

**CITY OF DALLAS**  
**CITY OF DALLAS FLEXIBLE SPENDING ACCOUNT**  
**SUMMARY PLAN DESCRIPTION**  
**For The**  
**Cafeteria Plan**  
**Health Flexible Spending Account**

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CITY OF DALLAS  
CITY OF DALLAS FLEXIBLE SPENDING ACCOUNT  
**SUMMARY PLAN DESCRIPTION**

**GENERAL INFORMATION ABOUT THE PLAN**

City of Dallas (the "Employer") is pleased to sponsor an employee benefit program known as the City of Dallas Flexible Spending Account (the "Plan") for you and your fellow employees. It is so-called because it lets you choose from several different benefit programs (which we refer to herein as "Benefit Plan Options") according to your individual needs, and allows you to use Pre-tax Contributions to pay for the benefits by entering into a salary reduction arrangement with your 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). Alternatively, you may choose to pay for any of the available benefits with after-tax contributions on a salary deduction basis to the extent described in your enrollment materials.

This Plan may have up to four very different 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 Pre-tax Contributions. For example, under this option you may pay for health coverage on a pre-tax basis or make pre-tax contributions to a health savings account (HSA) that you maintain.
- (ii) The Health Flexible Spending Account ("Health FSA"). The Health FSA allows you to elect to use a specified amount of Pre-tax Contributions to be used for reimbursement of Eligible Medical Expenses. The Health FSA is intended to qualified as a Code Section 105 self-insured medical reimbursement plan.
- (iii) The Dependent Care Spending Account ("Dependent Care FSA"). The Dependent Care FSA allows you to elect to use a specified amount of Pre-tax Contributions to be used for reimbursement of Employment Related Expenses. The Dependent Care FSA is intended to qualify as a Code Section 129 dependent care assistance plan.
- (iv) The Personal Care Account ("PCA Plan"). The PCA Plan is a component of a medical plan offered under the Cafeteria Plan; however, the PCA plan is not a component of the Cafeteria Plan. Its provisions are summarized herein for convenience purposes only. If offered your Employer may choose to make contributions to a health reimbursement account that provides reimbursement for otherwise unreimbursed medical expenses specified therein. Unlike the Health FSA, amounts that remain unused may carry forward into future years.

Each of these components is summarized in this document. Information relating to the Plan(s) 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 as well as the Plan Number(s) and any applicable contact information. Each summary and the attached Appendices constitute the Summary Plan Description for the City of Dallas Flexible Spending Account. The SPD (collectively, the Summary Plan Description or "SPD") describes the basic features of the Plan(s), how they operate, and how you can get the maximum advantage from them. The Plan(s) are also established pursuant to plan documents into which the SPD has been incorporated. However, if there is a conflict between the official plan document(s) and the SPD, the plan document(s) 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(s) 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 the Plan(s).

Participation in the Plan(s) does not give any Participant the right to be retained in the employ 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(s), you may also contact the Plan Administrator (who is identified in the Plan Information Summary).

## **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 (Benefit Plan Options) with pre-tax dollars ("Pre-tax Contributions"). The Benefit Plan Options to which you may contribute with Pre-tax Contributions under this Cafeteria Plan are described in the Plan Information Summary. Pre-tax Contributions (including pre-tax contributions to a health savings account (or "HSA") are described in more detail below.

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

Each employee of the Employer (or an Affiliated Employer identified 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". (See below for instructions on how to become a Participant.) You may not pay for the coverage of a non-dependent (as defined generally in Code Section 152 except as expanded in Code Section 105(b) for health benefits and Code Section 21 for Dependent Care FSA benefits)) with Pre-tax Contributions under this Plan.

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 details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plan Options, please refer to the plan summary for each Benefit Plan Option. If you do not have a summary for a Benefit Plan Option, you should contact the Plan Administrator for information on how to obtain a copy.

