summarized herein and detailed in any separate privacy notice. Employer may not use or disclose your PHI other than as summarized herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information for purposes of Health FSA administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations). 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.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious 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.

SPECIAL SITUATIONS

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

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers Compensation. We may release medical information about you for workers compensation or similar programs.

Public Health Risks. We may disclose medical information about you for public health activities (e.g., to prevent or control disease, injury, or disability).

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Personnel/Benefits Office, except as otherwise set forth in any separate Privacy Notice provided to you by Employer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. Employer will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Personnel/Benefits Office. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.
- Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. Employer may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations. You will be notified of where you can obtain an accounting of disclosure in the separate Privacy Notice. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. For example, Employer does not have to account for disclosures of your PHI (i) to carry out treatment, payment or healthcare operations, (ii) to correctional institutions or law enforcement officials, or (iii) for national security or intelligence purposes. Employer will not include in your accounting any of the disclosures for which there is an exception under HIPAA. Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Personnel Office except as otherwise provided in the separate privacy notice. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

When Employer no longer needs PHI disclosed to it by the Plan, for the purposes for which the PHI was disclosed, Employer must, if feasible, return or destroy the PHI that is no longer needed. If it is not feasible to return or destroy the PHI, Employer must limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE

We reserve the right to change this summary and the separate Privacy Notice that may be provided to you. 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. The notice will contain the effective date on the front page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Personnel Office except as otherwise provided in the separate Privacy Notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

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:

Enclosed you will find the forms to be used for submitting claims. Extra forms are available online at www.natlplan.com/employees.html and in the Participant Portal at www.wealthcareadmin.com.

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 _____ 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 January 31, 2017) 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.

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 the claim 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. For ALL medical expenses, itemized billings must be submitted to NPA for reimbursement. A cancelled check or cash register receipt cannot be accepted. The receipt must include the following information:
    - Date of service,
    - Description of services provided,
    - Patient name,
    - Provider name/ address,
    - Total amount of payment for which you are seeking reimbursement,
    - An Explanation of Benefits (EOB) from an insurance company, if applicable, must also be submitted.
    - Over the counter drugs must be accompanied by a written prescription from a doctor.

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. 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.

See following page for complete instructions.

	EXAMPLE	EXPENSE #1	EXPENSE #2	EXPENSE#3	EXPENSE #4
Date(s) Service Actually Provided	***10/1/13***				
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 Copay, 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

DEPENDENT CARE REIMBURSEMENT 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. See the following page for complete instructions.

	EXAMPLE	EXPENSE #1	EXPENSE #2	EXPENSE#3	EXPENSE #4
Date(s) Dependent Care Service Provided	**09/1/13 to 10/31/13**	_____ to _____	_____ to _____	_____ to _____	_____ to _____
Name and Age of Dependent	**Fred Jones Age 4**				
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**	$	$	$	$

Dependent Care Total Amount Claimed:	**$**

To the best of my knowledge and belief, my statements in this Dependent Care Reimbursement Request Form are complete and true. I understand that these dependent care expenses may not be used to claim any Federal Income Tax deductions or credit (including the Dependent Care Tax Credit). I agree to file IRS form 2441 with my tax return and provide any taxpayer identification number required thereon. I also acknowledge that should the actual annual expenses claimed be less than the amount available, such balance will be forfeited and will 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

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)

PARTICIPANT PORTAL ONLINE ACCOUNT ACCESS

Your Section 125 Cafeteria Plan with South San Antonio ISD allows you to have access to your Medical and/or Dependent Care Reimbursement account online. Please visit our administration website **www.wealthcareadmin.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 NPASOUTHSAN 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