

FLEXIBLE SPENDING ACCOUNT PLAN SUMMARY PLAN DESCRIPTION



Administered By:



Effective July 1, 2009

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PLAN INFORMATION APPENDIX PI-1

Introduction to the Flexible Spending Account Plan Summary Plan Description

Maricopa County (the "Employer") is pleased to sponsor an employee benefit program known as The Flexible Spending Account Plan (the "Plan"). There are two types of flexible spending accounts provided under the Plan: a Health Care Spending Account ("HCSA") and a Dependent Care Spending Account ("DCSA").

The Plan is called a "flexible" spending account plan because you determine the amount of unreimbursed eligible medical and/or dependent day care expenses that you (and where applicable, your eligible family members) will likely incur during the Plan Year and you elect to have the Employer withhold equal amounts from your pay (subject to Plan limitations) *on a pre-tax basis* for reimbursement of such expenses. Any amounts that you elect to have withheld for reimbursement of eligible medical expenses will be credited to the HCSA and any amounts that you elect to have withheld for reimbursement of dependent day care expenses will be credited to the DCSA. You must elect wisely because any amounts allocated to a flexible spending account that are not used for expenses incurred during the Plan Year will generally be forfeited.

The Plan is beneficial to you because amounts that you elect to have withheld from your pay for reimbursement of eligible medical and/or dependent day care expenses are withheld *before* any federal income and employment taxes (e.g., FICA and FUTA) are applied, and in most cases, before any applicable state taxes are applied. If you have unreimbursed medical and/or dependent day care expenses, participation in this Plan will actually increase your take home pay over what your net take home would be if you paid for such expenses with after-tax dollars.

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 format. We encourage you to read the entire SPD, but if you have questions about your rights and obligations under the Plan, please refer to the Table of Contents above for the Question that most resembles your question. Information relating to the Plan that is specific to your Employer is described in the Plan Information Appendix attached to this SPD. You will be referred to the Plan Information Appendix throughout the SPD. In addition, terms that are capitalized throughout are terms that are specifically defined in the SPD or the Plan document.

This SPD and the Plan Information Appendix attached hereto (collectively, the "SPD") describe the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a Plan document into which this SPD has been incorporated. If there is a conflict between the official Plan document and the SPD, the SPD will govern. The effective date of this SPD is set forth in the attached Plan Information Appendix.

If you have any questions regarding the terms of the Plan, the HCSA and/or the DCSA, contact the Plan Administrator identified in the Plan Information Appendix. The Plan Administrator's name, address and telephone number appear in the Plan Information Appendix attached to this SPD. Other important information has been provided in the Plan Information Appendix attached to this SPD.

Flexible Spending Account Plan Questions and Answers

Part I: General Information about the Plan

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

The purpose of the Plan is to allow eligible employees to use pre-tax dollars ("Pre-tax Contributions") to pay for certain otherwise unreimbursed medical and/or dependent day care expenses.

Q-2. Who can participate in the Plan?

Each employee of the Employer who satisfies the Plan's "Eligibility Requirements" will be eligible to begin participating in this Plan on the applicable "Eligibility Date." The Eligibility Requirements and the Eligibility Date are identified in the Plan Information Appendix. Those employees who actually participate in the Plan are called "Participants."

Q-3. When does my participation in the Plan end?

You continue to participate in the Plan until the earlier of the date that (i) you elect not to participate in this Plan; (ii) you no longer satisfy the Eligibility Requirements (e.g., you terminate employment); or (iii) the Plan is terminated or amended to exclude you or the class of employees of which you are a member.

If you cease to satisfy the Eligibility Requirements during the Plan Year but become eligible for the Plan again during the same Plan Year and more than 30 days after ceasing to satisfy the Eligibility Requirements, you may make new elections under the Plan. If you cease to satisfy the Eligibility Requirements during the Plan Year but become eligible for the Plan again during the Plan Year and within 30 days or less after ceasing to satisfy the Eligibility Requirements, your prior elections will be reinstated and will remain in effect for the remainder of the Plan Year.

Q-4. How do I become a Participant?

You become a Participant in the Plan by (i) completing the designated election form on which you indicate the amount of your pay you wish to have withheld and then allocated to the HCSA and/or the DCSA and (ii) timely submitting the election form to the entity/person designated on the election form during one of the enrollment periods described below. You will be provided with an election form (or you will be provided with access to an election form) on or before the beginning of the applicable enrollment period.

