



Pottstown School District  
FLEXIBLE BENEFITS PLAN  
SUMMARY PLAN DESCRIPTION

Effective Sep 1, 2026

This Summary Plan Description supersedes all other Summary Plan Descriptions for this Plan with an earlier effective date.

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# Introduction to the Flexible Benefits Plan

## *About this Plan*

Pottstown School District (the “Employer”) is pleased to offer you the Pottstown School District Flexible Benefits Plan (the “Plan”). The purpose of the Plan is to enable eligible employees of participating employers (“Eligible Employee”) to elect and pay their share of the cost of the certain qualified benefits (“Benefits”) identified in the Plan Information Appendix with amounts withheld from your pay before applicable taxes (“Pre-tax Salary Reductions”). This Plan also enables Eligible Employees to pay their share of the cost eligible medical expenses through a Health Care Spending Account (“HCSA”) and/or dependent day care expenses through a Dependent Care Spending Account (“DCSA”) with Pre-tax Salary Reductions. The HCSA and the DCSA are collectively referred to as “Spending Accounts”.

The Plan is called a “Flexible Benefits Plan” because you choose which Benefits you want for the Plan Year and, in the case of the Spending Accounts, you choose the amount of Pre-Tax Salary Reductions to set aside for eligible expenses. You must elect wisely because any amounts credited to a spending account that are not spent on expenses incurred during the Plan Year will generally be forfeited (with a limited exception for amounts credits to the HCSA). Also, you cannot use amounts credited to your HCSA for dependent day care expenses and you cannot use amounts credited to your DCSA for medical care expenses.

The Plan is beneficial to you because the Pre-tax Salary Reductions are not subject to any federal income and employment taxes (e.g., FICA and FUTA), and in most cases, state taxes. Participation in this Plan will increase your take home pay over what your take home would be if you paid for eligible expenses with after-tax dollars.

This Plan is intended to be a “Cafeteria Plan” established in accordance with Internal Revenue Code (“Code”) Section 125. The HCSA is also subject to Code Section 105 and the DCSA is subject to Code Section 129. It is intended that this Plan complies with the applicable Code sections; however, if there is a conflict between the terms of this SPD and an applicable Code Section, the conflict will be resolved in favor of the applicable Code Section.

## *About this SPD*

The SPD is divided into four parts: Part I-General Information about the Plan; Part II-HCSA Benefits; Part III-DCSA Benefits; and Part IV-the Plan Information Appendix. The first three parts of the SPD are in Question and Answer (“Q&A”) format. If you have questions about your rights and obligations under the Plan, please refer to the Table of Contents above for the Q&A that most resembles your question. The last part of this SPD—the Plan Information Appendix—identifies specific information related to your plan including but not limited to the following: the employer/plan sponsor information, the Benefits offered through this Plan, eligibility, maximum reimbursement amounts, and contact information for the third-party administrator and the plan administrator. Terms that are capitalized throughout are terms that are specifically defined in the SPD. If a term is capitalized but is not expressly defined in this SPD, the standard meaning will apply.

This SPD describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The SPD also serves as the official plan document.

## **Flexible Benefits Plan Questions and Answers**

# General Information about the Plan

## **Q-1. What is the purpose of the Plan?**

The purpose of the Plan is to enable Eligible Employees to elect and pay their share of the cost of the certain qualified benefits (“Benefits”) identified in the Plan Information Appendix with Pre-tax Salary Reductions that are described above. Included in this list of Benefit is a Health Care Spending Account (“HCSA”), which enables Participants who elect the HCSA to pay for eligible medical expenses incurred during the Plan Year, and a Dependent Care Spending Account (“DCSA”), which enables Participants who elect the DCSA to pay for eligible dependent day care expenses. The HCSA and the DCSA are collectively referred to as “Spending Accounts”.

**IMPORTANT: The terms and conditions of each benefit offered through this Plan (if any) are described in the documents and summaries relative to each Benefit—not this**

**Summary Plan Description. The terms and conditions of the HCSA and DCSA are described in this Summary Plan Description.**

## **Q-2. Who can participate in the Plan?**

Only Eligible Employees of Adopting Employers may participate and only to the extent that they have made a proper election to participate in accordance with this Plan. See the Plan Information Appendix for the Plan's eligibility requirements and for a list of Adopting Employers. Eligible Employees who make a proper election to participate are referred to as "Participants."

## **Q-3. How do I become a Participant?**

You become a Participant in the Plan by (i) timely and properly making an election during one of the applicable election periods and (ii) making the required contributions. You must make your election in accordance with the instructions provided by the Employer and in accordance with the terms of this SPD. NOTE: Generally, you cannot change your election during the Plan Year unless you experience a Change Event that starts a Mid-Year Election Period. The election periods are described in more detail below. The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Appendix.

## **Q-4. What are the election periods under the Plan?**

The Plan has three election periods: the Initial Election Period, the Annual Election Period, and the Mid-Year Election Period.

**NOTE: You must elect the specific spending account(s) in which you want to participate.**

### *The Initial Election Period*

The Initial Election Period begins on the date you become eligible and ends on the date identified by the Employer in your enrollment materials (usually 30 days but it could be longer). If you make an election to participate during the Initial Election Period, your

participation in the Benefits that you elect will begin on the Initial Coverage Effective Date identified in the Plan Information Appendix. If you do not make an affirmative election to participate in the Benefits during the Initial Election Period, you are deemed to have elected not to participate in this Plan except as otherwise described in the applicable enrollment materials. Elections that you make (or are deemed to make) during the Initial Election Period are effective for the remainder of the Plan Year and cannot be changed unless you cease to be an Eligible Employee or you experience a Change Event during the Plan Year and you change your election during the Mid-Year Election Period.

### *The Annual Election Period*

The Plan also has an "Annual Election Period" during which you may change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment materials distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you experience a Change Event that entitles you to a Mid-Year Election Period described below. NOTE: If you fail to make an affirmative election during the Annual Election Period, you may be deemed to have elected to continue your Benefit election in effect at the end of the Plan Year into the following Plan Year. This is called an "Evergreen Election." If the Plan doesn't adopt the Evergreen Election rule, you will not be permitted to make Pre-Tax Salary Reductions during the next Plan Year unless you make an affirmative election during the Annual Election Period. The enrollment materials will indicate if the Evergreen Election rule applies.

