COUNTY OF EL PASO
HEALTH CARE FLEXIBLE SPENDING ACCOUNT, HEALTH SAVINGS ACCOUNT, DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT AND PREMIUM PLAN ONLY

Plan Documents and Summary Plan Descriptions
Effective: January 1, 2020

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GENERAL INFORMATION

Employer/Plan Sponsor	County of El Paso 500 E. Overland El Paso, TX 79901 915-546-2218
Employer Identification Number	74-6000762
Plan Name	County of El Paso Health Care Flexible Spending Account, Health Savings Account, Dependent Care Flexible Spending Account, and Premium Only Plan
Plan Type	Health Care Flexible Spending Account, Health Savings Account, Dependent Care Flexible Spending Account
Plan Year	January 1 – December 1; Subsequent plan years January 1 – December 31
Plan Administrator	Aetna Life Insurance Company 2777 N. Stemmons Fwy, Suite 300 Dallas, TX 75207 888-678-8242
Type of Administration	The Plan is administered under a contract with PayFlex through Aetna Life Insurance Company.
Source of Contributions to the Plan	Both the employer and the employee for the Health Savings Account and employee for the Flexible Spending Accounts
Agent for Service of Legal Process	County Attorney's Office 500 E. San Antonio 915-546-2000

DEFINITIONS

In this section, you will find the definitions for the terms found throughout this summary plan description. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions should not be interpreted as indications that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this summary plan description for that information.**

"Alternate recipient" means any child of a participant who is recognized under a medical child support order as having a right to benefits under this Plan as a participant's dependent. For purposes of the benefits provided under this Plan, an alternate recipient shall be treated as a dependent.

"Benefit cost" means the cost of premiums for medical, dental, vision, prescription drug, and over-the-counter drug coverage for a participant, eligible legal spouse, and dependent children under the benefit plan which a participant is required, as a condition of coverage, to pay. It also includes Health Care Flexible Spending Account, Health Savings Account, and Dependent Care Flexible Spending Account.

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

" Code " means the Internal Revenue Code, as amended.

"Cosmetic surgery" means any procedure that is directed at improving the person's appearance and does not promote the proper function of the body or prevent or treat illness or disease.

"**Dependent"** means any of the following:

- Individuals who meet the definition of "dependent" under Internal Revenue Code Section 152, determined
  without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof;
- Eligible legal spouse
- Any child, adopted child, or eligible foster child (as each is defined in Code §152(f)(1)) of the
- Participant who as of the end of the taxable year has not attained age 27; or
- Any child of the participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and for purposes of the Dependent Care Component, a qualifying individual.

Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any Medical Child Support Order "MCSO", even if the child does not meet the definition of dependent.

" **Dependent care center"** means any facility which:

- Complies with all applicable laws and regulations of the state and unit of local government in which it is located;
- Provides care for more than six individuals (other than individuals who reside at the center); and
- Receives a fee, payment or grant for providing services for any of such individuals (regardless of whether such facilities operated for profit).

"Dependent Care Flexible Spending Account" means you can use your Dependent Care FSA to cover

the expenses of dependents, who are defined as:

- A dependent of a participant (as defined in Code § 152(a)(1) who is under the age of 13;
- A dependent of a participant, regardless of age, who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the participant for more than one- half of the tax year; or
- The eligible legal spouse of a participant who is physically or mentally incapable of caring for himself or herself who has the same principal place of abode as the participant for more than one-half of the tax year.

<u>"Earned income"</u> means the sum of the amounts set forth in the first section below, but shall exclude the amounts set forth in the second section below:

Earned income include the following:

- Wages, salaries, tips and other employee compensation, but only if such amounts are includable as gross income for the taxable year; and
- The amount of an employee's net earnings from self-employment for the taxable year (within the meaning of Code § 1402 (a)). Such net warnings shall be determined with regard to the deductions allowed to the employee under Code § 164 (f).

Excluded:

- Amounts received under this Plan or any other dependent care assistance plan under Code § 129;
- Amounts received as a pension or annuity (within the meaning of Code § 32 (c)(2);
- Amounts to which Code § 871(a) applies;
- Amounts attributed to an individual pursuant to community property laws (within the meaning of Code § 32 (c)(2);
- Amounts attributable to wages or salary which were reduced pursuant to a written salary reduction agreement; and
- Amounts received for services provided by the participant while the participant is incarcerated in a penal institution.

“Employee” means a full-time employee scheduled to work at least 30 hours per week of the participating employer; or (2) county and district officers and as otherwise permitted by the Plan Sponsor pursuant to Section 157.01(a) of the Texas Local Government Code, as amended.

“Family Status Change” means any of the following with respect to participation in the Plan:

- The termination of coverage due to the death of a participant;
- The termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a participant;
- The divorce or legal separation of a participant from his or her spouse;
- Transition from full-time to part-time work
- Birth of a child
- Death of the covered participant;
- A participant’s entitlement to Medicare coverage; or
- A dependent child ceasing to be a dependent child.

“FMLA leave” under the Family Medical Leave Act of 1993 means a leave of absence which the participating employer is required to extend an employee under the provisions of FMLA.

“Health care expense” means an expense incurred for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of function of the body.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“Incurred” means the date the service or the supply is obtained.

“Open enrollment period” means the month of October each year, but subject to change at the County’s discretion, when eligible employees may enroll for participation and make elections under the Plan for the following plan year.

“Participant” means an eligible employee who is participating in the Plan.

“Participating employer(s)” means the County of El Paso.

“Plan” means the County of El Paso, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Health Savings Account and Premium Only Plan.

“Plan Administrator” means PayFlex.

“Plan Sponsor” means the County of El Paso.

“Plan year” means the period from January 1 through December 31.

“Premium only plan” means the vehicle through which a participant pays his or her share of benefit costs by reducing his or her salary and using pre-tax dollars.

"Privacy standards" means the final rule implementing HIPAA's Standards for Privacy of individually Identifiable Health Information, as amended.

"Qualified beneficiary" means:

- An individual who, on the day before a qualifying event, is a eligible legal spouse or dependent child receiving health benefits under the Plan; or
- In the case of a qualifying event resulting in termination of coverage due to termination of employment or reduction in hours, an individual who, on the day before such qualifying event, is a participant.

A newborn child of, an adopted child or, or a child placed for adoption with, a qualified beneficiary (as defined in the first bullet above) will be entitled to the same continuation coverage period available to the qualified beneficiary; however, such child shall not become a qualified beneficiary.

A newborn child or child placed for adoption with a qualified beneficiary (as defined in the second bullet above) shall become a qualified beneficiary in his or her own right and shall be entitled to benefits as a qualified beneficiary.

A qualified beneficiary must notify the Plan Administrator within 31 days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

"Qualified dependent care flexible spending account" means the account established by the Plan Sponsor on behalf of a participant who elected to have amounts withheld from his or her salary in order to pay qualified dependent care flexible spending expenses.

"Qualified dependent care flexible spending expenses" means employment-related dependent care expenses which are eligible for reimbursement under the Plan as determined under Code §§ 129(e)(1) and 21(b). Such expenses include amounts paid for household services and for the care of qualifying individuals enabling the participant to be gainfully employed.

"Qualified Health Savings Account (HSA)" means the account established by the Plan Participant, which is owned by the participant, through which the participant may elect to reduce his or her salary in order to pay qualified medical spending expenses. This account may only be established in conjunction with participation in a qualified high deductible health plan or Consumer Driven Health Plan (CDHP).

