

Summary Plan Description Newark BOE

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Introduction to the Flexible Spending Account Plan

The **Flexible Spending Account** Plan (FSA) is a benefit plan offered to eligible employees of Newark Board of Education. There are two types of accounts available to you: **Health Care FSA** and **Dependent Day Care FSA**. These accounts allow you to pay for eligible health care and dependent day care with pre-tax dollars (for further information see "Contributions").

A **Health Care FSA** is used for eligible health care expenses incurred by you or your dependents. A **Dependent Day Care FSA** is used for eligible dependent day care expenses you must pay so that you (and your spouse, if you are married) can work or attend school. You may participate in a **Health Care FSA** or a **Dependent Day Care FSA** (for further information see "Expenses"). Money allocated to each account cannot be used to pay for a claim on another account. For example, money allocated for dependent day care expenses cannot be used to pay for a medical service.

You make contributions to your account(s) through payroll deductions. These deductions are made before taxes are taken out and, because these deductions lower your taxable salary, you may pay less in taxes.

When you incur **eligible Health Care or Dependent Day Care** expenses covered under your account(s), you submit a reimbursement request form, with the required third-party documentation, to WEX. WEX will review your claim and, if approved, reimburse you for eligible expenses.

It is very important that you estimate your expenses carefully. Internal Revenue Service (IRS) regulations require that if you do not incur eligible medical and dependent day care expenses by the end of the Plan Year, you must forfeit any money remaining in your health care and dependent day care accounts. This is known as the "use-it-or-lose-it" rule.

For **Health Care and Dependent Day Care FSA's**, you may submit reimbursement requests throughout the **Plan Year**. You have until 60 days after the plan year ends to submit your requests to WEX. You will lose any money remaining in your account after February 28 or 60 days after your termination date, whichever comes first - whether you have incurred eligible expenses or not.

Definitions for terms in bold face type may be found in the Definition of Terms section at the end of this document.

Please read this Summary Plan Description carefully. It summarizes the provisions of the Plan and will help you to take full advantage of this benefit provided to you by Newark Board of Education .

Newark Board of Education offers the Flexible Spending Account Plan to all eligible employees as a supplementary benefit.

WEX|PO Box 2663, Fargo, ND 58108

General Plan Information

Plan Name The official name of this benefit is the Flexible Spending Account Plan. It may also be referred to as the "Plan" or the "FSA."

Plan Identification 504

Type of Plan A Cafeteria Plan under Code Section 125.

Period of Coverage The period of coverage for this Plan is a 12-month period beginning on January 1 and ending on December 31.

Plan Year

The Plan Year for incurred expenses is from January 1 through December 31. Expenses may not be carried over from one Plan Year to the next except for health and dependent day care expenses that may be carried over through the designated 60-day grace period. Health Care and Dependent Day Care claims for incurred expenses may be submitted until 60 days after the end of the Plan Year or 60 days after you terminate employment if you terminate employment during the plan year.

Plan Administrator

Newark Board of Education is the Plan Administrator. The Plan Administrator has the discretionary authority to resolve any questions regarding the Plan, including the authority to interpret the terms of the Plan and to determine eligibility for and entitlement to the Plan benefits. The Plan Administrator assumes all duties and responsibilities, including fiduciary duties imposed upon the Plan Administrator by ERISA. The address of the Plan Administrator is:

WEX
c/o Newark Board of Education
PO Box 2663
Fargo, ND 58108

The company has contracted with WEX to provide day-to-day:

- Processing of the Plan reimbursement requests
- Determination of expense and dependent eligibility
- Documentation for claims, and

You may direct questions regarding any of these issues to:

WEX
PO Box 2663
Fargo, ND 58108



- Opinions on claims appeals

Phone: 877-837-5017

Fax: 253-793-3766

Plan Funding

All expenses reimbursed through this Plan are funded by the pre-tax contributions to the employee's FSA account(s). You may receive information concerning your account balances by contacting WEX at 877-837-5017 or by contacting your local Human Resource department.

Legal Actions

All legal processes should be served to:

WEX
c/o Newark Board of Education
PO Box 2663
Fargo, ND 58108

Eligibility

You are eligible to participate in the Plan regardless of how few hours you work. If you were not at work on the day coverage would begin, your coverage will become effective on the day you return to work.

Per Diem, seasonal, occasional or temporary employees are not eligible to participate in the Plan.

Dependent Status

Under your Health Care FSA, eligible dependents are any individual who is your tax dependent, but not applying the requirements that (1) an individual who is the dependent of another taxpayer is treated as having no dependents, (2) a married individual who files a joint return cannot be a dependent, and (3) gross income of a "qualifying relative" must be less than the exemption amount and with the following exception, (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents).

For purposes of this section a "qualifying relative" is defined as an individual who (1) has a relationship with the taxpayer as set forth in federal law, such as child, brother or sister, or father or mother, (2) receives over one-half of his or her support from the taxpayer and (3) has income that does not exceed the exemption amount for the tax year.

Notwithstanding the above, your Health FSA may reimburse the expenses of for your child until the calendar in which your child reaches age 26.

