

COUNTY OF SAN DIEGO

CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

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**COUNTY OF SAN DIEGO
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION**

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**COUNTY OF SAN DIEGO
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION (“SPD”)**

COUNTY OF SAN DIEGO (the “Employer”) is pleased to sponsor an employee benefit program known as a “Flexible Benefits Plan” (the “Plan”) for you and your fellow employees. It is so-called because it lets you choose from several different employee benefit plans (which we refer to as “Benefit Plan Options”) according to your individual needs, and allows you to use pretax dollars to pay for them by entering into a salary reduction arrangement with the Employer. This Plan helps you because the benefits you elect are nontaxable (i.e. you save social security and income taxes on the amount of your salary reduction).

This Plan has four components:

- i. A Cafeteria Plan Component. The Cafeteria Plan Component allows you to pay your share of certain underlying welfare benefit plans (called “Benefit Plan Options”) with Pretax Contributions.
- ii. The Health Care Spending Account (“HCSA”). The HCSA allows you to elect to use a specified amount of Pretax Contributions to be used for reimbursement of Eligible Medical Expenses. The HCSA is intended to qualify as a Code Section 105 self-insured medical reimbursement Plan.
- iii. The Limited Purpose Health Care Spending Account (“LPHCSA”). The LPHCSA allows you to elect to use a specified amount of Pretax Contributions to be used for reimbursement of Eligible Dental and Vision Expenses. The LPHCSA is intended to qualify as a Code Section 105 self-insured dental and vision reimbursement Plan.
- iv. The Dependent Care Spending Account (“DCSA”). The DCSA allows you to elect to use a specified amount of Pretax Contributions to be used for reimbursement of Employment Related Expenses. The DCSA is intended to qualify as a Code Section 129 dependent care assistance plan.

Each of the four components is summarized in this document. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary. For example, you can find the identity of the Third Party Administrator, the Employer, and the Plan Administrator in the Plan Information Summary on page 35 as well as the Plan Number and any applicable contact information. Each summary and the attached Appendices constitute the Summary Plan Description for the Cafeteria Plan. The SPD (collectively, the Summary Plan Description or “SPD”) describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. However, if there is a conflict between the official plan document and the SPD, the plan document will govern. Certain terms in this Summary are capitalized. Capitalized terms reflect important terms that are specifically defined in this Summary or in the Plan Document into which this Summary is incorporated. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan.

Participation in the Plan does not give any Participant the right to be retained in the employment of his or her Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator (who is identified in the Plan Information Summary).

COUNTY OF SAN DIEGO
Flexible Benefits Plan
SUMMARY PLAN DESCRIPTION

Cafeteria Plan Component Summary

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

The purpose of the Cafeteria Plan is to allow eligible employees to pay for certain benefit plans called “Benefit Plan Options” with pretax dollars called “Pretax Contributions”. The Benefit Plan Options to which you may contribute with Pretax Contributions under this Cafeteria Plan are described in the Plan Information Summary. Pretax Contributions are described in more detail below.

Q-2. Who can participate in the Cafeteria Plan?

Each employee of the Employer (or an Affiliated employer listed in the Plan Information Summary) who (i) satisfies the Cafeteria Plan Eligibility requirements and (ii) is also eligible to participate in any of the Benefit Plan Options, will be eligible to participate in this Cafeteria Plan. If you meet these requirements, you may become a Participant on the Cafeteria Plan Eligibility Date. The Cafeteria Plan Eligibility Requirements and Eligibility Date are described in the Plan Information Summary. Those employees who actually participate in the Cafeteria Plan are called “Participants.”

The terms of eligibility of this Cafeteria Plan do not override the terms of eligibility of each of the Benefit Plan Options. In other words, if you are eligible to participate in this Cafeteria Plan, it does not necessarily mean you are eligible to participate in the Benefit Plan Options. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plan Options, please refer to the plan summary of each of the Benefit Plan Option. If you do not have a summary for each of the Benefit Plan Option, you should contact the Plan Administrator for information on how to obtain a copy.

You may only pay for the coverage of yourself and your tax dependents as defined in Code Section 152 generally (except as otherwise defined in Code Section 105(b) and the regulations issued under Code Section 106) under this Plan and as set forth in the SPD.

Q-3. How do I become a participant?

If you have otherwise satisfied the Cafeteria Plan eligibility requirements, you become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an “Election Form”) on which you agree to pay for the Benefit Plan Options that you choose with Pretax Contributions. You will be provided with a Salary Reduction Agreement or Election Form on or before your Cafeteria Plan Eligibility Date. You must complete the form and submit it to the Plan Administrator or its designated third party administrator (as indicated on or with the Salary Reduction Agreement), during one of the election periods described in Q-6 below. You may also enroll during the year if you previously elected not to participate and you experience a change described below that allows you to become a participant during the year. If that occurs, you must complete an election change form during the Election Change Period described in Q-7 below. In no event can you become a Participant in this Cafeteria Plan prior to the date you complete and properly submit the Salary Reduction Agreement to the appropriate person(s).

In some cases, the Employer may require you to pay your share of the Benefit Plan Option coverage that you elect with Pretax Contributions. If that is the case, your election to participate in the Benefit Plan Options(s) will constitute an election under this Cafeteria Plan.

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

Q-4. When does my participation in the Cafeteria Plan end?

Your coverage under the Cafeteria Plan ends on the earliest of the following to occur:

- a. The date that you make an election not to participate in accordance with this Cafeteria Plan Summary
- b. The date you no longer satisfy the Eligibility Requirements of this Cafeteria Plan or all of the Benefit Plan Options;
- c. The date that you terminate employment with the Employer;
- d. The date that the Plan Administrator terminates your participation due to filing false or fraudulent claims for benefits; or
- e. The date that the Cafeteria Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Cafeteria Plan will *automatically* cease, and you will not be able to make any more Pretax Contributions under the Cafeteria Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g. a severance arrangement where the former employee is permitted to continue paying for a Benefit Plan Option out of severance pay on a pretax basis). If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan (or you become eligible again), you may make new elections, if you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility (subject to any limitations imposed by the Benefit Plan Option(s)). If you are rehired or again become eligible within 30 days or less of your termination date, your Cafeteria Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-5. What are tax advantages and disadvantages of participating in the Cafeteria Plan?

You save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. There is an example in Appendix II that illustrates the tax savings you might experience as a result of participating in the Cafeteria Plan.

Cafeteria 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.

Q-6. What are the election periods for entering the Cafeteria Plan?

The Cafeteria Plan basically has three election periods: (i) the “Initial Election Period”, (ii) the “Annual Election Period”, and (iii) the “Election Change Period, which is the period following the date you have a Change in Status Event. The following is a summary of the Initial Election Period and the Annual Election Period.

Q-6a. What is the Initial Election Period?

If you want to participate in the Cafeteria Plan when you are first hired, you must enroll during the “Initial Election Period” described in the enrollment materials you will receive. If you make an election during the Initial Election Period, your participation in this Cafeteria Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated third party administrator). The effective date of coverage under the Benefit Plan Options will be effective on the date established in the governing documents of the Benefit Plan Options. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event described in Q-7 below.

If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Cafeteria Plan for the remainder of the Plan Year. Failure to make an election under this Cafeteria Plan generally results in no coverage under the Benefit Plan Options; however, the Employer may provide coverage under certain Benefit Plan Options automatically. These automatic benefits are called “Default Benefits”. Any Default Benefit provided by your Employer will be identified in the enrollment material. In addition, your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a pretax basis. You will be notified in the enrollment material whether there will be a corresponding Pretax Contribution for such default benefits.

Q-6b. What is the Annual Election Period?

The Cafeteria Plan also has an “Annual Election Period” during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status Event described in Q-7 below.

If you fail to complete, sign and file a Salary Reduction Agreement during the Annual Election Period, you may be deemed to have elected to continue participation in the Cafeteria Plan with the same Benefit Plan Option elections that you had on the last day of the Plan Year in which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an “Evergreen Election”. Alternatively, the Plan Administrator may deem you to have elected not to participate in the Cafeteria Plan for the next Plan Year if you fail to make an election during the Annual Election Period. The

consequences of failing to make an election during the Annual Election Period are described in the Plan Information Summary.

Special Rule for Flexible Spending Accounts: Evergreen Elections do not apply to the Health Care Spending Account, the Limited Purpose Health Care Spending Account or the Dependent Care Spending Account. Consequently, you must make an election each Annual Election Period in order to participate during the next Plan Year.