"Qualified medical child support order" or "QMCSO" (to include National Medical Support Notice) means a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive health benefits for which a participant or eligible dependent is entitled under this Plan. In order for such order to be a qualified medical child support order, it must clearly specify the following:

- The name and last known mailing address (if any) of a participant and the name and mailing address of each such alternate recipient covered by the order;

- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this Plan.

In addition, a national medical support notice shall be deemed a qualified medical child support order if it:

- Contains the information set forth above in the definition of national medical support notice;
- Identified either the specific type of coverage or all available group health coverage. If the participating employer received a national medical support notice that does not designate either specific types of coverage or all available coverage, the participating employer and the Plan Administrator will assume that all are designated;
- Informs the Plan Administrator that, if a group health plan has multiple options and a participant is not enrolled, the issuing agency will select the Core Plan after the national medical support notice is qualified; and
- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan or upon the occurrence of certain specified events.
- Provides for child support with respect to a participant's child or directs a participant to provide coverage under a health benefit plan pursuant to a state domestic relations law (including community property law); or
- Enforces a law related to medical child support described in Section 13822 of the Omnibus Budget Reconciliation Act of 1993 with respect to a group health plan.
- The name of an issuing state agency;
- The name and mailing address of one or more alternate recipients or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient(s); and
- The identity of an underlying child support order.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to a participant and eligible dependents, except to the extent necessary to meet the requirements of a state law relating to medical child support order, as described in Social Security Act § 1098 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822).

"Qualified health care flexible spending account" means the account established by the Plan Sponsor on behalf of the participant through which the participant may elect to reduce his or her salary in order to pay qualified health care flexible spending expenses.

"Qualified health care flexible spending expenses" means a health care expense which is excludable as income according to Code § 105(b). Qualified health care flexible spending expenses are not otherwise reimbursable under the benefit plan or other plan or by an other entity and may not be claimed as a tax deduction by the participant. Qualified health care flexible spending expenses do not include the cost of insurance premiums.

"Salary reduction agreement" (Section 125 Cafeteria Plan) means an agreement by a participant to reduce his or her salary or wage in order to fund a qualified health care flexible spending account, health

savings account, a qualified dependent care flexible spending account, or to pay benefit costs. This written agreement can be in the form of a paper-based election or a web-based election made by the participant as provided for by the employer.

<u>"USERRA"</u> The Uniformed Services Employment and Reemployment Rights Act of 1994 is a Federal law that establishes rights and responsibilities for uniformed Service members and their civilian employers.

- Such individual was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code) ordered or called to active duty for a period in excess of 180 days or for an indefinite period; and

- Such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under such arrangements for the plan year which includes the date of such order or call.

SUMMARY OF BENEFITS

County of El Paso (the "Plan Sponsor") has adopted this Health Care Flexible Spending Account (FSA), Health Savings Account (HSA), Dependent Care Flexible Spending Account (Dependent Care FSA) and Premium Only Plan (the "Plan") as set forth herein and as amended from time to time for the exclusive benefit of eligible employees. The purpose of this Plan is to allow eligible employees to pay eligible qualified health care flexible spending expense, qualified dependent care flexible spending expenses, and their share of premiums under the benefit plan ("benefit costs") using pre-tax dollars. Members can use the money in their account(s) to reimburse themselves for qualified health care and dependent care expenses.

The intention of the Plan Sponsor is that the Plan qualifies as a "cafeteria plan" within the meaning of Code § 125 and the Plan shall be construed in a manner consistent with that Section. The tax implications of this Plan, however, are subject to rulings, regulations, and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, the Plan Sponsor does not represent or warrant to any participant that any particular tax consequence will result from participation in this Plan. By participating in this Plan, each participant understands and agrees that, in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from the Plan Sponsor.

This Plan is intended not to discriminate as to eligibility or benefits in favor of the prohibited group(s) under the Code §§ 105 and 125.

Benefit costs
By participating in the premium only plan, your portion of the benefit costs will be taken out of your salary and paid using pre-tax dollars.

Premium Plan only
The premium only plan is funded by your contributions under a salary reduction agreement with the participating employer. The contribution amounts paid under the salary reduction agreement will be adjusted automatically during a plan year to reflect changes in the benefit cost.

Order of funding
The total salary contribution amount for this Plan for any one time period may not exceed the amount of your salary or wages for that period. In the event that the total elected amount exceeds your salary or wages for a period, amounts available shall be used to fund the accounts in the following order: the premium only plan, the qualified health care flexible spending account, health savings account then the qualified dependent care flexible spending account. The total salary amount will be reduced by the contribution amount from your salary or wages for that period; however, future contributions will be adjusted to compensate for such reduction.

Accounting
The Plan Sponsor will maintain complete records of all amounts to be credited as a contribution. All contributions will be held as part of the general assets of the participating employer. No trust fund will

be established and no other segregation or investment of assets will be made to maintain accounts of contributions under this Plan.

All contributions made for the health care flexible spending account and dependent care flexible spending account are held by the County of El Paso until utilized by the participating member. All health savings account contributions are held by the health savings account banking partner in the name of the participant.

Effective date

This summary plan description is effective as of **July 1, 2017**, and each amendment is effective as of the date set forth therein (the "effective date").

Adoption of the summary plan description

The Plan Sponsor, as the settler of the Plan, hereby adopts this summary plan description as the written description of the Plan. This summary plan description amends and replaces any prior statement of the benefits contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Participation in the FSA, HSA, or Dependent Care FSA is voluntary. You decide whether you'd like to participate and how much money you'd like to set aside, within the minimums and maximums shown below.

	Health Care Flexible Spending Account	Health Savings Account	Dependent Care Flexible Spending Account
Your maximum annual contribution	$2,750	$3,550 individual $7,100 family	$5,000
Your minimum annual contribution	$260	$260	$260
Annual claim submission deadline	Claims must be received by PayFlex by March 31st	Claims must be received by PayFlex by March 31st	Claims must be received by PayFlex by March 31st

HOW THE FLEXIBLE SPENDING ACCOUNTS WORK

You fund your FSA(s) by directing a portion of your earnings to your account(s) on a pre-tax basis. You cannot deposit cash directly into your account(s). Once you decide how much you'll contribute for the year, you cannot change your election unless you have a qualified status change under IRS guidelines, nor can you transfer money from a Health Care FSA to an HSA, and Dependent Care FSA.

How Much You Can Contribute

You can contribute from $260 to $2,750 to your Health Care FSA each year, and you can contribute from $260 to $5,000 a year to your Dependent Care FSA, if married individual filing a separate tax return, maximum amount is $2,500. If you enroll during the year, you will be allowed a pro-rated maximum, based on the number of pay periods left in that calendar year.

Carefully calculate the amount you contribute to your Flexible Spending Accounts. The IRS imposes a "use it or lose it" rule on FSA plans: you forfeit any money that remains in your account after reimbursement of your eligible expenses for the year. See *Limits and Restrictions* for more information.

Limits and Restrictions

To preserve the favorable tax treatment of your contributions, there are several important limitations that you should understand before participating in the FSAs. First of all, an FSA is what is known as a "use it or lose it" arrangement, which means that if you do not spend all of the money in your account by the end of your plan year, you lose the unspent balance. Second you must decide how much to deposit for the year ***before*** each year begins – so you have to be careful in calculating your anticipated expenses for the coming year. Once you decide your contribution amount, you cannot change it during the year unless you experience a qualified family status change, so you should plan to deposit only as much as you expect to spend in the upcoming year.