**Special Rule for Flexible Spending Account elections: Evergreen Elections do not apply to Flexible Spending Account Elections. Consequently, you must make an election each Annual Election Period to participate in a Flexible Spending Account in the following Plan Year.**

### *The Mid-Year Election Period*

Generally, the election that you make (or are deemed to make) during an Initial or Annual Election Period cannot be changed during the Plan Year. If, however, you experience one of the Change Events identified in the Plan Information Appendix, a Mid-Year Election Period begins during which you may make certain changes to your Benefit elections for the remainder of the Plan Year. The Mid-Year Election period begins on the date of the

event and lasts 30 days (or such longer period identified in the written enrollment materials). See the Plan Information Appendix for more details regarding the events that start a Mid-Year Election Period and the election changes you may make.

**NOTE: Elections may also be modified by the Employer as necessary to ensure compliance with certain non-discrimination requirements set forth in Code Sections 105, 125 and/or 129 (as applicable).**

## **Q-5. When does my participation in the Plan end?**

You continue to participate in the Plan until the earliest of the following to occur:

- The date you revoke your election to participate in the Plan;
- If you fail to make a required contribution, your Participation ends on the last day of the last month for which you made a timely and complete contribution;
- The date you cease to be an Eligible Employee for all of the Benefits; or
- The date the Plan is terminated.

If your participation in a Benefit ends because you cease to be an Eligible Employee, but you become eligible again during the same plan year but more than 30 days later, you may make new elections under the Plan for the remainder of the Plan Year. If you cease to be eligible but become eligible again during the same Plan Year but less than 30 days after you ceased to be an Eligible Employee, your prior elections will be reinstated. Note: You cannot use contributions previously credited to your HCSA and/or DCSA (as applicable) during the Plan Year for expenses incurred during the period that you are not a Participant.

**NOTE:** If you take an approved paid leave of absence, you will typically remain an Eligible Employee and your participation in the Benefits (other than DCSA) will typically continue uninterrupted. If you take an unpaid leave of absence, your continued participation in the Benefits during the unpaid leave will depend on the Employer's unpaid leave policies, the plan documents for each Benefit, and applicable law. If you remain an Eligible Employee and you are permitted to continue participating, the manner in which you pay your share of the cost for each Benefit will be governed by the Employer's policies to the extent consistent with applicable IRS guidance (including 26 CFR 1.125-3).

See the Change Events section of the Plan Information Appendix for more details regarding the impact of leaves of absence on Spending Account elections.

### **Q-6. How do I make the required contributions ?**

When you make an election to participate, you will identify the Benefits in which you want to participate. If you elect a Flexible Spending Account, you will also identify the amount of Pre-tax Salary Reductions that you want credited to each account during the Plan Year (a pro-rata portion of that amount will be credited each pay period).

NOTE: Plan participation will reduce the amount of your compensation that is subject to income and employment taxes. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

### **Q-7. How long will the Plan remain in effect?**

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

### **Q-8. What happens if I have a dispute about my rights under the Plan (e.g. an election change or other issue germane to Pre-tax Contributions)?**

You have the right to a full and fair review process regarding any disputes you have under the Plan. If you are denied a claim related to Pre-tax Salary Reductions under this Plan (such as your ability to make or change Pre-tax Salary Reductions), your claim will be reviewed in accordance with the claims process established by the Employer.

# HCSA Benefits

The following Questions and Answers relate to the HCSA benefits. This section only applies to the extent that you have elected to allocate Pre-tax Salary Reductions to the HCSA.

## **Q-9. What is the HCSA?**

The Health Care Reimbursement Account (“HCSA”) is the portion of the Plan that enables you to pay for Eligible Medical Expenses with Pre-tax Salary Reductions. If you are an Eligible Employee for purposes of the HCSA (as defined in the Plan Information Appendix), and you want to participate, you must elect the HCSA during an applicable election period and then elect the amount of Pre-tax salary reductions you wish to set aside for yours and your Eligible Dependents’ Eligible Medical Expenses that you expect will be incurred during the Plan Year (not to exceed the Maximum Salary Reduction Election identified in the Plan Information Appendix). If you elect to participate in the HCSA, a pro-rata share of the annual amount you elect will be withheld from each paycheck. When you or your Eligible Dependents incur Eligible Medical Expenses, you may pay or seek reimbursement for those expenses as described below. NOTE: the HCSA is not an actual account established in your name. It is a notional bookkeeping account that records your Pre-tax Salary Reductions and reimbursements for the year.

The maximum HCSA reimbursement for a Plan Year is equal to the greater of the HCSA Pre-tax Salary Reduction amount you elect or the Pre-Tax Salary Reduction amount plus any non-elective Employer contributions (as described in the applicable enrollment materials).

You will find more details later in this SPD on the following:

- How much of the HCSA amount I elected is available for reimbursement at any given time during the Plan Year?
- What are Eligible Medical Expenses?
- When is an expense “incurred”?
- How am I reimbursed for Eligible Medical Expenses from the HCSA?

**Q-10. How much of the amount HCSA amount that I elected for the Plan Year is available for payment or reimbursement of Eligible Medical Expenses at any given time during the Plan Year?**

Unlike the DCSA, the full Pre-tax Salary Reduction amount that you elect for the HCSA for the Plan Year (reduced by reimbursements already made for expenses incurred during the Plan Year) is available for payment or reimbursement of Eligible Medical Expenses without regard to how much you have contributed at that point. For example, if you elected \$1200 and have already been reimbursed \$500, \$700 is still available even though you have only contributed \$500. NOTE: You must make the required contributions to become and remain a Participant; however, the amount available from your HCSA for payment or reimbursement of Eligible Medical Expenses is not based on how much you have already contributed.

**Q-11. How do I do I receive reimbursement from the HCSA?**

When you incur an Eligible Medical Expense, you file a claim with the Plan's Third-Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third-Party Administrator. You must include with your Request for Reimbursement Form a written statement from the service provider (e.g., a receipt, explanation of benefits or "EOB") associated with each expense that indicates the following:

- The name of the provider;
- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred;
- The amount of the expense;
- The name of the individual for whom the expense was incurred;
- Any other information that the Third-Party Administrator deems necessary.

You may be required to provide additional substantiation to the extent determined necessary to support your claim. For example, if the expense is for a service or item that could also have a non-medical purpose, you may be asked to provide a note from your

health care provider that the service or item was necessary to treat a medical condition. The Third-Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense," you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses prior to the end of the Run-out Period. The Run-out Period is described in the Plan Information Appendix.

