

**COUNTY OF SACRAMENTO**

**FLEXIBLE BENEFIT PLAN**

**SUMMARY PLAN DESCRIPTION**



**EFFECTIVE: OCTOBER 1, 1984**

**AMENDMENT AND  
RESTATEMENT EFFECTIVE: JANUARY 1, 2005**

# FLEXIBLE BENEFIT PLAN

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# INTRODUCTION

The County is pleased to sponsor an employee benefit program known as a “Flexible Benefit Plan” (the “Plan”). Under federal tax laws, this Plan is also known as a “Cafeteria Plan.” It is so-called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The County provides you with the opportunity to use pre-tax dollars to pay for these programs by entering into a Salary Reduction Agreement. This agreement allows you to pay for the Benefits you elect on a pre-tax basis. You save Social Security and income taxes on the amount of your Salary Reduction. There are three parts to this program: (1) pre-tax payment of insurance premiums; (2) Medical Reimbursement Account; and, (3) Dependent Care Reimbursement Account.

This booklet describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The booklet is only a summary of the key parts of the Plan and a brief description of your rights as a Participant. It is not a part of the official Plan Documents. If there is a conflict between the Plan Documents and this booklet, the Plan Documents will apply.

## Article I Definitions

### Definitions

The following words and phrases as used in this booklet shall have the following meanings, unless a different meaning is plainly required by context.

**1.01 “Anniversary Date”** means the first day of any subsequent Plan Year.

**1.02 “Annual Benefit”** means a Benefit elected hereunder and provided during the Plan Year.

**1.03 “Benefit Election Form”** means the Individual Participant Enrollment Form(s) used by the Plan Administrator by which an Eligible Employee or Participant enrolls and elects Benefits in accordance with Articles II, III, IV, and V, and otherwise agrees to a reduction of his or her salary or other Compensation to provide funds for the Benefits described in this Plan.

**1.04 “Benefits” or “Benefit”** means those Benefits or coverage available for election by a Participant under Articles III-VI.

**1.05 “Board of Supervisors”** means the duly elected Board of Supervisors of the County, as constituted from time to time.

**1.06 “Change in Status”** means:

- (a) A change in an Eligible Employee’s legal marital status: marriage, death of a Spouse, divorce, legal separation, and annulment;
- (b) A change in an Eligible Employee’s number of Dependents, either gaining or losing a Dependent, including a child placed for adoption, step-children, gain of a Dependent through legal guardianship, and/or a foster child;
- (c) A change in employment status of an Eligible Employee, Spouse, or Dependent that affects eligibility including a strike or lockout, commencement or return from an

unpaid leave of absence of more than thirty (30) days, change in worksite, and certain changes in the eligibility of the Spouse's employer's Section (§) 125 Plan;

- (d) An event causing an Eligible Employee's Dependent to satisfy or cease to satisfy eligibility requirements, such as: a change in age, Student status, change in legal custody, or similar circumstances. (A Dependent's loss of eligibility due to non-payment of contributions is not a qualifying event.);
- (e) A change in residence of an Eligible Employee, Spouse, or Dependent that triggers a gain or loss of eligibility, including moving in or out of a health plan's service area;
- (f) A commencement or termination of adoption proceedings;
- (g) A FMLA Leave;
- (h) A Judgment, Decree, or Order resulting in divorce, legal separation, annulment or change in legal custody;
- (i) A gain or loss of eligibility for Medicare, Medi-Cal, or Medicaid;
- (j) A Qualified Medical Child Support Order;
- (k) A cost change with automatic increase/decrease in elective contributions of a Benefit package including changes in administration costs or premium changes;
- (l) A significant cost increase/decrease of a Benefit package option;
- (m) A significant coverage curtailment of a Benefit package option;
- (n) An addition, significant improvement, or elimination of a Benefit package option;
- (o) A change in coverage of Spouse or Dependent under another employer's cafeteria Plan including during the other employer's open or annual enrollment Election Period;
- (p) A loss of coverage under a group health Plan of a government or an educational institution (A gain in coverage under a group health Plan of a government or an educational institution is NOT a Change in Status event);
- (q) A HIPAA special enrollment event;
- (r) A significant cost change imposed by a Dependent care provider who is not a relative of the employee;

**1.07 "Code"** means the Internal Revenue Code of 1986, as amended.

**1.08 "Compensation"** means the salary paid to an Eligible Employee by the County, including:

- (a) Any elective contribution made to any Flexible Benefit Plan maintained by the County as the result of a Salary Reduction Agreement entered into by the Participant;
- (b) Any County contributions made to the Plan as the result of a Salary Reduction Agreement pursuant to §5.01; and
- (c) Any County contribution to a tax-deferred annuity Plan under §457 of the Code, sponsored by the County (if any), as a result of a Salary Reduction Agreement entered into by the Participant for such purpose.

**1.09 “Consistent” and “Consistency”** mean the election change is on account of, and corresponds with, a Change in Status event that affects eligibility for coverage under the County’s Plan.

**1.10 “County”** means the County of Sacramento as the Employer, or successor thereof that subsequently adopts this Plan. Such term includes the Sacramento County Superior Court and any other organization that is a member of a controlled group of businesses within the meaning of Sections 414(b), (c), and (m) of the Code. Such definition shall be construed to include any organization that is exempt from Federal taxation under Code §501(c)(3).

**1.11 “Coverage Period”** means the Plan Year during which period the Benefits provided by this Plan shall be available to a Participant.

**1.12 “Dependent”** means any individual who is a Dependent of the Participant within the meaning of Code §152 including any modifications made by WFTRA to Code §105(b) and by IRS Notice 2004-79 to the Code §106 and in accordance with the individual requirements of the included programs. (See “Qualifying Child” and “Qualifying Relative” below)

**1.13 “Earned Income”** means all income derived from wages, salaries, tips, self-employment and other employee compensation (such as disability or wage continuation benefits) but does not include:

- (a) any amount received pursuant to this Plan;
- (b) any amount received as a pension or annuity; or
- (c) any amount received pursuant to worker’s compensation laws.

**1.14 “Effective Date”** means October 1, 1984, the date on which the Plan took effect. The Amended and Restated Plan is effective January 1, 2005.

**1.15 “Election Period”** ” means the time period established by the County Employee Benefits Office for making a Flex Plan election. This includes:

- (a) An annual enrollment period for the subsequent Plan Year;
- (b) An open enrollment period for newly hired employees;
- (c) An open enrollment period for newly Eligible Employees; and
- (d) The 30-day period following a Change in Status event.