Having a **Health Care FSA** limits your deductions for health care expenses. However, keep in mind that you can deduct unreimbursed health care expenses from your federal income tax only if they exceed the threshold established by the Internal Revenue Service.

To be eligible for reimbursement from the **Health Care FSA**, the expenses must be for you, your child, eligible spouse or a dependent under IRS guidelines.

Having a **Dependent Care FSA** limits the tax credits you may be able to take for dependent care expenses. You can use both the FSA and tax credit, provided you do not claim the same expenses for both. However, federal regulations require that your dependent care tax credit be reduced dollar for dollar by whatever you put into your FSA. You should ask your tax advisor to help you choose the right alternative for your tax bracket.

Establishing a Dependent Care FSA may have an impact on your cash flow. The way Dependent Care FSAs work, you essentially have to "pay twice" for your eligible expenses — first via the payroll deductions that you direct to your Account and again when you actually incur (and pay) the expense. It isn't until you receive your tax-free reimbursement from your Dependent Care FSA that you realize the Dependent Care FSA's full benefit. You should take this "cash flow effect" into account before deciding whether or not to sign up for the FSAs.

You cannot transfer funds between the HSA, Health Care FSA, and Dependent Care FSA.

You cannot carry over any unclaimed Dependent Care FSA balances from one year to the next. Any funds remaining in your Dependent Care FSA on December 31 will be forfeited unless they are used to cover expenses incurred during that calendar year and PayFlex receives your claim for reimbursement by the following March 31st.

You cannot carry over any unclaimed Health Care FSA balances from one year to the next. Any funds remaining in your Health Care FSA on December 31 will be forfeited unless they are used to cover expenses incurred during that calendar year and PayFlex receives your claim for reimbursement by the following March 31st.

Additional Limits on Dependent Care FSA Contributions

If Your Spouse Also Contributes to a Dependent Care FSA

The IRS sets additional limits on your contributions if you’re married and your spouse has a Dependent Care FSA through his or her employer:

You are limited to a **combined** Dependent Care FSA contribution of $5,000 in a calendar year. This limit applies whether you have one or more dependents receiving care.
If you file **separate** federal income tax returns, the most you can contribute is $2,500 a year.
If you file a **joint** return, you can’t contribute more than you earn (or what your spouse earns, if it's less than what you earn for the year, with a $5,000 limit).

If Your Spouse Is Either Disabled or a Full-Time Student

The IRS considers your spouse’s earnings to be $250 a month if you have one eligible dependent, and $500 if you have more than one eligible dependent.

How Participating in the FSAs Affects Taxes and Other Benefits

Establishing an FSA can also affect your tax strategy when you file your income tax return. You should consult with a tax advisor ***before*** signing up for the FSAs – you can't change your election once you’ve made it, unless you have a qualified family status change (as explained in *Making Changes*).

The Tax Advantages

The Internal Revenue Code allows your employer to take the money you direct to your FSAs out of your pay before federal and Social Security (FICA) taxes are deducted. That lowers your taxable income, so you pay less federal income tax and Social Security tax. Depending on where you live, your tax savings could be even greater, since most states recognize the tax-free status of FSA funds. What's more, any reimbursements you receive from your FSAs are free from federal tax as long as you have not taken (or do not intend to take) a tax deduction or credit for related expenses when you file your federal tax return.

Limits on Deductions

Participating in the FSAs can affect your tax strategy when you file your income tax return.

Setting up a Health Care FSA limits your deductions for health care expenses. Keep in mind, however, that you can deduct unreimbursed health care expenses from your federal income tax only if they exceed the annual threshold established by the Internal Revenue Service.
Using your Dependent Care FSA for dependent care expenses limits the tax credits you can take for those expenses. The federal income tax credit lets you subtract a percentage, based on your taxable income, of your expenses for dependent care from the federal taxes you owe. You can use both your Dependent Care FSA and the tax credit, but you can't claim the same expenses for both. Whatever you apply toward your federal income tax credit is reduced dollar for dollar by what you contribute to your Dependent Care FSA. Please consult your own tax advisor about changes in these amounts and your specific situation.

Impact on Other Benefits

Employer-Sponsored Benefits

While you are "reducing" your pay for tax purposes, your pay-related benefits (for example, any employer-sponsored life and disability insurance, and pension benefits) are not reduced. Your benefits from these plans will be based on your compensation before any amounts are deducted.

Social Security

Since your Social Security (FICA) taxes are based on your reduced pay, your future Social Security benefits may be slightly lower.

Your Flexible Spending Account Balance

The Explanation of Benefit (EOB) that PayFlex issues with each reimbursement is a good source of information. The EOB details the amount reimbursed and your current balance.

You can also access information about your FSA account status 24 hours a day, 7 days a week using Aetna Navigator™. Access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetnanavigator.com**. In addition to finding information about your FSA account(s), you can register to have EOBs suppressed and receive e-mail notification each time an FSA claim is paid.

HOW THE HEALTH SAVINGS ACCOUNT WORKS

You fund your HSA by directing a portion of your earnings to your account on a pre-tax basis by executing a valid salary reduction agreement or making direct contributions to the health savings account financial institution. You cannot deposit cash directly into your account. You can only enroll in HSA if under a high deductible plan (CDHP) per IRS regulation. HSA contributions may be increased or decreased once a month.

How Much You Can Contribute

You and/or your employer can contribute in an amount not to exceed $3,550 and $7,100 for a family to your HSA each year. An additional $1,000 contribution is allowable for individuals over the age of 55, as a catch up contribution. If you enroll during the year, you will be allowed a pro-rated maximum, based on the number of pay periods left in that calendar year.

Limits and Restrictions

To preserve the favorable tax treatment of your contributions, there are several important limitations that you should understand before participating in the HSA.

Having an **HSA** limits your deductions for health care expenses. However, keep in mind that you can deduct unreimbursed health care expenses from your federal income tax only if they exceed the threshold established by the Internal Revenue Service.

To be eligible for reimbursement from the **HSA**, the expenses must be for you, your child, eligible legal spouse or a dependent under IRS guidelines.

You cannot transfer funds between the HSA, FSA and Dependent Care FSAs.

You can carry over any unclaimed HSA balances from one year to the next. The funds will continue to earn interest (tax-free interest).

HSA accounts are portable. If you change workplaces or retire, the account may be taken with you.

How Participating in the HSAs Affects Taxes and Other Benefits

Establishing an HSA can also affect your tax strategy when you file your income tax return. You should consult with a tax advisor before signing up for the HSAs – you can change your election once you've made it.

The Tax Advantages

The Internal Revenue Code allows your employer to take the money you direct to your HSAs out of your pay before federal and Social Security (FICA) taxes are deducted. That lowers your taxable income, so you pay less federal income tax and Social Security tax. Depending on where you live, your tax savings

could be even greater, since most states recognize the tax-free status of HSA funds. What's more, any reimbursements you receive from your HSAs are free from federal tax as long as you have not taken (or do not intend to take) a tax deduction or credit for related expenses when you file your federal tax return.