NOTE: If your health plan administrator or insurance carrier automatically submits an EOB to the Third-Party Administrator for processing, you may not have to provide any additional substantiation or certification.

Alternatively, you may use an electronic payment card ("Electronic Payment Card" or the "Card") provided to you when you become a Participant in the Plan. The Electronic Payment Card enables you to pay for Eligible Medical Expenses at the point of sale instead of paying for them out of pocket first and then requesting a reimbursement from your HCSA as described above. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as described in this SPD and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement"). The following is a summary of how the Electronic Payment Card Program works.

NOTE: The Electronic Payment Card Program is governed by the terms of this SPD, the Cardholder Agreement that you receive with your Card, and applicable IRS guidance related to HCSA debit cards.

(a) You must make an election to use the Card. To be eligible for the Electronic Payment Card Program ("Program"), you must agree to abide by the terms and conditions of the Program as set forth herein and in the Cardholder Agreement, including any fees, limitations on use, the Plan's right to withhold and offset for ineligible claims, etc. A Cardholder Agreement will be provided to you. The Cardholder Agreement is a part of this Plan.

(b) The Card will be turned off when employment or coverage terminates. The Card will be turned off when you cease to be a Participant.

(c) You certify that you will only use the Card to pay for Eligible Medical Expenses. You certify during the applicable election period described above in Part I that you and any other cardholders will only use the Card to pay for Eligible Medical Expenses, that you have not been reimbursed for the expense, and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of Card use privileges.

(d) You can only use the Card at certain merchants. Use of the Card for Eligible Medical Expenses is limited to merchants identified by the Third-Party Administrator as having a medical merchant category code, certain Pharmacies that meet IRS requirements for HCSA Card use, and merchants that are participating in the Inventory Information Approval System (as defined by the IRS). If you have questions about whether the Card will work at a specific merchant, contact the Third-Party Administrator.

(e) You swipe the Card at the merchant like you do any other credit or debit card. When you incur an Eligible Medical Expense at an eligible merchant, such as a co-payment or prescription drug expense, you swipe the Card at the merchant much like you would a typical credit or debit card. The merchant is paid for the expense up to the maximum amount available through your HCSA. Every time you swipe the Card, you certify to the Plan that the expense that you are paying for with the Card is an Eligible Medical Expense, that you have not been reimbursed from any other source (e.g. other health insurance) and that you will not seek reimbursement from another source.

(f) You must obtain and retain a receipt/third party statement each time you swipe the Card. You must obtain a third-party statement from the merchant (e.g., receipt or invoice) that includes the following information each time you swipe the Card:

- The name of the provider;
- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred;
- The amount of the expense;
- The name of the individual for whom the expense was incurred;
- Any other information that the Third-Party Administrator deems necessary.

This statement provides substantiation required by the IRS that the expense is for an Eligible Medical Expense. You should retain this statement for at least one year following the close of the Plan Year in which the expense is incurred. In accordance with IRS guidance, some of the expenses that you pay for with the Card will not require additional substantiation. Unfortunately, many expenses that you pay for with the Card will require additional substantiation as required by the IRS. If substantiation is required, you will receive notice from the Third-Party Administrator requesting the substantiation. The notice from the Third-Party Administrator will provide instructions on when and where to provide that substantiation.

(g) You must pay back any improperly paid claims. If you are unable to provide adequate or timely substantiation as requested by the Third-Party Administrator, you must repay the Plan for the unsubstantiated expense. You can either repay the Plan with your own funds or, if Eligible Medical Expenses are submitted for reimbursement, those expenses will be offset by the amount of any unsubstantiated claims. The Third-Party Administrator will notify you of the date by which you must repay the unsubstantiated transactions. If you do not repay the Plan within the applicable time period, the Card will be turned off and an amount equal to the unsubstantiated expense will be offset against future Eligible Medical Expenses. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement) or the remaining unpaid amount may be treated by the Employer as any other bad debt, which will result in additional gross income for you.

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

## **Q-12. What is an “Eligible Medical Expense”?**

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

- The expense meets the requirement for Eligible Medical Expenses described in the Plan Information Appendix;
- The expense is for “Medical Care” as defined by Code Section 213(d). Whether an expense is for “medical care” is within the sole discretion of the Plan Administrator; and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An “Eligible Dependent” is your legal spouse (in accordance with federal law) and any other individual who is a “dependent” as defined in Code Section 105(b) (i.e., a dependent who is eligible to receive tax-free health coverage under the Code). Coverage for an individual covered as an Eligible Dependent under the HCSA ends on the date that the individual ceases to meet the requirements to be an Eligible Dependent (e.g. a Spouse ceases to be an Eligible Dependent on the date a divorce is final; a child ceases to be an Eligible Dependent on the last day of the calendar year that the child turned age 26).

The Code generally defines “Medical Care” as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over-the-counter drugs (and over-the-counter products and devices). Not every health-related expense you or your eligible dependents incur constitutes an expense for “medical care.” For example, an expense is not for “medical care,” as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third-Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition, and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. Expenses for over-the-counter drugs, except insulin, are only medical care if they are obtained pursuant to a valid prescription written by a physician.

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

- Health insurance premiums; and

- Expenses incurred for qualified long-term care services.

### **Q-13. Can I use my HCSA for Eligible Medical Expenses that are incurred at any time?**

No. Generally, your annual Pre-tax Salary Reductions may only be used for Eligible Medical Expenses incurred during the Plan Year and while you are a Participant (or if the expense is incurred by a dependent, the expense must be incurred while an Eligible Dependent). An expense is incurred when the service or treatment giving rise to the expense has been performed and not in advance of the services (with limited exceptions for orthodontic treatments that meet IRS guidelines).

**NOTE: Pre-tax Salary Reductions during a Plan Year may be used for Eligible Medical Expenses incurred within 2 months and 15 days immediately following the Plan Year, if your Employer has adopted a grace period or, alternatively, you may be able to carry over up to \$ 0.00 of unused Pre-tax Salary Reductions into following Plan Years if your Employer has adopted a Carry Over feature. See the Plan Information Appendix to see whether the employer has adopted a grace period or carry over feature and what the applicable requirements are.**

You will have until the end of the Run-out Period set forth in the Plan Information Appendix to submit for reimbursement any expenses incurred during the Plan Year. This is called the "Run-Out Period."

