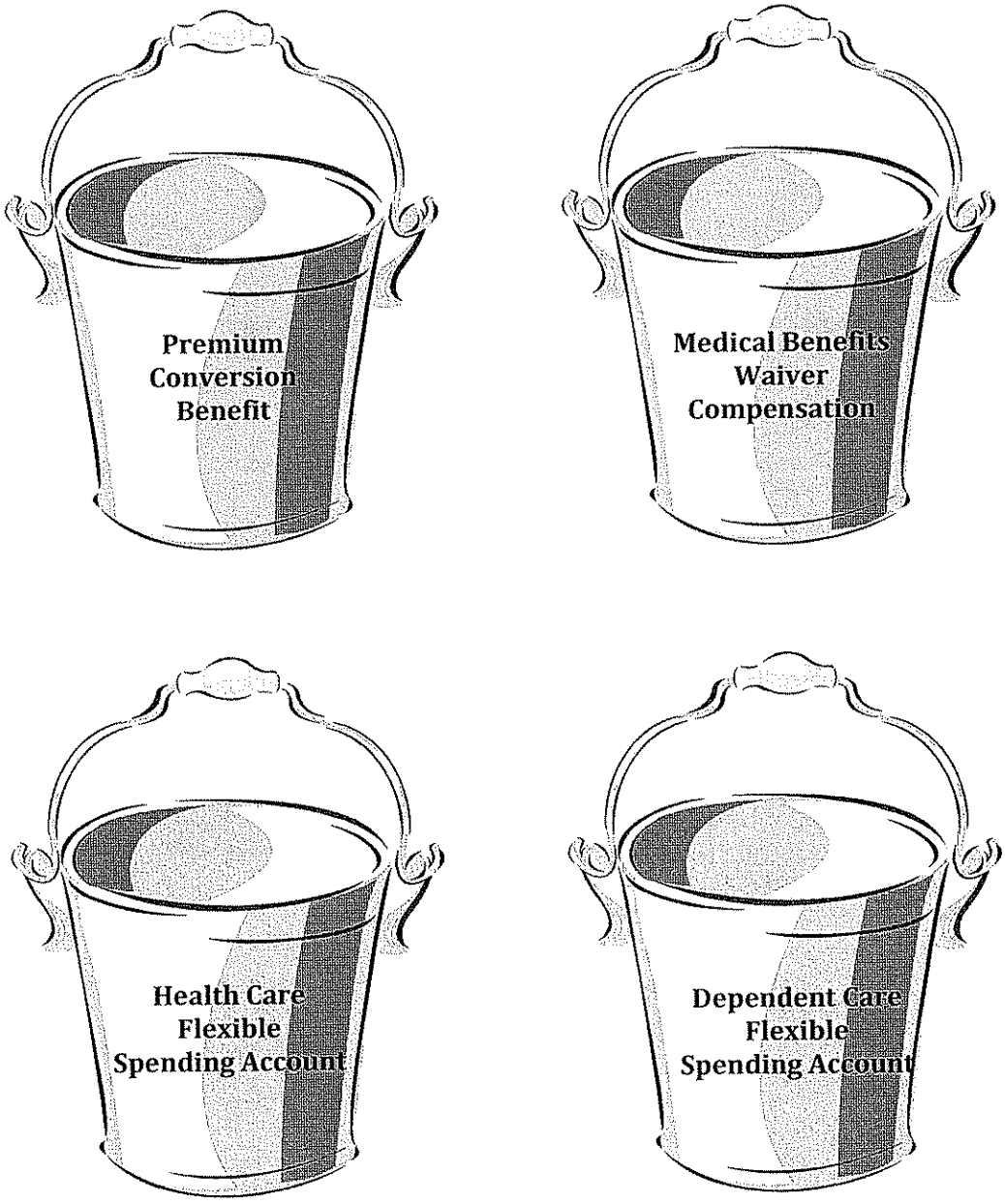
Delran Township Board of Education

Flexible Spending Account Plan

Plan Document and Summary Description

Amended and Restated Effective January 1, 2012



Plan Year 2012

Introduction

This combined summary description and plan document describes the cafeteria plan, pre-tax premium and flexible spending account (FSA) program permissible under Internal Revenue Code ("Code") Section 125 available to eligible employees of Delran Township Board of Education under the Delran Township Board of Education Flexible Spending Account Plan (the "Plan") on or after their effective date(s) for participation.