Under your Dependent Day Care FSA, dependents are defined as your children who are younger than the age of thirteen and any dependent adult (including your spouse) who is physically or mentally disabled and unable to care for him/herself. Children and adults that you do not claim as dependents on your

federal income taxes and any children age thirteen and older do not qualify as eligible dependents under your Dependent Day Care FSA. Under certain circumstances, the custodial parent may be reimbursed through their Dependent Day Care FSA for childcare, even if the child is not claimed as a dependent for tax purposes. Please contact a qualified tax expert for advice if you are unsure if you can claim your child as a dependent for your FSA under IRS rules.

Enrollment

Annually, you may enroll in the FSA Plan during Newark Board of Education's Open Enrollment Period. Open enrollment occurs during the fourth quarter of each year. Your enrollment during this period will be effective for the coming plan year.

If you are hired during the plan year, you may enroll on the first of the month following 30 days of employment. If you qualify to begin participation you must complete your enrollment no more than 30 days after your hire date. If you enroll after the Open Enrollment period, the maximum amount you may contribute to the Plan may be prorated.

If you experience a Qualifying Change in Life Status, you may enroll or make changes in your contributions to an existing Health Care or Dependent Day Care FSA within 30 days of the qualifying change in life status. If you qualify to begin or change your participation you must complete your enrollment within 30 days of your Qualifying Change in Life Status. The change in your contribution must correspond to your change in life status. The Plan Administrator will evaluate requests for changes in contributions on a case-by-case basis. Documentation of the change in life status may be required. If you enroll or change your contribution election to your existing FSA due to a Qualifying Change in Life Status the maximum amount you may contribute to your account will be pro-rated for the remainder of the plan year.

If you choose not to enroll in a Health Care or Dependent Day Care FSA when you are first eligible, you may then only enroll during Newark Board of Education's next Open Enrollment period or if you experience a Qualifying Change in Life Status.

If you leave employment with Newark Board of Education and return within the same calendar year, you must make a new election if you choose to participate. Your payroll deductions will be adjusted accordingly.

Termination in the Plan will be effective on the date of your termination from the company.

You must re-enroll during the Open Enrollment period each year if you wish to continue to participate in the FSA Plan.

Contributions

You decide how much to contribute to your **FSA** within certain minimum and maximum limitations. Your **annual contribution** must meet the criteria set below.

- The **minimum contribution** for a **Health Care** or **Dependent Care FSA** is \$0 per year.
- The **maximum contribution** for a **Health Care** is \$3,300 per year.
- The **maximum contribution** for a **Dependent Day Care FSA** is \$5,000 per year. If you are married and filing separate tax returns, your **maximum contribution** for a **Dependent Day Care FSA** is \$2,500 per year. If you are married and your spouse participates in a separate **Dependent Day Care FSA**, your **maximum contribution** is \$2,500 per year.

All contributions to the **FSA** must be made through payroll deductions. IRS regulations do not allow contributions from one **FSA** to be transferred to another **FSA** for any reason.

Changing Your Contribution

You may only change your contribution to the Health Care FSA and Dependent Day Care FSA during the year if you experience a **Qualifying Change in Life Status**. **Qualifying changes in life status** are limited to:

- Marriage, divorce, or legal separation
- Birth, adoption, or placement of a child for adoption
- Death of spouse or dependent
- Change in spouse's employment – loss of employment, commencement of employment, full-time to part-time, or part-time to full-time, disability
- Change in employee's employment - loss of employment, full-time to part-time, or part-time to full-time, disability

You may change your contribution due to one of the above life status changes, however, you may not increase or decrease your election so that your contribution is less than or greater than the allowable limits under the Plan. Also, you may not decrease your contribution to a level so that your annual contribution would equal less than the amount already reimbursed to you.

Your change in contribution must be necessary and consistent with your Qualifying Change in Life Status.

- You may change your Health Care FSA election during the year as a result of changes in your medical, dental or vision plans.
- You may change or terminate your Dependent Day Care FSA election only if the change in Life Status event affects the eligibility of dependent day care expenses for the available tax exclusion.
- You may change your future Dependent Day Care contributions to correspond with a change by your dependent day care provider. For example: if you terminate one dependent day care service provider and hire a new dependent day care service provider, you may change coverage to reflect the cost of the new service provider; and, if you terminated a dependent day care service provider because a relative becomes available to take care of the child at no charge, you may cancel coverage.

The Administrator may modify your election(s) downward during the Plan Year if you are a key employee or a highly compensated individual (as defined by the Code), if this is necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Any new contribution election will remain in effect unless you experience another Qualifying Change in Life Status.

Leave of Absence, Participation, and Contributions

If you take a qualifying leave of absence under the Family and Medical Leave Act of 1993 (FMLA), Newark Board of Education may elect to continue Health Care FSA coverage while you are on paid leave. If so, you will make your contribution on a pre-tax salary reduction basis.