### **Q-14. What if the Eligible Medical Expenses I or my Eligible Dependents incur during the Plan Year are less than my Pre-tax Salary Reductions for the year?**

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and your annual HCSA election. You will generally forfeit any unused Pre-tax Salary Reductions for a Plan Year; subject to any carryover or grace period described in the Plan Information Appendix.

### **Q-15. What happens if a claim for benefits under the HCSA is denied?**

If you are denied a benefit under the HCSA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

### **Q-16. What happens to unclaimed HCSA reimbursement checks?**

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

### **Q-17. What is COBRA continuation coverage?**

If you lose coverage under the HCSA due to certain events, a Federal law called "COBRA" entitles you to make an election to continue coverage under the HCSA under certain circumstances. Your COBRA rights and obligations with respect to the HCSA are described below.

#### When Coverage May Be Continued

If you are a Participant in the HCSA, then you generally have a right to choose continuation coverage under the HCSA if you lose your coverage because of:

- A reduction in your hours of employment; or
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the Spouse of a Participant, then you generally have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- The divorce or legal separation from the Participant.

In the case of a dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- His or her parents' divorce or legal separation; or
- He or she ceases to be a dependent child.

Those events that entitle you to elect coverage are called "Qualifying Events." Those covered individuals who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries." A child who is born to, or placed for adoption with, the Participant during a period of continuation coverage is also entitled to continuation coverage under COBRA as a Qualified Beneficiary.

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

#### Type of Continuation Coverage

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

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

## Notice Requirements

You or your covered dependents (including your spouse) must notify the COBRA Administrator identified in the Plan Information Appendix in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost under the Plan because of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's spouse is treated as notice to any covered dependents who reside with the spouse.

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

## Election Procedures and Deadlines

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

## Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium,

however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

### When Continuation Coverage Ends

You may be able to continue coverage under the HCSA until the end of the Plan Year in which the Qualifying Event occurs. However, continuation coverage may end earlier for any of the following reasons on the dates indicated:

- The last day of the last month for which a timely and complete COBRA premium is made (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or \$50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides group health coverage to any of its employees.

### **Q-18. Will my health information be kept confidential?**

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

### **Q-19. How long will the HCSA remain in effect?**

Although the Employer expects to maintain the HCSA indefinitely, it has the right to modify or terminate the program at any time and for any reason.

### **Q-20. How does the HCSA coordinate with any Health Reimbursement Arrangement (HRA) sponsored by the Employer in which I also participate? (Only if Applicable)**

Typically, a HCSA is the payor of last resort. This means the HCSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also

participating in an HRA sponsored by the Employer that covers expenses covered by this HCSA, the employer may require the HCSA pay first, rather than the HRA. If the HCSA pays first, you must exhaust your Health Care Account before using funds allocated to your HRA. The Plan Information Summary will indicate whether the HCSA or HRA must pay first.

## **Other Important HCSA Information**

### **ERISA Rights**

THIS SECTION ONLY APPLIES IF THE PLAN IS SUBJECT TO THE EMPLOYEES RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"). The HCSA Plan is an ERISA welfare benefit plan unless the Employer is a governmental employer or the HCSA is considered a Church Plan (as defined by ERISA). Contact the Plan Administrator for more information regarding the application of ERISA to the Plan.

As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

- Receive information about your Plan and benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all 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 SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (if any). The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage. You may continue health care coverage for yourself, spouse or dependent children if there is a loss of coverage under the Plan

as a result of a Qualifying Event. You or your eligible dependents will have to pay for such coverage. You should review the COBRA section of this SPD for more information concerning your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance with Your Questions**

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **Newborns' and Mothers' Health Protection Act of 1996**

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

# DCSA Benefits

The following Questions and Answers relate to the DCSA benefits. This section only applies to the extent that you have elected to allocate Pre-tax Salary Reductions to the DCSA.

## **Q-21. What is the DCSA?**

The Dependent Care Spending Account (“DCSA”) is the portion of the Plan that enables you to pay for Eligible Day Care Expenses with Pre-tax Salary Reductions. If you are an Eligible Employee for purposes of the DCSA (as defined in the Plan Information Appendix), and you want to participate, you estimate the amount of Eligible Day Care Expenses that you will incur during the Plan Year and you elect during the applicable enrollment period (see Part-1) to make Pre-tax Salary Reductions equal to that amount (not to exceed the Maximum Salary Reduction Election identified in the Plan Information Appendix). When you incur Eligible Day Care Expenses, you may pay or seek reimbursement for those expenses as described below.

NOTE: the DCSA is not an actual account established in your name similar to a checking account. It is a notional bookkeeping account that records your Pre-tax Salary Reductions and reimbursements for the year.

The maximum DCSA reimbursement for a Plan Year is equal to the greater of the HCSA Pre-tax Salary Reduction amount you elect or the Pre-Tax Salary Reduction amount plus any non-elective Employer contributions (as described in the applicable enrollment materials).

**You will find more details later in this SPD on the following:**

- How much of the amount I elected is available for reimbursement at any given time during the year?
- What are Eligible Day Care Expenses?
- When is an expense “incurred”?
- How do I pay or seek reimbursement of those expenses?

**Q-22. How much of the amount that I elected for the DCSA is available for payment or reimbursement of Eligible Day Care Expenses at any given time during the Plan Year?**

Unlike the HCSA, only the Pre-tax Salary Reductions credited to your account (reduced by prior reimbursements) at the time you request reimbursement are available for payment or reimbursement of Eligible Day Care Expenses at any given time during the Plan Year.

**Q-23. How do I receive reimbursement from the DCSA?**

When you incur an Eligible Day Care Expense, you file a claim with the Plan's Third-Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third-Party Administrator. You must include with your Request for Reimbursement Form a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following:

- The name of the provider
- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred;
- The amount of the expense;
- The name of the individual for whom the expense was incurred;
- Any other information that the Third-Party Administrator deems necessary.

The Third-Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Day Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Day Care Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Day Care Expenses prior to the end of the Run-out Period. The Run-out Period is described in the Plan Information Appendix.