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

Q-7. Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Cafeteria Plan during the Plan Year. There are, however, a few exceptions.

First, your election will automatically terminate if you terminate employment or lose eligibility under this Cafeteria Plan or under all of the Benefit Plan Options that you have chosen.

Second, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

- a. You experience a “Change of Status Event” that affects your eligibility under this Cafeteria Plan and/or Benefit Plan Option; or
- b. You experience a significant cost or coverage change; and
- c. You complete and submit a written Election Change Form within the Election Change period described in the Plan Information Summary.

Change in Status Events and Cost or Coverage Changes recognized by this Cafeteria Plan, and the rules surrounding election changes in the event you experience a Change in Status Event or Cost or Coverage Change are Described in Appendix II - Election Change Chart.

Third, an election under this cafeteria Plan 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 Cafeteria Plan from becoming discriminatory within the meaning of the applicable federal income tax law.

If coverage under a Benefit Plan Option ends, the corresponding Pretax Contributions for that coverage will automatically end. No election is needed to stop the contributions.

With respect to contributions to a health savings account, you may change your elections at any time similar to election changes you can make for contributions to a 401(k) plan.

Q-8. How is my Benefit Plan Option coverage paid for under this Cafeteria Plan?

You may be *required* to pay for any Benefit Plan Option coverage that you elect with Pretax Contributions. Alternatively, the Employer may allow you to pay your share of the contributions with after-tax contributions. The enrollment material you receive will indicate whether you have to pay with Pretax Contributions or whether you have an option to choose to pay with after-tax contributions.

When you elect to participate both in a Benefit Plan Option and this Cafeteria Plan, an amount equal to your share of the annual cost of those Benefit Plan Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use Pretax Contributions (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Plan Options you choose with Non-elective Employer Contributions. The amount of Non-elective Employer Contributions that is applied by the Employer towards the cost of the Benefit Plan Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion. The Non-elective Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Non-elective Employer Contribution be disbursed to you in the form of additional taxable compensation except as otherwise provided in the enrollment material or the Plan Information Summary.

The Employer may provide you with Employer contributions over which you have discretion to choose how to apply to the various Benefit Plan Options available under the Cafeteria Plan. These elective Employer contributions are called "Flexible Credits" or "Benefits Credits". The Flexible or Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

Q-9. What happens to my participation under the Cafeteria Plan if I take a leave of absence?

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Plan Options) during a leave of absence. The rules regarding coverage under the Benefit Plan Options during a leave of absence will be described in the Benefit Plan Option summaries.

- a. If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the Employer will continue to maintain your Benefit Plan Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).
- b. Your Employer may elect to continue all health coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).
- c. In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:
 - i. With after-tax dollars while you are on leave,
 - ii. 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 and will be applied uniformly to all Participants. 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 Administrator. The Election Change Chart will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

- d. If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Cafeteria Plan and the Benefit Plan Option upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plan Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.
- e. The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.
- f. If you are commencing or returning from unpaid FMLA leave, your election under this Cafeteria Plan for Benefit Plan Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plan Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.
- g. If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Cafeteria Plan or a Benefit Plan Option offered under this Cafeteria Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator.
- h. If you go on an unpaid non-FMLA leave that affects eligibility under this Cafeteria Plan or a Benefit Plan Option, the election change rules described herein will apply. Your coverage will be discontinued effective the first of the month following your last paid time unless you choose to continue your coverage. If you choose to continue your coverage, when you return from the leave you will be required to make contributions to "catch up" those contributions that were missed while you were on leave. If you do not continue your coverage during your leave, when you return to work you will have the option to reduce your annual election by the amount of contributions that you missed during your period of unpaid leave. When you return from leave without pay, you will be automatically re-enrolled in the same health plans you had prior to your leave without pay effective first of the month following your return. Proof of insurability may be required with certain health plans.

Q-10. How long will the Cafeteria 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. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Q-11. What happens if my request for a benefit under this Cafeteria Plan is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Cafeteria Plan.

COUNTY OF SAN DIEGO
Flexible Benefits Plan
SUMMARY PLAN DESCRIPTION

Health Care Spending Account Component Summary

Q-1. Who can participate in the Health Care Spending Account?

Each employee who satisfies the HCSA eligibility requirements is eligible to participate on the HCSA Eligibility Date. The HCSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the HCSA Eligibility Requirements, you become a participant in the HCSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods as described in the Cafeteria Plan Summary). Your participation in the HCSA will be effective on the date that you make an election or your HCSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to HCSA elections.

You may also become a participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year (See Q-7 of the Cafeteria Plan Summary for more details regarding mid-year election changes and the effective date of those changes).

Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the HCSA, Eligible Dependents are the following:

- Legal Spouse;
- Your children until the end of the month in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support,
- Unmarried children of any age who are physically or mentally handicapped;
- Any other person (including a domestic partner) who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

- Note: Children of Participants who are employed by Employer and eligible for their own benefits are considered Participants and may not be carried as Dependents.

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the HCSA, the HCSA will provide the health benefit coverage specified in the order to the person or persons (“alternate recipients”) named in the order to the extent the QMCSO does not require coverage the HCSA does not otherwise provide. “Alternate recipients” include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A “medical child support order” is a legal judgment, decree or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your HCSA, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan’s procedures governing qualified medical child support orders.

Q-3. What is my Health Care Spending Account?

If you elect to participate in the HCSA, the Employer will establish a “Health Care Spending Account” to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeper account. Benefits under the HCSA are paid as needed from the Employer’s trust fund except as otherwise set forth in the Plan Information Summary.

Q-4. When does my coverage under the Health Care Spending Account end?

Your coverage under the HCSA ends on the earlier of the following to occur:

- a. the date you elect not to participate in accordance with the Cafeteria Plan Summary;
- b. the last day of the Plan Year unless you make an election during the Annual Election Period;
- c. the date you no longer satisfy the HCSA Eligibility Requirements;
- d. the date you are terminated as a participant due to submission of false or fraudulent claims as determined by the Plan Administrator;
- e. the date you terminate employment or begin an unpaid leave of absence (you may choose to revoke your election during your unpaid leave of absence); or
- f. the date the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You may be entitled to elect Continuation Coverage (as described in Q-16 below) under the HCSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on earliest of the following to occur:

- a. the date your coverage ends;
- b. the date that your dependents cease to be eligible dependents (e.g. you and your spouse divorce);
- c. the date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the HCSA.

You and/or your covered dependents may be entitled to continue coverage if coverage is lost for certain reasons. The Continuation of Coverage provisions are described in more detail below.

Q-5. Can I ever change my Health Care Spending Account election?

You can change your election under the HCSA in the following situations:

- a. *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
- b. *Following a Change in Status Event.* You may change your HCSA election during the Plan Year only if you experience an applicable Change in Status Event. See Q-7 of the Cafeteria Plan Summary for more information on election changes. **NOTE: You may not make HCSA election changes as a result of any cost or coverage changes.**

Q-6. What happens to my Health Care Spending Account if I take an approved leave of absence?

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence. If your HCSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the HCSA at either:

- a. the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage); or
- b. at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions.

Under either scenario, expenses incurred during the period that your HCSA coverage was not in effect are not eligible for reimbursement under this HCSA.

Q-7. What is the maximum annual Health Care Spending Account amount that I may elect under the Health Care Spending Account, and how much will it cost?

You may elect any annual reimbursement amount subject to the Maximum Annual HCSA amount and the Minimum Reimbursement amount described in the Plan Information Summary. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Non-elective Employer Contributions and/or Benefits Credits allocated to your HCSA.

Any change in your HCSA election also will change the maximum available reimbursement for the period of coverage after the election. 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 third party administrator) will notify you of the applicable method when you make your election change.

Q-8. How are Health Care Spending Account benefits paid for under this Plan?

When you complete the Salary Reduction Agreement or Election Form, you specify the amount of Health Care Spending Account Reimbursement you wish to pay for with Pretax Contributions and/or Non-

elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment materials will indicate if Non-elective Employer Contributions or Benefit Credits are available for HCSA coverage. Thereafter, each paycheck will be reduced by an amount equal to pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Health Care Spending Account.

Q-9. What amounts will be available for Health Care Spending Account Reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full, annual amount of Health Care Reimbursement you have elected, reduced by the amount of previous HCSA reimbursements received during the Year, will be available at any time during the Plan Year, without regard to how much you have contributed.

Q-10. How do I receive reimbursement under the Health Care Spending Account?