If you take an approved unpaid leave of absence (or paid FMLA leave where coverage is not required to be continued), you may choose to continue your participation in the Health Care FSA Plan. You will not make contributions to the Health Care FSA while on leave of absence. Your pre-tax contributions will be re-amortized at the time you return to active status

Automatic Reduction or Termination of Election

If your compensation available for contribution to the Plan is reduced so that you are not able to contribute the full amount you agreed to contribute at enrollment, your level of contributions and the amount you are entitled to withdraw from your account will automatically be reduced for the remainder of the Plan Year to the amount of salary available for contribution. The amount of the reduction will be taken first from your account for dependent care expense reimbursement, and the balance of the reduction amount shall be taken from your account for health expense reimbursement. Your participation in the Plan will automatically terminate on the day you terminate employment with Newark Board of Education or change employment status from full-time to part-time. Any amounts then credited to your account for health expense reimbursement or dependent care expense reimbursement may be used for these respective expenses which you incurred during the coverage period of that year before the date of termination of your participation in the Plan.

Expenses

Eligible and ineligible expenses for a Health Care FSA and/or a Dependent Day Care FSA may change from year to year due to changes in tax laws. The lists below are only meant to provide a general outline for eligible and ineligible expenses. Before you enroll, you may want to contact WEX, toll free, at 1-877-837-5017 to determine if a particular expense is eligible under current tax laws. A complete description of eligible expenses can also be found in the Internal Revenue Service Publication 502.

Health Care FSA – Eligible Expenses

“Eligible health care expenses” mean expenses incurred by you and/or your dependents for “medical care” as defined in Code Sections 213(d). Generally, this means an item for which you could have claimed a medical care expense deduction on an itemized federal income tax return (without regard to any threshold limitation or time of payment) for which you have not otherwise been reimbursed or could be reimbursed from insurance or from some other source.

You, your spouse, or an eligible dependent must incur these expenses. Only those expenses incurred while you are a participant in the Flexible Spending Account Plan are eligible for reimbursement.

FSA Eligible Health Care Expenses

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| <ul style="list-style-type: none">• Acupuncture• Alcoholism Treatment• Ambulance• Artificial Limb• Autoette/Wheelchair• Bandages• Braille Books and Magazines• Chiropractor• Christian Science Practitioner (for medical care)• Coinsurance• Crutches• Deductibles• Diagnostic Services• Disabled Dependent Medical Care• Drug/Alcohol Addiction Treatment (including lodging and meals, if necessary for treatment)• Drugs and Medicines (prescribed by a physician)• Durable Medical Equipment• Guide Dog• Hearing Aids and Hearing Exams• Home Care• Hospital Services• Inpatient care for treatment of mental or physical handicap | <ul style="list-style-type: none">• Laboratory Fees• Lead Based Paint Removal (to prevent a child who has, or has had, lead poisoning from eating the paint would qualify)• Learning Disability counseling (If prescribed by a physician)• Lodging Essential to Medical Care (e.g. out of town hotel stay to see a specialist to treat a medical condition)• Maternity Care and Related Services• Medical Services (Physician, Surgeon, Specialists)• Medicine prescribed by a physician• Mentally Disabled, Special Home for• Nursing Services (in home if recommended by physician)• Operations• Organ Donor’s Medical Expense and Transportation• Osteopath• Oxygen• Prosthesis• Psychiatric Care• Psychoanalysis• Psychologist• Routine Physical Exam-Wellness Visit, Well Woman Exam |
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- Special Education (with physician's recommendation payments made for a mentally impaired or physically disabled person)
- Special Medical Equipment such as wheelchairs, crutches, and orthopedic shoes
- Sterilization
- Smoking Assist Programs
- Surgery
- Telephone/Television for the Hearing Impaired
- Therapy
- Transplants
- Transportation Essential to Medical Care (e.g. taxi, bus, train fare to physician's office)
- Vasectomy
- Weight-loss Program Prescribed by a Physician as Part of a Treatment Program
- Wig (to replace hair loss due to disease) with letter of medical necessity
- X-rays

Eligible Dental Expenses

- Crowns
- Dentures
- Orthodontics (braces, etc.)
- Preventative and basic procedures (e.g. Teeth cleaning, exam)
- Root canals
- Tooth extractions

Eligible Eye Care Expenses

Optometric services and medical expenses for eyeglasses and contact lenses needed for medical reasons are reimbursable. Eye exams and expenses for contact lens solutions are also reimbursable. However, premiums for contact lens replacement insurance are not reimbursable. Other vision services that are covered include:

- Contact lens cases
- Corrective swim goggles
- Eye charts
- Eyeglass cases
- Eyeglass cleaning supplies such as cleaning cloths
- Reading glasses
- Eyeglass repair or repair kits
- Safety glasses when the lenses correct visual acuity
- Sunglasses or sunglass clips when the lenses correct visual acuity
- Vision shaping

Eligible Over-the-Counter Medication Expenses

The Coronavirus Aid, Relief, and Economic Security Act "CARES Act" states that consumers can purchase OTC drugs and medicines with funds from their health savings account (HSA), flexible spending accounts (FSA) or health reimbursement arrangement (HRA). Consumers may also receive reimbursement for OTC purchases through those accounts. In addition, menstrual products are now considered a qualified medical expense, meaning consumers can pay for or be reimbursed for these products through an HSA, FSA or HRA. This provision is effective for purchases made after December 31, 2019, and for reimbursements of expenses incurred after December 31, 2019. It does not have an expiration date.

