

**Maricopa County Flexible
Spending Account
Summary Plan Description**



Administered By:



Effective July 1, 2014

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PLAN DESCRIPTION

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Introduction to the Flexible Spending Account Summary Plan Description

Maricopa County is pleased to sponsor an employee benefit called a Flexible Spending Account. There are two types of Flexible Spending Accounts provided under the Plan: a General Purpose Health Care Flexible Spending Account ("HCFSA") and a Dependent Care Flexible Spending Account ("DCFSA").

With a Flexible Spending Account you determine the amount of unreimbursed eligible medical and/or dependent care expenses that you (and where applicable, your eligible family members) will likely incur during the Plan Year for which you elect to have the County withhold equal amounts from your pay (subject to Plan limitations) *on a pre-tax basis* for reimbursement of such expenses. Any amounts that you elect to have withheld for reimbursement of eligible medical expenses will be credited to the HCFSA and any amounts that you elect to have withheld for reimbursement of dependent care expenses will be credited to the DCFSA. You must elect wisely because any amounts allocated to a Flexible Spending Account that are not used for expenses incurred during the Plan Year will generally be forfeited.

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

This Summary Plan Description is divided into four parts: Part I-General Information about the Plan; Part II-HCFSA Benefits; Part III-DCFSA Benefits; and Part IV-the Plan Information Appendix. The first three parts of the Summary Plan Description are in Question and Answer format. You should read the entire Summary Plan Description. Information relating to the Plan that is specific to your Employer is described in the Plan Information Appendix attached to this Summary Plan Description. You will be referred to the Plan Information Appendix throughout the Summary Plan Description. In addition, terms that are capitalized throughout are terms that are specifically defined in the Summary Plan Description.

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

If you have any questions regarding the terms of the Plan, the HCFSA and/or the DCFSA, contact the Plan Administrator identified in the Plan Information Appendix. Other important information has been provided in the Plan Information Appendix.

Flexible Spending Account Plan Questions and Answers

Part I: General Information about the Plan

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

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

Q-2. Who can participate in the Plan?

County employees who satisfy the Plan's "Eligibility Requirements" are eligible to participate in this Plan on the applicable "Eligibility Date". The Eligibility Requirements and the Eligibility Date are identified in the Plan Information Appendix. Those employees who actually participate in the Plan are called "Participants."

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

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

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

Q-4. How do I become a Participant?

You become a Participant in the Plan by (i) completing the required benefit election for which you indicate the amount of your pay you wish to have withheld and then allocated to the HCFSA and/or the DCFSA and (ii) timely submitting the election during one of the enrollment periods described below.

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

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

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

When you are first hired or newly benefits-eligible, you must enroll during the "Initial Enrollment Period" if you want to participate. The enrollment material provided by the Employer (or the Third Party Administrator identified in the Plan Information Appendix) will identify the beginning and end dates of the Initial Enrollment Period. If you make an election during the Initial Enrollment Period, your participation in the Flexible Spending Account(s) that you elect will begin on the later of your Eligibility Date or the date that your election is received and processed online. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and cannot be revoked during the Plan Year unless you experience a Qualifying Event that allows for a mid-year election change.

If you do not make an affirmative election to participate in the Flexible Spending Accounts during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year unless you experience a Qualifying Event that allows you to change that election during the Plan Year.

The Plan also has an annual Open Enrollment Period during which you may enroll, continue your previous election, or change your previous elections for the next Plan Year. You will be notified each year of the beginning and end dates of the annual Open Enrollment Period. You must make an affirmative election to participate, change your election, or continue your current election for the next Plan Year. The election that you make during the annual Open Enrollment Period is effective the first day of the following Plan Year and is irrevocable for the entire Plan Year unless you experience a Qualifying Event that allows a mid-year election change.

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

The Plan Year is a 12-month period. The beginning and end dates of the Plan Year are described in the Plan Information Appendix.

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

When you become a Participant in the Plan, your share of the contributions for the elected Flexible Spending Accounts will be paid with Pre-tax Contributions that you designated. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal taxes and state taxes have been deducted.

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

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution that you have elected to allocate to the HCFSA and/or the DCFSA. Your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable Eligibility Requirements. Otherwise, you may change your Pre-tax Contribution elections only during the annual Open Enrollment Period, and then, only for the next Plan Year.