Limits on Deductions

Setting up a HSA limits your deductions for health care expenses. Keep in mind, however, that you can deduct unreimbursed health care expenses from your federal income tax only if they exceed the annual threshold established by the Internal Revenue Service.

Impact on Other Benefits

Employer-Sponsored Benefits

While you are "reducing" your pay for tax purposes, your pay-related benefits (for example, any employer-sponsored life and disability insurance, and pension benefits) are not reduced. Your benefits from these plans will be based on your compensation before any amounts are deducted.

Social Security

Since your Social Security (FICA) taxes are based on your reduced pay, your future Social Security benefits may be slightly lower.

Your Health Savings Account Balance

The Explanation of Benefit (EOB) that PayFlex issues with each reimbursement is a good source of information. The EOB details the amount reimbursed and your current balance.

You can also access information about your HSA account status 24 hours a day, 7 days a week using Aetna Navigator™. Access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetnanavigator.com**. In addition to finding information about your HSA account(s), you can register to have EOBs suppressed and receive e-mail notification each time an HSA claim is paid.

YOUR HEALTH CARE FSA AND HSA

The Health Care FSA and HSA lets you pay many of your otherwise unreimbursed health care expenses with tax-free dollars. Since not every health care expense you incur is eligible for reimbursement through your FSA or HSA, it's important to know which are reimbursable and which are not.

If an expense is covered under any other plan(s), you cannot submit it for reimbursement under your Health Care FSA or HSA until the expense has been considered by the other plan(s).

Eligible Health Care Expenses

You can use your Health Care FSA or HSA to reimburse yourself for health care expenses that are considered "medical care" under section 213(d) of the Internal Revenue Code, as long as the expenses are not reimbursed by any health care plan. Tax rules change, so you should check with your tax advisor about the eligibility of specific expenses. You can get additional information about eligible health care expenses from IRS Publication 502, "Medical and Dental Expenses," which is available from your local IRS office and on the IRS website at **http://www.irs.gov**. Some eligible expenses include, but are not limited to the following:

Acupuncture
Alcoholism treatment
Ambulance service
Artificial limbs
Auto equipment such as special hand controls to assist the physically disabled
Blood pressure monitoring devices
Blood sugar kits and test strips
Birth control pills
Birth prevention surgery
Braille books and magazines
Chiropractic care
Christian Science practitioner fees
Co-payments
Contact lenses needed for medical reasons that are not covered by the Vision Care Plan
Contraceptives that are not covered by the Medical Plan
Crutches
Dental treatment not covered by the Dental Plan (not cosmetic)
Dentures
Drug abuse inpatient treatment
Elastic bandages
Eye exams, lenses and frames not covered in full by the Vision Care Plan
Fertility enhancement, as follows:

- procedures such as in vitro fertilization (including temporary storage of eggs or sperm), and
- infertility surgery, including an operation to reverse a prior sterilization procedure

First aid kits

Flu shots and other immunizations
Guide dog or other animal used by a visually-impaired or hearing-impaired person and their upkeep
Healing services
Hearing exams and hearing aids
Hospital services
Insulin
Laboratory fees
Laetrile (by prescription)
Laser eye surgery and radial keratotomy
Lead-based paint removal to protect a child who has, or who has had, lead paint poisoning from continued exposure
Legal fees directly related to committing a mentally ill person
Lodging while you receive medical care away from home. Care must be provided by a doctor in a licensed hospital or treatment facility, and the lodging must be primarily for, and essential to, medical care.
Long term care services required by a chronically ill person, if provided in accordance with a plan of care prescribed by a licensed health care practitioner
Medical information plan that maintains your medical information so it can be retrieved from a medical data bank for your medical care
Medical services and supplies not covered by your medical plan
Mental health care not covered by your medical plan
Obstetrical expenses
Organ donor expenses
Orthopedic shoes prescribed by a physician
Osteopathic services
Over-the-counter drugs/medications are eligible for healthcare FSA or HSA reimbursement with manual submission of claim with doctor's prescription. Examples of reimbursable expenses with doctor's prescription include charges for pain relievers, cold, flu and fever remedies, antibiotic products, and allergy medications
Over-the-counter items that do not require a physician's prescription, as long as they are for medical care, and not merely beneficial to your overall general health. Examples of these include contact lens solution, first aid bandages, and diabetes glucose monitor and related equipment
Oxygen and oxygen equipment
Physician, podiatrist, and osteopath fees not covered by medical plan
Prescription drugs and those not covered by your medical plan
Psychiatric care not covered by your medical plan
Prosthesis
Radial keratotomy
Ramps required by medical conditions
Rehabilitation therapies, including speech therapy, physical therapy, and occupational therapy
Rental of medical equipment
Routine physical examinations
Smoking cessation programs
Specialized equipment for the disabled, including:

- cost and repair of special telephone equipment that allows a hearing-impaired person to communicate over a regular telephone, and

- equipment that displays the audio part of television programs as subtitles for hearing-impaired people.

Sterilization surgery
Termination of pregnancy
Therapeutic are for substance abuse (drug or alcohol)
Transportation expenses if primarily for, and essential to, medical care
Wheelchairs
Weight loss programs prescribed by physicians for specific health problems
The following health care expenses also qualify for tax-free reimbursement through a Health Care FSA or HSA:

- Health plan copayment, deductible and coinsurance amounts on your and your eligible dependent's group plan
- Health care expenses that are not reimbursed by your health plan because they are above the customary charge or health care plan maximums

If you have any questions about what's considered an eligible expense under the Health Care FSA or HSA, you can call PayFlex at 888-678-8242.

You can also contact your local IRS office or visit the IRS website at http://www.irs.gov.

Ineligible Health Care Expenses

Just as important as understanding what's eligible for reimbursement through your FSA or HSA is knowing what's not generally eligible, including the following:

Expenses for which you've already been reimbursed by other health care plans (including Medicare, Medicaid, and your employer's or any other Medical, Dental and Vision Care Plans)
Expenses incurred by anyone other than you or your qualified dependents
Expenses that are not deductible on your federal income tax return
Babysitting, child care and nursing services for a normal, healthy baby. This includes the cost of a licensed practical nurse (L.P.N.) to care for a normal and healthy newborn.
Non prescribed Controlled substances
Cosmetic dental work
Cosmetic surgery (any procedure to improve the patient's appearance that does not meaningfully promote the proper function of the body, or prevent or treat illness or disease)
Custodial care in an institution
Diaper service
Electrolysis
Funeral and burial expenses
Health care plan contributions, including those for Medicare, your spouse's employer's plan, or any other private coverages
Health club dues
Health insurance premiums (except for the health savings account in the event of COBRA premiums)
Household help, even if such help is recommended by a physician
Illegal medical services or supplies
Maternity clothing
Medical savings account (MSA) contributions
Over-the-counter health aids that do not treat a specific medical condition, including those recommended by your physician
Over-the-counter items that are generally beneficial to health, but are not for medical care (for example: vitamins, minerals, weight loss aids)
Nursing home expenses (except under the health savings account)
Nutritional supplements, unless obtained legally with a physician's prescription
Personal use items, unless the item is used primarily to prevent or alleviate a physical or mental defect or illness
Prescription drugs for cosmetic purposes
Weight-loss programs not prescribed by a doctor
Special schooling for a child, even if the child may benefit from the course of study or disciplinary methods
Transportation to and from work, even if a physical condition requires special means of transportation
Up-front patient administration fees paid to a physician’s practice
This list should not be considered all-inclusive, and determination of non-qualified expense will be in accordance with Internal Revenue Code §§ 105(b) and 213(d) as stated at the time the expense is incurred.