If you elect to participate in the HCSA, you will have to take certain steps to be reimbursed for your Eligible Medical Expenses. When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing a request for reimbursement. You must include with your claim a written statement from an independent third party (e.g. a receipt, EOB, etc) associated with each expense that indicates the following:

- a. 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;
- b. The date the expense was incurred; and
- c. The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement 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 determine 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 during the Plan Year in which they were incurred or during the Run Out Period. The Run Out Period is described in the Plan Information Summary on page 35.

Q-11. What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" means an expense that has been incurred by your and/or your eligible dependents that satisfies the following conditions:

- a. The expense is for "medical care" as defined by Code Section 213(d) and 106(f);
- b. The expense has not been reimbursed by any other sources and you will not seek reimbursement for the expense from any other source.

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 & devices). Not every health related expense you or your eligible dependents incur constitutes an

expense for “medical care”. For example, an expense is not for “medical care”, as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In order to be reimbursed for the purchase of over the counter drugs, you must now provide proof of a valid prescription. The State of California requires a prescription to contain the following: 1) name and address of the patient; 2) name and quantity of the drug prescribed and the directions for use; 3) the date of issue; and 4) the name, address & telephone number of the prescriber along with his/her license classification. The prescription must also be signed by the prescriber (or certified nurse mid-wife, nurse practitioner, physician assistant, or naturopathic doctor).

Over the counter supplies (such as bandages, diabetic supplies, contact lens solution, hearing aid batteries, diagnostic devices, etc.) do not require a prescription. Insulin also does not require a prescription.

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

- a. Health insurance premiums;
- b. Expenses incurred for qualified long term care services;
- c. Expenses for cosmetic surgery or other similar procedures, unless the surgery is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- d. The salary expense of a nurse to care for a healthy newborn at home;
- e. Funeral and burial expenses;
- f. Expenses for Household and domestic help (even if recommended by a qualified physician due to an Employee’s or Dependent’s inability to perform physical housework);
- g. Expenses for custodial care;
- h. Costs for sending a child to a special school for Benefits that the child may receive from the course of study and disciplinary methods;
- i. Expenses for social activities, such as dance lessons (even if recommended by a physician for general health improvement);
- j. Expenses for cosmetics, toiletries, toothpaste, etc;
- k. Expenses for uniforms or special clothing, such as maternity clothing;
- l. Only reasonable quantities of over the counter drugs and supplies may be reimbursed in a single calendar month. Stockpiling of over the counter drugs and supplies is not allowed;
- m. Expenses for over the counter drugs without providing documentation indicating a valid prescription; and
- n. Expenses for marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician; and
- o. Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

Q-12. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred *during* the Plan Year and while you are a participant in the Plan, except for certain advance payments for orthodontic services. “Incurred” means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. There is an exception permitted for certain advance payments for orthodontic services. The participant must have paid for the orthodontic services in order to receive such services. In this instance, orthodontic services are deemed to be “incurred” when the participant makes the advance payment. You may not be reimbursed for any expenses arising before the HCSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year, or, after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

Q-13. What if the “Eligible Medical Expenses” I incur during the Plan Year are less than the annual amount I have elected for the Health Care Spending Account Reimbursement?

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 coverage level you have elected plus contributions carried over from the prior plan year up to \$500. Any amount allocated to a HCSA that exceeds the annual carryover amount of \$500, shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the Run Out Period described in the Plan Information Summary on page 35. 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 (per the Plan Administrator’s sole discretion).

Q-14. What happens if a Claim for Benefits under the Health Care Spending Account is denied?

You will have the right to a full and fair review process. You should refer to [Appendix I](#) for a detailed summary of the Claims Procedure under this Plan.

Q-15. What happens to unclaimed Health Care Spending Account Reimbursements?

Any HCSA reimbursement benefit payments 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-16. What is COBRA continuation coverage?

Federal law requires most private and governmental 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 are intended to summarize the continuation rights set forth

under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only “Qualified Beneficiaries” are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A “Qualified Beneficiary” is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee’s termination of employment or reduction in hours of employment	✓	✓	✓
2. Divorce or Legal Separation		✓	
3. Child ceasing to be an eligible dependent			✓
4. Death of the covered employee		✓	✓

Type of Continuation Coverage

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

If you do not choose continuation coverage, your coverage under the Health Care Spending Account 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 Summary on page 35 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 because of the event. Your written notice must identify the qualifying event, the date of the qualifying event, and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan 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. You may be required to provide additional supporting documentation.

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

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 for one of the reasons described above 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 Summary. 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 contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-elective Contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- a. if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or \$50, you will be given 30 days to cure the shortfall);
- b. if you become covered under another group health plan
- c. if you become entitled to Medicare; or
- d. if the employer no longer provides group health coverage to any of its employees.

Q-17. Will my health information be kept confidential?

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

Q-18. How long will the Health Care Spending Account 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 and for any reason.

False or Fraudulent Claims. The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits.

Newborns' and Mothers' Health Protection Act of 1996

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

COUNTY OF SAN DIEGO
Flexible Benefits Plan
SUMMARY PLAN DESCRIPTION

Limited Purpose Health Care Spending Account Component Summary

Q-1. Who can participate in the Limited Purpose Health Care Spending Account?

Each employee who satisfies the Limited Purpose Health Care Spending Account (LPHCSA) eligibility requirements is eligible to participate on the LPHCSA Eligibility Date. The LPHCSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the LPHCSA Eligibility Requirements, you become a participant in the LPHCSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods as described in the Cafeteria Plan Summary. Your participation in the LPHCSA will be effective on the date that you make an election or your LPHCSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to LPHCSA elections.

You may also become a participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year (See Q-7 of the Cafeteria Plan Summary for more details regarding mid-year election changes and the effective date of those changes).

Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the LPHCSA, Eligible Dependents are the following:

- Legal Spouse;
- Your children until the end of the month in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support,
- Unmarried children of any age who are physically or mentally handicapped;
- Any other person (including a domestic partner) who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

- o Note: Children of Participants who are employed by Employer and eligible for their own benefits are considered Participants and may not be carried as Dependents.

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the LPHCSA, the LPHCSA will provide the health benefit coverage specified in the order to the person or persons (“alternate recipients”) named in the order to the extent the QMCSO does not require coverage the LPHCSA does not otherwise provide. “Alternate recipients” include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A “medical child support order” is a legal judgment, decree or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your LPHCSA, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan’s procedures governing qualified medical child support orders.

Q-3. What is my Limited Purpose Health Care Spending Account?

If you elect to participate in the LPHCSA, the Employer will establish a “Limited Purpose Health Care Spending Account” to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeper account. Benefits under the LPHCSA are paid as needed from the Employer’s trust fund except as otherwise set forth in the Plan Information Summary.

Q-4. When does my coverage under the Limited Purpose Health Care Spending Account end?

Your coverage under the LPHCSA ends on the earlier of the following to occur:

- g. the date you elect not to participate in accordance with the Cafeteria Plan Summary;
- h. the last day of the Plan Year unless you make an election during the Annual Election Period;
- i. the date you no longer satisfy the LPHCSA Eligibility Requirements;
- j. the date you are terminated as a participant due to submission of false or fraudulent claims as determined by the Plan Administrator;
- k. the date you terminate employment or begin an unpaid leave of absence (you may choose to revoke your coverage during your unpaid leave of absence); or
- l. the date the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You may be entitled to elect Continuation Coverage (as described in Q-16 below) under the LPHCSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on earliest of the following to occur:

- d. the date your coverage ends;
- e. the date that your dependents cease to be eligible dependents (e.g. you and your spouse divorce);
- f. the date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the LPHCSA.

You and/or your covered dependents may be entitled to continue coverage if coverage is lost for certain reasons. The Continuation of Coverage provisions are described in more detail below.

Q-5. Can I ever change my Limited Purpose Health Care Spending Account election?

You can change your election under the HCSA in the following situations:

- c. *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
- d. *Following a Change in Status Event.* You may change your LPHCSA election during the Plan Year only if you experience an applicable Change in Status Event. See Q-7 of the Cafeteria Plan Summary for more information on election changes. **NOTE: You may not make LPHCSA election changes as a result of any cost or coverage changes.**

Q-6. What happens to my Limited Purpose Health Care Spending Account if I take an approved leave of absence?

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence. If your LPHCSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the LPHCSA at either:

- c. the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage); or
- d. at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions.

Under either scenario, expenses incurred during the period that your LPHCSA coverage was not in effect are not eligible for reimbursement under this LPHCSA.