There is an exception to the general rule that you cannot revoke your elections during the Plan Year: You may change or revoke your elections during the Plan Year if you process a Family Status Change through the Benefit Enrollment System within 30 days of experiencing a Qualifying Event. Note that not all of events apply to FSA elections.

Change in Status. If one or more of the following Qualifying Events occurs, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Qualifying Event (as described below).

A change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse);

A change in the number of your tax dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);

Any of the following events that change your employment status or that of your spouse or dependent that affect benefits eligibility under a cafeteria plan (including this Plan and the plan of another employer) or other employee benefit plan of yours, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, switching from part-time to full-time; a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age); and

A change in your, your spouse's or your dependent's place of residence.

The election change must be on account of and correspond with the Qualifying Event as determined by the Plan Administrator. With the exception of an election change to the HCFSA resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Qualifying Event if the event affects eligibility for coverage under the Plan. A Qualifying Event affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Qualifying Event:

Gain of Coverage Eligibility under Another Employer's Plan. For a Qualifying Event in which you, your spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Qualifying Event *only* if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.

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

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a DCFSA as part of its cafeteria plan. Mike elects to

reduce his salary by \$2,000 during a Plan Year to fund dependent care coverage for his daughter. In the middle of the Plan Year when his daughter turns 13 years old, she is no longer eligible to participate in the DCFSA. This constitutes a Qualifying Event, and Mike elects to cancel coverage under the DCFSA with this Qualifying Event.

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

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

3. **Entitlement to Medicare or Medicaid.** If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may cancel that person's HCFSA coverage. Similarly, if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's HCFSA coverage.

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

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

If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your HCFSA coverage on the same terms and conditions as though you were still active.

In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your HCFSA, you may pay your share of the

contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave (not to exceed the end of the Plan Year) with Pre- tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Plan Administrator.

If your HCFSA coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the HCFSA upon return from such leave on the same basis as you were participating in the HCFSA prior to the leave, or as otherwise required by the FMLA. Your HCFSA coverage may be automatically reinstated provided that coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

The Employer may, on a uniform and consistent basis, continue your HCFSA coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

If you are commencing or returning from unpaid FMLA leave, your DCFSA election under this Plan will be treated in the same manner that elections for non-health plans are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

Q-8. How long will the Plan remain in effect?

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

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

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

Flexible Spending Account Plan
Part II. HCFSA Benefits

The following Questions and Answers relate to the HCFSA benefit. This section only applies to the extent that you have elected to allocate Pre-tax Contributions to the HCFSA.

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

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

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

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

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

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

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

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

The full annual amount of reimbursement you have elected under the HCFSA will be available at any time during the Plan Year without regard to how much you have contributed to the HCFSA.

Q-14. How do I receive reimbursement under the HCFSA?

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

- The nature of the expense (e.g., what type of service or treatment was provided).
- If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug and a copy of the prescription;
- The date the expense was incurred; and
- The amount of the expense.

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

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

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

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

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

- The expense is for "medical care" as defined by Code Section 213(d). Final determination regarding whether an expense is for "medical care" is within the sole discretion of the Plan Administrator; and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An "Eligible Dependent" is your legal spouse and any other individual who is a "dependent" as defined in Code Section 105(b) (i.e., a dependent who is eligible to receive tax-free health coverage under the Code). Coverage for an individual covered as an Eligible Dependent under the HCFSA ends on the date that the individual ceases to meet the requirements to be an Eligible Dependent.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over-the-counter drugs (and over-the-counter products and devices). Not every health related expense you or your Eligible Dependents incur constitutes an expense for "medical care." For example, an expense that is not for "medical care," as that term is defined by the Code (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, at the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a healthcare provider showing that you have a medical condition

and/or the particular item is necessary to treat a medical condition. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator). Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

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

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

If you currently maintain or wish to establish a personal Health Savings Account (Limited Scope Flexible Spending Account):

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

- (i) Services or treatments for dental care (excluding premiums)
- (ii) Services or treatments for vision care (excluding premiums)

A HCFSA participant may only make an election during the annual Open Enrollment period and/or the initial enrollment period to limit reimbursement under this Health FSA to the medical expenses described in this Plan Description.