IMPORTANT: If you want tax-free reimbursement of unreimbursed medical expenses, you must affirmatively elect to participate in the HCSA. If you want tax-free reimbursement of dependent day care expenses, you must affirmatively elect to participate in the DCSA. You can choose either one or both.

You cannot become a Participant in this Plan prior to the date you complete and submit your election form.

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

Q-5. What are the enrollment periods under the Plan?

When you are first hired, you must enroll during the "Initial Enrollment Period" if you want to participate. The enrollment material provided by the Employer (or the Third Party Administrator identified in the Plan Information Appendix) will identify the beginning and end dates of the Initial Enrollment Period. If you make an election during the Initial Enrollment Period, your participation in the spending account(s) that you elect will begin on the later of your Eligibility Date or the date that your election is received and processed by the entity processing your election form. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you experience a specified event that will allow a mid-year election change (see below for more details on mid-year election changes).

If you do not make an affirmative election to participate in either of the spending accounts during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year unless you experience an event that allows you to change that election during the Plan Year.

The Plan also has an "Annual Enrollment Period" during which you may enroll (if you did not enroll during the Initial Election Period), continue your previous election or change your previous elections for the next Plan Year. You will be notified each year of the beginning and end dates of the Annual Enrollment Period. You must make an affirmative election to participate, change your election, or continue your current election for the next Plan Year. The election that you make during the Annual Enrollment Period is effective the first day of the following Plan Year and is irrevocable for the entire Plan Year unless you have experienced an event that allows a mid-year election change.

If you are a current Participant in the Plan and you fail to complete and submit an election form during the Annual Enrollment Period, you will be deemed to have elected not to participate during the next Plan Year.

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

Q-6. How are the contributions to the spending accounts made under the Plan?

When you become a Participant in the Plan, your share of the contributions for the elected spending accounts will be paid with Pre-tax Contributions that you elected on the election form. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal taxes (and in most cases, state taxes) have been deducted. In addition, all or a portion of the cost of the spending accounts may, in the Employer's discretion, be paid with contributions made by

the Employer on behalf of each Participant (these are called "Nonelective Contributions"). The amount of Nonelective Contribution that is applied towards one or both of the cost of the spending accounts for each Participant is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion. The Nonelective Contribution amount, if any, will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may provide you with Nonelective Contributions and then allow you to allocate the Nonelective Contributions towards one or both of the spending accounts (subject to restrictions described in the enrollment material).

Q-7. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution that you have elected to allocate to the HCSA and/or the DCSA. That being said, your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable Eligibility Requirements. Otherwise, you may change your Pre-tax Contribution elections only during the Annual Enrollment Period, and then, only for the coming Plan Year.

There is an important exception to this general rule that you cannot revoke your elections during the Plan Year: You may change or revoke your elections during the Plan Year if you submit a written request (or where applicable, an electronic request) for an election change with the Plan Administrator (or the Third Party Administrator identified in the Plan Information Appendix) within 30 days of experiencing one of the following events. Note that not all of the events apply to HCSA elections.

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, or ceasing to be a student; 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. With the exception of an election change to the HCSA resulting from birth, placement for adoption or adoption, all election changes are prospective. 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. 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.

3. **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.

4. **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.

5. **Change in Cost (applies only to DCSA elections).** If you are notified that the cost of your DCSA 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 DCSA coverage, however, your Pre-tax Contributions 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.

6. **Change in Coverage (applies only to DCSA elections).** If your coverage under the DCSA is significantly curtailed, you may revoke your election and either choose another day care provider or drop coverage altogether. Further, if you change day care providers, you may revise your elections to correspond to the new provider. 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.

Additionally, your election(s) may be modified downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

7. **Approved Leave of Absence.** If you take an approved leave of absence, your elections are subject to the following terms (depending, in part, on the type of leave you take):

- If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your HCSA coverage on the same terms and conditions as though you were still active.
- Your Employer may elect to continue all 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 with Pre-tax Contributions withheld from pay you receive while on leave.
- In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your HCSA, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave (not to exceed the end of the Plan Year) with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Plan Administrator.
- If your HCSA coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the HCSA upon return from such leave on the same basis as you were participating in the HCSA prior to the leave, or as otherwise required by the FMLA. Your HCSA coverage may be automatically reinstated provided that coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.
- The Employer may, on a uniform and consistent basis, continue your HCSA 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 Employer.
- If you are commencing or returning from unpaid FMLA leave, your DCSA election under this Plan shall be treated in the same manner that elections for non-health plans are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

Q-8. 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-9. What effect will Plan participation have on Social Security and other benefits?