Q-7. What is the maximum annual Limited Purpose Health Care Spending Account amount that I may elect under the Limited Purpose Health Care Spending Account, and how much will it cost?

You may elect any annual reimbursement amount subject to the Maximum Annual LPHCSA amount and the Minimum Reimbursement amount described in the Plan Information Summary. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Non-elective Employer Contributions and/or Benefits Credits allocated to your LPHCSA.

Any change in your LPHCSA election also will change the maximum available reimbursement for the period of coverage after the election. 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 third party administrator) will notify you of the applicable method when you make your election change.

Q-8. How are Limited Purpose Health Care Spending Account benefits paid for under this Plan?

When you complete the Salary Reduction Agreement or Election Form, you specify the amount of Limited Purpose Health Care Spending Account Reimbursement you wish to pay for with Pretax Contributions and/or Non-elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment materials will indicate if Non-elective Employer Contributions or Benefit Credits are available for LPHCSA coverage. Thereafter, each paycheck will be reduced by an amount equal to pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Limited Purpose Health Care Spending Account.

Q-9. What amounts will be available for Limited Purpose Health Care Spending Account Reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full, annual amount of Limited Purpose Health Care Reimbursement you have elected, reduced by the amount of previous LPHCSA reimbursements received during the Year, will be available at any time during the Plan Year, without regard to how much you have contributed.

Q-10. How do I receive reimbursement under the Limited Purpose Health Care Spending Account?

If you elect to participate in the LPHCSA, you will have to take certain steps to be reimbursed for your Eligible Dental and Vision Expenses. When you incur an Eligible Dental or Vision Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement. You must include with your Request for Reimbursement a written statement from an independent third party (e.g. a receipt, EOB, etc) associated with each expense that indicates the following:

- d. 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;
- e. The date the expense was incurred; and
- f. The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement from you. Reimbursement for expenses that are determined to be Eligible Dental and Vision 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 Dental or Vision Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Dental and Vision Expenses during the Plan Year in which they were incurred or during the Run Out Period. The Run Out Period is described in the Plan Information Summary.

Q-11. What is an "Eligible Dental or Vision Expense"?

An "Eligible Dental or Vision Expense" means an expense that has been incurred by your and/or your eligible dependents that satisfies the following conditions:

- c. The expense is for "medical care" as defined by Code Section 213(d) and 106(f), but is limited to the care of the eyes or teeth;

- d. The expense has not been reimbursed by any other sources and you will not seek reimbursement for the expense from any other source.

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

In order to be reimbursed for the purchase of over the counter drugs, you must now provide proof of a valid prescription. The State of California requires a prescription to contain the following: 1) name and address of the patient; 2) name and quantity of the drug prescribed and the directions for use; 3) the date of issue; and 4) the name, address & telephone number of the prescriber along with his/her license classification. The prescription must also be signed by the prescriber (or certified nurse mid-wife, nurse practitioner, physician assistant, or naturopathic doctor).

Over the counter supplies (such as contact lens solution, diagnostic devices, etc.) do not require a prescription.

In addition, certain expenses that might otherwise constitute “dental or vision care” are not reimbursable under any Health Care Spending Account (per IRS regulations):

- p. Dental or vision insurance premiums;
- q. Expenses for cosmetic surgery or other similar procedures, unless the surgery is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- r. Expenses for cosmetics, toiletries, toothpaste, etc;
- s. Only reasonable quantities of over the counter drugs and supplies may be reimbursed in a single calendar month. Stockpiling of over the counter drugs and supplies is not allowed;
- t. Expenses for over the counter drugs without providing documentation indicating a valid prescription; and
- u. Expenses for marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician; and
- v. Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

Q-12. When must the expenses be incurred in order to receive reimbursement?

Eligible Dental or Vision Expenses must be incurred *during* the Plan Year and while you are a participant in the Plan, except for certain advance payments for orthodontic services. “Incurred” means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. There is an exception permitted for certain advance payments for orthodontic services. The participant must have paid for the orthodontic services in order to receive such services. In this instance, orthodontic services are deemed to be “incurred” when the participant makes the advance payment. You may not be reimbursed for any expenses arising before the LPHCSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year, or, after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

Q-13. What if the “Eligible Dental or Vision Expenses” I incur during the Plan Year are less than the annual amount I have elected for the Limited Purpose Health Care Spending Account Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Dental or Vision Expenses you have incurred and the annual coverage level you have elected plus contributions carried over from the prior plan year up to \$500. If you elect a High-Deductible Health Plan (HDHP) and Health Savings Account (HSA), the County will convert up to \$500 of your general-purpose health care FSA to a limited-purpose health care FSA (LPFSA).

Any amount allocated to a LPHCSA that exceeds the annual carryover amount of \$500, shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the Run Out Period described in the Plan Information Summary on page 35. 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 (per the Plan Administrator’s sole discretion).

Q-14. What happens if a Claim for Benefits under the Limited Purpose Health Care Spending Account is denied?

You will have the right to a full and fair review process. You should refer to [Appendix I](#) for a detailed summary of the Claims Procedure under this Plan.

Q-15. What happens to unclaimed Limited Purpose Health Care Spending Account Reimbursements?

Any LPHCSA reimbursement benefit payments 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-16. What is COBRA continuation coverage?

Federal law requires most private and governmental 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 this LPHCSA, unless the Employer sponsoring the LPHCSA is not

subject to these rules (e.g. the employer is a “small-employer” or the LPHCSA is a church Plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules

(thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only “Qualified Beneficiaries” are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A “Qualified Beneficiary” is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee’s termination of employment or reduction in hours of employment	✓	✓	✓
2. Divorce or Legal Separation		✓	
3. Child ceasing to be an eligible dependent			✓
4. Death of the covered employee		✓	✓

Type of Continuation Coverage

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

If you do not choose continuation coverage, your coverage under the Limited Purpose Health Care Spending Account 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 Summary on page 35 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 because of the event. Your written notice must identify the qualifying event, the date of the qualifying event, and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan 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. You may be required to provide additional supporting documentation.

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

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 for one of the reasons described above 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 Summary. 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 contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-elective Contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- e. if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or \$50, you will be given 30 days to cure the shortfall);
- f. if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- g. if you become entitled to Medicare; or
- h. if the employer no longer provides group health coverage to any of its employees.

Q-17. Will my health information be kept confidential?

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

Q-18. How long will the Limited Purpose Health Care Spending Account 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 and for any reason.

False or Fraudulent Claims. The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits.

COUNTY OF SAN DIEGO
Flexible Benefits Plan
SUMMARY PLAN DESCRIPTION

Dependent Care Spending Account Component Summary

Q-1. Who can participate in the Dependent Care Spending Account?

Each Employee who satisfies the DCSA Eligibility Requirements is eligible to participate in the DCSA on the DCSA Eligibility Date. The DCSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the DCSA Eligibility Requirements, you become a participant in the DCSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in Q-6 of the Cafeteria Plan Summary. Your participation in the DCSA will be effective on the date that you make the election or your DCSA Eligibility date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to DCSA elections.

You may also become a participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year (See Q-7 of the Cafeteria Plan Summary for more details regarding mid-year election changes and the effective date of those changes).

Q-3. What is my “Dependent Care Spending Account”?

If you elect to participate in the DCSA, the Employer will establish a “Dependent Care Spending Account” to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Q-4. When does my coverage under the Dependent Care Spending Account end?

Your coverage under the DCSA ends on the earlier of the following to occur:

- a. the date you elect not to participate in accordance with the Cafeteria Plan Summary;
- b. the last day of the Plan Year unless you make an election during the Annual Election Period;
- c. the date you no longer satisfy the DCSA Eligibility Requirements
- d. the date you terminate employment or begin an unpaid leave of absence; or
- e. the date the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

Q-5. Can I ever change my Dependent Care Spending Account election?

You can change your election under the DCSA in the following situations:

- a. *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
- b. *Following a Change in Status Event or Cost or Coverage Change.* You may change your DCSA election during the Plan Year only if you experience an applicable Change in Status Event or there is a significant cost or coverage change.. See Q-7 of the Cafeteria Plan Summary for more information on election changes.

Q-6. What happens to my Dependent Care Spending Account if I take an unpaid leave of absence?

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any specific changes you can make during a leave of absence.

Q-7. What is the maximum annual Dependent Care Spending Account Reimbursement that I may elect under the Dependent Care Spending Account?