This document provides no guarantee that you are eligible to participate in every benefit or program described. Each benefit program may have its own eligibility requirements, so be sure to review individual eligibility requirements set forth in your referenced Plan materials.

The Plan, through this document and referenced documents, is intended to qualify as a "cafeteria plan" and to satisfy the requirements of Code Sections 125, 129 and 105(e) for document and summary description purposes, and to provide employees health care and dependent care flexible spending account (FSA) benefits, waiver compensation benefits, and the opportunity to make pre-tax contributions toward certain benefits.

The Health Care FSA component is intended to qualify as a self-insured medical reimbursement plan under Code Section 105, and the medical care expenses reimbursed thereunder are intended to be eligible for exclusion from participating employees' gross income under Code Section 105(b). The dependent care FSA component of this Plan is intended to qualify as a "dependent care assistance program" under Code section 129, and the dependent care expenses reimbursed thereunder are intended to be eligible for exclusion from participating employees' gross income under Code section 129(a). Although addressed within this document, the Health Care FSA and the Dependent Care FSA components of this Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code sections 105 and 129 and other applicable federal requirements.

If you have any questions about this document or certain provisions of the Plan, please call your local Human Resource Department.

Every effort has been made to ensure that the information in this document is complete and accurate. The Plan is established with the intention of being maintained for an indefinite period of time; however, Delran Township Board of Education, in its sole discretion and in accordance with the *Amendment and Termination* section set forth below may amend or terminate any of the benefit programs or any provision of the Plan at any time. No termination or amendment shall operate to reduce the amount of any benefit payment under the Plan for charges incurred prior to the effective date of such termination or amendment.

This document is intended to comply with the requirements of applicable laws and regulations. It does not create a contract or guarantee of employment between Delran Township Board of Education and any individual. Your employment is always on an at-will basis. Delran Township Board of Education or you may terminate the employment relationship without notice at any time and for any reason.

What is the Flexible Spending Account Plan?

The Flexible Spending Account Plan is permissible under Internal Revenue Code (IRC) Section 125 and consists of several programs. They are:

- the Premium Conversion Benefit Program,
- the Benefit Waiver Compensation Program,
- the Health Care Flexible Spending Account (Health Care FSA) Program, and
- the Dependent Care Flexible Spending Account (Dependent Care FSA) Program.

You are encouraged to read this plan document/summary brochure carefully. It covers the major features of the Plan's applicable rules and regulations.

Who is Eligible to Enroll?

You are eligible to participate in the Plan if you are scheduled to work at least 20 hours per week. If you were not at work on the day coverage would begin, your coverage will become effective on the day you return to work. If you are hired on September 1st, you are eligible to participate on your date of hire. If you are hired on any other day of the year, participation in the plan becomes effective on the first of the month following 60 days of employment.

Seasonal, occasional, temporary and contract employees as well as sole proprietors, partner in a partnership or 2% or greater shareholders in an S-corporation are not eligible to participate in the **Plan**.

Elections under the Plan generally remain in effect during the Plan Year and your elections cannot change unless an approved Status Change Event occurs mid-year. See the section titled "Making Changes during the Year" below, for more information.

The Premium Conversion Program

The Premium Conversion Program enables eligible employees to pay for their health plan contributions on a before-tax basis, thereby reducing their gross income for federal and Social Security tax purposes. You will receive information about your portion of the cost for the benefit programs offered under the Plan during open enrollment or for new hires before you enroll. You may obtain this information by contacting your local Human Resource Department.

How do I enroll?

Annually, you may enroll in the Plan during Delran Township Board of Education's Open Enrollment Periods. There are two open enrollment periods as described below:

Health and Dependent Care Open Enrollment:

Open enrollment for the FSAs occurs during the fourth quarter of each year. Your election made during open enrollment will be for the plan year period of January 1st – December 31st. For example: Open enrollment for the 2012 FSA plan year occurred during November of 2011. Elections made November 2011 will be effective for the period of January 1, 2012 – December 31, 2012.