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

Eligible Medical Expenses must be incurred *during* the Plan Year and while a Participant. An expense is incurred when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the HCFSA becomes effective, before your HCFSA election becomes effective, or after a separation from service (except for expenses incurred during an applicable COBRA continuation period).

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

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

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual reimbursement amount that you have elected. Amounts allocated to the HCFSA will be forfeited by the Participant if they have not been applied by the end of the Run-out Period to

reimburse expenses incurred during the Plan Year. The Run-out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

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

Q-18. What happens if a claim for benefits under the HCFSA is denied?

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

Q-19. What happens to unclaimed HCSA reimbursements?

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

Q-20. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the HCFSA.

When Coverage May Be Continued

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

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

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

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

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

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

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

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. If you do not choose continuation coverage, your coverage under the HCFSA will end with the date you would otherwise lose coverage.

Notice Requirements

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

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

Election Procedures and Deadlines

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

Cost

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

When Continuation Coverage Ends

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

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

Q-21. Will my health information be kept confidential?

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

Q-22. How long will the HCFSA remain in effect?

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

Flexible Spending Account Plan
Part III. DCFSA Benefits

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

Q-23. What is the "Dependent Care Spending Account"?

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

Q-24. What is the maximum reimbursement amount that I may elect under the DCFSA?

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

Q-25. How are amounts allocated to the DCFSA withheld from my pay?

When you enroll online, you specify the amount of reimbursement for Eligible Dependent Care Expenses you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution will be withheld from each paycheck by your Employer.

Q-26. What amounts will be available for reimbursement of Eligible Care Expenses at any particular time during the Plan Year?

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

Q-27. How do I receive reimbursement under the DCFSA?

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

- The nature of the expense;
- The date or dates the services were provided; and
- The amount of the expense.

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

Q-28. What are "Eligible Care Expenses"?

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

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

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

An individual that you can claim on your federal income tax return as a "Qualifying Child" (as defined in Code Section 152(a)(1)) and who is age 12 or under, or

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

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

pay for care. Expenses for overnight stays or overnight camp are not Eligible Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities. .

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

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

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

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

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

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

Eligible Care Expenses must be incurred *during* the Plan Year and while a Participant. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the DCFSA becomes effective, before your DCFSA election becomes effective, or after a separation from service.

Q-30. What if the Eligible Dependent Care Expenses I incur during the Plan Year are less than the annual amount I have allocated to the DCFSA?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Dependent Care Expenses you have incurred and the annual reimbursement amount that you have elected. Except as otherwise set forth in the Plan Information Appendix, any amount allocated to the DCFSA shall be forfeited by the Participant if it has not been applied by the end of the Run-out Period to reimburse expenses incurred during the Plan Year. The Run-out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs.

Q-31. What happens if a claim for benefits under the DCFSA is denied?

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

Q-32. What happens to unclaimed DCFSA reimbursements?

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

Q-33. Will I be taxed on the DCFSA reimbursement I receive?

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

Q-34. If I participate in the DCFSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

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

**Flexible Spending Account Plan
Plan Information Appendix**

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

I. EMPLOYER/PLAN SPONSOR INFORMATION

| | |
|---|--|
| 1. Name, address, and telephone number of the Employer/Plan Sponsor: | Maricopa County 301 W. JEFFERSON ST. SUITE 3200 PHOENIX, AZ - 85003 602-506-1010 |
| 2. Employer's federal tax identification number: | 86-6000472 |
| 3. Adopting Employers participating in the Plan: | N/A |
| 4. Effective Date of the Plan: | July 1, 2014 |
| 5. Effective Date of Amendment / Restatement (if different from 4): | N/A |
| 6. The initial Plan Year: | July 1, 2008 through June 30, 2009 |
| 7. All subsequent Plan Years: | July 1st- June 30th |
| 8. Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities inconsistencies, or omissions in the Plan and in this SPD. | Plan Administrator: Maricopa County Department of Employee Benefits and Health Employee Benefits Division 301 W. Jefferson Street Phoenix, AZ 85003 602-506-1010 |
| 9. Plan Number: | N/A |
| 10. Third-Party Administrator: | ADP Benefit Services 2575 Westside Parkway, Suite 500 Alpharetta, GA 30004-3852 800-654-6695 |
| 11. COBRA Administrator: | ADP |

II. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, and ELECTIONS

(a) The Flexible Spending Account Plan

Each employee who is scheduled to work at least 19+ hours per week and benefits-eligible contract employees who are not required to work a specific number of Hours ("Eligibility Requirements") will be eligible to participate in this Plan on first day of the third pay period following date of hire or benefits-eligibility date ("Eligibility Date").