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

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

- (i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;
- (ii) The date that you no longer satisfy the Eligibility Requirements of this Cafeteria Plan or all of the Benefit Plan Options;
- (iii) The date that you terminate employment with the Employer; or
- (iv) 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 Pre-tax 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 pre-tax 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-4. How do I become a participant?**

If you have otherwise satisfied the Cafeteria Plan's 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 your share of the Benefit Plan Options that you choose with Pre-tax Contributions. You will be provided with a Salary Reduction Agreement on or before your Cafeteria Plan Eligibility Date. You must complete the form and submit it to the Plan Administrator or the Third Party Administrator (per the instructions provided on or with your 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-8.** 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. The Third Party Administrator is identified in the Plan Information Summary.

In some cases, the Employer may *require* you to pay your share of the Benefit Plan Option coverage that you elect with Pre-tax Contributions. If that is the case, your election to participate in the Benefit Plan Option(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-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 the Plan Information Summary 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 (described below). The following is a summary of the Initial Election Period and the Annual Election Period.

### *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. 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-8.** 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 pre-tax basis. You will be notified in the enrollment material whether there will be a corresponding Pre-tax Contribution for such default benefits.

### *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 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 under this Cafeteria Plan during the Annual Election Period are described in the Plan Information Summary. **Special Rule for Reimbursement Accounts: Evergreen Elections do not apply to elections for Health Savings Accounts (HSA) or Health or Dependent Care Reimbursement Accounts (Health FSA or Dependent Care FSA), if offered under the Plan, unless specifically stated by the employer in the enrollment material. Consequently, you generally must make an election each Annual Election Period in order to participate in the Reimbursement Accounts 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. How is my Benefit Plan Option coverage paid for under this Plan?**

You may be *required* to pay for any Benefit Plan Option coverage that you elect with Pre-tax 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 Pre-Tax 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 Pre-tax 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 Nonelective Employer Contributions. The amount of Nonelective 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 at any time. The Nonelective 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 Nonelective Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in 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 "Benefit 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-8. 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 in Status Event" that affects your eligibility under this Cafeteria Plan and/or a 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 the Election Change Chart attached to this SPD. Note: If you elect to contribute to a Health Savings Account (to the extent offered under the Plan), there are special rules regarding mid-year election changes. See the Health Savings Account section of this SPD for more information on Health Savings Account elections made under this Plan.

Third, an election under this Cafeteria Plan may be modified 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 Pre-tax Contributions for that coverage will automatically end. No election is needed to stop the contributions.

**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 specific election changes that you can make under this Cafeteria Plan following a leave of absence are described in the Election Change Chart and the rules regarding coverage under the Benefit Plan Options during a leave of absence will be described in the Benefit Plan Option summaries. If there is a conflict between the Election Change Chart/Benefit Plan Option Summaries and this Q-9, the Election Change Chart or Benefit Plan Option summary, whichever is applicable, controls.

- (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) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you. However, pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year.

- (iii) 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. If you go on an unpaid leave that affects eligibility under this Cafeteria Plan or a Benefit Plan Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

**Q-10. How long will the Cafeteria Plan remain in effect?**

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and 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 (e.g. an election change or other issue germane to Pre-tax Contributions) 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.

## HEALTH FSA COMPONENT SUMMARY

### Q-1. Who can participate in the Health FSA?

Each employee who satisfies the Health FSA Eligibility requirements is eligible to participate on the Health FSA Eligibility Date. The Health FSA 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 Health FSA's Eligibility requirements, you become a participant in the Health FSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods described in the Cafeteria Plan Summary. Your participation in the Health FSA will be effective on the date that you make the election or your Health FSA 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 Health FSA 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-8.** 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 Health FSA, Eligible Dependents are the following:

- (i) Your legal Spouse (as determined by state law to the extent consistent with the federal Defense of Marriage Act) and
- (ii) any other individuals who would qualify as a tax Dependent under Code Section 105(b).

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA 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 Health FSA 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 Health Care Account, 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.