**1.16 “Eligible Employee”**

- (a) An Eligible Employee is defined as 1) a regular employee who is working full time or part time for the County; or 2) any regular employee who temporarily transfers to a temporary position. A regular employee for purposes of this Plan means any officer or employee, in civil service or not in civil service, who occupies a permanent position, whether part time or full time, established in accordance with the annual salary ordinance, in a class which is intended for permanent or career-type employment;
- (b) An Eligible Employee includes Elected Officials and full-time and part-time Court employees;
- (c) For the purposes of this Plan, part time is defined as working at least twenty (20) hours per week or forty (40) hours in a bi-weekly pay period. Full time is defined as

working at least forty (40) hours per week or eighty (80) hours in a bi-weekly pay period.

- (d) An Eligible Employee **is not** an employee of a temporary agency, a contractor, a judge of the superior or municipal court, or any other person who does not occupy a permanent position in accordance with the annual salary ordinance.

**1.17 “Employer”** means County of Sacramento, or successor thereof that subsequently adopts this Plan.

**1.18 “Fiduciary”** means any person who has discretionary authority with respect to administration of the Plan, handling of the Plan’s assets, or acts as a professional investment advisor or fund manager with respect to the Plan’s assets.

**1.19 “Flexible Credits”** means authorized Employer-provided dollars, if any, which an Eligible Employee can choose to allocate to tax-qualified Benefits, and therefore may not be subject to Federal, state, or local tax. The actual amount of Flexible Credits, if any, to be allocated to each Eligible Employee will be determined by a formula developed by the County, subject to annual adjustment, and which will be annually communicated to employees. Flexible Credits are sometimes referred to as the County contribution.

**1.20 “FMLA”** means the Family and Medical Leave Act of 1993 (29 USCS §2601 *et seq.*), as amended.

**1.21 “FMLA Leave”** means a leave of absence that the County extends, in accordance with the law, to an employee under the provisions of the FMLA.

**1.22 “Grace Period”** means the 2 month plus 15-day period following the end of a Plan Year during which a Participant can be reimbursed with funds carried over from the prior Plan Year for eligible expenses incurred within that specified period.

**1.23 “Individual Benefit Account”** means the amount of Salary Reduction that a Participant has elected to be credited to his or her Dependent Care and/or Medical Reimbursement Account.

**1.24 “Medical Premium Benefits”** means the amount, if any, of Salary Reduction necessary to provide the Participant’s premium contribution for the medical insurance coverage chosen.

**1.25 “Participant”** means an Eligible Employee who becomes a Participant pursuant to Articles II, III, IV, and V. An Eligible Employee continues to participate until he or she no longer meets eligibility requirements or is no longer eligible for Continuation Coverage.

**1.26 “Plan”** means the Flexible Benefit Plan created by the adoption of the Plan Document, as it may be amended from time to time.

**1.27 “Plan Administrator”** or **“Administrator”** means the person appointed by the County with authority and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the County.

**1.28 “Plan Year”** means the annual accounting period of the Plan, which shall begin on January 1<sup>st</sup> and end on December 31<sup>st</sup> of each year.

**1.29 “Qualified Benefit”** means any Benefit excluded from taxation under Chapter 1 of the Code (other than Sections 117, 124, 127, or 132), including (a) any group-term life insurance coverage that is includible in gross income only by virtue of exceeding the

dollar limitation on nontaxable coverage under Code §79; and (b) any other Benefit permitted by the Income Tax Regulations.

**1.30 “Qualifying Child”** To have Dependent status as a Qualifying Child, the individual must:

- Be the unmarried child (natural, step, legal guardian, or adopted);
- Reside with the employee for more than half the year;
- Be under age 19 at the end of a Plan Year; or, in the case of a full-time Student, be under the age of 24 at the end of a Plan Year; or permanently disabled with no age limit; and
- Have provided one-half or less of his or her own support for the year.

**1.31 “Qualifying Relative”** To have Dependent status as a Qualifying Relative, the individual must:

- Not be a Qualifying Child;
- Bear a special relationship to the employee and share the employee’s residence as a member of the household;
- Receive more than half of his/her support from the employee; and
- Have gross income for the year that is less than the dependent exemption amount listed in Tax Code §151(d) (\$3,200 in 2005).

**1.32 “Reimbursable Expense”** means any out-of-pocket expense incurred by a Participant that qualifies for reimbursement under either the Medical Reimbursement Account Benefit or Dependent Care Reimbursement Account Benefit.

**1.33 “Salary Reduction”** means the amount of salary an Eligible Employee elects to pay for Benefits under the Plan on a pre-tax basis.

**1.34 “Salary Reduction Agreement”** means the written agreement by which an Eligible Employee agrees to reduce his or her salary on a pre-tax basis to pay for Benefits under the Plan.

**1.35 “Spouse”** means an individual who is legally married to a Participant, but shall not include an individual separated from the Participant under a legal separation decree.

**1.36 “Student”** means an individual who, during the Plan Year, is enrolled as a full time student at an accredited education institution. An educational institution is any college, university or other accredited institution of post-secondary education, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

**1.37 “Uniformed Services”** means any branch of the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

## Article II General Plan Information

### **2.01 What is the purpose of the Plan?**

The purpose of the Plan is to allow Eligible Employees to elect Benefits and use funds provided by the County through an employee Salary Reduction Agreement, to pay for one or more of the Benefits offered through the Plan on a tax preferred basis.

### **2.02 When did the Plan take effect?**

The Plan became effective October 1, 1984. It was amended and restated effective January 1, 2005.

### **2.03 What are a Participant's key responsibilities under the Plan?**

It is a Participant's responsibility to: 1) ensure that Benefits are provided to only the Participant, Spouse and Code §152 dependents as defined by the Plan; 2) provide accurate and reliable information to the Plan Administrator upon request; 3) provide documentation as requested by the Plan Administrator to verify the status of a Spouse or Dependents (such as marriage certificate, birth certificates, adoption or guardianship papers, etc.) or to establish the occurrence of a Change in Status event (such as a divorce decree, Student verification, verification of a change in coverage from another employer, or similar); and 4) notify the Plan Administrator of any circumstance that may affect the pre-tax status of benefits under the plan (this includes immediately notifying the Administrator if anyone for whom they have been obtaining Benefits under the Plan is no longer a legal Spouse or Dependent as defined by the Plan).

### **2.04 Who can participate in the Plan?**

Each Eligible Employee.

### **2.05 Who is an "Eligible Employee?"**

Please see Article I, §1.16. Any person who is covered by a collective bargaining agreement, which does not provide for inclusion in this Plan, shall not be an Eligible Employee.

### **2.06 When is an Employee a Participant?**

Each Eligible Employee shall become a Participant on the later of:

- (a) The Effective Date;
- (b) The first day of the month following the day on which the Eligible Employee meets the requirements for participation;
- (c) The first day of the month following the day on which the Eligible Employee has completed and filed a Benefit Election Form.