YOUR DEPENDENT CARE FSA

You can use the Dependent Care FSA to reimburse yourself with tax-free funds for certain dependent care expenses incurred because you (and your spouse, if you are married) work or are looking for work.

Eligibility

If you are married, you may participate in the Dependent Care FSA only if your spouse:

Works full-time or part-time;
Is actively looking for work; or
Has no earned income for the year and:

- is a full-time student for at least five months of the year; or
- is incapable of caring for himself or herself or for the dependent.

Who Qualifies as a Dependent

You can use your Dependent Care FSA to cover the expenses of dependents, who are defined as:

- Children who are under age 13 when the care is provided and for whom you can claim an exemption on your federal income tax return;
- Your spouse who is mentally or physically incapable of self-care; and
- Your dependent who is physically or mentally incapable of self-care, and for whom you can claim an exemption (or could claim as a dependent if he or she didn't have a gross annual income of $3,000 or more).

You can use your Dependent Care FSA to pay expenses for a qualifying child for whom you have joint custody if you pay more than half of the child's support and have custody during the year longer than the other parent. The costs associated with caring for the elderly also qualify for reimbursement if they live in your home at least eight hours a day and are completely incapable of caring for themselves.

Eligible Dependent Care Expenses

The Dependent Care FSA is strictly monitored by the IRS. .The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of eligible expenses will be in accordance with Code §§ 21 and 129, as stated at the time the expense is incurred. Keep in mind that the expenses must be work-related to qualify as eligible expenses. The IRS considers expenses "work-related" only if they meet *both* of the following rules:

- They allow you (and your spouse) to work or look for work; and
- They are for the care of a qualified person.
- You can pay the following work-related expenses through your Dependent Care FSA:
- Fees of a licensed dependent care center that cares for your dependent child.
- After-school care expenses.
- Wages of individuals who provide care inside or outside your home for your dependent child under age 13 or a qualifying individual over age 13 who is incapable of self-support.
- Federal and state employment taxes you pay for an individual you employ to provide dependent care.

- Day camps.

Wages paid to a baby sitter, unless you or your spouse claims the sitter as a dependent. Care can be provided in, or outside of, your home.

Services of a Dependent Care Center (such as a daycare center or nursery school if the facility:

- provides care for more than six individuals (other than those who reside there),
- receives a fee, payment or grant for providing its services, and
- complies with all applicable state and local laws and regulations.

Cost for adult care at facilities away from home, such as family daycare centers, as long as your dependent spends at least 8 hours at home.

Wages paid to a housekeeper for providing care to an eligible dependent. Household services, including the cost to perform ordinary services needed to run your home which are at least partly for the care of a qualifying individual, are covered as long as the person providing the services is not your dependent under age 19 or anyone you or your spouse claim as a dependent for tax purposes.

If you have any questions about what's considered an eligible expense under the Dependent Care FSA, you can call PayFlex at 888-678-8242. You can also contact your local IRS office or visit the IRS website at http://www.irs.gov.

Ineligible Dependent Care Expenses

You cannot use your Dependent Care FSA to reimburse yourself for services that:

Allow you to participate in leisure-time activities;

Allow you to attend school part-time;

Enable you to attend educational programs, meetings or seminars; or

Are primarily medical in nature (such as in-house nursing care).

Educational expenses for a child in first grade or above.

Transportation, entertainment, food or clothing unless such items are incidental and cannot be separated from the cost of the care provided.

Household expenses that are not attributable at least in part to the care of the qualifying individual.

Expenses for a camp where a qualifying individual spends the night.

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with Code §§ 21 and 129, as stated at the time the expense is incurred.

ELIGIBILITY

You can participate in the Flexible Spending Account (FSA) or Health Saving Account program, if you are considered a full-time employee scheduled to work at least 30 hours per week. For a newly-hired (or newly eligible) employee, participation begins the first of the month following the date of hire. You will automatically be enrolled in the Premium Only Plan if you participate in the Health benefit plan.

You can sign up for the following:

- Health Care FSA and Dependent Care FSA
- Health Savings Account and Dependent Care FSA
- Healthcare FSA only
- Health Savings Account only
- Dependent Care FSA only

In order to qualify to contribute to the health savings account, an individual must be enrolled in a qualified high deductible health plan or consumer driven health plan. The individual may not have coverage outside of the employer's plan that doesn't meet the IRS' definition of a qualified high deductible health plan.

Participation is completely voluntary; it's up to you to decide which FSA or HSA (if any) meets your needs. Only employees can enroll in the Flexible Spending Accounts or Health Savings Account, but the FSAs or HSAs can be used to reimburse your dependents' eligible expenses, as well as your own.

How to Enroll

Eligible employees who wish to participate in the Health Care FSA, Health Savings Account, or Dependent Care FSA must complete the **Salary Reduction Agreement** and indicate the contribution amount**.** If you participate in the benefit plan, your salary will be reduced by the amount indicated so that your share of the premiums for the benefit plan are paid using pre-tax dollars.

If you do not submit the salary reduction agreement with your contribution amount to the Plan Sponsor within 31 days of becoming eligible, or during the open enrollment period, it will be assumed that you have decided not to participate in the Plan, and you will not have the opportunity to enroll until the next open enrollment period or following a change in status event described below.

Unless you experience a change in circumstances, as described below, your salary reduction agreement will continue in force for that plan year, and you will be required to complete a new salary reduction agreement for each subsequent plan year for which you decide to participate in the Plan.

Open Enrollment

The annual enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary. The elections you make will be in effect for the following plan year.

If you are already enrolled in the FSA, HSA, or Dependent Care FSA and wish to continue participating, you must re-enroll to continue your participation.

Participation in the benefit plan

You may elect not to participate in the benefit plan by completing and filing an appropriate election/declination form with the Plan Sponsor within 31 days of your original eligibility period or an open enrollment period. However, if you participate in the Health Plan you will automatically be enrolled in the Premium Only Plan.

When Participation Begins

New Employees
For a newly-hired (or newly eligible) employee, participation begins the first of the month following the date of hire. You must complete a proper salary reduction agreement within 31 days from your original eligibility date in order to participate in the Plan for the plan year.

Annual Enrollment
Your annual election will go into effect on January 1.

Making Changes
The IRS requires that your FSA elections stay in effect throughout the full Plan year unless you are enrolled in the Health Savings Account (HSA). Once made, you can't change your election during the year unless you experience a "qualified family status change under IRS guidelines."

Defining a Family Status Change for the Health Care FSA, HSA, and Dependent Care FSA
The following are examples of events that may qualify as family status changes for the FSA, HSA, and Dependent Care:
- Marriage
- Divorce, legal separation, or annulment
- Birth or adoption of a child
- Death of a spouse or child
- Termination or commencement of employment by you or your spouse.
- Transition from part-time to full-time work, or from full-time to part-time work, by you or your spouse
- An unpaid leave of absence taken by you or your spouse
- Place of residence change by you, your spouse, or your dependent, which results in a change in eligibility.
- Your dependent satisfies or ceases to satisfy the requirements for coverage.
- Commencement or return from an unpaid leave of absence by you or your spouse.
- A significant change in the cost of dependent care as it relates to your dependent care spending account.
- A change in dependent care providers as it relates to your dependent care spending account.
- A dependent care provider's cessation of business as it relates to your dependent care spending account.
- The entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid by you, your spouse, or your dependent.
- If you, your spouse, or your dependent becomes eligible for COBRA continuation coverage under the benefit plan, you may elect to change your contributions to the qualified health care flexible spending account.
- If a local disaster declaration has been issued by your local government causing for your day care facility to be temporarily closed, pursuant to IRS Notice 2020-29.