The employee's commencement of participation in the Plan is conditioned on the employee properly enrolling online through ADP or through a paper enrollment form (Group Insurance Qualified Status Change form).

III. SPENDING ACCOUNT REIMBURSEMENT LIMITS

(a)(1) HCFSAs Reimbursement: The HCFSAs Reimbursement Amount shall not exceed the amount elected under the Plan, which cannot exceed \$2,500.00 per Plan Year. The HCFSAs Minimum Reimbursement Amount that may be elected is \$240.00

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

| | |
|---|-----|
| Does the Employer sponsor an HRA? | No |
| Does this HCFSAs or the HRA pay first with respect to any expenses that are covered by both the HRA and HCFSAs? | N/A |

(b) DCFSA Reimbursement. The DCFSA Reimbursement Amount shall not exceed the amount elected, which cannot exceed the statutory maximum. The DCSA minimum reimbursement amount that may be elected is \$240.00.

The statutory maximum annual amount is currently \$5,000.00 per Plan Year if you (this only applies if "statutory maximum" is identified as the maximum manual reimbursement that may be elected under the DCFSA):

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

If you are married and reside together, but file a separate federal income tax return, the statutory maximum reimbursement amount under the DCFSA that you may elect is \$2,500.

IV. RUN-OUT PERIOD FOR PLAN YEAR EXPENSES

- (a) The Run-out Period for active employees enrolled in the Health Care FSA is September 15th following the end of the Plan Year.
- (b) The Run-out Period for Participants whose coverage is terminated is 60 days.
- (c) The Run-out Period for active employees enrolled in the Dependent Care FSA is August 31st following the end of the plan year.

V. CLAIMS AND APPEAL PROCEDURES

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

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

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

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

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

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

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

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any

additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

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

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The Plan Administrator is required to give the Participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination.
- Each Participant has the right to request and obtain documents, records and other information as it pertains to their Benefit Plan(s).

VI. GRACE PERIOD

The Employer established a "grace period" for the HCFSA that follows the end of the Plan Year during which any amounts unused at the end of the Plan Year may be used to reimburse Eligible Expenses incurred during the grace period.

The grace period will begin on the first day of the next Plan Year and will end on September 15.

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

- A Participant in the HCFSA on the last day of the Plan Year to which the grace period relates, or
- A Qualified Beneficiary who is receiving COBRA coverage under the HCFSA on the last day of the Plan Year to which the grace period relates.

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

VII. ELECTRONIC PAYMENT CARDS

The Employer permits Participants to use an electronic payment cards to pay for Eligible Expenses at the point of service. The following rules apply.

Electronic Payment Card Terms of Usage

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

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

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

(a) *You must make an election to use the Card.* A Cardholder Agreement will be provided to you. The Card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program. The Cardholder Agreement is part of the terms and conditions of your Plan and this Plan Description.

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

(c) *You must certify proper use of the Card.* As specified in the Cardholder Agreement, you certify during the applicable election period that the amounts in your HCFSA will only be used for Eligible Medical Expenses, that you have not been reimbursed for the expense, and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of Card use privileges.

(d) *Reimbursement under the Card is limited to certain merchants.* Use of the Card for Eligible Medical Expenses is limited to merchants identified by the Plan Administrator or its designee as an eligible merchant. The Card will be administered in accordance with applicable IRS guidance.

(e) *You swipe the Card at the merchant like you do any other credit or debit card.* When you incur an Eligible Medical Expense at an eligible merchant, such as a copayment or prescription drug expense, you swipe the Card at the merchant much like you would a typical credit or debit card. The merchant is paid for the expense up to the maximum reimbursement amount available under the HCFSA. Every time you swipe the Card, you certify to the Plan that the expense for which payment under the HCFSA is being made is an Eligible Medical Expense, that you have not been reimbursed from any other source and you will not seek reimbursement from another source.

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

- The nature of the expense (e.g., what type of service or treatment was provided);
- If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred; and

- The amount of the expense.

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

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

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