- Acetaminophen
- Acne products
- Allergy products
- Antacid remedies
- Antibiotic creams/ointments
- Anti-fungal foot sprays/creams
- Aspirin
- Baby care products
- Band aids
- Bandages and wraps
- Braces and supports
- Catheters

- Cold remedies (including shower vapor tabs and vapor units)
- Contact Lens solutions and supplies
- Contraceptives and family planning items
- Cough syrups and drops
- Denture Adhesives
- Diagnostic tests and monitors and first aid supplies, peroxide and rubbing alcohol
- Eye drops
- Hand sanitizer and sanitizing wipes
- Ibuprofen
- Insulin and diabetic supplies
- Laxatives
- Medical masks
- Menstrual products
- Migraine remedies
- Motion sickness remedies
- Nasal sprays
- Pain relievers
- Sleep aids
- Topical creams for itching, stinging, burning, pain relief, sore healing or insect bites

Health Care FSA – Ineligible Expenses

The items or services listed below are currently ineligible for reimbursement from the **Health Care FSA**. Please note that any expense incurred prior to your first participation date or after your plan termination date are ineligible for reimbursement. Also, any expense that you claim as a deductible on your federal income tax form is ineligible for reimbursement.

Items Not Eligible for FSA Reimbursement

- Adoption - the cost of the adoption itself is not covered, however health-related expenses such as physicals for the adoptive parents and pre-adoption counseling may be covered
- Age Management Systems (Cenegenics)
- Annual medical contract fees for exclusive provider care
- Shields, Gel Pads
- Clothing
- Cosmetic Procedures
- Cushions
- Dental bleaching or any other teeth whitening
- Dental Enamel Micro-Abrasion
- Domestic help fees (for services of a non-medical nature)
- Driving Lessons
- Electric toothbrush replacement brushes
- Electrolysis or hair removal
- Facial Tissues, Antiviral
- Finance charges
- Fluoride - Expenses paid for over-the-counter fluorides such as toothpaste with fluoride, or fluoride mouth wash or rinse
- Glucerna Shakes
- Hair loss treatments (non-prescription) such as over-the-counter medications are not covered. However, prescription medications prescribed by a physician to treat a medical condition are covered.
- Hair transplant
- Health club dues/memberships, for general well-being unless part of a medically prescribed regimen to treat a specific condition. Physician's diagnosis letter required.
- Insurance premiums of any kind. (See exceptions for HRA and HSA.)
- Interest
- Lactation Consultation
- Laetrile, even if prescribed by a Physician
- Late charges
- Late payment interest
- Lens replacement insurance
- Marijuana, even if prescribed for medicinal purposes
- Massage therapy for general well-being, unless accompanied by a physician's diagnosis letter
- Medicine flavorings
- Missed appointment fees
- Over-the-counter items which are items not categorized as a medicine or drug and may include, but are not limited to, nail clippers, pumice stones are not reimbursable, unless accompanied by a physician's diagnosis letter. Over-the-counter toiletries or personal hygiene items which may

include, but are not limited to shampoo, toothpaste, conditioners, hand creams, deodorant, shaving cream, razors, dental floss, body powders, hair gels/sprays, make-up, nail polish accessories, soap, mouthwash, etc., are not reimbursable.

- Pastoral Counseling
- Personal Trainer
- Physical therapy treatments for general well-being
- Pill bags
- Postage
- Pre-seed moisturizers
- Saddle Soap
- Savings Club
- Shampoo that is non-medicated
- Spider vein therapy such as with sclerosing agent injections are considered cosmetic. However, if the therapy is for other than a diagnosis of spider vein therapy the charges are reimbursable when accompanied by a physician's diagnosis letter.
- Supplements - taken for general well-being.
- Tanning lotions without sun protection
- Tips paid for taxi fares, etc.
- Ultrasound - 4D/Elective
- Union dues
- Vitamins taken for general well-being
- Warranties
- Weight loss program food or convenience items such as water bottles
- Weight loss machines

For more information about what items are, and are not, deductible Health Care Expenses, consult IRS Publication 502 (Medical and Dental Expenses), under the headings "What Medical Expenses are Deductible:" and "What Expenses Are Not Deductible?" Review the Publication with caution because it was meant only to help taxpayers figure out their tax deductions, not to explain what is reimbursable under a Health Care FSA.

Dependent Day Care FSA – Eligible Expenses

Dependent Day Care expenses” means employment-related expenses incurred on behalf of any Dependent:

- Under age 13 for whom you are entitled to claim a dependent exemption on your federal income tax return (if you are a divorced parent, a child is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
- Spouse or a person who is your dependent under federal tax law (even if you cannot claim the dependency exemption on your federal income tax return), who is physically or mentally incapable of self-care.

The following list is meant to provide a guideline for you to determine if an expense is eligible for reimbursement.

Eligible Expenses

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| • Day care | • Day camp |
| • Nursery School | • Elder care |
| • After-school care programs | • Home healthcare worker |

Claims must be expenses necessary for you (and your spouse, if married) to work, look for work or attend school. Expenses incurred because your spouse is physically or mentally incapable of self-care are also eligible.

Dependent Day Care FSA – Ineligible Expenses

The items or services listed below are currently ineligible for reimbursement from the **Dependent Day Care FSA**. Please note that any expense incurred prior to your first participation date or after your plan termination date is ineligible for reimbursement. Also, any expense that you claim as a deductible on your federal income tax form is ineligible for reimbursement.