Any other change in status that the Plan Sponsor, in its sole discretion, determines will permit a change or revocation of an election during a plan year according to regulations and ruling under the Internal Revenue Service.

If You Have a Family Status Change

If you experience such a change in status and wish to change your level of coverage you must submit written notification and proof, if applicable, to the Plan Sponsor within 31 days of your change in status, as well as a new salary reduction agreement reflecting your new contribution elections. The change in your Health Care FSA or Dependent Care FSA election must be due to and consistent with the change in your family status.

For example:

- If you have a child and cover the baby under your employer Medical Plan, you could increase the amount you are contributing to your FSA or HSA, but you could not stop your contributions.;
- The change in status results in you or your spouse or dependent child, gaining or losing eligibility for health coverage under the benefit plan or another health plan of your spouse's or dependent child's employer; and
- The election change corresponds with that gain or loss of coverage.

You should contact the Plan Sponsor immediately after the change takes place to make sure you allow yourself enough time to take the appropriate action. Your Plan Sponsor will explain the procedure to you.

The Plan Sponsor reserves the right to require you to submit proof of any change in status at your expense. The change in coverage becomes effective with the first pay period following the date the written notification is received by the Plan Sponsor, except that coverage for birth, adoption, or placement for adoption becomes effective the date of the event. Any such change will remain in effect for the remainder of the plan year.

If you don't report the family status change within the 31-day period, you will not be allowed to make the change until the next open enrollment period.

If You Take a Leave of Absence

Paid Leave of Absence

Your participation in the Health Care FSA, HSA, or Dependent Care FSA will not be affected if you are granted a paid leave of absence. Payroll deductions will continue, and you can still use your Health Care FSA, HSA, or Dependent Care to reimburse yourself for eligible expenses. You may elect a family status change as explained in *Making Changes* if your change in election is consistent with the circumstances of your leave.

FMLA leave

If the leave of absence is qualified under the federal Family and Medical Leave Act (FMLA), you have the option to terminate your participation in the Plan or continue your participation in the Plan and make payments as determined by the Plan Sponsor in compliance with FMLA requirements. In addition, the Plan Sponsor must apply special detailed rules for administering Plan coverage during and after a Participant's unpaid FMLA leave. Contact the Plan Sponsor for more information.

Military Leave - USERRA

If you are absent from employment because you are in the uniformed service, you may elect to continue your coverage under this Plan for up to 24 months. If you elected to continue coverage under USERRA before December 10,2004, the maximum period for continuing coverage is 18 months. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan's open enrollment period, and pay your contribution in accordance with the options outlined above for a participant who goes on FMLA leave.

Unpaid Leave of Absence

While on an unpaid leave of absence, you can continue your Health Care FSA or HSA by making payments on an after-tax basis (see Plan Sponsor for details). If you do not make your payments by the deadline or if you do not elect to continue your Health Care FSA or HSA you will be offered COBRA coverage. (See *Continued Participation in the Health Care FSA, HSA, or Dependent Care FSA* for details.) If no COBRA coverage is elected, you will be eligible only for reimbursements for claims incurred before your leave or the date you stopped making contributions, whichever is later.
If you are on an unpaid leave of absence, your contributions and participation in the Dependent Care FSA will end. You can continue to be reimbursed from your Dependent Care FSA for eligible expenses you had incurred while you were actively at work; you will ***not*** be reimbursed for expenses incurred while on leave. Any balance in your Account from contributions made before your leave can be used for claims incurred upon your return to work.

When Your Employment Ends

Health Care FSA and Dependent Care FSA

If you terminate employment with the participating employer, your participation in this Plan will terminate on the last pay period, unless you elect to continue your participation in accordance with the guidelines provided in the "COBRA continuation coverage" section. Any qualified health care flexible spending expenses or qualified dependent care flexible spending expenses incurred during the plan year prior to the date of termination will be reimbursed by the Plan in accordance with the guidelines in the section, "Benefits". Your participation in this Plan will also terminate if the participating employer decides to terminate this Plan, or if you voluntarily decide not to participate under the terms of this Plan.

If your participation in this Plan terminates because you are no longer eligible to participate, you may either revoke your election to participate and terminate your participation in the Plan for the remainder of the plan year or continue your participation in accordance with the "COBRA continuation of coverage" section. If you do not make payments as required under COBRA, it will be assumed that you elected to revoke your participation in this Plan.

If you do not complete and file a salary reduction agreement during the annual enrollment period, your participation will end at the end of the plan year.

Health Savings Account

HSA accounts are portable. If you change workplaces or retire, the account may be taken with you.

If You Are Rehired

If your employment terminates, and you return to eligible employment with your participating employer more than 30 days following termination of your participation, you may rejoin the Plan and make a new election for the remainder of the plan year, as long as the termination was not for the purpose of altering the original election.

Continued Participation in the Health Care FSA (COBRA)

The following people are known as qualified beneficiaries and may elect COBRA coverage that will include the benefits to which they were entitled to under the Plan on the day before one of the qualifying events:

- The eligible legal spouse or any dependent child of the participant under the Plan.
- The participant, if the qualifying event is the termination of coverage due to termination of employment or reduction in hours.

Under some circumstances, you and your eligible dependents can still participate in the Health Care FSA even after your coverage ends. This continued coverage is available if your coverage ends because:

- Your employment terminates for any reason other than gross misconduct;
- Your scheduled work hours are reduced;
- You retire;
- You divorce or legally separate;
- You die;
- A dependent child ceases to be a dependent under the terms of the Plan; or
- The participant becomes entitled to Medicare benefits.

This extended coverage is provided through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and applies to the Health Care FSA only, not to the Dependent Care FSA. The COBRA provisions are described below.

COBRA Coverage

Even if you're no longer eligible, you (and in some cases, your dependents) can still contribute to the Health Care FSA on an after-tax basis. In most cases, the Plan Sponsor (or your employer's COBRA Administrator) will let you (or your dependents) know when you (or they) are eligible for continued coverage. Once you are notified by the COBRA Administrator, you have 60 days to respond if you want to continue coverage. You have to contribute the same amount you were contributing before losing eligibility (plus a 2% administrative fee) and you have 45 days from the time you are billed to send your money. Other than that, the same rules that govern active employees apply.

If a dependent under the Plan has a newborn child, adopts a child, or a child is placed for adoption with that dependent, that child will be entitled to the same COBRA coverage period, but will not become a qualified beneficiary in his or her own right.

If you have a newborn child, adopt a child, or a child is placed for adoption with you, that child will become a qualified beneficiary in his or her right.

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Sponsor will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Continuation of Coverage

If you have experienced a qualifying event and have a positive balance in your qualified health care flexible spending account at the time of the event (taking into account all claims submitted before the date of the event), you may be eligible to continue participation in this Plan under COBRA. Your COBRA coverage period ends on the last day of the plan year in which the qualifying event occurs.