The annual amount cannot exceed the maximum DCSA reimbursement amount specified in Section 129 of the Internal Revenue Code. The IRS Code Section 129 maximum amount is currently \$5,000 per Plan Year if you:

- a. are married and file a joint return;
- b. 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 Dependents for whom you are eligible to receive tax-free reimbursements under the DCSA;
or
- c. are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Spending Account Reimbursement that you may elect is \$2,500. In addition, the amount of reimbursement that you receive on a tax-free basis during the Plan Year cannot exceed the lesser of the earned income (as defined in Code Section 32) or your spouse earned income.

Your spouse will be deemed to have earned income of \$250 if you have one Qualifying Individual and \$500 if you have two or more Qualifying Individuals (described below), for each month in which your spouse is:

- a. physically or mentally incapable of caring for himself or herself; or
- b. a full-time student (as defined by Code Section 21).

Q-8. How do I pay for Dependent Care Spending Account Reimbursements?

When you complete the Salary Reduction Agreement or Election Form, you specify the amount of DCSA Reimbursement you wish to pay for with Pretax Contributions and/or Non-elective Employer

Contributions (or Benefits Credits), to the extent available. Your enrollment material will indicate if Non-elective Contributions or Benefits Credits are available for DCSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Health Care Spending Account, will be deducted from each paycheck by your Employer.

Q-9. What is an “Eligible Employment Related Expense” for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses (“Eligible Employment Related Expenses”). Generally, an expense must meet all of the following conditions for it to be an Eligible Dependent Care Expense:

- a. The expense is incurred for services rendered after the date of your election to receive DCSA Reimbursement benefits and during the calendar year to which it applies.
- b. Each individual for whom you incur the expense is a "Qualifying Individual." A Qualifying Individual is:
 - (i) An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support.
 - (ii) a Spouse or other tax Dependent (as defined in Code Section 152) 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.

Note: There is a special rule for children of divorced parents. If you are divorced, the child is a qualifying individual of the “custodial” parent (as defined in Code Section 152);
- c. The expense is incurred for the 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. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.
- d. 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 must regularly spend at least 8 hours per day in your home.
- e. 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.
- f. The expense is not paid or payable to 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.
- g. 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 17 “Your Federal Income Tax” for further guidance as to what is or is not an Eligible Employment Related Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for 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-10. How do I receive reimbursement under the Dependent Care Spending Account?

If you elect to participate in the DCSA, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expense. When you incur an Eligible Employment Related Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement. You must include with your Request for Reimbursement a written statement from an independent third party (e.g. a receipt, etc) associated with each expense that indicates the following:

- a. The date the expense was incurred; and
- b. The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement from you. Reimbursement for expenses that are determined to be Eligible Employment Related 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 Employment Related Expense” you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Employment Related Expenses during the Plan Year in which they were incurred or during the Run Out Period. The Run Out Period is described in the Plan Information Summary.

If your claim was for an amount that was more than your current Dependent Care Spending Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate.

You must incur the expense in order to receive payment. “Incurred” means the service has been provided without regard to whether you have paid for the service. Payments for advance services are not reimbursable because they have not yet been incurred. For example, Employee A pays the monthly day care fee on January 1 and then submits a copy of the receipt on January 3. The expense for the entire month is not reimbursable until the services for that month have been performed. In addition, you must certify with each claim that you have not been reimbursed for the expense(s) from any other source and you will not seek reimbursement from any other source.

Q-11. When must the expenses be incurred in order to receive reimbursement?

Eligible Employment Related Expenses must be incurred *during* the Plan Year. You may not be reimbursed for any expense arising before the DCSA become effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year and unless noted otherwise in the Plan Information Summary, after your participation the DCSA ends.

Q-12. What if the “Eligible Employment Related Expenses” I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Spending Account Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred, on the one hand, and the annual DCSA reimbursement you have elected and paid for, on the other. Any amount credited to a DCSA shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by the end of the Run Out Period following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs and/or otherwise permitted under applicable law.

Q-13. Will I be taxed on the Dependent Care Spending Account benefits I receive?

You will not normally be taxed on your Dependent Care reimbursements so long as your family aggregate DCSA reimbursement (under this DCSA and/or another employer’s DCSA) does not exceed the maximum annual reimbursement limits described 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-14. If I participate in the Dependent Care Spending Account, will I still be able to claim the household and dependent care credit on my federal income tax return?

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

Q-15. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$3,000 of such expenses for one Qualifying Individual, or \$6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of \$1,050 for one Qualifying Individual or \$2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross incomes over \$15,000.

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

Q-16. What happens to unclaimed Dependent Care Spending Account Reimbursements?

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

Q-17. What happens if my claim for reimbursement under the Dependent Care Spending Account is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Q-18 How long will the Dependent Care Spending Account 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.

False or Fraudulent Claims. The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits.

PLAN INFORMATION SUMMARY
To the COUNTY OF SAN DIEGO Plan
SUMMARY PLAN DESCRIPTION

This Appendix provides information specific to the **COUNTY OF SAN DIEGO** Cafeteria Plan.

A. Employer/Plan Sponsor Information

1.	Name, address & phone number of Client or Plan Sponsor:	COUNTY OF SAN DIEGO 5530 Overland Avenue, Suite 210 San Diego, CA 92123 1 888 550.2203
2.	Name, address & phone number of Plan Administrator: <i>The Plan Administrator shall have 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 the SPD issued in connection with the Plan.</i>	COUNTY OF SAN DIEGO 5530 Overland Avenue, Suite 210 San Diego, CA 92123 1 888 550.2203
3.	Federal Tax Identification	95-60000934 W
4.	Controlling Law:	California
5.	Plan Number:	
6.	Original Effective Date: <i>This is the date that the Plan was first established.</i>	October 1, 1990
7.	Amended and Restated Date:	March 1, 2006 January 1, 2008 January 1, 2010 June 1, 2010 January 1, 2011 January 1, 2013 January 1, 2014 January 1, 2016
8.	Initial Plan Year:	October 1, 2006 - September 30, 2007
9.	All subsequent Plan Years (If different from 8)	October 1, 2007 - December 31, 2007 January 1, 2008 - December 31, 2008 January 1 - December 31 for all subsequent years
11.	Adopting Employers participating in the Plan:	N/A
12.	Third Party Administrator:	ASI Flex, P.O. Box 6044 Columbia, MO 65205-6044

B. Cafeteria Plan Component Information

- (a) **Cafeteria Plan Eligibility Requirements and Eligibility Date.** Each active employee of the County of San Diego who is authorized to work 20 or more hours per week or an elected official of the County of San Diego and who is eligible for coverage or participation under any of the Benefit Plan Options (“Cafeteria Plan Eligibility Requirements”) will be eligible to participate in this Plan on the **first day of the month following month of hire provided that the employee has completed enrollment and returned all supporting documentation within 30-days of hire.** If completed enrollment and supporting documentation are not received by the end of the hire month, benefits will be effective the first day of the month following receipt of enrollment and supporting documentation. If enrollment is not completed within 30-days of hire, the employee’s plan participation will be defaulted to the Kaiser HMO Plan at the Employee Only level of coverage. All other elections will be forfeited.

The Employee’s commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in this SPD. Eligibility for coverage under any given Benefit Plan Option shall be determined not by this Plan but by the terms of that Benefit Plan Option.

Each newly hired Hourly or Special Rate employee shall become eligible for health insurance upon his/her hire date. The effective date of coverage shall be the first day of the month following a waiting period of approximately 60 days from the 1st of the month from his/her hire date. Employees eligible for coverage under this section will be enrolled in the County’s least costly health plan. An employee eligible for coverage under this section may elect employee only coverage, or they may choose coverage for themselves and their dependents.

- (b) **Cafeteria Plan Annual Election Rules.** With respect to Benefit Plan Option elections (other than the HCSA, LPHCSA and DCSA elections), failure to make an election during the Annual Election Period will result in the following deemed election(s):

The employee will be deemed to have elected to continue the benefit elections that were in effect as of the end of the plan year in which the Annual Election period took place, unless the employee enters his/her election changes in eBenefits during the Open Enrollment Period for the following plan year.