NOTE: Your participation in this Health FSA could disqualify your spouse from establishing a health savings account as defined in Code Section 223 or from making/receiving tax favored contributions to the health savings account (unless you have elected the limited reimbursement option set forth below). If a spouse maintains a Code Section 223 health savings account or wishes to establish a Code Section 223 health savings account, the Health FSA participant may make an election during the initial enrollment period and/or the annual enrollment period to exclude all family members from coverage and cover only the participant. The election that you make in accordance with this paragraph during the annual enrollment period will be effective as of the first day of the following plan year. The election that you make during the initial enrollment period will be effective the same date that any other election made during the initial enrollment period would be effective.

### **Q-3. What is my "Health Care Account?"**

If you elect to participate in the Health FSA, the Employer will establish a "Health Care 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. Benefits under the Health FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

### **Q-4. When does coverage under the Health FSA end?**

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

- (i) the date that you elect not to participate in accordance with the Cafeteria Plan Summary;
- (ii) the last day of the Plan Year unless you make an election during the Annual Election Period;
- (iii) the date that you no longer satisfy the Health FSA Eligibility Requirements;
- (iv) the date that you terminate employment; or
- (v) the date that 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 Health FSA 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:

- (i) the date your coverage ends;
- (ii) the date that your dependents cease to be eligible dependents (e.g. you and your spouse divorce);
- (iii) 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 Health FSA.

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 FSA election?**

You can change your election under the Health FSA in the following situations:

- (i) *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.
- (ii) *Following a Change In Status Event.* You may change your Health FSA election during the Plan Year only if you experience an applicable Change in Status Event. See **Q-8.** of the Cafeteria Plan Summary for more information on election changes. **NOTE: You may not make Health FSA election changes as a result of any cost or coverage changes.**

**Q-6. What happens to my Health Care 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 Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA 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 Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

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

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount and 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 Nonelective Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Any change in your Health FSA 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 claims administrator) will notify you of the applicable method when you make your election change.

**Q-8. How are Health Care Reimbursement benefits paid for under this Plan?**

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Nonelective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment material will indicate if Nonelective Contributions or Benefit Credits are available for Health FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Nonelective Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

**Q-9. What amounts will be available for Health Care 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 Health Care 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 FSA?**

Under this Health FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see “Traditional Paper Claims” below for more information). Alternatively, you can use an electronic payment card (see “Electronic Payment Card” below for more information) to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the “Program”) as set forth herein and in the Electronic Payment Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in the program, limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan’s Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from 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 Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an “Eligible Medical Expense” you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses 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.

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

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

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

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your Health FSA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) *Health FSA reimbursement under the card is limited to health care providers (including pharmacies).* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you will not be able to use the card at a regular retail store – e.g., a supermarket, grocery store, or discount store with a pharmacy.

(e) *You swipe the card at the health care provider like you do any other credit or debit card.* When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Health FSA (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Health FSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

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

You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement is required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator that a third party statement is needed. You must provide the third party statement to the Claims Administrator within 45 days (or such longer period provided in the letter from the Claims Administrator) of the request.

(g) *There are situations where the third party statement will not be required to be provided to the Claims Administrator.* There may be situations in which you will not be required to provide the written statement to the claims administrator. More detail as to which situations apply under your Plan is specified in the Cardholder Agreement:

- **Co-Pay Match:** As specified in the Cardholder Agreement, no written statement is necessary if the Electronic Payment Card payment matches a specific co-payment you have under the component medical plan for the particular service that was provided. For example, if you have a \$10 co-pay for physician office visits, and the payment was made to a physician office in the amount of \$10, you will not be required to provide the third party statement to the Claims Administrator.
- **Previously Approved Claim Match:** As specified in the Cardholder Agreement, no written statement is required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the claims administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount.
- **Provider Match Program:** As specified in the Cardholder Agreement, no third party statement is required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefits manager) that identifies the nature of your expense and verifies the amount.

*Note: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.*

(h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under either the Health FSA or the Dependent Care FSA. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement). Lastly, the employer may treat the unreimbursed amount as a bad business debt, which could have income tax implications for you.