## Q-24. What are “Eligible Day Care Expenses”?

You may be reimbursed for work-related dependent day care expenses (“Eligible Day Care Expenses”). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

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

- An individual that you can claim on your federal income tax return as a “Qualifying Child” (as defined in Code Section 152(a)(1)) and who is age 12 or under, or
- A spouse or other tax “Dependent” (as defined generally in Code Section 21) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this DCSA only, a “Dependent” under Code Section 21 means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d); (ii) the individual is a child of a Participant who is a tax dependent of another taxpayer under Code Section 152; or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the “custodial parent” (as defined in Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on his or her tax return.

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your spouse, if applicable) are not working or looking for work; however, an allocation is not required for

temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not Eligible Day Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for “custodial” care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

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

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

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

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

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

**Q-25. Can I use my DCSA for Eligible Day Care Expenses that are incurred at any time?**

You may only use your DCSA for Eligible Day Care Expenses that are incurred during the Plan Year and while a Participant, except as noted below. An expense is “incurred” when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the DCSA becomes effective or before your DCSA election becomes effective. In addition, if you cease to be a Participant, you may continue to be reimbursed for expenses incurred after the date you cease to be a Participant in the DCSA and prior to the end of the Plan Year up to your DCSA balance (i.e. the Pre-tax Salary Reductions credited to your DCSA minus prior reimbursements) on the date you cease to be a Participant.

Your DCSA may be used for Eligible Day Care Expenses incurred within 2½ months immediately following the Plan Year, if your Employer has elected to add a grace period. See the Plan Information Appendix to see whether a grace period applies.

**Q-26. What if the Eligible Day Care Expenses I incur during the Plan Year are less than my Pre-tax Salary Reductions for the DCSA for the year?**

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Day Care Expenses you have incurred and the annual reimbursement amount that you have elected. Any Pre-tax Salary Reductions credited to the DCSA during the year will be forfeited if not used for Eligible Day Care Expenses incurred during the Plan Year. You have until March 31 of the following year to submit expenses incurred during the Plan Year for reimbursement.

**Q-27. What happens if a claim for benefits under the DCSA is denied?**

If you are denied a benefit under the DCSA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

### **Q-28. What happens to unclaimed DCSA reimbursements?**

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

### **Q-29. Will I be taxed on the DCSA reimbursement I receive?**

You will not normally be taxed on your DCSA reimbursement, provided that your family's aggregate dependent day care reimbursement (under this DCSA and/or another employer's DCSA) does not exceed the maximum DCSA amount identified in the Plan Information Appendix. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

### **Q-30. If I participate in the DCSA, will I still be able to claim the household and dependent care credit on my federal income tax return?**

You may not claim any other tax benefit for the tax-free amounts received by you under this DCSA, although the balance of your Eligible Day Care Expenses not reimbursed under this DCSA may be eligible for the dependent care credit.

### **Q-31. What is the household and dependent care credit?**

The household and dependent care credit is an allowance for a percentage of your annual Eligible Day Care Expenses as a credit against your federal income tax liability under the Code. In determining what the tax credit would be, you may take into account only \$3,000 of such expenses for one Qualifying Individual, or \$6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Day Care Expenses (to a maximum credit amount of \$1,050 for one Qualifying Individual or \$2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below

20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross income over \$15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Day Care Expenses of \$3,600, and that your adjusted gross income is \$21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first \$3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each \$2,000 of your adjusted gross income over \$. The calculation is:  $35\% - [(\$21,000 - 15,000)/\$2,000 \times 1\%] = 32\%$ . Thus, your tax credit would be  $\$3,000 \times 32\% = \$960$ . If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been  $\$3,600 \times 32\% = \$1,152$ , because the entire expense would have been considered, not just the first \$3,000.

## Flexible Benefits Plan Information Appendix

This Plan Information Appendix provides information specific to the Pottstown School District Flexible Spending Account Plan.

### I. EMPLOYER/PLAN SPONSOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:		Pottstown School District  230 Beech Street, Pottstown PA 19406
2. Employer's federal tax identification number:		236004120
3. Plan Year:		09/01 thru 08/31
The first Plan Year that the plan is in existence may be a short Plan Year and a subsequent Plan Year may be a short plan year if the Employer changes the Plan Year.		
4. Name, address, and telephone number of the Plan Administrator:  The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD except as otherwise delegated to a third party as set forth herein.		Same as Employer/Plan Sponsor
5. Plan Number:		525
6. Effective Date of Plan		Sep 1, 2026

7. Third-Party Administrator:		OCA Benefit Services 3705 Quakerbridge Rd. Suite 216 Mercerville, NJ, 08619
8. COBRA Administrator:		Contact your Plan Administrator
9. Adopting Employers		None

**II. BENEFITS OFFERED THROUGH THIS PLAN**

Health FSA and Dependent Care Accounts

**III. ELIGIBILITY REQUIREMENTS**

For the Health FSA to be considered an excepted benefit, employees must be eligible to enroll (although they don't need to elect) in the company-sponsored medical plan. Unless specified below, all employees eligible to enroll in the company-sponsored medical plan are eligible to participate in the HCSA and DCSA.

***The following employees are not eligible even though they meet the above requirement:***

No exclusions

The Initial Coverage Effective Date is Sep 1, 2026. Employees must remain eligible during any applicable waiting period.

The Employee's commencement of participation in the Plan is conditioned on the Employee properly enrolling as summarized in the SPD. An "Employee" is limited to individuals who are considered by the Employer to be a common law employee and to whom the Employer furnishes a W-2. Any other individual who is not considered by the Employer to be a common law employee (regardless of any subsequent determination by a court or governmental agency) is not eligible even if they otherwise satisfy other eligibility requirements (such as hours per week). Employees subject to a collective bargaining agreement are not eligible for this Plan even if they otherwise satisfy the general eligibility requirements.

#### IV. SPENDING ACCOUNT MAXIMUM CONTRIBUTION AND REIMBURSEMENTS

- **HCSA:** The maximum amount of Pre-tax Salary Reductions that you may elect to contribute to your HCSA during the Plan Year is the amount determined by your employer and communicated to you in your enrollment materials (not to exceed the limit established by the IRS). The maximum reimbursement is equal to the greater of the annual Pre-tax Salary Reductions you elect or the Pre-tax Salary Reductions You elect plus any Employer non-elective contributions (as set forth in the enrollment materials).
- **DCSA.** The maximum amount of Pre-tax Salary Reductions that you may elect to contribute to your DCSA during the Plan Year is \$7,500 (not to exceed the limit statutory limit). The maximum reimbursement is equal to the greater of the annual Pre-tax Salary Reductions you elect or the Pre-tax Salary Reductions You elect plus any Employer non-elective contributions (as set forth in the enrollment materials).