- (c) **Change of Election Period.** If you experience a Change in Status Event or Cost or coverage Change as described in the Cafeteria Plan Summary and in the Election Change chart, you may make the permitted election changes described in the Election Change Chart if you complete and submit an election change form with **60 days** after the date of the event. If you are participating in an insured arrangement that provides a longer election change period, the election change period described in the insurance policy will apply.
- (d) **Cash-Out Options:** Additional taxable compensation for certain Employees who opt-out of certain Benefit Plan Options or who do not use all of the allotted amount of Non-elective Contributions (as described in the enrollment materials) **is not** offered under the Plan. The available Cash-Out Option amount will be set forth in the enrollment material

- (e) **Benefits Plan Options:** The Employer elects to offer to eligible Employees the following Benefit Plan Option(s) subject to the terms and conditions of the plan and the terms and conditions of the Benefit Plan Options. These Benefit Plan Option(s) are specifically incorporated herein by reference.

The maximum Pretax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Plan Options selected reduced by any Non-elective Contributions made by the Employer. It is intended that such Pretax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

1. **Medical**
2. **Dental**
3. **Vision**
4. **Health savings account**

C. Health Care Spending Account Component Information

- (a) **HCSA Eligibility Requirements and Eligibility Date.** Each active employee of the County of San Diego who is authorized to work 20 or more hours per week or an elected official of the County of San Diego (“HCSA Plan Eligibility Requirements”) will be eligible to participate in this Plan on the first day of the month following month of hire provided that the employee has completed enrollment and returned all supporting documentation within 30-days of hire. If completed enrollment is not received by the end of the month of hire, benefits will be effective the first day of the month following receipt of enrollment and supporting documentation. Enrollment must be received in the Employee Benefits Division within 30 days of hire in order for benefits to commence. (“HCSA Eligibility Date”).
- (b) **Annual Health Care Spending Account Amount.** The maximum annual HCSA reimbursement each year may not exceed the lesser of HCSA reimbursement amount elected for that year or **\$2,650**. The minimum reimbursement amount that may be elected under the HCSA is **\$120 annually and \$5 per pay period**.
- (c) **Run-Out Period.** The Run Out Period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.
- i. The Run Out Period for active employees ends **3 months after end of plan year**.
 - ii. The Run Out Period for terminated employees ends **3 months after end of plan year**.
- (d) **COBRA Administrator.** The COBRA administration for the HCSA is administered by a third party.
- (e) **Method of Funding.** HCSA Benefits are paid from a Flex Forfeiture Trust Fund account that is established for each unique plan year.

D. Limited Purpose Health Care Spending Account Component Information

- (a) **LPHCSA Eligibility Requirements and Eligibility Date.** Each active employee of the County of San Diego who is authorized to work 20 or more hours per week or an elected official of the County of San Diego (“LPHCSA Eligibility Requirements”) will be eligible to participate in this Plan on the first day of the month following month of hire provided that the employee has completed enrollment and returned all supporting documentation within 30-days of hire. If completed enrollment is not received by the end of the month of hire, benefits will be effective the first day of the month following receipt of enrollment and supporting documentation. Enrollment must be received in the Employee Benefits Division within 30 days of hire in order for benefits to commence. (“LPHCSA Eligibility Date”).
- (b) **Annual Limited Purpose Health Care Spending Account Amount.** The maximum annual LPHCSA reimbursement each year may not exceed the lesser of LPHCSA reimbursement amount elected for that year or **\$2,650**. The minimum reimbursement amount that may be elected under the LPHCSA is **\$120 annually and \$5 per pay period**.
- (c) **Run-Out Period.** The Run Out Period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.
- i. The Run Out Period for active employees ends **3 months after end of plan year**.
 - ii. The Run Out Period for terminated employees ends **3 months after end of plan year**.
- (d) **COBRA Administrator.** The COBRA administration for the LPHCSA administered by a third party.
- (e) **Method of Funding.** LPHCSA Benefits are paid from a Flex Forfeiture Trust Fund account that is established for each unique plan year.

E. Dependent Care Spending Account Component Information

- (a) **DCSA Eligibility Requirements and Eligibility Date.** Each active employee of the County of San Diego who is authorized to work 20 or more hours per week or an elected official of the County of San Diego (DCSA Eligibility Requirements) will be eligible to participate in this Plan on the first day of the month following month of hire provided that the employee has completed enrollment and returned all supporting documentation within 30-days of hire. If completed enrollment is not received by the end of the month of hire, benefits will be effective the first day of the month following receipt of enrollment and supporting documentation. Enrollment must be received in the Employee Benefits Division within 30 days of hire in order for benefits to commence. (“DCSA Eligibility Date”).
- (b) **Annual Dependent Care Spending Account Amount.** The maximum annual DCSA reimbursement each year may not exceed the lesser of DCSA reimbursement amount elected for that year or **\$5,000** (or \$2,500 for married filing separate returns). The minimum reimbursement amount that may be elected under the DCSA is **\$120 annually and \$5 per pay period**.
- (c) **Run-Out Period.** The Run Out Period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.
- iii. The Run Out Period for active employees ends **3 months after end of plan year**.
 - iv. The Run Out Period for terminated employees ends **3 months after end of plan year**.
- (d) **Method of Funding. DCSA Benefits are paid from** a Flex Forfeiture Trust Fund account that is established for each unique plan year.

APPENDIX I – CLAIMS REVIEW PROCEDURE

The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan. The procedure set forth below does not apply to benefit claims filed under the Benefit Plan Options other than the Health Care Spending Account, Limited Purpose Health Care Spending Account and Dependent Care Spending Account.

Step 1: *Notice of Denial 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:

- a. the reason(s) for the denial and the Plan provisions on which the denial is based;
- b. 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;
- c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- d. 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 must file your appeal 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: *Second Notice of Denial is received from Third Party Administrator.* If the claim is again denied, you will be notified in writing by the third party administrator as soon as possible but no later than 30 days after receipt of the appeal.

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 and you wish to appeal, you must file a written appeal with the Plan Administrator within time period set forth in 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 will 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:

- a. Health Care Spending Account and Limited Purpose Health Care Spending Account: 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 will not be involved in the appeal);
- b. On each level of appeal, the third party administrator will review relevant information that you submit even if it is new information; and
- c. You cannot file suit in federal court until you have exhausted these appeals procedures.

APPENDIX II – ELECTION CHANGE CHART

The following is a summary of the election changes that are permitted under this Plan. Also, election changes that are permitted under this Plan may not be permitted under the Benefit Plan Option (e.g., the insurance carrier may not allow a change). If a change is not permitted under a Benefit Plan Option, no election change is permitted under the Plan. Likewise, a Benefit Plan Option may allow an election change that is not permitted by this Plan. In that case, your pretax reduction may not be changed even though a coverage change is permitted.

First, we describe the general rules regarding election changes that are established by the IRS and recognized by this Plan. Then, you should look to the chart to determine under what circumstances you are permitted to make an election under this Plan and the scope of the changes you may make.

1. **Change in Status.** Election changes may be allowed if a Participant or a Participant's Spouse or Dependent experiences one of the Change in Status Events set forth in the chart. The election change must be on account of and correspond with the Change in Status Event as determined by the Plan Administrator (or its designated Third Party Administrator). With the exception of enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective (generally the first of the month following the date you make a new election with the Third Party Administrator but it may be earlier depending on the Employer's internal policies or procedures). As a general rule, a desired election change will be found to be consistent with a Change in Status Event if the event the Change in Status affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving a divorce, annulment or legal separation, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, an election to cancel accident or health benefits for any individual other than the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gain eligibility for coverage under another employer's cafeteria plan or benefit plan as a result of a change in marital status or a change in the Participant's, the Participant's Spouse's, or the Participant's Dependent's employment status, an election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Dependent Care Spending Account Benefits.* With respect to the Dependent Care Spending Account benefit, an election change is permitted only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care Spending Account expenses for the available tax exclusion.

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

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plan Options offered under the Plan).* For group term life insurance, disability income and accidental death and dismemberment benefits only if a Participant experiences any Change in Status (as described above), an election to either increase or decrease coverage is permitted.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects \$10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If a Participant, Participant's Spouse and/or Dependent are entitled to special enrollment rights under a Benefit Plan Option that is a group health plan, an election change to correspond with the special enrollment right is permitted. Thus, for example, if an otherwise eligible employee declined enrollment in medical coverage for the employee or the employee's eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), the employee may be able to elect medical coverage under the Plan for the employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee gains a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may also be able to enroll the employee, the employee's Spouse, and the employee's newly acquired Dependent, provided that a

request for enrollment is made within the Change of Election 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 60 days. Please refer to the group health plan summary description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, separation, annulment or custody change requires a Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, an election change to provide coverage for the Dependent child identified in the order is permissible. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.
4. **Entitlement to Medicare or Medicaid.** If a Participant or the Participant's Dependents become entitled to Medicare or Medicaid, an election to cancel that person's accident or health coverage is permitted. Similarly, if a Participant or Participant's Dependents who have been entitled to Medicare or Medicaid loses eligibility for such, you may elect to begin or increase that person's accident or health coverage.
5. **Change in Cost.** If the cost of a Benefit Plan Option significantly increases, a Participant may choose to make an increase in contributions, revoke the election and receive coverage under another Benefit Plan Option that provides similar coverage, or drop coverage altogether *if no similar coverage exists*. If the cost of a Benefit Plan Option significantly decreases, a Participant who elected to participate in another Benefit Plan Option may revoke the election and elect to receive coverage provided under the Benefit Plan Option that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Plan may elect to participate in the Benefit Plan Option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plan Options, however, Pretax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Health Care Spending Account.)