Medical, Prescription Drug, and Dental Benefits Open Enrollment:

Open enrollment for other benefits such as medical, prescription drug, and dental benefits occur during the second quarter of each year. For example the 2012 open enrollment for the medical, prescription drug, and dental benefits will occur in May/June of 2012. Elections made May/June 2012 will be effective for the plan year period of July 1, 2012 – June 30, 2013.

How the Premium Conversion Program Affects Your Taxes

Effect on Gross Salary: There is a reduction in the taxes withheld from your gross salary. The reduction in gross salary will be shown on your Form W-2.

Premium Conversion Program Tax Savings: Savings will vary and be based on, among other things, your health plan option, whether you have individual or family health coverage, the number of withholding allowances that you claim for tax purposes, and your salary.

Change Premiums from Pre-Tax to Post-Tax: While automatically enrolled on a pre-tax basis, you may choose post-tax premiums if you wish. Changing from one to the other can be done during the Annual Open Enrollment Period. Employees, however, must decide to pay premiums on either a pre-tax or post-tax basis for an entire Plan Year.

Social Security Tax (FICA): Note that you will not be paying Social Security taxes on any before-tax contribution to coverage under the benefit programs. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the benefit programs will normally be greater than any eventual reduction in Social Security benefits.

Status Change Event

Enrollment in the Premium Conversion Program remains in effect during the Plan Year and your status cannot change unless an approved Status Change Event occurs mid-year. Similarly, employees who waived enrollment in the Premium Conversion Program may enroll mid-year only if they incur a Status Change Event.

The Benefit Waiver Compensation Program

The Benefit Waiver Compensation Program enables eligible employees who have other eligible group health coverage to waive that coverage in return for a cash incentive payment.

In accordance with New Jersey law, eligible employees can agree to waive medical coverage with the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) to which he/she is entitled because he/she is covered under other health coverage. The employee is not eligible for the waiver incentive if his/her other coverage is with the SHBP or SEHBP. (Employees must submit proof of the other health coverage to the employer along with the waiver form.) In place of health benefit coverage, the employer will pay the following according to the level of coverage waived:

Coverage Level	Waiver Amount
• Single	$1,000.00
• Parent Child	$1,350.00
• Husband/Wife	$2,200.00
• Family	$2,500.00

Taxes will be deducted from the payments.

An employee may resume SHBP or SEHBP coverage when he/she is no longer covered by the other health coverage, provided that he/she notifies the Health Benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

A completed Health Benefits Program Application must be attached to either a waiver or a reinstatement. If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. A reinstatement application must be filed within 60

days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

Employees are advised that consideration paid by the employer for the waiver of SHBP coverage is subject to taxation. The Authority shall strictly adhere to any and all prevailing withholding, reporting, and/or other tax authority requirements in effect from time to time. Employees are encouraged to consult with their accountants and/or tax consultants prior to waiving coverage. The amount to be paid by the employer to its employees in consideration for waiving SHBP coverage may be modified by the employer from time to time, within the limits set forth in New Jersey law.

For more information about the Waiver Compensation Program, please contact Human Resources.

Flexible Spending Account Plan (FSA)

The Flexible Spending Account Plan (FSA) is a benefit plan offered to eligible employees. FSA benefits offer you the opportunity to save tax dollars on your eligible out-of-pocket costs. There are two types of accounts available to you: Health Care FSA and Dependent Care FSA. These accounts allow you to pay for eligible health care and dependent day care with pre-tax dollars.

A Health Care FSA is used for eligible health care expenses incurred by you or your dependents. A Dependent 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 and/or a Dependent Care FSA. 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 and/or Dependent Care expenses covered under your account(s), you submit a reimbursement request form, with the required third-party documentation, to Benefit Express. Benefit Express 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 Care FSA's, you may submit reimbursement requests throughout the Plan Year. You have until 90 days after the plan year ends or 90 days after you terminate your employment to submit your requests to Benefit Express. You will lose any money remaining in your account after March 31 or 90 days after your termination date, whichever comes first – whether you have incurred eligible expenses or not.

Please read this section carefully. It summarizes the provisions of the FSA benefits and will help you to take full advantage of this benefit provided to you by Delran Township Board of Education.

