

JEFFERSON COUNTY

FLEXIBLE SPENDING ACCOUNT

PLAN DOCUMENT

Plan Year 2013

## **ARTICLE I. INTRODUCTION AND PURPOSE OF PLAN**

Jefferson County hereby amends its flexible spending benefit plan under the terms and conditions set forth in this document. The Plan is to be known as the Flexible Spending Account (FSA).

The purpose of the FSA plan (the Plan) is to allow eligible Jefferson County Employees to pay Benefit Premiums and other health care and dependent care expenses using pretax dollars.

The Plan consists of three components: the premium conversion plan; the health care flexible spending account; and the dependent care flexible spending account.

The Plan is intended to qualify as a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and shall be construed in a manner consistent with that Section. The tax implications of this Plan, however, are subject to rulings, regulations and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, Jefferson County does not represent or warrant to any Participant that any particular tax consequence will result from participation in this Plan. By participating in the Plan, each Participant understands and agrees that in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges, and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from Jefferson County.

This Plan is intended not to discriminate as to eligibility or benefits in favor of any prohibited groups under Sections 105, 125, and 129 of the Code.

## **ARTICLE II. DEFINITIONS**

The following words and phrases have the following meaning, unless a different meaning is plainly required by text:

- 2.1 **Agreement to Participate** means the agreement evidencing an Eligible Employee’s election to participate in the Plan and setting forth the amount of Medical Reimbursement Benefits and/or Dependent Care Reimbursement Benefits to be made available to the Participant for a Plan Year or portion of a Plan Year as reimbursement for Qualified Expenses.
- 2.2 **Benefit Premiums(s)** means the premiums of medical, dental and/or life insurance under the Benefit Plan, which a Participant is required as a condition for coverage, to pay.
- 2.3 **Benefit Plan** means the group plan offered by Jefferson County for health insurance, dental insurance, and supplemental life insurance.
- 2.4 **Cafeteria Plan** means the FSA Benefits Plan.
- 2.5 **Claims Administrator** for the purpose of this Plan is CIGNA.

- 2.6 **Code** means the Internal Revenue Code of 1986, as amended.
- 2.7 **Dependent** means an individual who is a dependent within the meaning of Section 152(a) of the Code of a Participant in the Plan.
- 2.8 **Dependent Care Expenses** means expenses incurred by a Participant for the care of a Dependent or Spouse of the Participant or for related household services, which would be considered employment-related expenses under Section 21(b)(2) of the Code.
- 2.9 **Dependent Care Reimbursement Benefits** means for any Plan year the amount available to a Participant as benefits in the form of reimbursements of Dependent Care Expenses.
- 2.10 **Dependent Care Reimbursement Benefits Account** means the account established by the Claims Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Dependent Care Expenses shall be paid.
- 2.11 **Eligible Employee** means an individual employed by Jefferson County as a full-time employee who regularly works at least 40 hours or more per week.
- 2.12 **Employer** means Jefferson County.
- 2.13 **Medical Reimbursement Benefits** means for any Plan Year the amount available to a Participant as benefits in the form of reimbursements of Qualified Expenses.
- 2.14 **Medical Reimbursement Benefits Account** means the account established by the Claims Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Qualified Expenses shall be paid.
- 2.15 **Participant** means any Eligible Employee who has met the eligibility requirements of the Plan and has elected to participate in the Plan by providing the Claims Administrator with an executed FSA Enrollment Form.
- 2.16 **Plan** means this FSA cafeteria plan.
- 2.17 **Plan Year** means a twelve (12) consecutive month period beginning January 1 and ending on December 31.
- 2.18 **Qualified Dependent Care Expenses** means dependent care expenses eligible for reimbursement under the Plan as determined under Sections 129(e)(1) and 21(b) of the Code. Such expenses include amounts paid for household services and for the care of Qualifying Individuals enabling the Participant and the Participants spouse, if married, to be gainfully employed.
- 2.19 **Qualified Expenses** means medical expenses incurred during a Plan Year by a Participant, the Participants Spouse or the Participant's Dependents, while the Participant is a Participant, otherwise allowed as a deduction for medical expenses under Section 213(d) of the Code, which are not otherwise reimbursable under the Benefit Plan or other plan or entity, but not including any Benefit

premium or the premiums paid for any other health insurance coverage. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