Ineligible Expenses

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|--|---|
| • Any expenses incurred prior to your enrollment date | • Over-night camp |
| • Any payment for childcare to a person who can also be claimed by the employee as a dependent | • Clothing or equipment required for camp |
| • Any payment for child care to a relative under the age of 19 to provide care for your dependents | • Educational fees |
| | • Field trip fees |
| | • Weekend or evening-out babysitting |

Incurring Expenses

For expenses to be reimbursed to you, they must have been incurred during the Plan Year. This occurs when the service is provided, not when the expense is paid. Note, if you have paid for the expense but if the services have not yet been rendered, then the expense has not been incurred for this purpose.

If you pay for your child's day care on the first day of the month for care given during the entire month, the expense has not been incurred until the end of that month.

You may not be reimbursed for any expenses incurred before the Plan Year begins, before your specific effective date in the Plan, after the close of the Plan Year, or after a separation from service (unless you elect COBRA Coverage for the Health Care account).

Reimbursement

When you incur an eligible expense, you must submit a request for reimbursement on the Flexible Spending Account Reimbursement Request Form to WEX. Supporting documentation must accompany all FSA reimbursement requests. IRS Guidelines require the submission of third-party documentation which includes:

- **Date of Service**
- **For Whom Service Was Provided**
- **Name of Person/Group Providing Services** (For Dependent Day Care expenses, it must include the providers Federal Tax ID number, or Social Security Number)
- **Description of Service**
- **Total Cost of Service**

Acceptable documentation generally includes an Explanation of Benefits (EOB) from your medical insurance carrier and/or a receipt from your provider detailing the date of service, description of service and total cost of the service. CANCELLED CHECKS, CREDIT CARD RECEIPTS OR STATEMENTS, OR BALANCE FORWARD STATEMENTS are not acceptable forms of documentation.

The request must also include a written statement from you that the expense has not been reimbursed or is not reimbursable under any other plan. Signing the Reimbursement Form includes the required statement that you have not already received reimbursement for the requested amount(s).

Under your **Health Care FSA** you can be reimbursed up to the amount you elected to contribute for that year less any amounts already paid to you, regardless of the amount you have contributed when you submit the claim. Under your **Dependent Day Care FSA**, you can be reimbursed up to the balance in your account at the time payment is made.

Generally, requests received by the end of business day Tuesday (CST) will be reviewed on Thursday and approved payments will be processed on Friday (subject to holiday schedules and a 15-day extension for matters beyond the Administrator's control). The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The minimum reimbursement amount is \$25.00. Approved claims will be accumulated until the total payment exceeds \$25.00 before payment is made. However, at the end of each **Plan Year**, you will be allowed to submit any amount to close out your account for the year.

To have your claims processed as soon as possible, please note that it is not necessary for you to have actually paid the bill for an expense – only for you to have incurred the expense, and certify that it is not being paid for or reimbursed from any other source.

Claims for expenses incurred during the **Plan Year** must be submitted no later than 60 days following the end of the **Plan Year** February 28 or 60 days after your termination date, whichever comes first. Any funds left in your account at that time will be forfeited.

You may obtain a Flexible Spending Account Reimbursement Request Form from and must submit your request for reimbursement with substantiating documentation to:

WEX
PO Box 2663
Fargo, ND 58108

Phone: 877-837-5017
Fax: 253-793-3766

Forfeitures

If your expenses during the Plan year are less than the annual amount that you elected, you will not be entitled to receive any direct or indirect payment for the difference. The difference will be forfeited. This is known as the "use it or lose it rule" imposed by the IRS.

Forfeited amounts will be used by the Plan to offset reasonable administrative expenses and future costs.

Any payments that are unclaimed (for example, uncashed benefit checks) for 180 days or more after the check was issued will be forfeited.

Denying Claims

If your claim is denied, in whole or in part, you will be notified in writing within 30 days of the date your claim was received of the reason(s) your claim has been denied. These reasons include but are not limited to ineligible expenses per IRS regulations, submission of claims incurred prior to or after the benefit effective or termination date, incorrectly completed reimbursement form or no supporting documentation, or unacceptable supporting documentation.

If you feel a claim was incorrectly denied, you should contact WEX and ask for a review of your claim.

Your appeal must be made in writing within 180 days of the denial. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reason(s) that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim.

Your claim will be reconsidered and you will receive written notice of the decision within 60 days. All interpretations of the Plan Administrator will be final and binding.

Tax Implications – Income Taxes Medicare and Social Security

When you establish a **Health Care FSA** or a **Dependent Day Care FSA**, you choose to have a certain amount deducted from your paycheck each week. This deduction is made before taxes are calculated. Therefore, your taxable income is lower. In addition, you are not taxed on the money you take out of your account to pay for eligible expenses.

However, expenses that are reimbursed to you through your **FSA** cannot be included as itemized deductions on your federal income tax form. You may wish to consult a tax advisor to determine if you will pay less in taxes by using an **FSA** to pay for your eligible expenses or by itemizing your eligible expenses on your tax form.