### **2.07 What Benefits are offered through the Plan?**

The Plan has 4 major types of Benefits:

- (a) Medical Premium Benefits (for details, see Article III);
- (b) Dependent Care Reimbursement Account Benefits (for details, see Article IV);
- (c) Medical Reimbursement Account Benefits (for details, see Article V);
- (d) Taxable cash payments in the form of regular salary (for details, see Article VI).

## **2.08 How do I become a Participant?**

You become a Participant upon meeting the eligibility requirements of the Plan. Your starting election under every Plan option is \$0, or no coverage, unless otherwise specified by an applicable County labor agreement or County policy. You may change your starting elections by timely signing a Benefit Election Form (the "Enrollment Form") on which you elect one or more of the Benefits available under the Plan. Your Benefit options are based upon your representation unit. As part of this agreement, you agree to use Salary Reduction to pay for the Benefits elected. Enrollment Forms are available in the Employee Benefits Office. You will have thirty (30) days in which to complete the Enrollment Form and turn it in to the Employee Benefits Office. During the Annual Enrollment Period, Benefits for the subsequent 12-month period starting January 1 may be elected. If you are a new employee, you may become a Participant on the first day of the month following your date of hire or Effective Date following the eligibility requirements being met, described in Article 1.16 and Article 2.05 above.

## **2.09 What are the enrollment periods for entering the Plan?**

An Eligible Employee may enroll during the thirty (30) day period following the employee's date of hire or return from an unpaid leave of absence. Thereafter, an Eligible Employee may enroll for a subsequent Plan Year during Annual Enrollment held in the fall each year, or within thirty (30) days of a Change in Status event.

## **2.10 Can I change my election during the Plan Year?**

Generally, during the Plan Year, you cannot change your election to participate in the Plan or vary the Benefits elected. Your election will terminate if you are no longer working for the County, or, in the case of the Medical Reimbursement Account Plan described below, the employee does not pay the required contributions for the Benefit elected. Otherwise, you may change an election only during the Annual Enrollment Period, and then, only for the coming Plan Year.

There is an important exception to this general rule. An employee may change or revoke a previous election at any time during the Plan Year if there is one or more of the following significant status changes, called "Change in Status" events. The list below is not intended to be exhaustive. Provided that all other requirements are met, the Administrator may grant an election change if the Administrator determines within his/her sole discretion that the Change in Status event falls within the permissible limits of the Code.

In order to make an election change mid-year, there are three (3) requirements:

- (1) There must be a Change in Status event
- (2) The employee's election change must be Consistent with and on account of the Change in Status event; and
- (3) The employee must inform the County's Employee Benefits Office within thirty **(30)** days of the Change in Status event.

**Table A**

**Each Change in Status is applicable to one or more of the following types of Plans:**

**(H)=Health Plans;  
(M)=Medical Reimbursement Account;  
(D)=Dependent Care Reimbursement Account.**

Change in Eligible Employee's legal marital status: marriage, divorce, death of Spouse, legal separation, or annulment;	H M D
Change in Eligible Employee's number of Dependents (either gain or loss of a Dependent), including birth, adoption, placement for adoption, or death;	H M D
Change in employment status of Eligible Employee, Spouse, or Dependent that affects eligibility, either commencement of employment, termination of employment, change in hours, strike or lockout, change in worksite, or return from an unpaid leave of absence greater than 30 days;	H M D
Dependent satisfies or ceases to satisfy Dependent eligibility requirements due to attainment of age, gain or loss of Student status, marriage or any similar circumstance; this does not include Dependent's loss of eligibility due to non-payment of contributions;	H M D
Commencement or termination of adoption proceedings;	H M D

**Table A (Continued)**

**Each Change in Status is applicable to one or more of the following types of Plans:**

**(H)=Health Plans;  
(M)=Medical Reimbursement Account;  
(D)=Dependent Care Reimbursement Account.**

Change in residence of Eligible Employee, Spouse or Dependent, affecting eligibility for coverage, including moving in or out of a program service area;	H
Either commencement of or return from FMLA Leave;	H M D
Judgment, Decree, or Order resulting in divorce, legal separation, annulment, or change in legal custody;	H M
Gain or loss of eligibility for Medicare, Medi-Cal, or Medicaid;	H M
Qualified Medical Child Support Orders;	H M
Cost changes with automatic increase/decrease in elective contributions of a Benefit package including changes in administration costs or premium changes;	H D
Significant cost increase/decrease of a Benefit package option for you, your Spouse, or Dependent;	H D

Significant coverage loss from a Benefit package option for you, your Spouse, or Dependent;	H D
Addition, significant improvement, or elimination of a Benefit package option for you, your Spouse, or Dependent;	H D
Change in coverage of Spouse or Dependent under another employer's cafeteria plan including during the other employer's open or annual enrollment Election Period;	H D
Loss of coverage under a group health plan of a governmental or education institution;	H
HIPAA special enrollment event;	H D
A significant cost change imposed by a Dependent care provider who is not a relative of the employee;	D
Any event that results in a Dependent becoming ineligible will result in a corresponding change of election under the cafeteria Plan. The change will be effective prospectively based on when the Plan Administrator is informed of the Dependent's ineligibility, or automatically at the beginning of the next Plan Year if the Administrator is not notified earlier.	H

Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a highly-compensated officer of the County; or if you are a member of the "highly paid" group of employees (as defined by the Code), to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

### **2.11 What are my Individual Benefit Accounts?**

If you elect Benefits under the Plan, one or more Individual Benefit Accounts ("Accounts") will be set up in your name to keep a record of the Benefits to which you are entitled. The number of Accounts established depends on what Benefits you have elected. For example, if you have chosen to participate in the Medical Reimbursement Account Plan and the Dependent Care Reimbursement Account Plan, two Accounts will be maintained in your name.

### **2.12 How are my Accounts funded?**

When you complete the Enrollment Form, you specify which Benefits you wish to pay for through Salary Reduction. Thereafter, your Accounts will be credited with that portion of your gross income you have elected to forego through Salary Reduction. These portions will be credited as of each pay period. For example, suppose you have elected the following:

<b><u>Benefit Elected</u></b>	<b><u>Annual Cost</u></b>
Medical Reimbursement	1,200.00
<u>Dependent Care Reimbursement</u>	<u>2,400.00</u>
Total Annual Cost	\$3,600.00

Assuming your deductions are taken twice per month (even though you are paid on a bi-weekly basis, deductions are only taken on the first two pay dates of each month), the cost of the above Benefits **per paycheck** would be \$150.00.