- 2.20 **Qualifying Individual** for purposes of the Dependent Care Flexible Spending Account Plan, means:
- a. a dependent of a Participant who is under the age of thirteen (13) and with respect to whom the Participant is entitled to a deduction under Section 151c of the Code;
  - b. a dependent of a Participant who is physically or mentally incapable of self-care (within the meaning of Section 21 of the Code)
  - c. the Spouse of a Participant who is physically or mentally incapable of self-care (within the meaning of Section 21 of the Code).
- 2.21 **Salary Reduction Agreement** means a written agreement by a Participant to reduce salary or wages for purposes of making contribution towards benefits under this Plan.
- 2.22 **Spouse** means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.
- 2.23 **Status Change** means a change in status, such as the marriage or divorce of the Participant, the adoption, birth, or death of a child or other Dependent of the Participant or the Participant's Spouse; the emancipation or coming of age of a child of the Participant so that the child is no longer eligible as a Dependent under the Plan; the employment status, work schedule, residence or work site of the Participant or Participants Spouse.

### **ARTICLE III. ELIGIBILITY AND PARTICIPATION**

- 3.1 **Eligibility.** All Eligible Employees are eligible to participate in the Plan. An Employee must be eligible to participate in the Benefit Plan on the first day of the Plan Year to be a Participant in the Plan on that day. Employees who become eligible during the Plan Year shall be allowed to participate in the Plan for the remainder of the Plan Year following their hire date.
- 3.2 **Participation.** Participation is established on a Plan Year to Plan Year basis. Each Eligible Employee shall be a Participant in the Plan for a Plan Year as follows:
- a. For purposes of receiving Benefit Premiums benefits under section 5.1, participation will be automatic, unless an Employee elects not to participate under this Plan for a Plan Year. An Employee who is eligible to participate may elect not to participate by completing and filing an appropriate declination form with the Claims Administrator within 30 days of eligibility date. An employee who elects not to participate with regard to payment of Benefit Premiums shall pay for such Benefit Premiums under the Benefit Plan on an after-tax basis.

- b. For purposes of receiving reimbursement from the health care flexible spending account plan and/or the dependent care flexible spending account plan, participation begins when the appropriate valid FSA enrollment form has been executed by the Participant and filed with the Claims Administrator. A Participant's enrollment shall terminate at the end of the Plan Year. A Participant must make an affirmative election for enrollment for each Plan Year.

3.3 **Irrevocability.** A Participant may not revoke or amend participation in the Plan during a Plan Year except due to a change in status and the revocation or amendment corresponds to, is consistent with, and due to the change in status as defined in Section 125 of the Code. Changes in status are defined as changes in:

- a. **Legal marital status.** Events that change an employee's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.
- b. **Number of dependents.** Events that change an employee's number of dependents, including the following: birth; death; adoption; and placement for adoption. In the case of dependent care, the change must be in the number of qualifying individuals as defined in IRC section 21(b)(1).
- c. **Employment Status.** Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent:
- a termination or commencement of employment;
  - a strike or lockout;
  - a commencement of or return from an unpaid leave of absence of more than 30 days; and
  - a change in work-site.
- d. **Dependent satisfies or ceases to satisfy eligibility requirements.** Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

An election change is allowed only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a benefit plan.

A revocation or amendment of participation must be made within thirty (30) days after the change in status occurs and will be effective for the balance of the Plan Year in which the election is made, beginning on the effective date of the change in status.

The Claims Administrator will allow a participant to cease participation in a Health Care Reimbursement Benefits Account or Dependent Care Reimbursement Benefits Account if the participant receives a statement, after the Employer's annual enrollment, showing they are a participant, and the participant did not intend to enroll in a FSA Account for the Plan Year. The change must be made within ten (10) days of receiving the statement.

3.4 **Termination of Participation.** Except as provided in Section 3.5 below, participation in the Plan terminates on the date the Participant dies, resigns or terminates employment with the Employer;

the date the Participant fails to make required contributions under the Plan; or the date the Plan terminates.

The former Participant shall be entitled to submit a request for reimbursement of Qualified Health Care Expenses and Qualified Dependent Care Expenses, in accordance with Article VII, provided such Qualified Health Care and Dependent Care Expenses were incurred while the former Participant participated in the Plan.

A former Participant may under certain circumstances elect to continue coverage for Qualified Health Care Expenses by submitting the required self-payment contributions as set forth in Section 3.6.