Delran Township Board of Education offers the Health Care FSA and Dependent Care FSA to all eligible employees as a supplementary benefit. Questions about these benefits may be directed to:

Benefit Express
P.O. Box 189

Arlington Heights, IL 60006
Phone: 877 837 5017

Plan Year/Coverage Period. The period of coverage for the FSA is a 12 month period beginning on January 1 and ending on December 31. Expenses may not be carried over from one Plan Year to the next. Health Care and Dependent Care claims for incurred expenses may be submitted until 90 days after the end of the Plan Year or 90 days after you terminate employment if you terminate employment during the Plan Year.

Plan Administrator. Delran Township 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. The address of the Plan Administrator is:

Delran Township Board of Education
52 Hartford Road
Delran, NJ 08075

Delran Township Board of Education has contracted with Benefit Express to provide day-to-day:

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

You may direct questions regarding any of these issues to:

Benefit Express
P.O. Box 189
Arlington Heights, IL 60006
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. You may receive information concerning your account balances by contacting Benefit Express at 877-837-5017 or by contacting your local Human Resource department.

Dependent Status. For purposes of a health care FSA, eligible dependent is defined to mean (1) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year, and (2) your tax dependent under the Code except that an individual's status as a dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition.

Under your Dependent 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 Care FSA. Under certain circumstances, the custodial parent may be reimbursed through their Dependent 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 Delran Township Board of Education's FSA 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 experience a Status Change Event, you may enroll or make changes in your contributions to an existing Health Care or Dependent Care FSA within 31 days of the qualifying change in life status. If you qualify to begin or change your participation you must complete your enrollment within 31 days of Status Change Event. 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 choose not to enroll in a Health Care FSA or Dependent Care FSA when you are first eligible, you may then only enroll during Delran Township Board of Education 's next Open Enrollment period or if you experience a Status Change Event.

If you leave employment with Delran Township Board of Education and return within 30 days of the same calendar year, you may resume your previous level of benefit. Your payroll deductions will be adjusted accordingly.

Termination in the Plan will be effective on the date of your termination from Delran Township Board of Education.

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 annual contribution is $250.00. You may choose to contribute this to a Health Care FSA or a Dependent Care FSA.

The maximum contribution for a Health Care FSA is $2500.00 per year.

The maximum contribution for a Dependent Care FSA is $5000.00 per year.

If you are married and filing separate tax returns, your maximum contribution for a Dependent Care FSA is $2500.00 per year. If you are married and your spouse participates in a separate Dependent Day Care FSA, your maximum contribution is $2500.00 per year.

If you join the Plan mid-year, or make a mid-year adjustment to your contribution level, the minimum and maximum levels will be pro-rated. For example, if you enrolled in the Health Care FSA on October 1 at that time, you would be allowed to contribute up to a maximum of $625.00 (1/4 of the annual maximum allowable amount).

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.

Making Changes during the Year. In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at annual enrollment generally remain in effect for the following Plan Year. 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.

The federal government rules govern when you can change certain benefit coverage elections outside of annual open enrollment. These rules apply to before-tax coverage elections you make for your medical premium, waiver compensation, and FSA coverage. In general, the coverage levels you choose at open enrollment remain in effect for the following Plan Year. However, you may be able to change your elections during the plan year if you experience a change in status, as further explained below. 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.

You must make any status-related changes to your coverage within 31 days of the change in status.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.)

Qualified changes in status
The following is a list of qualified changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below):

- Legal marital status. Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment
- Number of dependents. Any event that changes your number of tax dependents, including birth, legal guardianship, death, adoption, and placement for adoption
- Employment status. Any event that changes your, your spouse's, or your other dependent's employment status and results in gaining or losing eligibility for coverage. Examples include:
    - Beginning or terminating employment;
    - Starting or returning from an unpaid leave of absence;
    - Changing from part-time to full-time employment or vice versa; and
    - A change in work location.

- Dependent status. Any event that causes your tax dependent to become eligible or ineligible for coverage under the plan
- Residence. A change in residence that causes an employee, spouse, or dependent to gain or lose eligibility for a plan or a different benefit option available under the plan (e.g., moving outside your medical or dental program's network service area)
- COBRA. Eligibility of an employee, spouse, or dependent for COBRA
- HIPAA Special Enrollment Events: Events such as the loss of other coverage that qualify as special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA) or an event that involves loss of Medicaid or State Child Health Insurance Program (CHIP) coverage or eligibility for state premium assistance.