<b><u>Benefit Elected</u></b>	<b><u>Per Pay Period Cost</u></b>
Medical Reimbursement (\$1,200 / 24)	50.00
<u>Dependent Care Reimbursement (\$2,400 / 24)</u>	<u>100.00</u>
Total per Pay Period Cost	\$ 150.00
Total Monthly Cost (\$150 x 2)	\$ 300.00
Total Annual Cost (\$300 x 12)	\$3,600.00

The amount that is available in any one of your Accounts at any particular time will depend on the Benefits you have elected.

If you elect Medical Reimbursement Benefits, your corresponding Individual Benefit Account will be credited to reflect your Salary Reductions, although the full, annual amount of the Benefit will, at all times, be available to you (less any previously paid Benefits).

If you have chosen to participate in the Dependent Care Assistance Plan, your corresponding Benefit Account will be credited with the amount you set aside from each paycheck, and will accumulate until you submit a documented claim for reimbursement of eligible expenses. Maximum allowable reimbursement is limited to the balance in your Dependent Care Assistance Plan at any given time.

**2.13 How much may be credited to my Individual Benefit Accounts during any one Plan Year?**

The total amounts that may be credited to your Individual Benefit Accounts during any one Plan Year will be limited to \$7,400 (up to \$5,000 for DCRA and up to \$2,400 for MRA). Additionally, you may have any additional amount reduced from your salary as required to pay your portion of the health insurance premium required for the medical insurance plan option that you have selected.

**2.14 Who holds the funds I have set aside under the Plan?**

The County holds any money you set aside under the Plan. The money you set aside for reimbursement of your medical expenses, or for reimbursement of your work-related dependent care expenses, will be segregated by the County into a Trust fund as soon as is administratively possible after an amount has been deducted from your paycheck. Payroll deductions for medical insurance premiums will be forwarded to the respective insurance companies as the premiums become payable, normally monthly.

**2.15 Will my Accounts earn any interest?**

No interest or other earnings will be due or credited to your Accounts at any time.

**2.16 How do I receive my Benefits under the Plan?**

Medical Premium Benefits will be automatically deducted from your pay. The County-provided funds and any deducted amounts will be sent directly to the insurance company on your behalf.

If you have elected to participate in either the Medical Reimbursement Account (MRA) or Dependent Care Reimbursement Account (DCRA) Plan, you must take certain steps to be reimbursed for your eligible expenses. When you incur an expense that is eligible for payment out of one of your Accounts, you submit a claim to the Claims Administrator on a claim form which is available through the Employee Benefits Office. See Article IV, below, for an explanation of the requirements for reimbursement under the Dependent Care Reimbursement Account Plan, and Article V below, for a description of the reimbursement procedures that apply to the Medical Reimbursement Account Plan. You may not be reimbursed for any expenses with respect to your current year of participation that arise before the Plan or your enrollment became effective (both MRA and DCRA Plans) nor for any expense incurred after the close of the Plan Year, except as provided under the Grace Period provisions of the Plan. No reimbursement shall be made for any service incurred after coverage has ended under the Plan due either to termination from employment with the County or unpaid Leave of Absence.

Please review the lists of eligible expenses included with the Claims Instructions for assistance in determining what an “eligible expense” is. You are also encouraged to consult your personal tax advisor or IRS Publication 502, “Medical and Dental Expenses” or IRS Publication 503, “Child and Dependent Care Expenses” for further guidance as to what is or is not an eligible expense.

Note that it is not necessary that you have actually paid an amount due for medical expenses or for Dependent care expenses; only that you have *incurred* the expense, and that it is not being paid for by insurance or from any other source.

### **2.17. How and when do I submit my claims for reimbursement?**

In order to be reimbursed for your current expenses, you must submit your claim form with proof of the expenses to the Plan's Claims Administrator. Reimbursement checks (or direct deposit vouchers) are issued every two weeks. In addition, you will have until April 30 following the end of the Plan Year in which to submit a claim for reimbursement for eligible expenses incurred during the previous Plan Year. You will be notified in writing if any claim for Benefits is denied.

### **2.18 What is the “Grace Period”?**

The Grace Period is the two (2) month and 15 day period following the end of a Plan Year. Claims that you incur during the Grace Period may be reimbursed from money set aside during the prior Plan Year. A Grace Period shall apply only if you are participating in the Plan on the last day of the Plan Year (ie. had a full required Salary Reduction for the month of December, or self-paid the full premium for December due to being on a Leave without Pay or COBRA). The Grace Period applies to both the Dependent Care Reimbursement and Medical Reimbursement Accounts.

For example, if you go to the dentist for a filling on February 1, 2006 and have \$50 left to pay after your insurance has paid its part. This service occurred during the Grace Period (two (2) month and 15 day period following the end of the Plan Year) and you may have it reimbursed from any funds you have left over in your Individual Account from the 2005 Plan Year. If you have used all of your prior year funds, this claim may be reimbursed from your 2006 Plan Year Account.

### **2.19 How do I file a Grace Period claim?**

A Grace Period claim is filed in the same manner as a regular claim, using a reimbursement form provided by the Claim Administrator. There may be a box for you to

check on the form to indicate that you are applying for reimbursement from prior year funds, if available. The Plan Administrator may also establish an automatic process whereby claims for services falling in the Grace Period are automatically charged first against any Individual Account balance that is left over from the immediately prior year. The Grace Period is designed to help you minimize any loss of funds that might otherwise occur. Grace Period claims must be filed on or before April 30<sup>th</sup> immediately following the end of the Grace Period.

**2.20 Will unused year-end Account balances be carried over to the next Plan Year?**

No. Under the federal tax law, any unused amounts credited to your Individual Benefit Account(s) as of the end of the Grace Period will be forfeited if not claimed by April 30 following the end of the Plan Year. Likewise, any medical or Dependent care balances incurred in a previous Plan Year can not be paid with funds from your current Plan Year Account(s).

**2.21 What happens to the contributions that are not reimbursed to the Participants?**

The Department of Labor requires that Salary Reductions be used for the benefit of the Participants or to cover reasonable administrative expenses. At the end of the run-out period for the Plan Year, any remaining funds in your Individual Benefit Accounts will be used as follows: first, to offset any losses experienced by the Employer during the Plan Year; second, to offset the cost of administering the Flexible Benefit Plan during the Plan Year; and third, if any funds are available, to provide increased Benefits or reduced premiums to Participants in subsequent Plan Years.

**2.22 May I withdraw cash from any of my Individual Benefit Accounts?**

No. Your Individual Benefit Account balances may only be used to reimburse you for eligible expenses associated with the specific account.