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

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

### *a. General Rule*

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

- The expense is for "medical care" as defined by Code Section 213(d);
- The expense has not been reimbursed by any other source 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 addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

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

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

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

- (a) Services or treatments for dental care (excluding premiums)
- (b) Services or treatments for vision care (excluding premiums)
- (c) Services or treatments for “preventive care”. Preventive care is defined in accordance with applicable rules and regulations. This may include any prescription or over the counter drugs to the extent such drugs are taken by an eligible individual (i) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e. the eligible individual is asymptomatic) (ii) to prevent the recurrence of a condition from which the eligible individual has recovered or (iii) as part of a preventive care treatment program (e.g. a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

A Health FSA participant may make an election during the annual enrollment period and/or the initial enrollment period to limit reimbursement under this Health FSA to medical expenses described above. The election that you make in accordance with this paragraph during the annual enrollment period will be effective as of the first day of the following plan year. The election that you make during the initial enrollment period will be effective the same date that any other election made during the initial enrollment period would be effective.

**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. “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. You may not be reimbursed for any expenses arising before the Health FSA 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 Health Care 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. Any amount allocated to a Health Care Account will 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. 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 FSA 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-15. What happens to unclaimed Health Care Reimbursements?**

Any Health Care 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 Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the employer is a "small employer" or the Health FSA is a church Plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and 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 Health FSA 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 FSA 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 (if a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) date of the event (ii) the date on which coverage is lost because of the event or (iii) the date that you are notified of your obligation to provide notice of such an event through this SPD or the General Notice provided by the Plan Administrator. 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.

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. 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 1<sup>st</sup> 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:

- 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);
- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if you become entitled to Medicare; or
- 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 Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

**Q-18. How long will the Health FSA 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.

**Q-19. How does this Health FSA interact with a Personal Care account (PCA) Sponsored by the Employer?**

Typically, a Health FSA is the payor of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an PCA that covers expenses covered by this Health FSA, the employer may require the Health FSA pay first, rather than the PCA. If the Health FSA pays first, you must exhaust your Health Care Account before using funds allocated to your PCA. The Plan Information Summary will indicate whether the Health FSA or PCA must pay first.

## PLAN INFORMATION SUMMARY

**This Appendix provides information specific to the City of Dallas. The Effective Date of this Plan Information Summary is January 1, 2005. This Plan Information Summary replaces and supercedes any other Plan Information Summary with an earlier effective date.**

### I. EMPLOYER/PLAN SPONSOR/THIRD PARTY ADMINISTRATOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	City of Dallas 1500 Marilla Street Dallas, TX 75201 (214) 670-3120
2. Name, address, and telephone number of the Plan Administrator:  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.	City of Dallas 1500 Marilla Street Dallas, TX 75201 (214) 670-3120
3. Employer's federal tax identification number:	756000508
4. Plan Number:	501
5. Effective Date of the Plan:  This is the date that the Plan was first established.	January 1, 2005
6. Effective Date of this SPD  Note: This is the most recent date of the SPD other than the Plan Information Summary and the Appendices.	January 1, 2005
7. Plan Year:	January 1, 2005 through December 31, 2005
8. Adopting Employers participating in the Plan:	N/A
9. Third Party Administrator:	Humana

## II. CAFETERIA PLAN COMPONENT INFORMATION

(a) **Eligibility Requirements and Eligibility Date.** Full time employees age 18 or older 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 January 1, 2005 ("Cafeteria Plan Eligibility Date").

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.

(b) **Annual Election Rules.** With respect to Benefit Plan Option elections (other than the Health FSA and Dependent FSA elections), failure to make an election during the Annual Election Period will result in the one of following deemed election(s):

{ X } The employee will be deemed to have elected not to participate during the subsequent plan year. Coverage under the Benefit Plan Options offered under the Plan will end the last day of the Plan Year made.