FSA contributions are not subject to Social Security taxes (FICA), Medicare, state income taxes (except in New Jersey and Pennsylvania), and some local income taxes.

Because you do not pay Social Security taxes on your **FSA** contributions, your benefits from Social Security may be reduced slightly.

FSA Effects on Other Employee Benefits

Contributions to a Flexible Spending Account will not affect your Life Insurance, 401k, Short-term Disability or Long-term Disability. These benefits will continue to be based on your salary without regard to any amounts contributed to your FSA.

Coordination of Benefits

You or your Dependents may be covered by other company sponsored health and welfare plans. If so, benefits from that plan and benefits under the Medical, Dental and/or Vision Benefits are coordinated so both plans do not pay for the same expenses.

If both you and your spouse work for Newark Board of Education, you cannot claim each other as dependents and submit claims for benefits twice. Only one of you can claim your children as Dependents.

If you are both participating in a Flexible Spending Account, you cannot submit the same claim twice.

COBRA Coverage

Under COBRA, Newark Board of Education is required to provide you and your qualified dependents with the opportunity to reimburse medical care, dental care, and/or vision care expenses under the Plan for a limited period of time, unless your participation was terminated due to gross misconduct. This coverage is paid by you or your Qualified Dependents when certain defined events occur that otherwise would cause you and/or your Qualified Dependents to lose coverage. Guidelines and timetables that pertain to FSA administration for active employees will also apply to individuals covered under COBRA.

Please note that COBRA coverage will not be offered if you or your Qualified Dependents were not eligible for benefits prior to your qualifying event.

Following a qualifying event (described below), Newark Board of Education must offer you and your Qualified Dependents the opportunity to participate in the Health Care FSA Benefit on an after-tax basis through the remainder of the year in which you qualify for COBRA (as explained below). The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all Qualified Dependents. This allows you to be reimbursed for expenses that you incur after your qualifying event, but

before the end of the calendar year. You may not re-enroll in the cafeteria plan during any annual enrollment for any calendar year that follows your qualifying event.

Qualified Dependent

This term refers to your spouse and/or dependent child(ren) who are or were covered under one of the Newark Board of Education plans on the day before the qualifying event, and who have experienced a qualifying event that leads to a loss of coverage. This also includes a child who is born or placed for adoption with you during the period of COBRA coverage. Whether an individual is a Qualified Dependent is important because each qualified dependent has a separate right to elect COBRA coverage. COBRA documents may use the term "qualified beneficiary" which refers to you and your Qualified Dependents.

Please remember that if you did not enroll any of your dependents in any of the Newark Board of Education plans (for whatever reason) prior to a qualifying event, even though they were otherwise eligible, they will not be considered Qualified Dependents for COBRA coverage.

Qualifying Event

COBRA coverage is offered to you and/or your Qualified Dependents when a qualifying event occurs. A qualifying event is defined as a loss of coverage due to one of the following reasons:

- Your death,
- A change of your employment status, such as your termination of employment from Newark Board of Education or a reduction in your working hours,
- Your divorce or legal separation,
- The bankruptcy of Newark Board of Education ,
- You or any of your qualified beneficiaries are on military leave,
- You elect Medicare as primary coverage, or
- Your dependent child loses eligibility for coverage.

Coverage in effect at the time of the qualifying event terminates on the date that the qualifying life event occurs.

COBRA coverage for the Health Care FSA will terminate:

- If you fail to make a timely COBRA premium payment. An initial premium payment following the election of COBRA coverage is considered timely if received within 45 days of such election. Any subsequent premium is considered timely if it is paid within 30 days from the due date.
- CLIENT terminates the Health Care FSA.
- You notify the Administrator that you wish to cancel your coverage.

COBRA Offer

When Newark Board of Education receives notice of a qualifying event, the COBRA Administrator is required to notify you and your Qualified Dependents in writing of your COBRA rights. If you, your spouse and dependent child(ren) live together at the same address, the Administrator satisfies this requirement by mailing one notice addressed to you. The notice will be mailed to your current address on file. It is important to keep your current address information on file with WEX and COBRA Administrator. Following Newark Board of Education receipt of notice of the qualifying event, Newark Board of Education has 30 days to notify the COBRA Administrator from the qualifying event or the loss of coverage, whichever is later. The COBRA Administrator has 14 days from the date of receiving notice of any qualifying event to mail the notification.

COBRA Election

Once you and your Qualified Dependents receive notice of your COBRA rights from the appropriate administrator, you have 60 days from the date of the notification, or the date your coverage terminates (whichever is later), to elect COBRA coverage. You or your Qualified Dependents elect COBRA coverage by completing and returning the election form, sent with the notice, to the appropriate administrator at the address listed on the form by the deadline indicated above.

Qualified Dependents may waive their rights to COBRA coverage rather than make a COBRA election. However, qualified dependents are permitted to revoke such waiver at any time during the 60-day election period if they change their minds and decide to elect COBRA coverage. Once the 60-day election period ends, the waiver cannot be revoked.

Dependent Rights to COBRA for the FSA Plan

Qualified Dependents do not have an independent right to make their own after-tax contributions to a cafeteria plan.