**2.23 May I shift amounts from one Individual Benefit Account to another?**

No. You may not transfer credits from one Individual Benefit Account to another. For example, credits in your Dependent Care Reimbursement Account may only be used for Dependent care expenses; no amount would be available for any other purpose.

**2.24 Can I stay in the Plan if I am absent on a family medical leave?**

Yes. If you are on a leave of absence covered by the Family and Medical Leave Act (FMLA) for periods up to a total of twelve (12) weeks during the Plan Year, you are entitled to maintain the coverage you had as an active employee under the Plan, during your absence. Of course, if you stay in the Plan during a family leave covered under the FMLA, you must make the contributions for the coverage during your absence using one of the following methods:

- (a) Prepayment. Under the prepayment option, you may (at your option) increase your Salary Reduction in an amount sufficient to cover the premiums that will come due during the FMLA Leave.
- (b) Pay-as-you-go. With the pay-as-you-go option, you continue to make contributions on a regular basis throughout the FMLA Leave. If you continue to receive your salary while you are gone, the contributions will be paid with pre-tax money as if you had not taken the leave. On the other hand, if your FMLA Leave is unpaid and you choose this option, you will have to reimburse the County at regular intervals from your after-tax funds for the amount that comes due during the leave.

- (c) Catch-Up. If both you and the County agree to use the catch-up option, you and the County must agree in advance of the Coverage Period that:
  - (i) You will continue coverage while on an unpaid FMLA Leave;
  - (ii) The County will assume responsibility for advancing funds on your behalf during the FMLA Leave; and
  - (iii) You must pay these advance amounts when you return from FMLA Leave.

### **2.25 What if I am absent from work for duty in the Uniformed Services?**

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) as amended. You may be eligible to continue your coverage under the Plan by making contributions under the options described in Article 2.32 (please contact the Employee Benefits Office for more details).

### **2.26 What if I terminate my employment during the Plan Year?**

In the event you cease to be an Eligible Employee, your participation in the Plan will end at the same time your employment terminates.

The Plan shall reimburse any eligible expenses which were incurred during the Plan Year, less Benefits already paid during the Plan Year; for

- (a) Dependent Care expenses, up to the amount of your contribution for Benefits, less Benefits already paid during the Plan Year; and
- (b) Medical expenses incurred prior to your employment termination, up to the amount of your Annual Benefit less Benefits already paid during the Plan Year.

However, no reimbursement will be made for any medical expense incurred during a period for which the Participant has not made the required contributions under the Plan.

You shall be entitled to submit a claim for reimbursement of eligible expenses at any time up to April 30 following the close of the Plan Year.

Notwithstanding the preceding paragraph, you (and your Dependents) may have the right to elect continuation coverage as described in 2.32 below.

### **2.27 Will I have to pay any administrative costs under the Plan?**

No. The County bears the cost of administering the Plan.

### **2.28 How long will the Plan remain in effect?**

Although the County expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. This Plan may be amended or terminated by a written resolution adopted by a majority of the County's Board of Supervisors. The Plan will also automatically terminate if the County;

- (a) Is legally dissolved;
- (b) Makes a general assignment for the benefit of its creditors;
- (c) Files for liquidation under the Bankruptcy Code;
- (d) Merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the

County's successor in interest agrees to assume the liabilities under this Plan as to the Participants and Eligible Dependents.

If the Plan is terminated, credits to your Individual Benefit Accounts will be used to provide Benefits through the end of the Plan Year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

### **2.29 Are my Benefits taxable?**

Since the Plan is intended to meet certain requirements of the Code, eligible Benefits you receive under the Plan are not taxable to you under present law. However, neither the County, the Plan Administrator, nor the Plan's Claims Administrator can guarantee the tax treatment to any given Participant, as individual circumstances may produce differing results. In case of doubt, you should consult your own tax adviser.

### **2.30 Will my Social Security benefits be affected?**

Because these contributions are deducted before Social Security taxes are calculated, your Social Security benefits may be slightly reduced because when you receive tax-free Benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

### **2.31 What happens if my claim for Benefits is denied?**

The Plan's Claims Administrator will notify you in writing within sixty (60) days of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim. You may request a review any time within the 60-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review all important documents held by the Plan Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within sixty (60) days of the date of your request for a review.

### **2.32 What is "Continuation Coverage" and how does it work?**

"Continuation Coverage" refers to your right, your Spouse's right and/or your Dependents' right, to continue to be covered under the Medical Reimbursement Account Plan, or under any of the medical insurance benefit Plans described in Article III if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is:

- (a) Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below the minimum as stated, above, in Article 1.16;
- (b) Your death;
- (c) Divorce or legal separation from your Spouse;
- (d) Your eligibility to receive Medicare benefits; or
- (e) When a Dependent ceases to be a Dependent.

It is your responsibility to inform the Employee Benefits Office of any Change in Status within thirty (30) days of the occurrence. The Employee Benefits Office, in turn, has a

legal obligation to furnish you, your Spouse, and/or your Dependents, with written options to continue the coverage provided through this Plan. The notification you will receive will explain the terms and conditions of the continued coverage.

Note: The County's Flexible Benefit Plan will permit Continuation Coverage under the Medical Reimbursement Plan only for the balance of the then current Plan Year. The employee cost is 102% of the previous amount of Salary Reduction and contributions will be on an "after tax" basis rather than pre-tax.

## **Article III Medical Premium Benefits**

### **3.01 What additional Benefits are available under the County's Flexible Spending Plan?**

In addition to the reimbursement-type Benefits described in Articles IV and V below, you will be able to participate in the insurance programs offered by the County by indicating your choice on the Benefit Election Form, financing your share of the cost by Salary Reductions, as described earlier. The Benefits available are determined by your representation unit.

For the details regarding the medical plans offered, eligibility provisions, benefit amounts, and premium schedules, please contact the Employee Benefits Office.

### **3.02 When can I make a Plan change or change my covered Dependents?**

Each year during Annual Enrollment you may change Plans and/or add or delete Dependents effective with the new Plan year. Changes made during Annual Enrollment are effective on January 1<sup>st</sup> of the following year.

### **3.03 Can I make a Plan change at any other time of the year?**

You may make a Plan change other than at Annual Enrollment due to a Change in Status event as provided by the IRS (Refer to Sections 1.06 and 2.10). For example, suppose you are covered by a catastrophic Plan (a high deductible Plan) by the County. Your Spouse is employed by a private company, which provides family medical coverage through Kaiser Permanente. Your Spouse loses his/her job and Kaiser family group medical coverage (a Change in Status event). You would have the option to change Plans and/or coverage as long as the election change was Consistent with and on account of the Change in Status event and was requested within thirty (30) days of the Change in Status event.