{ N/A } The employee will be deemed to have elected to continue his or her Benefit Plan Option elections in effect as of the end of the Plan Year in which the Annual Election Period took place. This is called an "Evergreen election".

(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 within 30 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) **Benefit 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 Pre-tax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Plan Options selected reduced any Nonelective Contributions made by the Employer. It is intended that such Pre-tax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

The following Benefit Plan Options are made available under the Plan to all those eligible Employees who make an appropriate election.

1. City of Dallas Health Flexible Spending Account Plan

## HEALTH FSA COMPONENT INFORMATION

- (a) **Health FSA Eligibility Requirements and Eligibility Date.** Full time employees age 18 or older (“Health FSA Eligibility Requirements”) eligible to participate in the Health FSA on January 1, 2005 (“Health FSA Eligibility Date”).
- (b) **Annual Health Care Reimbursement Amounts.** The Maximum Annual Reimbursement Amount each year may not exceed the lesser of Health FSA reimbursement amount elected for that year or \$5,000, The minimum reimbursement amount that may be elected under the Health FSA is \$1.
- (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 90 days after the end of the Plan Year.
  - (ii) The Run Out Period for terminated employees ends 90 days after the end of the Plan Year
- (d) **COBRA Administrator.** The COBRA administrator for the Health FSA is Humana.
- (e) **Method of Funding:** Health FSA Benefits are paid from general assets

## APPENDIX I

### CLAIMS REVIEW PROCEDURE CHART

**The Effective Date of this Appendix I is January 1, 2005. It should replace and supercede any other Appendix I with an earlier date.**

The Plan has established the following claims review procedure in the event your 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 FSA and Dependant Care FSA.

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

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

- 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 and you wish to 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:** *Notice of Denial is received from Third Party Administrator.* If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Third Party Administrator.

**Step 5:** *Review your notice carefully.* You should take the same action that you took 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 2<sup>nd</sup> 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 the 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 would support your claim.

If the Plan Administrator denies your 2<sup>nd</sup> 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:

- (Health FSA and PCA Only) 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);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

## **MISCELLANEOUS RIGHTS UNDER THE PCA AND HEALTH FSA**

### **ERISA Rights (not applicable to non-ERISA Plans)**

The PCA and Health FSA Plans may be ERISA welfare benefit plans if your employer is a private employer. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

#### *Receive Information About Your Plan and Benefits*

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

#### *Continue Group Health Plan Coverage*

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents will have to pay for such coverage. You should review the relevant sections of the PCA and Health FSA Summary for more information concerning your COBRA continuation coverage rights.

*(To the extent the PCA and/or Health FSA is subject to HIPAA's portability rules)* You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

#### *Prudent Actions by Plan Fiduciaries*

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

#### *Enforce Your Rights*

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### *Assistance with Your Questions*

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **Newborns' and Mothers' Health Protection Act of 1996**

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

## **APPENDIX II**

### **ELECTION CHANGE CHART**

**The Effective Date of this Appendix II is January 1, 2005. It should replace and supercede any other Appendix II with an earlier date.**

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 pre-tax 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. 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. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent. Contact the Third Party Administrator for more information.

*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 Reimbursement Plan Benefits** With respect to the Dependent Care FSA 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 FSA expenses for the available tax exclusion.

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

- **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 Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. 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 either 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 Option options, however, Pre-tax 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 FSA, to the extent offered under the Plan.)

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 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 FSA, to the extent offered under the Plan.)

The following is a chart reflecting the election changes that may be made under the Plan with respect to each Benefit Plan Option. 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.

Event	Major Medical	Dental and Vision	Health FSA
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Event	Major Medical	Dental and Vision	Health FSA
<b><u>I. Change in Status</u></b>			
<b>A. Change in Employee’s Legal Marital Status</b>	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); coverage option (e.g., HMO to PPO) change may be made; 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 enroll or 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).
<b>2. Lose spouse</b> (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; coverage option (e.g., HMO to PPO) change may be made; 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, 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.)	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 where coverage lost under spouse’s health plan.
<b>B. Change in the Number of Employee’s Dependents</b>			
<b>1. Gain Dependent</b> (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); coverage option (e.g., HMO to PPO) change may be made; employee may revoke or decrease employee’s or dependent’s coverage if employee becomes eligible	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).