Cost for COBRA

The premium that you are charged for COBRA coverage for the Health Care FSA is based on your monthly contribution before your employment terminated. You may be charged no more than 102% of your normal

contribution amount. The additional 2% above the premium cost covers Newark Board of Education cost of administering COBRA.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is an order or judgment from a state court, or an order issued through an administrative process under state law, directing the Plan Administrator to cover children under the Plan. If the Administrator receives a QMCSO, the Plan Administrator may be required by law to comply with the order allowing an employee's child(ren) to be covered under the Plan. The child(ren) will be covered according to the terms of the QMCSO, and applicable law. The company will determine the validity of any medical child support order that it receives and will notify affected participants of any action taken in response to any order received. No coverage is provided if you do not have custody of the children while the QMCSO evaluation is pending.

Other Federal Mandates

Because the Health Care FSA is considered as a group health plan under federal law, many federal mandates will apply to your coverage under the Plan. The following is a summary of each mandate.

The Newborns' and Mothers' Health Protection Act of 1996

The Health Care FSA under the Plan 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 medical care provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after consulting with the mother. In any case, federal law prohibits the Plan from requiring that a medical care provider obtain authorization for a length of stay that is less than or equal to 48 (or 96) hours.

Coverage for Mastectomy

Federal law requires the Health Care FSA under Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of mastectomy, including lymph edemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and related services will be subject to deductibles and co-insurance amounts that are consistent with those that apply to other benefits under the Plan.

Michelle's Law

Michelle's Law provides continued benefits under the Health Care FSA for dependent children who are covered under the Plan as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the Plan, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence.

This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the Plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

- begins while the child is suffering from a serious illness or injury,
- is medically necessary, and
- causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

- is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the Plan would otherwise terminate, and
- stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If any expenses provided by the Plan are changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the Plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

**Coordination With
COBRA Continuation
Coverage**

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the Plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

**Genetic Information
Nondiscrimination Act of
2008 ("GINA")**

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any the benefits under the Health Care FSA.

GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and
- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

**Mental Health and
Substance Abuse Benefit**

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") imposes significant new requirements on the Plan that offer mental health and substance abuse benefits. Current law prohibits health plans from imposing lower annual and lifetime limits on mental health coverage than on other types of medical coverage. The MHPAEA further limits other types of financial and non-financial limitations that plans may impose on mental health coverage and substance abuse benefits. Some of the MHPAEA's key provisions are as follows:

- Financial limitations—including limitations on deductibles, copayments, coinsurance, and out of pocket expenses—imposed on mental health and substance abuse benefits may not be higher than those imposed on other types of medical coverage;
- The Plan may not place limits on the scope or duration of treatment for mental health or substance abuse that are more restrictive than for other types of medical treatment;
- The Plan must provide, upon request, information to plan participants and providers regarding the criteria for determining whether mental health or substance abuse treatment is medically necessary, and the reasons for denial of coverage; and
- Coverage of mental health and substance abuse benefits by out-of-network providers must be on par with out-of-network coverage for medical treatment.

Privacy Rights

Disclosures of enrollment/disenrollment information permitted: The Plan may disclose to your company information on whether you are participating in the Health Care, or are enrolled in or have disenrolled. For purposes of this article, "Protected Health Information" ("PHI") means individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in federal regulations. For purposes of this article, Electronic Protected Health Information or Electronic PHI means PHI that is transmitted by or maintained in electronic media.

Uses and disclosures of summary health information permitted: The Plan may disclose Summary Health Information to your company, provided your company requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

"Summary Health Information" means information that (a) summarizes the claims history, claims, expenses, or type of claims experienced by individuals for whom your company had provided health benefits under the Plan; and (b) from which the information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

Required uses and disclosures of PHI permitted for plan administrative purposes: Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification, the Plan (or an insurance company on behalf of the Plan) may disclose PHI and Electronic PHI to your company, provided your company uses or discloses such PHI and Electronic PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by your company on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by your company in connection with any other benefit or benefit plan of your company, and they do not include any employment-related functions.

Enrollment and disenrollment functions performed by your company are performed on behalf of you and your dependents, and are not Plan administration functions. Enrollment and disenrollment information held by the company is held in its capacity as the plan sponsor and is not PHI.

Notwithstanding the provisions of this Plan to the contrary, in no event shall your company be permitted to use or disclose PHI in a manner that is inconsistent with federal regulations.

PHI to be disclosed for plan administration purposes: Your company agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, your company shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to your company with respect to PHI;

- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your company;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for;
- make available PHI to comply with HIPAA's right to access in accordance with federal regulations;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with federal regulations;
- make available the information required to provide an accounting of disclosures in accordance with federal regulations;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that your company still maintains, in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and.
- ensure that the adequate separation between the Plan and your Company (i.e. the "firewall"), required in federal regulations, is established.

Your company further agrees that it creates, receives, maintains or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information and information disclosed pursuant to a signed authorization that complies with the federal requirements which are not subject to these restrictions) on behalf of the Plan, it will:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives maintains or transmits on behalf of the Plan;
- ensure that the adequate separation between the Plan and your company (i.e., the firewall), is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the Plan any security incident of which it becomes aware, as follows: your Company will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition the Company will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Those permitted to disclose information: Your company shall allow those classes of employees or other persons in your Company's control designated by your Company to be given access to PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that your company performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to

disciplinary action by your company for non-compliance pursuant to your company's employee discipline and termination procedures.