### **3.04 Do I have to notify you within thirty (30) days of any Change in Status event in order to add or delete Dependents or make a Plan change?**

Yes. The 30-day window applies to all Change in Status events, e.g., birth or adoption of a child, an over-age Dependent, or marriage. In addition, IRS regulations require that your election change must be Consistent with and on account of your Change in Status event.

### **3.05 When can I make a change if I miss the thirty (30) day window?**

If you do not make the change within thirty (30) days of the Change in Status event, you will have to wait until the next Annual Enrollment period to make the change. The Effective Date of that change would be the subsequent January 1.

## **Article IV Dependent Care Reimbursement Account Benefits**

Another major feature of the County's Flexible Benefit Plan is your opportunity to elect to receive income-tax-free reimbursement for some or all of your work-related Dependent Care expenses under the Dependent Care Reimbursement Account Plan ("DCRA"). Under this Plan, you contribute pre-tax funds, through a Salary Reduction Agreement with the County, to reimburse yourself for eligible Dependent Care expenses. This arrangement may help you because the Benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your Salary Reduction.

### **4.01 Who can participate in the Plan?**

Each Eligible Employee.

### **4.02 How do I become a Participant?**

By electing DCRA Benefits during your first 30 days of employment, during the Annual Enrollment Period, or within 30 days of a Change in Status event (such as birth of your child, or adoption).

### **4.03 What is my "Dependent Care Reimbursement Account"?**

If you elect Benefits under this Plan, a Dependent Care Reimbursement Account ("Account") will be set up in your name to keep a record of the Benefits to which you are entitled.

### **4.04 What are the maximum DCRA Benefits I may elect?**

You may elect up to \$5,000 per Plan Year if you are married and file a joint return or are a single parent. You may elect up to \$2,500 if you are married and file a separate tax return.

### **4.05 How is my Account funded?**

When you complete the Benefit Election Form, you specify the amount of DCRA Benefits for which you wish to pay with your Salary Reduction. Thereafter, your Account will be credited with that portion of your gross income you have elected to forego through Salary Reduction. These funds will be withheld from your paycheck and credited to your Account over 24 pay periods (the County pays on a bi-weekly basis; during the months when three pay dates occur, the deductions will only be taken on the first two pay dates of each month).

For example, suppose you have elected to be reimbursed for \$3,600 per year for eligible Dependent care expenses, and you have chosen no other Benefits under the County's Flexible Benefit Plan.

<u><b>Benefit Elected</b></u>	<u><b>Per Pay Period Cost</b></u>
Dependent Care Reimbursement (\$3,600 / 24)	\$150.00

The amount available in your Account at any particular time will be whatever has been credited to such Account, year-to-date, less any reimbursements.

### **4.06 Who is an Eligible Dependent for whom I can claim a reimbursement?**

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under age 13, and whom you could claim as a Dependent on your federal income tax return; any other Dependent who is mentally or physically unable of caring for himself or herself; or your Spouse, if your Spouse is physically or mentally

incapacitated. (See Sections §1.12 “Dependent,” §1.30 “Qualifying Child,” and §1.31 “Qualifying Relative” for dependent definitions.)

#### **4.07 How do I receive my Benefits under the Plan?**

If you have elected to participate in this Plan, you will have to take certain steps to be reimbursed for your eligible Dependent care expenses. When you incur an expense that is eligible for payment, you must submit a claim to the Plan's Claims Administrator on a “Flexible Spending Account Claim Form” that is available in the Employee Benefits Office. If there are enough credits in your Dependent Care Reimbursement Account, you will be reimbursed for your eligible expenses in accordance with the schedule provided by the County. If your claim was for an amount that was more than your current Account balance, the excess part of the claim will be carried over, to be paid out upon your request and as your balance becomes adequate. Remember though, that you cannot be reimbursed for any expenses above your year-to-date credits to your Dependent Care Reimbursement Account. You may not be reimbursed for any expenses that arise before your Enrollment becomes effective, or for any expense incurred after the close of the Plan Year. Please review the list of eligible Dependent care expenses included with the Claims Instructions for assistance in determining what is an “eligible expense.” You are also encouraged to consult with your personal tax advisor and review IRS Publication 503, “Child and Dependent Care Expenses” for further guidance as to what is or is not an eligible expense if you are unsure.

To have your claims processed as soon as possible, please read the Claims Instructions you have been furnished. Please note that it is not necessary for you to have actually paid an amount due for eligible Dependent care expenses, only that you have incurred the expense, and that services have been rendered. You must also provide confirmation that the expense is not being paid for or reimbursed from any other source.

#### **4.08 Will I be taxed on the DCRA Benefits I receive?**

You will not normally be taxed on your DCRA Benefits, up to the limits set out in Article 4.04. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers of any persons who provided you with Dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

#### **4.09 Are there any other limits on what DCRA Benefits are tax-free?**

In addition to the dollar limitations discussed in Article 4.04 above, there are Earned Income limits:

- (a) Your Earned Income for the year, if you are not married as of the end of the year;
- (b) The lesser of your Earned Income for the year, or your Spouse's Earned Income, if you are married at the end of the year; or
- (c) If your Spouse is a full time Student or is disabled, your Spouse is considered under the federal tax rules as if he/she has a monthly-Earned Income of \$250 (if DCRA Benefits are provided for only one Dependent), or \$500 (if DCRA reimbursements are made for two or more Dependents).

**4.10 If I participate in the DCRA, will I still be able to claim the household and Dependent care credit on my federal income tax return?**

No. You may not claim any other tax benefit for the tax-free amounts received by you under this Plan. However, the balance of your unclaimed qualified Dependent care expenses may be eligible for the dependent care credit. Please consult your tax advisor.

**4.11 What is the household and dependent care credit?**

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Work-Related Dependent Care Expenses as a credit against your Federal income tax liability under the Code.

**4.12 When would I be better off to include the County's reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free, and forego the credit reimbursements under the DCRA?**

Because the actual determination of the preferable method for treating Benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household, number of Dependents, etc.), you will need to decide between claiming the credit on your tax return or utilizing the DCRA. You will be furnished with a worksheet to help you make the necessary calculations; you should consult your tax adviser if you need assistance using the calculation worksheet.

**Article V Medical Reimbursement Account Plan Benefits**

One of the important features of the County's Flexible Benefit Plan is your opportunity to elect to receive income-tax-free reimbursement for some or all of your medical expenses under a related Medical Reimbursement Account Plan. Under the Plan, you elect a specific level of medical expense reimbursement Benefits, paying for the coverage through a Salary Reduction Agreement with the County. This arrangement may help you because the Benefits you elect are not taxed and you save social security and income taxes on the amount of the expenses you pay.

**5.01 Who can participate in the Plan?**

Each Eligible Employee (See §1.16 above).