You should note that the statutory DCSA annual maximum reimbursement is currently \$7,500 per calendar year (irrespective of the Plan Year) if you:

- Are married and file a joint return;
- Are married but your spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Qualifying Individuals for whom you are eligible to receive tax-free reimbursements under the DCSA; or
- Are single.

If you are married and reside together, but file a separate federal income tax return, the statutory DCSA annual maximum reimbursement amount is \$3,750.

In no event can you receive tax-free reimbursements more than Your and Your spouse's earned income (as defined in Code Section 32). If your spouse is incapacitated (as defined by the IRS for DCSA purposes) or a full-time student, your spouse's monthly earned income is deemed to be \$250 if you have only one (1) Qualifying Child and \$500 if you two (2) or more Qualifying Children.

## **V. RUN OUT PERIOD, GRACE PERIOD, AND CARRY OVER**

**Run Out Period:** The Plan's run out period for a Plan Year is **90 days** following the end of the Plan Year. If you cease to be a Participant during the Plan Year, the Plan's run out period is **90 days** after the date that you cease to be a Participant.

**HCSA Grace Period:** The Employer has a Grace Period for the HCSA. If the Employer has adopted a Grace Period, the terms of the Grace Period Appendix attached hereto.

NOTE: You cannot have both a grace period and a carryover.

**DCSA Grace Period:** The Employer has adopted a grace period for the DCSA. If the Employer has adopted a Grace Period, the terms of the Grace Period Appendix attached hereto. NOTE: You cannot have both a grace period and a carryover

## **VI. CLAIMS AND APPEAL PROCEDURES**

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

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

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

- The reason(s) for the denial and the Plan provisions on which the denial is based;

- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim.

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

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

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

**Step 6:** If you still disagree with the Third-Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator. If you still do not agree with the Third-Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third-Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

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

### **Important Information**

Other important information regarding your appeals:

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

## **VII. CHANGE EVENTS**

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Salary Reductions that you have elected to allocate to the HCSA and/or the DCSA during the Plan Year. Notwithstanding the general rule, your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable Eligibility Requirements. Also, you may change or revoke your elections during the Plan Year if you submit a written request (or where applicable, an electronic request) to the Plan Administrator to change your election within 30 days of experiencing one of the following Change Events. Note that only some of the events apply to HCSA elections.

Except for an election change to group health plan benefits (to the extent that they provide other than excepted benefits) resulting from birth, placement for adoption or adoption, all election changes are prospectively effective on the Sep 1, 2026. Election changes to group health plans (to the extent that they provide other than excepted benefits) as a result of birth, adoption or placement for adoption are effective on the date of the birth, adoption or placement for adoption.

**1. Change in Status.** If one or more of the following “Changes in Status” occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events

described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

- A change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse);
- A change in the number of your tax dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);
- Any of the following events that change the employment status of you, your spouse, or your dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the plan of another employer) or other employee benefit plan of an employer of you, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age); and
- A change in your, your spouse's or your dependent's place of residence.

The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage under the Plan. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

*Gain of Coverage Eligibility under Another Employer's Plan.* For a Change in Status in which you, your spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change

in Status only if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.

*Dependent Care Reimbursement Plan Benefits.* With respect to the Dependent Care Reimbursement Plan benefit, you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by \$2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

## **2. Affordable Care Act Related Events**

- An employee who was expected to average 30 hours of service or more per week in a month experiences an employment status change (such as change from full-time to part-time) such that the employee is no longer expected to average 30 hours or more per week each month but does not otherwise lose eligibility under a group health plan that provides minimum essential coverage ("MEC"). In this situation, the employee may prospectively revoke their election under the Plan with respect to the MEC offered through the Plan provided that (i) the employee makes his or her requested election change within the Plan's election change period and (ii) the employee certifies his or her intent to enroll the employee and any other dependents whose coverage is revoked in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- Employee is eligible to enroll in a Qualified Health Plan offered in the Marketplace ("Qualified Health Plan") during the Marketplace's special or annual enrollment

period. In this situation, the employee will be permitted to prospectively revoke his or her election with respect to a group health plan that provides minimum essential coverage provided that (i) the employee makes his or her requested election change within the Plan's election change period and (ii) the employee certifies his or her intent to enroll the employee and any other dependents whose coverage is revoked in new coverage under a Qualified Health Plan that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

**3. Special Enrollment Rights (NOTE: This applies only to HCSA elections and only to the extent that the HCSA is not an "excepted benefit" as defined by the Health Insurance Portability and Accountability Act of 1996).** If you, your spouse and/or a dependent are entitled to special enrollment rights under HCSA as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in for yourself or your eligible dependents because of other medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect HCSA coverage for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within the 30-day election change period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days.

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

**5. Entitlement to Medicare or Medicaid.** If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may cancel that person's HCSA coverage. Similarly,

if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's HCSA coverage.

**6. Change in Cost (does not apply to HCSA elections).** If you are notified that the cost of your coverage under the Plan has significantly increased or decreased or will significantly increase or decrease during the Plan Year, you may make certain prospective election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and choose another day care provider, or drop coverage altogether if you are unable to find another provider. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. For insignificant increases or decreases in the cost of coverage, however, your Pre-tax Salary Reductions will change automatically to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

**7. Change in Coverage (does not apply to HCSA elections).** If your coverage is significantly curtailed, you may revoke your election and either choose another similar benefit option sponsored the Employer or another employer, or you may drop coverage if no similar coverage is available. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (i) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (ii) the plan year for this Plan is different from the plan year of the other employer plan.