Your company shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

PHI to be disclosed to your company: The Plan shall disclose PHI to your company only upon the receipt of a certification by your company that the Plan has been amended to incorporate the provisions of federal regulations, and that your company agrees to the conditions of disclosure set forth in this summary.

Amendment and Termination of Plan

Newark Board of Education reserves the right to amend or terminate this **Flexible Spending Account** Plan at any time. Any amendment or termination of the **Plan** will not affect the right of **Plan** participants to reimbursement for eligible expenses they incur prior to said amendment or termination. Any amendment or termination of the **Plan** shall become effective as of the end of a pay period.

Statement of ERISA Rights

Participants in the **Plan** are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Examine, without charge, at the **Plan Administrator's** office and at other specified locations, such as worksites and union halls, all documents governing the **Plan**, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500) filed by the **Plan** with the U.S. Department of Labor.

Obtain, upon written request to the **Plan Administrator**, copies of documents governing the operation of the **Plan**, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The **Plan Administrator** may make a reasonable charge for the copies.

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

In addition to creating rights for **Plan** participants, ERISA imposes obligations upon the people who are responsible for the operation of the **Plan**. The people who operate the **Plan**, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all **Plan** participants. No one, including Newark Board of Education, a union, or any other person, may fire an employee or discriminate against an employee to prevent the employee from obtaining any benefit under the **Plan** or exercising their rights under ERISA.

If claims for benefits under the **Plan** are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the **Plan** review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the **Plan** and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the **Plan Administrator** to provide the materials and pay the participant up to \$110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the **Plan Administrator**. If a claim for benefits is denied or ignored in whole or in part, the participant may file suit in a state or federal court.

If it should happen that **Plan** fiduciaries misuse the **Plan's** money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees: for example, if it finds the participant's claim frivolous.

Participants should contact the **Plan Administrator** for questions about the **Plan**. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Definition of Terms

Annual Contribution – represents the total dollar amount you want to have deducted from your annual salary. The total annual amount you elect to deduct will be divided equally among your paychecks throughout the **Plan Year**. The Annual Contribution is subject to minimum and maximum limitations. If you begin participation in an **FSA** midyear, your annual contribution limitations will be prorated for the time remaining in the **Plan Year**.

COBRA – means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Dependent – means any individual who is your tax dependent, with the following exception, (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. In addition, any child who has turned age 26 during the year will be treated as a dependent

The Plan will provide benefits in accordance with the requirements of any Qualified Medical Child Support Order (QMCSO), even if the child does not meet the definition of "Dependent".

Dependent Day Care FSA – an account that allows you to contribute your pre-tax dollars to pay for eligible dependent day care expenses you incur throughout the Plan Year.

Eligible Dependents – are those dependents that you claim on your federal income tax form or any child under age 26. Under certain circumstances, the custodial parent may be reimbursed through their **Dependent Day Care FSA** for childcare, even if the child is not claimed as a dependent for tax purposes. Please contact a qualified tax expert for advice if you are unsure if you can claim your child as a dependent for your **FSA** under IRS rules.

Eligible Expenses – are those expenses that can be reimbursed to you through your **FSA**. These expenses meet the requirements set forth by the Internal Revenue Code regulating **Flexible Spending Accounts**.

ERISA – means the Employee Retirement Income Security Act of 1974, **as amended from time to time**.

Flexible Spending Account or FSA or Plan – is a benefit that allows employees to set aside a portion of their pre-tax earnings to pay for eligible expenses throughout the **Plan Year**.

Health Care FSA – an account that allows you to contribute your pre-tax dollars to pay for eligible medical, dental, and vision expenses you incur throughout the Plan Year.

HIPAA – the Health Insurance Portability and Accountability Act of 1996, which is a far-reaching legislation designed to improve the portability of health coverage and to make other changes to the health care delivery system.

Incurred Expense – an expense is considered incurred when an eligible service has been delivered.

Maximum Contribution – is the maximum dollar amount you are allowed to contribute to your **FSA**. The exact dollar amounts for the maximum monthly and annual contributions allowed may be found in the Contributions Section of this document.

Minimum Contribution – is the minimum dollar amount you are allowed to contribute to your **FSA**. The exact dollar amounts for the minimum monthly and annual contributions allowed may be found in the Contributions Section of this document.

Plan Administrator – is the party with the discretionary authority to interpret Plan documents. The **Plan Administrator** assumes all responsibilities imposed by ERISA.

Plan Year – The 12-month period beginning on January 1 and ending on December 31.

Qualifying Change in Life Status – is defined by the IRS as an event caused by marriage, divorce, addition or loss of a dependent, change in your employment from full-time to part-time or vice-versa, or a change in spouse's employment. When a change in family status occurs, you are eligible to enroll in an **FSA** Plan, change your contribution amount(s), or stop your **Plan** participation. If you elect to change your contribution amount(s) due to a qualifying change in family status, that contribution change must be consistent with your change in family status. For example, if you experience a loss of a dependent, you may only decrease your contributions, not increase them.