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage.** If coverage under a Benefit Plan Option is significantly curtailed, a Participant may elect to revoke his or her election and elect coverage under another Benefit Plan Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, a Participant may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, a Participant may revoke his or her election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, a Participant may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different

from the Plan Year of the other employer plan. Finally, a Participant may change his or her election to add coverage under this Plan for the Participant, the Participant's Spouse or Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Health Care Spending Account or the Limited Scope Health Care Spending Account.)

The following is a chart reflecting the election changes that may be made under the Plan with respect to each Benefit Plan Option, with the exception of contributions to a health savings account which may be made at any time, although as soon as administratively practicable. In addition, election changes that are permitted under this Plan are subject to any limitations imposed by the Benefit Plan Options. If an election change is permitted by this Plan but not by the Benefit Plan Option, no election change under this Plan is permitted.

Change in Status Event	Major Medical	Dental and Vision	Health Care Spending Account (HCSA) and Limited Scope Health Care Spending Account (LSHCSA)	Dependent Care Spending Account (DCSA)	Employee Group Life and AD&D coverage
I. Change in Status					
A. Change in Employee's Legal Marital Status					
1. Marriage	Employee may enroll or increase election for newly eligible spouse and dependent children (Note: Under IRS "tag-along" interpretation, new and preexisting dependents may be enrolled); employee may revoke or decrease Employee's or dependent's coverage only when such coverage becomes effective or is increased under the spouse's plan. Also, see HIPAA special enrollment rule below.	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may increase election for newly eligible spouse or dependents, or likely decrease election if employee or dependents become an eligible dependent under new spouse's health plan (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase to accommodate newly eligible dependents or decrease or cease coverage if new spouse is not employed or makes a DCSA coverage election under spouse's plan.	Employee may increase coverage for dependent who gains eligibility.
2. Lose spouse (divorce, legal separation, annulment, death of spouse) (See loss of dependent eligibility below for discussion of dependent eligibility loss following divorce, separation, etc.)	Employee may revoke election only for spouse; employee may elect coverage for self or dependents who lose eligibility under spouse's plan if such individual loses eligibility as a result of the divorce, legal separation, annulment,	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may decrease election for former spouse who loses eligibility (Note: HIPAA special enrollment rights likely do not apply). Employee may enroll or increase election	Employee may enroll or increase to accommodate newly eligible dependents (e.g., due to death of spouse) or decrease or cease coverage if eligibility is lost (e.g., because dependent now resides with ex-spouse).	Employee may decrease coverage for dependent who loses eligibility

Change in Status Event	Major Medical	Dental and Vision	Health Care Spending Account (HCSA) and Limited Scope Health Care Spending Account (LSHCSA)	Dependent Care Spending Account (DCSA)	Employee Group Life and AD&D coverage
	or death. (Note: Under IRS “tag-along” interpretation, any dependents may be enrolled so long as at least one dependent has lost coverage under the spouse’s plan.)		where coverage lost under spouse’s health plan.		
B. Change in the Number of Employee’s Dependents					
1. Gain Dependent (birth, adoption)	Employee may enroll or increase coverage for newly-eligible dependent (and any other dependents who were not previously covered under IRS “tag-along” rule); employee may revoke or decrease employee’s or dependent’s coverage if employee becomes eligible under spouse’s plan. Also, see HIPAA special enrollment rule below.	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may increase coverage for newly-eligible dependent. (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase to accommodate newly eligible dependents (and any other dependents who were not previously covered under IRS “tag-along” rule).	Employee may increase coverage for dependent who gains eligibility.
2. Lose Dependent (death)	Employee may drop coverage only for the dependent who loses eligibility;	Same as previous column.	Employee may decrease election for dependent who loses eligibility.	Employee may decrease election for dependent who loses eligibility.	Employee may decrease coverage for dependent who loses eligibility.
C. Change in Employment Status of Employee, Spouse, or Dependent That Affects Eligibility					
1. Commencement of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) That Triggers Eligibility					
a. Commencement of Employment by Employee or Other Change in Employment Status (e.g., PT to FT, hourly to salaried, etc.) Triggering Eligibility Under Component Plan	Provided eligibility was gained for this coverage, employee may add coverage for employee, spouse or dependents. .	Same as previous column.	Same as previous column.	Same as previous column.	Employee may enroll, increase, decrease, or cease coverage.

Change in Status Event	Major Medical	Dental and Vision	Health Care Spending Account (HCSA) and Limited Scope Health Care Spending Account (LSHCSA)	Dependent Care Spending Account (DCSA)	Employee Group Life and AD&D coverage
b. Commencement of Employment by Spouse or Dependent or Other Employment Event Triggering Eligibility Under Their Employer's Plan	Employee may revoke or decrease election as to employee's, spouse's, or dependent's coverage if employee, spouse or dependent is added to spouse's or dependent's coverage.;	Same as previous column.	Employee may apparently decrease or cease HCSA election if gains eligibility for health coverage under spouse's or dependent's plan.	Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work). Employee may revoke election as to dependent's coverage if dependent is added to spouse's plan.	Employee may decrease or cease coverage.
2. Termination of Employment by Employee, Spouse, or Dependent (or Other Change in Employment-Status) That Causes Loss of Eligibility					
a. Termination of Employee's Employment or Other Change in Employment Status (e.g., unpaid leave, FT to PT, strike, salaried to hourly, etc.) Resulting in a Loss of Eligibility	Employee may revoke or decrease election for employee, spouse or dependents who lose eligibility under the plan. In addition, other previously eligible dependents may also be enrolled under "tag-along" rule.	Same as previous column.	Same as previous column.	Employee may revoke or decrease election to reflect loss of eligibility.	Employee may decrease or cease coverage.
i. Termination and Rehire Within 30 Days	Prior elections at termination are reinstated unless another event has occurred that allows a change (as an alternative, employer may prohibit participation until next plan year).	Same as previous column.	Same as previous column.	Same as previous column.	Same as previous column.
ii. Termination and Rehire After 30 Days	Employee may make new elections.	Same as previous column.	Same as previous column.	Same as previous column.	Same as previous column.
b. Termination of Spouse's or Dependent's Employment (or other change in employment status resulting in a loss of eligibility under their employer's plan)	Employee may enroll or increase election for employee, spouse or dependents who lose eligibility under spouse's or dependent's employer's plan. In addition, other previously eligible dependents may also be enrolled under "tag-along" rule. See	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may increase HCSA or LPHCSA election if spouse or dependent loses eligibility for health coverage (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase if spouse or dependent loses eligibility for DCSA. Employee may decrease or cease DCSA election if spouse's loss of employment renders dependents ineligible.	Employee may enroll or increase coverage.

Change in Status Event	Major Medical	Dental and Vision	Health Care Spending Account (HCSA) and Limited Scope Health Care Spending Account (LSHCSA)	Dependent Care Spending Account (DCSA)	Employee Group Life and AD&D coverage
	HIPAA special enrollment rule below.				

D. Event Causing Employee’s Dependent to Satisfy or Cease to Satisfy Eligibility Requirements

(Also see discussion of gain/loss of eligibility under dependent or spouse’s employer’s plan)

1. Event by Which Dependent Satisfies Eligibility Requirements Under Employer’s Plan (attaining a specified age, becoming single, etc.)	Employee may enroll or increase election for affected dependent. In addition, employee may apparently add previously eligible (but not enrolled) dependents under “tag-along” rule.	Same as previous column.	Employee may increase election only if dependent gains eligibility under HCSA or LSHCSA.	Employee may increase election or enroll to take into account expenses of affected dependent.	Employee may increase coverage only for affected dependent.
2. Event by Which Dependent Ceases to Satisfy Eligibility Requirements Under Employer’s Plan (attaining a specified age, getting married, ceasing to be a student, etc.)	Employee may decrease or revoke election only for affected dependent.	Same as previous column.	Employee may decrease election to take into account ineligibility of expenses of affected dependent, but only if eligibility is lost.	Employee may decrease or drop election to take into account expenses of affected dependent.	Employee may, decrease coverage only for affected dependent.