**5.02 How do I become a Participant?**

By electing Medical Reimbursement Account Benefits during the annual enrollment period or other Election Period as provided in §1.15 above.

**5.03 What is my "Medical Reimbursement Account?"**

If you elect Benefits under this Plan, a Medical Reimbursement Account (the "Account") will be set up in your name to keep a record of the Benefits you are entitled to, as well as the salary you had reduced to pay for such Benefits during the Plan Year.

**5.04 What Annual Benefits are available under the Medical Reimbursement Plan, and how much will they cost?**

You may choose any amount of Annual Benefit, up to \$2,400. Your annual salary will be reduced by the amount that corresponds to the Benefit level you have chosen.

<u>Plan Year Benefit Amount</u>	<u>Plan Year Salary Reduction</u>
\$1	\$1
to	to
\$2,400	\$2,400

**5.05 How is my Medical Reimbursement Account Benefit paid for?**

When you complete the Benefit Election Form, you specify the amount of Medical Reimbursement Account Benefits you wish to pay for with your Salary Reduction. Thereafter, you must pay for such Benefit by having an equal portion of the annual Salary Reduction deducted from each paycheck. The full amount of the coverage you have elected will be available to reimburse you for your out-of-pocket medical expenses at any time during the Plan Year, so long as you continue Salary Reduction.

For example, suppose you have elected to be reimbursed for up to \$2,400 per year for eligible medical expenses, and you have chosen no other Benefits under the Flexible Benefit Plan. Your gross pay will be reduced by \$100.00 (\$2,400/24 pay periods) during the first two pay dates of each month. Your Account would be credited (and funded) with a total of \$2,400 during the Plan Year.

**5.06 What amounts will be available for reimbursement Benefits at any particular time during the Plan Year?**

Provided that you continue Salary Reduction to pay for this Benefit, the full, annual amount of coverage you have elected will be available as a Benefit at any time during the Plan Year, reduced, however, by the amount of prior reimbursements received during the Plan Year.

**5.07 How do I receive my Benefits under the Plan?**

If you elect to participate in this Plan, you will have to take certain steps to be reimbursed for your eligible medical, dental, and vision expenses. When you incur an expense that is eligible for payment, you must submit a claim to the Plan's Claims Administrator on a "Flexible Spending Account Claim Form" that is available in the Employee Benefits Office. If you are continuing Salary Reduction for the coverage you have elected, you will be reimbursed for your eligible expenses in accordance with the schedule provided by the County discussed in §2.16. Remember, though, you cannot be reimbursed for more than the annual amount of Benefit you have elected.

To have your claims processed as soon as possible, please read the claims instructions. Please note that it is not necessary for you to have actually paid an amount due for an eligible medical expense, only that you have incurred the expense and that services have been rendered during the Plan Year. You must also provide confirmation that it is not being paid for or reimbursed from any other eligible source.

**5.08 What is an eligible expense?**

An "eligible expense" means any item for which you could have claimed a medical, dental, or vision expense deduction on an itemized federal income tax return for which you have not otherwise been reimbursed from insurance or some other source. Eligible expenses also includes expenses incurred by the Employee or Dependents (as defined by §152) for medical care as permitted under §105(b) of the Code (including eligible over-the-counter drugs and medicines).

Please review the list of eligible medical, dental, and vision expenses included with the Claims instructions for assistance in determining what an eligible expense is. You are also encouraged to consult with your personal tax advisor and review IRS Publication 502, "Medical and Dental Expenses" for further guidance as to what is or is not an eligible expense.

#### **5.09 When must the expenses be incurred that I may be reimbursed for?**

Eligible expenses must have been incurred during the Plan Year or during the Grace Period. You may not be reimbursed for any expenses arising;

- 1) Before the Plan became effective;
- 2) Before your Benefit Election became effective;
- 3) For any expenses incurred after the close of the Plan Year and the Grace Period;
- 4) For any period in which you do not meet eligibility requirements; or
- 5) For any period after your termination from employment.

#### **5.10 What is the time period in which claims must be submitted?**

Reimbursement claims must be submitted to the Plan Administrator by April 30 following the close of the Plan Year for which the Benefit election is effective, and during which such expense was incurred, in order to be eligible for reimbursement. Likewise, if a Participant terminates participation in the Plan with a credit balance in any Benefit Account, such Participant shall be entitled to submit to the Plan Administrator any claims for reimbursement from his or her MRA for Reimbursable Expenses incurred during that Plan Year and prior to termination of the Eligible Employee's coverage for MRA reimbursements (e.g., prior to the date that employment terminated) and for DCRA for Reimbursable Expenses incurred during the Plan Year in which you terminated employment.

#### **5.11 What if the medical, dental, and vision expenses I incur during the Plan Year are less than the Annual Benefit I have elected?**

You may also be reimbursed for any expenses you incur during the Grace Period. Beyond that, according to the Internal Revenue Service Regulations, you cannot receive any direct or indirect payment or refund that represents the difference between the actual medical expenses that you have incurred during the Plan Year for which you have been (or will be) reimbursed and the Annual Benefit you have elected and paid for.

### **Article VI Cash Benefits**

The County may provide each Participant with Flexible Credits that can be used, in addition to your Salary Reduction amounts, for the purchase of your Benefits under the Plan. The amount of the Flexible Credits available during each Plan Year, if any, is established by the County in its discretion. The Flexible Credits must be used for the purchase of coverage under the County's health Plans, either employee-only or employee-and-Dependent coverage.

## **ARTICLE VII Claims Procedures**

### **7.01 Claims Submission Procedure**

Any Participant, beneficiary, or his or her duly authorized representative may file a claim for a Plan Benefit to which the claimant believes that they are entitled. Such a claim must be in writing on a Benefit Claim Form and delivered to the Plan Administrator, in person, by fax, or by mail, postage paid. Within sixty (60) days after receipt of such claim, the Plan Administrator shall send to the claimant, by mail, postage paid, notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed sixty (60) days from the end of the initial period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 60-day period. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part. If notice of the denial of a claim is not furnished in accordance with §7.01, the claim shall be deemed denied and the claimant shall be permitted to exercise his or her right to review pursuant to §7.03, §7.04 and §7.05.

### **7.02 Requirement for Written Notice of Claim Denial**

The Plan Administrator shall provide to every claimant who is denied a claim for Benefits a written notice containing the following information and setting forth in a manner calculated to be understood by the claimant:

- (a) The specific reason or reasons for the denial;
- (b) Specific reference to pertinent Plan provisions on which the denial is based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary, and
- (d) An explanation of the Plan's claim review procedure.