**8. Approved Leave of Absence—special rules for the Spending Accounts.** If you take an approved leave of absence, your Spending Account elections are subject to the following terms (depending, in part, on the type of leave you take):

**HCSA Option:**

1. Your Employer may choose to continue HCSA coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave.

2. If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), on the same terms and conditions as though you were still active to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage). Alternatively, the Employer may require all Participants to continue HCSA coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator. The Employer may, on a uniform and consistent basis, continue your coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.
3. If your HCSA coverage ceases while on FMLA leave, you will be permitted to re-enter the HCSA option upon return from such leave on the same basis as you were participating prior to the leave, or as otherwise required by the FMLA. Your coverage under the HCSA may be automatically reinstated provided that HCSA coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.
4. You will have two reinstatement options upon return from FMLA leave:
  - a. You may reinstate the Annual Reimbursement Amount available prior to the leave reduced by the contributions you fail to make while out on leave. Your pre-leave Pre-tax Salary Reduction amount will remain the same. For example: Assume Bob takes a leave of absence on April 1. His HCSA election for the year is \$1,200 (\$100 Pre-Tax Salary reduction per month) and he received no reimbursements before his leave began, therefore, his HCSA balance on April is \$1,200. His coverage ceased during the leave, which lasted 3 months (through June 30). If Bob elects this option upon return, his maximum Annual Reimbursement Amount for the remainder of the year will be \$900 [\$1200 pre-leave Annual Reimbursement Account reduced by \$300 (\$100 for each month he was out on leave)] Bob's monthly Pre-tax Salary Reduction amount will be \$100.
  - b. You may reinstate the Annual Reimbursement Amount available prior to the leave. The contributions that you fail to make during your leave will be pro-

rated over the remaining months in the Plan Year and added to the original monthly Pre-tax Salary Reduction amount. For example, assume Bob elects this option upon return from leave. Bob will have a \$1200 maximum Reimbursement Amount available when he returns but his monthly Pre-tax Salary Reduction amount will be \$150 (\$300 pro-rated over the remaining 6 months).

- c. If your coverage ceases during the leave, you are not eligible for reimbursement of expenses incurred during the period in which your coverage was ineffective regardless of which reinstatement option you have.

**DCSA Option:** Your DCSA elections under this Plan shall be treated in the same manner that the Employer treats elections for non-health benefits with respect to Participants commencing and returning from unpaid non-FMLA leave.

## **GRACE PERIOD APPENDIX**

### **For The Pottstown School District Flexible Benefit Plan**

The Employer has established a “grace period” for the HCSA and/or DCSA (as noted in the Plan Information Appendix) that follows the end of the Plan Year during which amounts you have allocated to the applicable spending account(s) that are unused at the end of the Plan Year may be used to reimburse eligible expenses (with respect to the applicable spending account) incurred during the grace period.

The grace period will begin on the first day of the next Plan Year and will end two (2) months and fifteen (15) days later. For example, if the Plan Year ends December 31 of Plan Year #1, the grace period begins January 1 of Plan Year #2 and ends March 15 of Plan Year #2.

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

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

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the Plan Year to which the grace period relates to the extent such expenses have not yet been submitted for reimbursement. Previous claims will not be reprocessed or recharacterized so as to change the order in which they were received.
- For example, assume that \$200 remains in your HCSA account at the end of the Plan Year #1 and further assume that you have elected to allocate \$2400 to the HCSA for Plan Year #2. If you submit for reimbursement an Eligible Medical

Expense of \$500 that was incurred in Plan Year #2, \$200 of your claim will be paid out of the unused amounts remaining in your HCSA from the Plan Year #1 and the remaining \$300 will be paid out of amounts allocated to your HCSA for Plan Year #2.

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

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

Pottstown School District  
HEALTH CARE SPENDING ACCOUNT (“HCSA”)

HIPAA PRIVACY AND SECURITY APPENDIX  
Effective Sep 1, 2026

**HIPAA PRIVACY**

**1.01 Scope and Purpose.** The HCSA (the “Plan”) will use protected health information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as set forth below.

**2.02 Definitions.** For purposes of this Appendix, the following definitions shall apply:

- a. **“Breach”** shall mean the acquisition, access, use, or disclosure of an individual’s PHI in a manner not permitted under the Privacy Rule that compromises the security or privacy of the PHI. A Breach does not include:
  - i. an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure;
  - ii. an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or
  - iii. a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

- b. “Electronic Protected Health Information” or “Electronic PHI” means PHI that is transmitted by or maintained in electronic media.
- c. “Health Care Operations,” as defined under 45 C.F.R. Section 164.501, means any of the following activities to the extent that they are related to the Plan’s covered functions:
  - i. Conducting quality assessment and improvement activities; population-based activities related to health improvement, reduction of health care costs, case management and care coordination; contacting health care providers and patients regarding treatment alternatives; and related functions that do not include treatment;
  - ii. Reviewing competence or qualifications of health care professionals and evaluating provider and Plan performance;
  - iii. Underwriting and other activities that relate to the creation, renewal or replacement of a contract of health insurance or health benefits; and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance);
  - iv. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
  - v. Business planning and development, such as cost-management and planning-related analysis related to managing and operating the Plan, and development or improvement of coverage policies; and
  - vi. Business management and general administrative activities, including, but not limited to: (A) management activities related to implementation of and compliance with the requirements of the Privacy Rule; (B) customer service, including the provision of data analyses for the Plan sponsor, provided that PHI is not disclosed to the Plan sponsor; (C) resolution of internal grievances; (D) due diligence related to the sale, transfer, merger or consolidation of all or part of the Plan with another entity directly regulated under the Privacy Rule, or an entity that, following such activity, will be subject to the Privacy Rule; and (E) consistent with applicable requirements

of the Privacy Rule, creating de-identified information, as defined in 45 C.F.R. Section 164.514(b)(2), or a limited data set, as defined under 45 C.F.R. Section 164.514(d)(2).

- d. "Payment," as defined under 45 C.F.R. Section 164.501, means activities undertaken by the Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care. Such activities include, but are not limited to:
- i. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
  - ii. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
  - iii. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related health care data processing;
  - iv. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
  - v. Utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services; and
  - vi. Disclosure to consumer reporting agencies of necessary information relating to collection of premiums or reimbursement.
- e. "Privacy Policy" means the Employer's internal HIPAA privacy and security policies and procedures.
- f. "Protected Health Information" or "PHI" means individually identifiable health information that (i) relates to the past, present or future physical or mental condition of a current or former Participant, provision of health care to a Participant, or payment for such health care; (ii) can either identify the Participant,

or there is a reasonable basis to believe the information can be used to identify the Participant; and (iii) is received, created, maintained or transmitted by or on behalf of the Plan.