Consistency requirements
Except for election changes due to a HIPAA and or Medicare/CHIP special enrollment, the changes you make must be "due to and consistent with" your qualified change in status. To satisfy the federally

required "consistency rule," your qualified change in status and corresponding change in coverage must meet both of the following requirements.

- *Effect on eligibility*. The qualified change in status must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.
- *Corresponding election change*. The election change must correspond with the qualified change in status. For example, if your dependent loses eligibility for coverage under the terms of the medical program, you may cancel medical coverage only for that dependent. Additionally, you may increase, decrease or begin contributions to your FSA(s) if you have or adopt a child or a child is placed with you for adoption. The Plan Administrator will determine whether a requested change is due to and consistent with a qualified change in status.

Coverage and cost events
In some instances, you can make changes to your benefits coverage for other reasons, such as mid-year events affecting the cost of coverage or the type of coverage provided, as described below. Note: *These rules do not apply for purposes of a health FSA*. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Coverage Events -If Delran Township Board of Education adds or eliminates a coverage option in the middle of the coverage year, or if coverage sponsored by JTMU is significantly limited or ends, you and your eligible dependents may revoke your elections and elect coverage under another option that provides similar coverage. If no other similar coverage is available, you may revoke your existing election.

For example, if there is an overall reduction under a coverage option that reduces coverage to participants in general, participants enrolled in that coverage option may elect to enroll in another option providing similar coverage (if the other coverage option permits). Additionally, if Delran Township Board of Education adds an HMO or other coverage option mid-year, participants can drop their existing coverage and enroll in the new coverage option (if the new coverage option permits). You or your eligible dependents may also enroll in the new coverage option even if not previously enrolled for coverage at all (if the new coverage option permits).

Also, if an election change is permitted during a different open enrollment period applicable to a plan of another employer (or, if applicable, to another plan sponsored by Delran Township Board of Education), you may make a corresponding mid-year election change. This rule applies to the medical elections but not to the Health Care FSA.

If another employer's plan allows your spouse or other dependent to change his or her elections in accordance with IRS regulations, you may make a corresponding mid-year election change to your coverage.

You may not decrease or end health FSA contributions or enroll for a health FSA when your spouse becomes eligible for coverage under another plan. You may not end health FSA contributions if you become eligible for coverage under another plan.

Cost Events - You must contact the Plan Administrator within 30 days of a cost event. Otherwise, your next opportunity to make changes will be the next annual open enrollment period or when you have a qualified change in status or other applicable event, whichever occurs first.

Medical Coverage Costs. If your cost for medical coverage increases or decreases significantly during the year, you may make a corresponding election change. For example, you may elect another coverage option with similar coverage, or drop coverage if no similar coverage is available. Additionally, if there is a significant decrease in the cost of a coverage option during the year, you may enroll in that coverage option, even if you declined to enroll in that coverage option earlier.

Any change in the cost of your coverage option that is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Special note regarding domestic partner coverage - The events qualifying you to make a mid-year election change described in this section also apply to events related to a qualified domestic partner. However, IRS rules generally do not permit you to make a mid-year change "on a pre-tax basis" for such events unless they involve a tax dependent.

Other rules

Receipt of Court Orders and QMCSOs - You will be permitted to revoke an election for accident or health benefits during a period of coverage and make a new election if a judgment, decree, or order (collectively an "order") requires accident or health coverage for your child or for a foster child who is your dependent. The order must have resulted from a divorce, legal separation, annulment, or change in legal custody, and includes a qualified medical child support order (QMCSO). The plan may automatically change your benefit election to provide coverage for your child if the order requires coverage under the plan.

You may also decrease your coverage for a child, if the order requires the child's other parent to provide coverage and your spouse's or former spouse's plan actually provides that coverage. You also may make other corresponding changes to your benefit elections under the Plan, to the extent permitted by the Internal Revenue Code (the Code) and the Plan.

Medicare or Medicaid Entitlement - You may change an election for health coverage mid-year if you, your spouse, or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A or Part B of Medicare, or under Medicaid. However, you are limited to reducing your health coverage only for the person who becomes entitled to Medicare or Medicaid, and you are limited to adding health coverage only for the person who loses eligibility for Medicare or Medicaid.