### **7.03 Right to Request Hearing on Benefit Denial**

Within sixty (60) days after the receipt by the claimant of written notification of the denial (in whole or in part) of his claim, the claimant or his duly authorized representative may:

- (a) Make a written application to the Plan Administrator, in person or by certified mail, postage paid, to be afforded a review of such denial;
- (b) Review pertinent documents; and
- (c) Submit issues and comments in writing.

### **7.04 Disposition of Disputed Claims**

Upon receipt of a request for review, the Plan Administrator shall make a prompt decision on the review matter. The decision on such review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent Plan or insurance policy provisions on which the decision was based. The decision upon review shall be made not later than sixty (60) days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than one hundred twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial sixty (60) day period. If notice of the decision

on the review is not furnished in accordance with this §7.04, the claim shall be deemed denied and the Claimant shall be permitted to exercise his right to legal remedy pursuant to §7.05.

### **7.05 Preservation of Remedies**

After exhaustion of the claims procedure as provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy.

## **Article VIII Participant Rights**

As a Participant in the County's Flexible Benefit Plan, you are entitled to certain rights and protections. All Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, if any.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for copying these documents.
- In addition, 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 the County, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Benefit from the Plan, or from exercising your rights.

If your claim for a Benefit 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 Administrator review and reconsider your claim. There are steps you may take to enforce the above rights. If you have a claim for Benefits which is denied or ignored in whole or in part, you may file suit in a state or 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. If you have any questions about the Plan, you should contact the Plan Administrator.

## **ARTICLE IX AMENDMENT OR TERMINATION OF PLAN**

### **9.01 Permanency**

While the County fully expects that this Plan will continue indefinitely, permanency of the Plan will be subject to the County's right to amend or terminate the Plan, as provided in §9.02, §9.03, and §9.04 below.

### **9.02 County's Right to Amend the Plan**

The County reserves the right to amend the Plan at any time and from time-to-time, if deemed necessary or appropriate to meet the requirements of Code §105, or any similar provisions of subsequent revenue or other laws, or the rules and regulations in effect under any of such laws or to conform with governmental regulations or other policies, to

modify or amend in whole or in part any or all of the provisions of the Plan; provided, however, that no such modification or amendment shall make it possible for any Expense Reimbursement Account Balance to be used for, or diverted to, purposes other than for the exclusive benefit of Participants and their beneficiaries under the Plan.

This Plan may be amended by a written resolution adopted by a majority of the Board of Supervisors of the County.

### **9.03 County's Right to Terminate the Plan**

The County reserves the right to discontinue or terminate the Plan without prejudice at any time without prior notice. Termination of the Plan shall be effected by a written resolution adopted by a majority of the County's Board of Supervisors. Furthermore, the Plan will also automatically terminate if the County (1) is legally dissolved, (2) makes a general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy Code, (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the County's successor in interest agrees to assume the liabilities under this Plan as to the Participants and Eligible Dependents.

### **9.04 Determination of Effective Date of Amendment or Termination**

Any such amendment, discontinuance, or termination shall be effective as of such date as the Board of Supervisors shall determine. No amendment discontinuance or termination shall allow the return to any County of any Account Balance or its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries.

## **Article X HIPAA Privacy Practices**

The County of Sacramento protects the privacy of your protected health information (PHI). PHI is health information that includes your name, Social Security number, or other information that reveals who you are. We also require insurance carriers and business associates to protect your PHI. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, member-identifiable medical information is shared with Employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your personal representative's) written authorization, except as described in our **Notice of Privacy Practices**. Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our **Notice of Privacy Practices** describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available either by accessing the County of Sacramento Web site located at <http://www.saccounty.net/>, or by calling the Employee Benefits Office at (916) 874-9092, 8a.m. to 5p.m., Monday through Friday.

## **Article XI EXPERIENCE GAINS**

### **11.01 Experience Gains**

Any experience gains will be used as follows: first to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the contributions paid by such Participants through Salary Reductions; second, to offset the cost of administering the Flexible Benefit Plan during the Plan Year; and third, to provide increased Benefits or reduced premiums to Participants in subsequent years in any reasonable or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Flexible Benefit Plan Benefit payments that are unclaimed by the close of the Plan Year following the period of coverage in which the expense occurred shall be forfeited and applied as described above.

## **Article XII GENERAL PROVISIONS**

### **12.01 Applicable Laws**

The provisions of the Plan shall be construed, administered, and enforced according to applicable Federal law and the laws of the State of California.

### **12.02 Tax Effects**

Neither the County nor the Plan Administrator makes any warranty or other representation as to whether any payments made to or on behalf of any Participant hereunder will be treated as excludable from gross income for state or federal income tax purposes.

### **12.03 Gender and Number**

Unless indicated otherwise by the context, masculine pronouns include the feminine as well as the masculine gender, and the singular shall include the plural.

### **12.04 Headings**

The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

### **12.05 Importation of Drugs and Medicines from Other Countries**

In general, you cannot include in your medical expenses the cost of medicines or prescribed drugs brought in (or ordered shipped) from another country, because you can only include the cost of medicines or drugs that were imported legally. Publication 502 notes two exceptions from the general prohibition: 1) prescribed drugs and medicines that the Food and Drug Administration (FDA) announces can be legally imported by individuals; and 2) prescribed drugs and medicines purchased and consumed in another country, if the medicines and drugs are legal in both the U.S. and the other country.

**Article XIII Administrative Information**

**Name of Plan:**  
**County of Sacramento**  
**FLEXIBLE BENEFIT PLAN**

**Sponsoring Employer and Plan Administrator**

County of Sacramento  
700 H Street, Room 6750  
Sacramento, CA 95814  
(916) 874-2020

The Sponsoring Employer is the Administrator of the Plan(s).

Sponsor's Employer Identification Number:

94-6000529

Plan Number:

502

**Plan's Agent for Service of Legal Process**

County of Sacramento  
700 H Street, Room 6750  
Sacramento, CA 95814

**Claims Administrator**

Flex-Plan Services Incorporated  
330 120<sup>th</sup> Ave. NE, Ste 200  
Bellevue, WA 98005  
**(800) 669-3539, Ext. 107**  
[www.flex-Plan.com](http://www.flex-Plan.com)

**Submit Claims To:**

Flex Plan Services  
PO Box 70366  
Bellevue, WA 98007

The Plan is administered by the County, with the assistance of the Claims Administrator (above) and Benefits under the Plans are payable out of the general assets of the County except to the extent that the County has chosen to utilize insurance companies for the payment of Benefits.

The Plans are welfare benefit Plans providing employees with the choice to allocate Salary Reduction contributions to the purchase of certain welfare benefits selected by the County. The designated agent for service of legal process is County of Sacramento.