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

Flexible Spending Account Plan
Part II. 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 Contributions to the HCSA.

Q-10. What is the "Health Care Spending Account"?

The Health Care Spending Account ("HCSA") is the portion of the Plan that provides for reimbursement of Eligible Medical Expenses incurred by the Participant and his/her Eligible Dependents. If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions (and where applicable, any non-elective Employer contributions) allocated to the account and the reimbursements for Eligible Medical Expenses to which you are entitled during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Q-11. What is the maximum annual reimbursement amount that I may elect under the HCSA?

You may choose any reimbursement amount you desire subject to the maximum annual HCSA Reimbursement Amount (and HCSA Minimum Reimbursement Amount) described in the Plan Information Appendix.

Any change in your election affecting annual contributions to the HCSA will change the maximum available reimbursement for the remainder of the Plan Year. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-12. How are amounts allocated to the HCSA withheld from my pay?

When you enroll online, you specify the amount of reimbursement for Eligible Medical Expenses you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any non-elective Employer Contributions (if any) allocated to your HCSA, will be withheld from each paycheck by your Employer.

Q-13. What amounts will be available for reimbursement of Eligible Medical Expenses at any particular time during the Plan Year?

The full annual amount of reimbursement you have elected under the HCSA (reduced by prior reimbursements made during the Plan Year) will be available at any time during the Plan Year without regard to how much you have contributed to the HCSA.

Q-14. How do I receive reimbursement under 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 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; and
- The amount of the expense.

You may be required to provide additional substantiation to the extent determined necessary to support your claim. 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.

You may also be able to use an electronic payment card to pay expenses at the time they are incurred. If the Employer provides an electronic payment card, the terms of the electronic payment card will be set forth in the Plan Information Appendix.

Q-15. What is an "Eligible Medical Expense"?

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

- The expense is for "medical care" as defined by Code Section 213(d). 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.

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. Also, "stockpiling" of over-the-counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator). Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

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;
- Expenses incurred for qualified long term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Appendix and/or enrollment material.

If you currently maintain or wish to establish a personal Health Savings Account (Limited Reimbursement Option)

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

- (i) Services or treatments for dental care (excluding premiums)**
- (ii) Services or treatments for vision care (excluding premiums)**
- (iii) Services or treatments for "preventive care". Preventive care is defined in accordance with applicable rules and regulations, including but not limited to the guidance set forth in IRS Notice 2004-23 and Notice 2004-50. This may include any prescription or over the counter drugs to the extent such drugs are taken by an eligible individual (a) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e. the eligible individual is asymptomatic) (b) to prevent the recurrence of a condition from which the eligible individual has recovered or (c) as part of a preventive care treatment program (e.g. a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition. The Plan Administrator has sole discretion to determine if the expense constitutes preventive care.**

An HCSA participant may only make an election during the annual enrollment period and/or the initial enrollment period to limit reimbursement under this Health FSA to the medical expenses described in this SPD.

Q-16. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred *during* the Plan Year and while a Participant. 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 HCSA becomes effective, before your HCSA election becomes effective, or after a separation from service (except for expenses incurred during an applicable COBRA continuation period).

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

Q-17. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have allocated to the HCSA?

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 the annual reimbursement amount that you have elected. Except as otherwise set forth in the Plan Information Appendix, any amount allocated to the HCSA will be forfeited by the Participant if it has not been applied by the end of the Run-out Period to reimburse expenses incurred during the Plan Year. The Run-out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the HCSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year.

Q-18. 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-19. What happens to unclaimed HCSA reimbursements?

Any reimbursements 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 shall be forfeited.

Q-20. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the HCSA, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

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 particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. 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 first day of the month following the month for which you made a timely and complete premium payment (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 under which you are not subject to a pre-existing condition exclusion limitation *after you have elected COBRA continuation coverage*;
- The date that you first become entitled to Medicare *after you have elected COBRA continuation coverage*; or
- The date the Employer no longer provides group health coverage to any of its employees.

Q-21. 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-22. How does this HCSA interact with a Health Reimbursement Arrangement sponsored by my Employer?