Family and Medical Leave Act - If you take an FMLA leave, you may continue your group health coverage for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. Delran Township Board of Education may require that you continue all health benefits (including health FSA), provided that participants on non- FMLA paid leave are required to continue coverage. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute your share of the cost of group health coverage during the leave by pre-paying for your coverage on a pre-tax basis, paying for coverage during your leave on an after-tax basis, and/or catching up with pre-tax contributions upon your return from leave. You also have the option to suspend your health coverage during the leave. If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

Special Rules Apply to Your Health Care FSA - When you take an FMLA leave, the entire amount you elected under your health FSA will be available to you during your leave period, less any prior reimbursement, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your coverage under the health care FSA will terminate while you are on

FMLA leave. In that case, you may not receive reimbursement for any health care expenses you incurred after your coverage terminated.

If your coverage terminates during your leave, you may be reinstated in your health FSA elections, if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level in effect before your FMLA leave, or you may elect to increase your contribution level to "make up" for the contributions you missed during your leave. If you simply resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave. If you elect make up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave.

Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, you may not retroactively elect health FSA coverage for expenses incurred after your coverage terminated.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage.

Deadline for making an election change
If you experience an event described above, your Plan Administrator must receive written notice of the election change within 31 days of the event. Delran Township Board of Education reserves the right to request proof of a qualified change in status.

Change in election effective date
In general, your change in election will not be effective earlier than the first day of the month immediately following the date the appropriate election form is completed and returned to the Plan Administrator. However, any election change made due to the birth, adoption or placement for adoption of a child and made within 31 days of such event will be effective retroactive to the date of the birth, adoption or placement for adoption and you will be permitted to pay for this retroactive coverage with pre-tax salary deductions.

Leave of Absence, Participation, and Contributions. If you take a qualifying leave of absence under the Family and Medical Leave Act of 1993 (FMLA), Delran Township 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. During your leave you may choose to continue to make your Health Care FSA contributions on an after-tax basis, or you may choose to pre-pay all, or a portion, of your share of the premium for the expected duration of the leave on a pre-tax basis out of your pre-leave compensation, or by other arrangements agreed upon between you and the Administrator. You must file a contribution repayment form with your local Human Resource department within 30 days of your return to work.

If you choose not to continue to pay your FSA account deductions, you cannot be reimbursed for any expenses incurred during that time.

Expenses. Eligible and ineligible expenses for a Health Care FSA and/or a Dependent 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 Benefit Express, 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 IRS Publication 502. Publication 502 is available from your nearest IRS office or by calling the IRS at 1-800-829-3676. You also may obtain a copy online by accessing http://www.irs.gov. But use caution when referring to Publication 502, because it is meant only to help taxpayers determine their tax deductions, not describe the expenses that are reimbursable under a FSA.

Not all expenses that are deductible are reimbursable under a Health Care FSA. For example, the publication states that you may get a deduction for expenses *paid* during the year. For purposes of your Health Care FSA, you may be reimbursed generally only for expenses you *incur* during the year - no matter when you pay for them. (*Expenses are incurred on the date you receive the healthcare services - that is, the date you see the doctor or other healthcare provider.*) As another example, health insurance premiums, long-term care contracts and long-term care services are listed as deductible expenses in the publication; however, they generally are not reimbursable from your Health Care FSA. And not all expenses that are reimbursable under a Health Care FSA are deductible. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

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 FSA benefit are eligible for reimbursement.

Heath Care FSA Eligible Expenses

- 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
- 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
- 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
- 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 (amounts paid for drugs used to stop smoking must be prescribed)
- 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)
- X-rays

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

Health FSA 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 that Require a Physician's Prescription
Distributions from the Health Care FSA will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This rule does not apply to reimbursements for the cost of insulin, which will be permitted, even if purchased without a prescription.

Eligible expenses that *will require a physician's prescription* for reimbursement may include, but are not limited to:

- Acetaminophen
- Acne products
- Allergy products
- Antacid remedies
- Antibiotic creams/ointments
- Anti-fungal foot sprays/creams
- Aspirin
- Baby care products
- Cold remedies (including shower vapor tabs and vapor units)
- Cough syrups and drops
- Eye drops
- Ibuprofen
- Laxatives
- Migraine remedies
- Motion sickness
- Nasal sprays
- Pain relievers
- Sleep aids
- Topical creams for itching, stinging, burning, pain relief, sore healing or insect bites

Items that are *eligible without a physician's prescription* include, but are not limited to:

- Band aids
- Bandages and wraps
- Braces and supports
- Catheters
- Contact lens solutions and supplies
- Contraceptives and family planning items
- Denture adhesives
- Insulin and diabetic supplies
- Diagnostic tests and monitors and first aid supplies, peroxide and rubbing alcohol

Health 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.