- 3.5 **Participation by Rehired Employees.** If participation terminates due to a separation of service and the individual returns to eligible employment the Participant may make a new election for the remainder of the Plan Year. If contributions were not made during the separation of service, the Participant will not be able to be reimbursed for expenses incurred during the separation.
- 3.6 **Continuation of Coverage.** If on the date of the Qualifying Event, a former Participant or a Qualified Beneficiary has remaining Qualified Health Care Expenses in excess of remaining contributions, then he/she may continue coverage for Qualified Health Care Expenses for the remainder of the Plan Year, by making an election to do so with the Claims Administrator and submitting the applicable self-payment contribution.

In the case of a Qualifying Event of the Participant (death or termination of employment or reduction in hours) a Qualified Beneficiary will receive information concerning continuation of coverage.

In the case of a Qualifying Event of the Qualified Beneficiary (legal separation or divorce, or a child no longer qualifies as a Dependent) a Qualified Beneficiary must notify the Employer within thirty (30) days of the Qualifying Event. If notice is not received within thirty (30) days of the Qualifying Event, the Qualified Beneficiary will not be eligible for continuation coverage.

After notification of continuation of coverage, the former Participant or Qualified Beneficiary will have sixty (60) days to elect continuation coverage, after the later of:

- a. the date that the former Participant or Qualified Beneficiary would lose coverage on account of the Qualifying Event; or
- b. the date that the former Participant or Qualified Beneficiary is sent such notice.

The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Claims Administrator within forty-five (45) days of the date the former Participant or Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first (1<sup>st</sup>) day of the month for which coverage is elected, and shall be considered timely if received within thirty (30) days of the date due.

If premiums are not received in a timely manner, coverage will terminate. No claims will be paid until premium payment is received by the Claims Administrator in accordance with paragraph 4.

The election must specify which Qualified Beneficiary(s) are electing COBRA continuation coverage. If it does not specify the Qualified Beneficiary(s), the election shall be deemed to be an election on behalf of all Qualified Beneficiaries.

Termination of Continuation of Coverage. Continuation of coverage as provided under this section will terminate on the earliest of the following dates, as applicable:

- a. the date after election of continuation coverage that the former Participant or Qualified Beneficiary first becomes covered under any other group medical coverage as an employee or dependent.
- b. the end of the period for which the last payment was made for coverage in a timely manner;
- c. the end of the Plan Year; or
- d. the date the Employer ceases to provide the health flexible spending account plan.

3.7 **Death of a Participant.** With respect to Qualified Dependent Expenses, if a Participant dies, the Participant's participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of the Participant's estate, may submit claims for expenses or benefits for the remainder of the Plan Year or until the account balance is exhausted. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Claims Administrator may designate the Participant's Spouse, one (1) of the Participant's dependents, or a representative of the Participant's estate.

#### **ARTICLE IV. BENEFITS**

4.1 **Qualified Health Care Expenses.** The Claims Administrator shall reimburse a Participant for Qualified Health Care Expenses incurred by the Participant or the Participant's Spouse or Dependent Child.

Reimbursement for Qualified Health Care Expenses during a Plan Year is limited to the annualized amount directed by the Participant to the health care spending account under a valid FSA enrollment form.

4.2 **Qualified Dependent Care Expenses.** The Claims Administrator shall reimburse a Participant for Qualified Dependent Care Expenses in accordance with the provisions of section 5.3.

Reimbursement for Qualified Dependent Care Expenses during a Plan Year is limited to the amount of expenses incurred, not to exceed the amount in the Participant's account at the time a claim is made.

## ARTICLE V. FUNDING

5.1 **Funding of Benefit Premiums.** Jefferson County will reduce the Participant's salary or wage each pay period by the amount of the Benefit Premiums under the Benefit Plan before taxes are calculated. The premium amounts paid through salary reduction may be adjusted during a Plan Year to reflect changes in the Benefit Premiums.

5.2 **Funding of Qualified Health Care Expense Account.** Qualified Health Care Expenses shall be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year.

A Participant's salary or wage may be reduced under this section 5.2 in an amount not to exceed \$2,500.00. The salary reduction amount so elected shall be funded pro rata over twenty-four (24) consecutive pay periods in the Plan Year. The salary reduction amount for any one (1) pay period may not exceed the amount of the Participant's salary or wage for that period.