Typically, a HCSA is the payer of last resort. This means the HCSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in a Health Reimbursement Arrangement or "HRA" 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 HCSA balance before using funds allocated to your HRA. The Plan Information Appendix will indicate whether the HCSA or HRA must pay first.

Q-23. 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.

Other Important HCSA Information

ERISA Rights

The HCSA Plan is an ERISA welfare benefit 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 HCSA appendix for more information concerning your COBRA continuation coverage rights.

(To the extent the HCSA is subject to HIPAA's portability rules) You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you move to another plan and you have creditable coverage from this

Plan. You will be provided a certificate of creditable coverage, free of charge, from the HCSA when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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).

Flexible Spending Account Plan
Part III. 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 Contributions to the DCSA.

Q-24. What is the "Dependent Care Spending Account"?

The DCSA is the portion of the Plan that provides for reimbursement of Eligible Day Care Expenses incurred by the Participant. If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions (and where applicable, any non-elective Employer contributions) allocated to the account and the reimbursements for Eligible Day Care Expenses to which you are entitled during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Q-25. What is the maximum reimbursement amount that I may elect under the DCSA?

You may choose any reimbursement amount you desire subject to the maximum annual DCSA Reimbursement Amount (and DCSA Minimum Reimbursement Amount) described in the Plan Information Appendix. In addition, the amount of reimbursement that you receive cannot exceed the lesser of your or your spouse's earned income (as defined in Code Section 32). For purposes of this DCSA, your spouse will be deemed to have earned income of \$250 (\$500 if you have two or more Qualifying Individuals (as defined in Q-29), for each month that your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student (as defined by Code Section 21).

Q-26. How are amounts allocated to the DCSA withheld from my pay?

When you enroll online, you specify the amount of reimbursement for Eligible Day Care Expenses you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any non-elective Employer Contributions (if any) allocated to your DCSA sub-account, will be withheld from each paycheck by your Employer.

Q-27. What amounts will be available for reimbursement of Eligible Day Care Expenses at any particular time during the Plan Year?

Under the DCSA, you may be reimbursed only up to the amount of your DCSA sub-account balance at the time the request for reimbursement is processed.

Q-28. How do I receive reimbursement under 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 nature of the expense;
- The date or dates the services were provided; and
- The amount of the expense.

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-29. 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-30. When must the expenses be incurred in order to receive reimbursement?

Eligible Day Care Expenses must be incurred *during* the Plan Year and while a Participant. 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, before your DCSA election becomes effective, or after a separation from service.

Q-31. What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount I have allocated to the DCSA?

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. Except as otherwise set forth in the Plan Information Appendix, any amount allocated to the DCSA shall be forfeited by the Participant if it has not been applied by the end of the Run-out Period to reimburse expenses incurred during the Plan Year. The Run-out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

Q-32 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-33. 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-34. 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 statutory limits set forth above. 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-35. 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-36. 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 \$15,000. 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 taken into account, not just the first \$3,000.

**Flexible Spending Account Plan
Plan Information Appendix**

This Plan Information Appendix provides information specific to the Maricopa County Flexible Spending Account Plan.

I. EMPLOYER/PLAN SPONSOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	Maricopa County 301 W JEFFERSON STREET PHOENIX, AZ 85003 602-372-2837
2. Employer's federal tax identification number:	86-6000472
3. Adopting Employers participating in the Plan:	N/A
4. Effective Date of the Plan:	July 1st, 2009
5. Effective Date of Amendment / Restatement (if different from 4):	N/A
6. The initial Plan Year:	July 1st, 2009 to June 30th
7. All subsequent Plan Years:	July 1st- June 30th
8. 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.	Maricopa County 301 W. Jefferson Street Phoenix, AZ 85003 602-506-1010
9. Plan Number:	N/A
10. Third-Party Administrator:	ADP Benefit Services 2575 Westside Parkway, Suite 500 Alpharetta, GA 30004-3852
11. COBRA Administrator:	COBRA

II. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, and ELECTIONS

(a) The Flexible Spending Account Plan

Each employee who works at least 20+ hours (Contract employees are not required to work for a specific # of Hours) (“Eligibility Requirements”) will be eligible to participate in this Plan on first day of the month following hire (“Eligibility Date”).

The employee's commencement of participation in the Plan is conditioned on the employee properly enrolling online as summarized in the SPD.