- 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
- Breast Pump, 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
- Glucerin 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, feminine hygiene products, etc., 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 Care FSA Eligible Expenses
Dependent 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.

Dependent Care FSA Eligible Expenses
- Day care
- Nursery School
- After-school care programs
- Day camp
- Elder care
- 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 Care FSA Ineligible Expenses
The items or services listed below are currently ineligible for reimbursement from the Dependent 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.

- Any expenses incurred prior to your enrollment date
- Any payment for childcare to a person who can also be claimed by the employee as a dependent
- Any payment for child care to a relative under the age of 19 to provide care for your dependents
- Over-night camp
- Clothing or equipment required for camp
- 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 FSA).

Reimbursement. When you incur an eligible expense, you must submit a request for reimbursement on the Flexible Spending Account Reimbursement Request Form to Benefit Express. 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.

Reimbursement of over-the-counter medications and supplies may require copies of box-tops and/or a physician's note.

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 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 90 days following the end of the Plan Year (March 31) or 90 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:

Benefit Express
P.O. Box 189
Arlington Heights, IL 60006
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 Benefit Express 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 and Social Security. When you establish a Health Care FSA, and/or a Dependent 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 a 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, 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.

Note about domestic/civil union partners. In accordance with federal tax provisions, funds in an FSA account may only be used for an employee's spouse, children under 27 (for health FSA) and tax dependents (as defined under Code 105(b)). Expenses incurred by non tax dependents, i.e., a domestic or civil union partner that is not also the employee's tax dependent) are typically not eligible for FSA reimbursement.

General Provisions

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 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 Delran Township 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 FSA, you cannot submit the same claim twice.

COBRA Coverage. Under COBRA, Delran Township 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), Delran Township 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 Delran Township 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 Delran Township 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 Delran Township Board of Education or a reduction in your working hours,
- Your divorce or legal separation,
- The bankruptcy of Delran Township 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.
- Delran Township Board of Education terminates the Health Care FSA.
- You notify the Plan Administrator that you wish to cancel your coverage.

COBRA Offer
When Delran Township 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 Delran Township Board of Education and COBRA Administrator. Following Delran Township Board of Education's receipt of notice of the qualifying event, Delran Township 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.

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 Delran Township Board of Education 's cost of administering COBRA.

USERRA Rights
If you take a military leave, whether for active duty or for training, you may be entitled to extend your health coverage for up to 24 months (or the day you fail to return to work after the end of the leave if sooner) as long as you give Delran Township Board of Education advance notice of the leave (with certain exceptions). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from Delran Township Board of Education , can not exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more for your health coverage contribution than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

COBRA continuation coverage will run concurrently with military leave continuation coverage, under USERRA, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period.

Contacting Delran Township Board of Education
If you have any questions about COBRA coverage or the application of the law, please contact your local Human Resource Department. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Plan Informed of Address Changes
In order to protect your and your family's rights, you should keep Delran Township Board of Education informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to Delran Township Board of Education. Notices should be sent to the Plan Administrator.

Qualified Medical Child Support Order. 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. Delran Township Board of Education 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.

Certificate of Creditable Coverage. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you and your spouse and your dependents that lose group health coverage must receive certification of your coverage under the Plan. You may need this certification in the event you become covered by a new plan under a different employer, or under an individual policy.

You, your spouse and/or dependent(s) will receive a coverage certification when your group health plan coverage terminates (including when the plan's lifetime limit on all benefits is met), again when COBRA coverage terminates (if you elected COBRA), and upon your written request (if the request is made within 24 months following either termination of coverage). A request for a certificate may also be made by or on behalf of any individual who is currently covered by the plan (e.g., if an employee currently covered by a Delran Township Board of Education group health plan would like to join his or her spouse's employer plan at the spouse's open enrollment). The certificate request also may come from a new plan in which the individual enrolls, if the individual authorizes the new plan to make such a request. To request a certificate, please contact your local Human Resource Department.