- g. “Responsible Employee” means an employee (including a contract, temporary or leased employee) of the Plan or of the Employer whose duties (A) require that the employee have access to PHI for purposes of Plan Payment or Health Care Operations; or (B) make it likely that he will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 1.03. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates, receives, maintains or transmits PHI on behalf of the Plan, even though his duties do not (or are not expected to) include creating, receiving, maintaining or transmitting PHI. Responsible Employees are within the Employer’s HIPAA firewall when they perform Plan functions.
- h. “Security Incident” as defined under 45 C.F.R. Section 164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- i. “Security Rule” means the regulations issued under HIPAA concerning the security of Electronic PHI.

**1.03 Responsible Employees.** Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health Plan administration functions that the Employer performs on behalf of the Plan pursuant to Section 1.04.

- a. Employer employees who perform the following functions on behalf of the Plan are Responsible Employees:
  - i. claims determination and processing functions;
  - ii. Plan vendor relations functions;
  - iii. benefits education and information functions;
  - iv. Plan administration activities;
  - v. legal department activities;

- vi. Plan compliance activities;
  - vii. information systems support activities;
  - viii. internal audit functions; and
  - ix. human resources functions.
- b. In addition to those individuals described in subsection (a), the Administrator who performs claims appeals and other decision-making functions on behalf of the Plan, the Plan's HIPAA privacy officer and security official, and Employer employees to whom the Plan's HIPAA privacy officer and security official has delegated any of the following responsibilities shall also be Responsible Employees:
- i. implementation, interpretation and amendment of the Privacy Policy;
  - ii. Privacy Rule or Security Rule training for Employer employees;
  - iii. investigation of and response to complaints by Participants and/or employees;
  - iv. preparation and maintenance of the Plan's privacy notice;
  - v. distribution of the Plan's privacy notice;
  - vi. response to requests by Participants to inspect or copy PHI;
  - vii. response to requests by Participants to restrict the use or disclosure of their PHI;
  - viii. response to requests by Participants to receive communications of their PHI by alternate means or in an alternate manner;
  - ix. amendment and response to requests to amend Participants' PHI;
  - x. response to requests by Participants for an accounting of disclosures of their PHI;
  - xi. response to requests for information by the Department of Health and Human Services;
  - xii. approval of disclosures to law enforcement or to the military for government purposes;
  - xiii. maintenance of records and other documentation required by the Privacy Rule or Security Rule;
  - xiv. negotiation of Privacy Rule and Security Rule provisions and/or reasonable security provisions into contracts with third party service providers;
  - xv. maintenance of Plan PHI or Electronic PHI security documentation; or
  - xvi. approval of access to Electronic PHI.

**1.04 Permitted Uses and Disclosures.** Responsible Employees may access, request, receive, use, disclose, create and/or transmit PHI only to perform certain permitted and required functions on behalf of the Plan, consistent with the Privacy Policy. This includes:

- a. uses and disclosures for the Plan's own Payment and Health Care Operations functions;
- b. uses and disclosures for another HIPAA covered entity's Payment and Health Care Operation functions to the extent permitted under HIPAA;
- c. disclosures to a health care provider, as defined under 45 C.F.R. Section 160.103, for the health care provider's treatment activities;
- d. disclosures to the Employer, acting in its role as Plan Sponsor, of (i) summary health information for purposes of obtaining health insurance coverage or premium bids for the Plan or for making decisions to modify, amend or terminate the Plan; or (ii) enrollment or disenrollment information;
- e. disclosures of a Participant's PHI to the Participant or his personal representative, as defined under 45 C.F.R. Section 164.502(g);
- f. disclosures to a Participant's family members or friends involved in the Participant's health care or payment for the Participant's health care, or to notify a Participant's family in the event of an emergency or disaster relief situation;
- g. uses and disclosures to comply with workers' compensation laws;
- h. uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;
- i. disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule or Security Rule;
- j. uses and disclosures for other governmental purposes, such as for national security purposes;

- k. uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
- l. uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;
- m. uses and disclosures required by other applicable laws; and
- n. uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 C.F.R. Section 164.508.

Notwithstanding anything in the Plan to the contrary, the use or disclosure of PHI that is genetic information about an individual for underwriting purposes shall not be permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal or replacement of a contract of health insurance.

**1.05 Certification Requirement.** The Plan shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

- a. not to use or further disclose PHI other than as permitted or required by this Appendix and the Privacy Policy or as required by law;
- b. to take reasonable steps to ensure that any agents, including subcontractors, to whom the Employer provides PHI or Electronic PHI, received from the Plan agree:
  - i. to the same restrictions and conditions that apply to the Employer with respect to such PHI; and
  - ii. implement reasonable and appropriate security measures to protect such Electronic PHI.
- c. not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer except

to the extent permitted within the Organized Health Care Arrangement of which the Plan is a part;

- d. to report to the Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 1.04, or any Security Incident, of which the Employer becomes aware;
- e. to make available PHI for inspection and copying in accordance with 45 C.F.R. Section 164.524;
- f. to make available PHI for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526;
- g. to make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;
- h. to make its internal practices, books and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule or the Security Rule;
- i. if feasible, to return or destroy all PHI and Electronic PHI, received from the Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI 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 PHI infeasible and Electronic PHI;
- j. to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and
- k. to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic PHI that the Employer creates, receives, maintains or transmits on behalf of the Plan.

**1.06 Organized Health Care Arrangement.** The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other benefit under a covered group health plan (under 45 C.F.R. § 160.103) provided by the Employer.

**1.07 Mitigation.** In the event of non-compliance with any of the provisions set forth in this Appendix:

- a. The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document his investigation efforts and findings.
- b. If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Appendix, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.
- c. If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

**1.08 Breach Notification.** Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 C.F.R. Section 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 C.F.R. Section 164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

**1.09 Privacy Official.** The Plan shall designate a Privacy Official, who will be responsible for the Plan's compliance with HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition, and

notwithstanding any provision of this Plan to the contrary, the Privacy Official shall have the authority to and be responsible for:

- a. Accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Appendix;
- b. Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Employer;
- c. Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the requirements of HIPAA;
- d. Establishing and overseeing proper training of the Plan, or Employer personnel who will have access to PHI;
- e. Any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of this Appendix.

**1.10 Noncompliance.** The Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Appendix.

**1.11 Interpretation and Limited Applicability.** This Appendix serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Appendix nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the Benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Appendix are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

**1.12 Services Performed for the Employer.** Notwithstanding any other provision of this Plan to the contrary, all services performed by a business associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and

enrollment in the Plan. If a business associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Plan.