Event	Major Medical	Dental and Vision	Health FSA
	under spouse's plan. Also, see HIPAA special enrollment rule below.		
<b>2. Lose Dependent (death)</b>	Employee may drop coverage only for the dependent who loses eligibility; coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Employee may decrease or cease election for dependent who loses eligibility.
<b>C. Change in Employment Status of Employee, Spouse, or Dependent That Affects Eligibility</b>			
<b>1. Commencement of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) That Triggers Eligibility</b>			
<b>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</b>	Provided eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependents and coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Same as previous column.
<b>b. Commencement of Employment by Spouse or Dependent or Other Employment Event Triggering Eligibility Under Their Employer's Plan</b>	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; coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Employee may apparently decrease or cease FSA election if gains eligibility for health coverage under spouse's or dependent's plan.
<b>2. Termination of Employment by Employee, Spouse, or Dependent (or Other Change in Employment-Status) That Causes Loss of Eligibility</b>			
<b>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</b>	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. Coverage option (HMO	Same as previous column.	Same as previous column.

Event	Major Medical	Dental and Vision	Health FSA
	to PPO) change may be made.		
<b>i. Termination and Rehire Within 30 Days</b>	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.
<b>ii. Termination and Rehire After 30 Days</b>	Employee may make new elections.	Same as previous column.	Same as previous column.
<b>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)</b>	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. Coverage option (e.g., HMO to PPO) change may be made; See HIPAA special enrollment rule below.	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase FSA election if spouse or dependent loses eligibility for health coverage (Note: HIPAA special enrollment rights likely do not apply).
<b>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)</b>			
<b>1. Event by Which Dependent Satisfies Eligibility Requirements Under Employer's Plan (attaining a specified age, becoming single, becoming a student, etc.)</b>	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; coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Employee may increase election or enroll only if dependent gains eligibility under Health FSA.
<b>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.)</b>	Employee may decrease or revoke election only for affected dependent. Coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Employee may decrease election to take into account ineligibility of expenses of affected dependent, but only if eligibility is lost.
<b>E. Change in Place of Residence of Employee, Spouse, or Dependent</b>			

Event	Major Medical	Dental and Vision	Health FSA
<b>1. Move Triggers Eligibility</b>	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; coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	No change allowed, even if underlying health coverage change occurs.
<b>2. Move Causes Loss of Eligibility (e.g., employee or dependent moves outside HMO service area)</b>	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.
<b>II. Cost Changes With Automatic Increase/Decrease in Elective Contributions (including employer motivated changes and changes in employee contribution rates)</b>	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.
<b>III. Significant Cost Changes</b>	<p><b>Significant Cost Increase:</b> Affected employee may increase election correspondingly OR revoke election and elect coverage under another benefit package option providing similar coverage. If no option providing similar coverage is available, employee may revoke election.</p> <p><b>Significant Cost Decrease:</b> 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>	Same as previous column.	No change permitted.
<b>IV. Significant Coverage Curtailment (With or Without Loss of Coverage)</b>	<b>Without Loss of Coverage:</b> Affected participant may revoke election for curtailed coverage and make new prospective election for	Same as previous column.	No change permitted.