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

If you or a covered family member does not understand any part of this section or if you have questions about this information or your obligations, please contact your local Human Resources Department.

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

The Newborns' and Mothers' Health Protection Act of 1996
A health care 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 a health care 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 lymphedemas (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.

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 benefits. 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 a 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 your 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. Delran Township Board of Education reserves the right to amend or terminate this Plan, in whole or in part, 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, termination or other action by Delran Township Board of Education with respect to the Plan shall be by a duly adopted resolution of the Board of Directors (or other governing body) or may be made by any person duly authorized to take such action on behalf of the Board of Directors.

Application of Other Plans. If you are electing one or more premium payment benefits under the cafeteria plan option, you are subject to the provisions, conditions, limitations, and exclusions of the health and/or welfare benefit program(s) for the premium payment benefit which you elect.

Irrevocability of Elections. Except as described in this document, a participant's election under the cafeteria plan is irrevocable for the duration of the period of coverage to which it relates. In other words, unless an exception applies, the participant may not change any elections for the duration of the period of coverage regarding: (a) participation in this Plan; (b) salary reduction amounts; or (c) election of particular benefit package options.

Effect of Mistakes. In the event of a mistake as to the eligibility or participation of an employee, the allocations made to the account of any participant, or the amount of benefits paid or to be paid to a participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such participant or other person the credits to the account or distributions to which he or she is properly entitled under the cafeteria plan. Such action by the Plan Administrator may include withholding of any amounts due to the plan or Delran Township Board of Education from compensation paid by Delran Township Board of Education.

No Guarantee of Tax Consequences. Neither the Plan Administrator nor Delran Township Board of Education makes any commitment or guarantee that any amounts paid to or for the benefit of a participant under the cafeteria plan will be excludable from the participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each participant to determine whether each payment under this plan is excludable from the participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the participant has any reason to believe that such payment is not so excludable.

Indemnification of Delran Township Board of Education. If any participant receives one or more payments or reimbursements under this plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such participant shall indemnify and reimburse Delran Township Board of Education for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Important Legal Notice. The Plan Administrator shall be responsible for the general administration of the Plan. The Plan Administrator shall have discretionary authority to administer each benefit in accordance with its terms, including the discretion to interpret the provisions of each benefit and determine the eligibility of each claim. All decisions by the Plan Administrator shall be final and binding on all parties.

Waiver of Terms. No term, condition or provision of the Plan shall be deemed waived, and the provisions of the Plan will be enforced, unless Delran Township Board of Education or you specifically waive in writing the condition or provision. The written waiver will not be deemed a continuing waiver unless stated specifically in the waiver, and each waiver will operate only as to the specific term or condition waived.

Excess Payments. If the Plan has made an erroneous or excess payment to or on behalf of you, your spouse or dependents, the Plan Administrator shall be entitled to take action to correct the error, including recovering the excess from you, your spouse or dependents. To the extent permitted by applicable law, the recovery of the overpayment may be made by offsetting the amount of any other benefit or amount payable to or on behalf of you, your spouse or dependents by the amount of the overpayment.

Limitation of Rights. This document will not be held or construed to give any person any legal or equitable right against Delran Township Board of Education , the Plan Administrator, or any other person connected with Delran Township Board of Education or the Plan, except as expressly provided in this document or as provided by applicable law; or to give any person any legal or equitable right to any assets of the Plan.

Severability. If any provision of this Document is held invalid or unenforceable, its invalidity or unenforceability will not affect any other provision of this Document. The Document shall be construed and enforced as if such provision had not been included in this Document.

Applicable Law. This Document shall be construed in accordance with the laws of the State of New Jersey, except to the extent such laws are pre-empted by the law of any other state or by federal law.

Paperless Communications. Notwithstanding anything contained in this document to the contrary, Delran Township Board of Education may from time to time establish uniform procedures whereby with respect to any or all instances in this document where a writing is required, including but not limited to any required written notice, election, consent, authorization, instruction, direction, designation, request or claim communication may be made by any other means designated by Delran Township Board of Education , including paperless communication, and such alternative communication shall be deemed to constitute a writing to the extent permitted by applicable law, provided that such alternative communication is carried out in accordance with such procedures in effect at such time.