Who's Eligible to Continue to Participate Through Year-End	In the Event
You	Your employment terminates
You	Your working hours are reduced
Your dependents	You die
Your dependents	You divorce or legally separate

Losing Continued Coverage

Continued participation will end sooner than the time limits shown in the chart if the Health Care FSA is discontinued or if you do not make your contributions on time.

CLAIMING REIMBURSEMENT

When You Can File Claims

Only expenses incurred during the plan year are reimbursable through your FSA for that plan year; the previous year's expenses are ***not*** eligible for reimbursement. However, all claims for reimbursement must be submitted within 90 days following the end of the plan year or earlier, or the claims will be denied. This limitation does not apply to the health savings account.

Reimbursement for qualified health care flexible spending expenses is limited to the annualized amount that you have elected to reduce your salary or wages and contribute to the qualified health care flexible spending account for the plan year under a valid salary reduction agreement. Reimbursements for qualified dependent care flexible spending expenses is limited to the amount that you have elected to reduce your salary or wages to contribute to the qualified dependent care flexible spending account for the plan year under a valid salary reduction agreement for that plan year.

To the extent that it is not used to pay claims, the amount of contributions to your qualified dependent care flexible spending account will also accumulate throughout the plan year. If you submit an eligible claim during the plan year in an amount that exceeds your current qualified dependent care flexible spending account balance, the Plan will reimburse your claim expense up to the total amount of contributions in your qualified dependent care flexible spending account, less any amounts already used to pay claims. As contribution amounts become available in your qualified dependent care flexible spending account, they may be used to reimburse any unpaid balance from a previously submitted qualified dependent care flexible spending expense. At no time during the plan year will the amount paid for claims exceed the amount of contributions made to the qualified dependent care flexible spending account.

In no instance can amounts contributed to a qualified health care flexible spending account be used to reimburse qualified dependent care flexible spending expenses, or vice versa.

Withdraw any or all of the balance of qualified health care flexible spend account for expenses other than qualified medical expenses.

The only exception to this rule is under USERRA.

Documenting Your Claim

Health Care Expenses

When you submit a claim for reimbursement from your Health Care FSA or HSA, you must provide a copy of:

The Explanation of Benefits (EOB) you received from PayFlex (or your dependent's health care plan) showing how much, if any, of your claim was paid; or

Itemized bills from suppliers for expenses not covered by any health care plan. The itemized bill should include the following information:

- patient name,
- diagnosis,
- type of service,
- charge, and
- date of service.

Your claim will not be accepted if the required information is not provided. You can use the "Flexible Spending Account Health Care Reimbursement" form to ensure that your claim submission contains all of the required information. Copies of the form are available from Member Services, on Aetna's website (visit the Forms Library on Aetna Navigator), and from your Human Resources Representative.

Your Health Care FSA includes a minimum reimbursement amount (refer to the *Summary of Benefits*). If your claim for reimbursement is less than the Plan's minimum, the claim will be processed, but reimbursement will not be issued until:

- You submit additional covered expenses, and the accumulated total reaches the Plan's minimum; or
- The end of the plan year.

Participants in the health savings account may only use funds that have been deducted and put in the member's account.

You may either use your debit card (for FSA or HSA) or you may submit a properly completed and documented claim to:

PayFlex Systems USA, Inc.

P.O. Box 4000

Richmond, KY 40476-4000

Fax: (888) 238-3539

It must include the following information:

- The name of the person or persons on whose behalf the expenses have been incurred.
- The nature of the expenses incurred (that is, a description of the services or supplies being claimed).

- The date the expenses were incurred.
- Evidence that such expenses have not otherwise been paid, or are otherwise payable, through any coverage
- (insured or self-insured) or fee-for-service arrangement, or from any other source.

The claim must include written evidence from an independent third party documenting the above information. If the expenses are not reimbursable under any benefit plan, include a copy of the provider's statement that shows the date(s) of service, an explanation of services, and the name of the provider, along with a copy of the Explanation of Benefits or denial letters) from the benefit plan(s). Canceled checks or balance due statements are not acceptable.

You must also submit a signed statement in a form furnished and approved the Plan Administrator certifying that the expenses for which you are seeking reimbursement are expenses which you believe in good faith are reimbursement under the Plan.

The Plan Administrator, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are eligible for reimbursement under this Plan.

The Plan will pay properly submitted claims for reimbursement at such intervals as the Plan Administrator may consider appropriate.

Dependent Care Expenses

To file a claim for reimbursement, complete the “Dependent Care Reimbursement” form. Copies of the form are available from Aetna Member Services, on the Aetna website (visit the Forms Library on Aetna Navigator), and from your Human Resources Representative. You must provide the following information in your claim submission:

- Dependent’s name
- Provider’s name, address and tax ID (or Social Security) number
- The cost, nature and place of the service(s) performed
- Proof of payment*

An indication of whether the provider is related to you and, if so, how (if the provider is your child, you must also include the child's age)

* You may submit an itemized statement or you can ask your dependent care provider to sign the claim form as verification of payment.

You are also required to report your provider's taxpayer identification number or Social Security number when you file your tax return.

You must submit properly completed and documented:

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
Fax: (888) 238-3539

It must include the following information:

- A list of names of the eligible qualifying individual for whom the expenses were incurred, the ages of such qualifying individual, and the qualifying individual’s relationship to you.
- If any of the services were performed outside of your home for a qualifying individual incapable of caring for him or herself, a statement as to whether the qualifying individual regularly spends at least eight hours a day in your home.
- If any of the services are performed for a qualifying individual who is physically or mentally incapable of caring for himself or herself, a statement to that effect.
- A description of the nature and date of performance of the qualifying services for which cost you wish to be reimbursed.

- If you are married and your spouse is not employed, a statement that your spouse is incapacitated, or that your spouse is a student, and indicating the months of the year during which the spouse attends an educational institution of a full-time basis.
- A statement as to the amount, if any, of tax-exempt dependent care assistance benefits received from any other employer for you or your spouse during the plan year.
- Evidence of indebtedness or payment by you to the third party who performed the services.
- Written evidence, signed by an independent third party stating that the expenses have been incurred, the amount of such expenses, the date of services, and such other information as the Plan Administrator in its sole discretion may request.
- A statement as to where the services were performed.
- A statement indicating whether the services are necessary to enable you to be gainfully employed.
- A statement that the expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.
- A statement, signed by you and is such form as determined by the Plan Administrator, certifying that the expenses for which reimbursement is sought are expense that you believe in good faith are eligible for reimbursement.

You must also attach a paid receipt from your day care provider or from the individual who provides the care. The social security number of the federal tax identification number of the provider **must** appear on the claim form or receipt. The individual who provides the care cannot be your spouse or a dependent under the age of 19.

The Plan Administrator, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this Plan.

The Plan will pay properly submitted claims for reimbursement at such intervals as the Plan Administrator may consider appropriate.

Reimbursement

PayFlex processes FSA claims as they are received, and issues FSA claim payments daily.

You can be reimbursed through your Health Care FSA for qualifying health care expenses up to the annual amount you elected at enrollment – even if all of it hasn't been deducted from your paychecks. You can be reimbursed for dependent care expenses only up to the amount in your Dependent Care FSA when you file a claim. Any unpaid amounts still due you will be processed in the next claim cycle when (and if) you have enough money in your Dependent Care FSA to cover them.