Event	Major Medical	Dental and Vision	Health FSA
	<p>coverage under another benefit package option which provides similar coverage.</p> <p><b>With Loss of Coverage:</b> Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option which provides similar coverage OR drop coverage if no similar benefit package option is available.</p>		
<p><b>V. Addition or Significant Improvement of Benefit Package Option</b></p>	<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>	<p>Same as previous column.</p>	<p>No change permitted.</p>
<p><b>VI. Change in Coverage Under Other Employer's Cafeteria Plan or Qualified Benefits Plan</b> (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>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 plan.</p>	<p>Same as previous column.</p>	<p>No change permitted.</p>

Event	Major Medical	Dental and Vision	Health FSA
<b>A. Other Employer's Plan Increases Coverage</b>	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.
<b>B. Other Employer's Plan Decreases or Ceases Coverage</b>	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.
<b>C. Open Enrollment Under Plan of Other Employer</b>	Corresponding changes can be made under employer's plan.	Corresponding changes can be made under employer's plan.	No change permitted.
<b>VII. FMLA Leave</b> <b>(Employees can fund this coverage by (1) pre-paying their contribution obligations on a pre-tax basis (so long as the leave does not straddle two plan years); (2) making contributions on a month-by-month basis (pre-tax if they are receiving salary continuation payments); or (3) catching up on their contributions upon returning from the leave.)</b>			
<b>A. Employee's Commencement of FMLA Leave</b>	Employee can make same elections as employee on non-FMLA leave. In addition, an employer must allow an employee on unpaid FMLA leave either to revoke coverage or to continue coverage but allow employee to discontinue payment of his or her share of the contribution during the leave (the employer may recover the employee's share of contributions when the employee returns to work). FMLA also allows	Same as previous column.	Same as previous column.

Event	Major Medical	Dental and Vision	Health FSA
	<p>an employer to require that employees on paid FMLA leave continue coverage if employees on non-FMLA paid leave are required to continue coverage.</p>		
<p><b>B. Employee's Return from FMLA Leave</b></p>	<p>Employee may make a new election if coverage terminated while on FMLA leave. In addition, an employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from a non-FMLA paid leave are required to be reinstated in their elections.</p>	<p>Same as previous column.</p>	<p>Same as previous column. Note that, upon return, an employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) or at a level reduced prorate for the missed contributions.</p>

Event	Major Medical	Dental and Vision	Health FSA
<b>IX. HIPAA Special Enrollment Rights (See related exception for addition of new dependents)</b>			
<b>A. Special Enrollment for Loss of Other Health Coverage</b>	<p>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.)</p> <p>Though unclear, it appears that tag-along concepts may apply.</p>	<p>No change permitted, unless plan is subject to HIPAA.</p>	<p>No change permitted, unless health FSA is subject to HIPAA.</p>
<b>B. Special Enrollment for Acquisition of New Dependent by Birth, Marriage, Adoption, or Placement for Adoption</b> (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.	<p>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.</p>	<p>No change permitted, unless plan is subject to HIPAA.</p>	<p>No change permitted, unless health FSA is subject to HIPAA.</p>

Event	Major Medical	Dental and Vision	Health FSA
<b>X. COBRA Events</b>	Employee may increase pre-tax contributions under employer's plan for coverage if COBRA event (or similar state law continuation coverage event) occurs with respect to the employee, spouse, or dependents with respect to which the COBRA qualifying event occurred (such as a loss of eligibility for regular coverage due to loss of dependent status or a reduction in hours, etc.) and if applicable, the individual still qualifies as a tax dependent of employee.	Same as previous column.	No change permitted.
<b>XI. Judgment, Decree, or Order</b>			
<b>A. Order That Requires Coverage for the Child Under Employee's Plan</b>	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.
<b>B. Order That Requires Spouse, Former Spouse, or Other Individual to Provide Coverage for the Child</b>	Employee may change election to cancel coverage for the child.	Same as previous column.	Same as previous column.
<b>XII. Medicare or Medicaid</b>			
<b>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)</b>	Employee may elect to cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Unlikely that employee can elect to drop dental or vision coverage; presumably, employee must retain coverage.	Employee may apparently decrease or revoke election or increase election if Health FSA is dropped due to Medicare/Medicaid and prior employer coverage was more comprehensive.
<b>B. Employee, Spouse, or Dependent Loses Eligibility for Medicare or Medicaid (other than coverage solely for pediatric vaccines)</b>	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.	Unlikely that employee can elect to add dental or vision coverage; presumably, employee cannot.	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.