III. Spending Account Reimbursement Limits

(a)(1) HCSA Reimbursement: The HCSA Reimbursement Amount shall not exceed the amount elected under the Plan, which cannot exceed \$5200.00 per Plan Year. The HCSA Minimum Reimbursement Amount that may be elected is \$26.00.

(a)(2) Interaction with HRA. See below regarding this HCSA’s rules with respect to coordination with an HRA

Does the Employer sponsors an HRA?	Error! Reference source not found.
Does this HCSA or the HRA pay first with respect to any expenses that are covered by both the HRA and HCSA?	Error! Reference source not found.

(b) DCSA Reimbursement. The DCSA Reimbursement Amount shall not exceed the amount elected, which cannot exceed the statutory maximum. The DCSA minimum reimbursement amount that may be elected is \$26.00.

You should note that the statutory maximum annual amount is currently \$5,000 per Plan Year if you (this only applies if "statutory maximum" is identified as the maximum manual reimbursement that may be elected under the DCSA):

- 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 maximum reimbursement amount under the DCSA that you may elect is \$2,500.

IV. RUN-OUT PERIOD FOR PLAN YEAR EXPENSES

(a) The Run-out Period for active employees is 150 days after the end of the Plan Year.

- (b) The Run-out Period for Participants whose coverage is terminated employees is 60 days.

V. 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 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 Benefit Plan(s).

VI. GRACE PERIOD

The Employer [Error! Reference source not found.](#) established a "grace period" for the [Error! Reference source not found.](#) that follows the end of the Plan Year during which any amounts unused at the end of the Plan Year may be used to reimburse Eligible Expenses 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, 2005, the grace period begins January 1, 2006 and ends March 15, 2006.

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

- A Participant in the HCSA and/or DCSA (as applicable) on the last day of the Plan Year to which the grace period relates, or
- (for HCSA only) 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.

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. The Employer may establish procedures whereby reimbursement for expenses incurred during the grace period (to the extent submitted before the end of the Run-out Period applicable to the prior Plan Year) are reprocessed so that you are able to maximize your annual election amount for the current Plan Year. The procedures will be uniform and nondiscriminatory.

VII. ELECTRONIC PAYMENT CARDS

The Employer **Error! Reference source not found.** permit Participants to use an electronic payment cards to pay for Eligible Expenses at the point of service. If the Employer permits Participants to use an electronic payment card, the following rules apply.

Electronic Payment Card Terms of Usage

You may use the electronic payment card to pay for **HCSA expenses**.

You have two reimbursement options under the account(s) identified above. You can complete and submit a written claim for reimbursement ("Traditional Paper Claims") as indicated above. Alternatively, you may use an electronic payment card ("Electronic Payment Card" or the "Card") provided by the Employer to pay the expense. 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 set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the program, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc). The following is a summary of how the Electronic Payment Card option works.

Electronic Payment Card: The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

(a) *You must make an election to use the Card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. A Cardholder Agreement will be provided to you. The Card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

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

(c) *You must certify proper use of the Card.* As specified in the Cardholder Agreement, you certify during the applicable election period that the amounts in your HCSA will only be used 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) *Reimbursement under the Card is limited to certain merchants.* Use of the Card for Eligible Medical Expenses is limited to merchants identified by the Plan Administrator or its designee as an eligible merchant. The Card will be administered in accordance with applicable IRS guidance.

(e) *You swipe the Card at the merchant like you do any other credit or debit card.* When you incur an Eligible 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 reimbursement amount available under the HCSA. Every time you swipe the Card, you certify to the Plan that the expense for which payment under the HCSA is being made is an Eligible Medical Expense, that you have not been reimbursed from any other source and you will not seek reimbursement from another source.

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

- 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; and
- The amount of the expense.

You should retain this receipt for one year following the close of the Plan Year in which the expense is incurred. Even though payment is made under the Card arrangement, a written third party statement is generally required to be submitted (except as otherwise set forth in the applicable law and/or related guidance). You will receive a letter from the Third Party Administrator that a third party statement is needed. You must provide the third party statement to the Third Party Administrator within 45 days (or such longer period provided in the letter from the Third Party Administrator) of the request. In accordance with applicable guidance, there may be situations in which the Third Party Administrator does not ask for substantiation related to a Card swipe.

(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. The deadline for repaying the Plan is set forth in the Cardholder Agreement. 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.