You will receive an Explanation of Benefit (EOB), which reflects the status of your account, each time you submit a request for reimbursement (for example, the amount of the claim, how much of it is eligible for reimbursement, what's been paid to date from your FSA, any amounts still payable, and any balance remaining in your Account).

If any balance is left in your FSA(s) at the end of the year, and claims for that balance are not filed with PayFlex by March 31st of the following year, ***the remaining balance will be lost***.

If you have any questions about your Health Care or Dependent Care FSA claims, call PayFlex Member Services.

How to Appeal a Denied Claim

If your claim is entirely or partially denied the reason(s) for the denial will appear on the Explanation of Benefit (EOB) you receive from PayFlex.

Please note: If PayFlex does not process your FSA claim because information is missing needed to complete processing. This is not considered a denied claim.

Health Care FSA Claims

If you think your claim has been wrongfully denied, you have 180 days after receiving the written denial to request a review. Your request for a review, called an appeal, must be submitted to PayFlex in writing. Be sure to explain why you think you are entitled to reimbursement, and attach any documentation that will support your claim. The Plan's named fiduciary for appeal of denied claims must respond to your written request for a review within 30 days of receiving it, explaining the reasons for their decision in clear, understandable language. You can also follow this procedure if you do not receive any response to your claim within 30 days after you've initially filed it with PayFlex.

Dependent Care FSA Claims

If you think your claim has been wrongfully denied, you have 60 days after receiving the written denial to request a review. Your request for a review, called an appeal, must be submitted to PayFlex in writing. Be sure to explain why you think you are entitled to reimbursement, and attach any documentation that will support your claim. You may have a qualified person represent you at your own expense, and you have the right to examine the relevant portions of any documents that PayFlex referred to in its claim processing. Normally, the Plan Sponsor will send you its written decision within 60 days, explaining the reasons in clear, understandable language. (If a longer period is required, you will be told, in writing, how much longer it will take.)

You can also follow this procedure if you do not receive any response to your claim within 90 days after you've initially filed it with PayFlex.

HSA Claims

If you think your claim has been wrongfully denied, you have 180 days after receiving the written denial to request a review. Your request for a review, called an appeal, must be submitted to PayFlex in writing. Be sure to explain why you think you are entitled to reimbursement, and attach any documentation that will support your claim. PayFlex must respond to your written request for a review within 30 days of receiving it, explaining the reasons for their decision in clear, understandable language. You can also follow this procedure if you do not receive any response to your claim within 30 days after you've initially filed it with PayFlex.

If you have any questions regarding the claims appeal process, or if you need assistance filing your appeal, contact your Human Resources Representative.

MISCELLANEOUS INFORMATION

Will the Plan release my information to anyone?
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or participant for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the privacy standards. Any participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision. See HIPAA Privacy Practices on page 46.

What if the Plan makes an error?
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate participation nor cause participation to be in force or to continue in force. Rather, the effective dates of participation shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

In the event that is has determined that the Plan Administrator has mistakenly reimbursed an expense which did not qualify under the terms of the Plan, the Plan Administrator may adjust your pay and appropriately credit the qualified health care flexible spending account, qualified dependent care flexible spending account or premium only plan.

What if the employee makes an error?
In the case of an employee mistake, a correction will only be allowed as permitted by law.

Will the Plan conform with applicable laws?
This Plan shall be deemed automatically to be amended to conform as required by an applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this summary plan description.

What constitutes a fraudulent claim?
The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of participation under this Plan.

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person other than you, your spouse or your dependent according to the Plan;
- Attempting to file a claim for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the Plan or;
- Providing any false or misleading information to the Plan.

How will this document be interpreted?
The use of masculine pronouns in this summary plan description shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this summary plan description are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this summary plan description applies to participants.

How may a Plan provision be waived?
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the on specifically waived.

Is this summary plan description a contract between the employer and participants?
This summary plan description and any amendments constitute the terms and provisions of coverage under this Plan. The summary plan description shall not be deemed to constitute a contract of any type between the participating employer and any participant or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this summary plan description shall be deemed to give any employee the right to be retained in the service of the participating employer or to interfere with the right of the participating employer to discharge any employee at any time.

May I appoint an authorized representative?
A participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. To appoint such a representative, the participant must complete a form which can be obtained from the Plan Administrator. In the event a participant designates an authorized representative, all future communications form the Plan will be with the representative, rather than the participant, unless the participant directs the Plan Administrator, in writing, to the contrary.

How will the Plan pay benefits?
All benefits under this Plan are payable, in U.S. dollars, to the participant or, if appropriate, the alternate recipient. In the event of the death or incapacity of a participant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, the Plan Administrator may, in its sole discretion, make any and all payments due under the plan to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such participant.

What if my claim is for non-U.S. providers?
Qualified health care flexible spending expenses and qualified dependent care flexible spending expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a “non-U.S. provider”) may be reimbursed under the following conditions:

- The participant is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;
- The non-U.S. provider shall be subject to, and in compliance with, all requirements under Code § 105; and
- Claims for benefits must be submitted to the Plan in English.

How will the Plan recover payments made in error?
Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the participant on whose behalf such payment was made.

A participant, spouse, dependent, provider, another benefit plan, insurer, or any other person or entity

who receives a payment made in error under the terms of the Plan, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum, payroll deduction, or other arrangement.

Participants accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with the requirements of this Plan. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation costs and actual attorney's fees incurred.

How will the Plan handle medical child support orders?
The Plan Sponsor shall adhere to the terms of any medical child support order that satisfies the requirements of this section. The Plan Sponsor shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a medical child support order that is qualified medical support order if such an individual is not al- ready covered by the Plan as a dependent.

The Plan Sponsor shall promptly notify the participant and each alternate recipient of:

- The receipt of a medical child support order by the Plan; and
- The Plan's procedures for determining the qualified status of medical child support orders.

Within a reasonable period after receipt of a medical child support order, the Plan Sponsor shall determine whether such order is a qualified medical child support order and shall notify the participant and each alternate recipient of such determination. If the participant or any affected alternate recipient disagrees with the determinations of the Plan Sponsor it is the responsibility of the affected employee to provide a modified, court-approved medical child support order.

Upon receiving a national medical support notice, the Plan Sponsor shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the Plan, and if so:
    - o Whether the child is covered under the Plan;
    - o Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Sponsor shall:

- Establish reasonable procedures for determining the qualified status of a medical child support order or a national medical support notice; and
- Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the order.

Payments under this Plan pursuant to a medical child support order described in this section in

reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial or legal guardian.

Will the Plan provide a statement of benefits?
Throughout the plan year, the Plan Administrator will provide access to a web-based online system to each participant who received benefits under the Plan which will show the amounts paid or the expenses incurred by the Plan Administrator in providing reimbursement under the Plan for qualified dependent care flexible spending expenses, qualified health care flexible spending expenses, health savings account and benefit costs for the prior plan year.

HIPAA PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the general information section.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to

the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

OTHER INSTRUCTIONS FOR NOTICE

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Amendment or Termination of the Plan

[County of El Paso] has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any non-forfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description covers the major features of the Health Care Flexible Spending Account, Health Savings Account, and Dependent Care Flexible Spending Account program administered by Aetna Life Insurance Company. The plan description has been designed to provide a clear and understandable summary of the Plan, and serves as the Summary Plan Description (SPD).