E. Enrollment in a Healthcare Exchange

1. Exchange Enrollment	Employee may revoke election for the employee and any related dependents as long as the revocation is consistent and corresponds to the intended enrollment in Exchange coverage for the Employee and any related individuals ceasing coverage. The coverage must be effective no later than the first day following the last day of employer-provided coverage.	Rarely will dental and vision plans provide minimum essential coverage. If a dental or vision plan does provide minimum essential coverage, then it would be the same as the previous column. No change would be permitted where coverage is an excepted benefit.	No change allowed.	No change allowed.	No change allowed.
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F. Change in Place of Residence of Employee, Spouse, or Dependent

Change in Status Event	Major Medical	Dental and Vision	Health Care Spending Account (HCSA) and Limited Scope Health Care Spending Account (LSHCSA)	Dependent Care Spending Account (DCSA)	Employee Group Life and AD&D coverage
1. Move Triggers Eligibility	Employee may enroll or increase election for newly eligible employee, spouse, or dependent. Also, other previously eligible dependents may be re-enrolled under “tag-along” rule.	Same as previous column.	No change allowed, even if underlying health coverage change occurs.	N/A. Dependent care eligibility is not generally affected by place of residence (but see change in coverage below).	Employee may increase or decrease coverage for affected dependents only.
2. Move Causes Loss of Eligibility (e.g., employee or dependent moves outside HMO service area)	Employee may revoke election or make new election if the change in residence affects the employee’s, spouse’s or dependent’s eligibility for coverage option.	Same as previous column.	No change allowed, even if underlying health coverage change occurs.	N/A. Dependent care eligibility is not generally affected by place of residence (but see change in coverage below).	Employee may decrease or cease coverage for affected dependents only.
II. Cost Changes With Automatic Increase/Decrease in Elective Contributions (including employer motivated changes and changes in employee contribution rates)					
	Plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees’ elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	Same as previous column.	No change permitted.	Application is unclear. Presumably, plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees’ elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	Same as Major Medical column.
III. Significant Cost Changes					
	Significant Cost Increase: Affected employee may increase election correspondingly OR revoke election and elect coverage under another benefit plan option providing similar coverage. If no option providing similar coverage is available, employee may revoke election. Significant Cost	Same as previous column.	No change permitted.	Same as Major Medical column for significant cost increase, except no change can be made when the cost change is imposed by a dependent care provider who is a relative of the employee.	Same as Major Medical column.

Change in Status Event	Major Medical	Dental and Vision	Health Care Spending Account (HCSA) and Limited Scope Health Care Spending Account (LSHCSA)	Dependent Care Spending Account (DCSA)	Employee Group Life and AD&D coverage
	<p>Decrease: Employees may elect coverage (even if had not participated before) with decreased cost, and may drop election for similar coverage option.</p> <p>Though unclear, it appears that tag-along concepts may apply.</p>				
IV. Significant Coverage Curtailment (With or Without Loss of Coverage)					
	<p>Without Loss of Coverage: Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit plan option which provides similar coverage.</p> <p>With Loss of Coverage: Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit plan option which provides similar coverage OR drop coverage if no similar benefit plan option is available.</p>	Same as previous column.	No change permitted.	Election change may apparently be made whenever there is a change in provider or a change in hours of dependent care.	Same as Major Medical column.
V. Addition or Significant Improvement of Benefit Plan Option					
	<p>Eligible employees (whether currently participating or not) may revoke their existing election and elect the newly added (or newly improved) option.</p> <p>Though unclear, it appears that tag-along concepts may apply.</p>	Same as previous column.	No change permitted.	Eligible employees (whether currently participating or not) may revoke their existing election and elect the newly added (or newly improved) option.	Same as previous column.

Change in Status Event	Major Medical	Dental and Vision	Health Care Spending Account (HCSA) and Limited Scope Health Care Spending Account (LSHCSA)	Dependent Care Spending Account (DCSA)	Employee Group Life and AD&D coverage
<p>VI. Change in Coverage Under Other Employer’s Cafeteria Plan or Qualified Benefits Plan (In order for election changes to be permitted under this exception, the election change must be on account of and correspond with the change in coverage under the other employer’s cafeteria plan or qualified benefits plan. In addition, either (1) the plan of the other employer must permit elections specified under the Regulations and an election must actually be made under such plan; or (2) the employee’s cafeteria plan must permit elections for a period of coverage different from that under the other employer plan (“Election Lock” rule).</p>					
<p>A. Other Employer’s Plan Increases Coverage</p>					
	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer’s plan.	Same as previous column.	No change permitted.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer’s plan	Same as previous column.

B. Other Employer's Plan Decreases or Ceases Coverage					
	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer's plan.	Same as previous column.	No change permitted.	Employee may increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer's plan.	Same as previous column.
C. Open Enrollment Under Plan of Other Employer					
	Corresponding changes can be made under employer's plan.	Corresponding changes can be made under employer's plan.	No change permitted.	Corresponding changes can be made under employer's plan.	Corresponding changes can be made under employer's plan.

IX. HIPAA Special Enrollment Rights (See related exception for addition of new dependents)					
A. Special Enrollment for Loss of Other Health Coverage					
	Employee may elect coverage for employee, spouse, or dependent who has lost other coverage (COBRA coverage exhausted or terminated, no longer eligible for non-COBRA coverage or employer contributions for non-COBRA coverage terminated, etc.) Though unclear, it appears that tag-along concepts may apply.	No change permitted, unless plan is subject to HIPAA.	No change permitted, unless HCSA or LSHCSA is subject to HIPAA.	No change permitted.	No change permitted.
B. Special Enrollment for Acquisition of New Dependent by Birth, Marriage, Adoption, or Placement for Adoption. (If newborn or newly adopted child is enrolled under HIPAA's special rules, child's coverage may be retroactive to date of birth, adoption, or placement for adoption; employee may change salary reduction election to pay for extra cost of child's coverage retroactive to date of birth, adoption, or placement for adoption. For marriage, coverage is effective prospectively.)					
	Employee may elect coverage for employee, spouse, or dependent. Example provides that election of coverage may also extend to previously eligible (but not yet enrolled) dependents.	No change permitted, unless plan is subject to HIPAA.	No change permitted, unless HCSA or LSHCSA is subject to HIPAA.	No change permitted.	No change permitted.
X. Judgment, Decree, or Order					
A. Order That Requires Coverage for the Child Under Employee's Plan					
	Employee may change election to provide coverage for the child. Though unclear, it appears that tag-along concepts may apply.	Same as previous column.	Same as previous column.	No change permitted.	No change permitted.
B. Order That Requires Spouse, Former Spouse, or Other Individual to Provide Coverage for the Child					
	Employee may change election to cancel coverage for the child.	Same as previous column.	Same as previous column.	Same as previous column.	No change permitted.
XI. Medicare or Medicaid					
A. Employee, Spouse, or Dependent Enrolled in Employer's Accident or Health Plan Becomes Entitled to Medicare or Medicaid. (Other than coverage solely for pediatric vaccines)					
	Employee may elect to cancel or reduce	Unlikely that employee can elect	Employee may apparently decrease	Same as previous column.	No change permitted

	coverage for employee, spouse, or dependent, as applicable.	to drop dental or vision coverage; presumably, employee must retain coverage.	or revoke election or increase election if HCSA or LSHCSA is dropped due to Medicare/Medicaid and prior employer coverage was more comprehensive.		
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B. Employee, Spouse, or Dependent Loses Eligibility for Medicare or Medicaid. (Other than coverage solely for pediatric vaccines)

	<p>Employee may elect to commence or increase coverage for employee, spouse, or dependent, as applicable. Though unclear, it appears that tag-along concepts may apply.</p>	<p>Unlikely that employee can elect to add dental or vision coverage; presumably, employee cannot.</p>	<p>Employee may apparently increase or decrease or revoke election where employer plan elected due to loss of eligibility for Medicare/Medicaid is more comprehensive than Medicare/Medicaid</p>	<p>No change permitted.</p>	<p>No change permitted.</p>
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