The Claims Administrator shall establish individual health care reimbursement accounts for each Participant and shall credit to each Participants account the salary reduction amounts elected by the Participant on the FSA enrollment form.

The Claims Administrator shall reimburse Participants for Qualified Health Care Expenses in accordance with Article VII.

5.3 **Funding of Dependent Care Expense Account.** Qualified Dependent Care Expenses may be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year, not to exceed the amount in the Participant's account at the time reimbursement is requested.

A Participant's salary or wage may be reduced under this section 5.3 in an amount not to exceed \$5,000 (\$2,500 if the employee is married and files a separate federal tax return) or the employee's earned income, whichever is lower, for the Plan Year. The salary reduction amount for any one (1) pay period may not exceed the amount of the Participant's salary or wage for that period.

The Claims Administrator shall establish individual dependent care reimbursement accounts for each Participant and shall credit to each Participant's account the salary reduction amounts elected by the Participant on the FSA enrollment form.

5.4 **Accounting.** The Claims Administrator shall maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of Qualified Health Care Expenses or Qualified Dependent Care Expenses on behalf of any Participant.

## **ARTICLE VI. SALARY REDUCTION ELECTIONS**

6.1 **Election Period for Salary Reduction.** In order to fund a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for a Plan Year, a Participant must complete and file with the Claims Administrator a FSA enrollment form within the applicable election period as determined by the Claims Administrator.

6.2 **Termination, Revocation, or Amendment of Salary Reduction Elections.** A Participant's Salary Reduction Agreement election for a Plan Year with respect to Qualified Health Care Expenses and Qualified Dependent Care Expenses shall terminate at the end of the Plan Year. A Participant must make an affirmative election for participation each Plan Year. A Participant's enrollment for the Plan Year with respect to Benefit Premiums shall not terminate at the end of the Plan Year.

Termination, revocation or amendment of salary reduction elections may only be made by a Participant in accordance with Article III.

6.3 **Limitations on Exclusion From Gross Income for Dependent Care Expense Account.** Unless otherwise provided by the Code, reimbursements under the Plan for Qualified Dependent Care Expenses shall be excluded from the gross income of a Participant during a Plan Year in accordance with Code Section 129. Exclusion from gross income under the Plan shall not exceed:

- a. in the case of an Employee who is not married at the close of such Plan Year, the Earned Income of such Employee for such Plan Year; or
- b. in the case of an Employee who is married at the close of such Plan Year, the lesser of the Earned Income of such Employee or the Earned Income of the Spouse of such Employee for such Plan Year.

The aggregate amount excluded from the gross income of a Participant under this Plan for a Plan Year shall not exceed \$5,000 (\$2,500 in the case of a separate return by a married individual).

To the extent reimbursements exceed the maximum amount excludable from a Participant's gross income, the reimbursements shall be treated as taxable income to the Participant.

The amount excluded from the income of an Employee under the Plan for any Plan Year shall include:

- a. Payments made or incurred to an individual who can be claimed as a Dependent Child of the Employee or the Spouse of such Employee; or
- b. Payments made or incurred to an individual who is a child under the age of nineteen (19) at the end of the plan year of such Employee or the Spouse of such Employee.

- 6.4 **Forfeiture of Salary Reduction Amounts.** If a Participant fails to claim any amounts in the health or dependent care flexible spending account plan by the time allowed in section 7.4, d., and section 7.5, d., such amounts shall be forfeited by the Participant to the Employer.
- 6.5 **Amendment of Salary Reduction Elections Due to Family and Medical Leave (FMLA) or Military Leave.** A Participant may elect to revoke or continue his/her Health or Dependent Care Expense Account coverage while on unpaid leave under FMLA or on military leave, as long as the Participant remains eligible for coverage.

If a Participant wishes to continue coverage while on unpaid leave, the Participant may pay contributions in advance of the leave, while on leave, or may catch up contributions upon return from the leave.

A Participant may make after-tax contributions to fund a Qualified Health Care Expense Account during an unpaid leave of absence, or the Participant may make pretax contributions by increasing the salary reduction contributions before taking the leave, but only for the portion of the leave which occurs during the Plan Year, or make pretax contributions after the leave, by salary reduction.

If the Participant does not make payments, participation will cease after a thirty (30) day grace period. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed as described in Article IV herein.

If coverage was terminated while on FMLA leave or a qualified military leave under the Uniformed Services Employment and Re-employment Rights Act, upon return to employment the Participant may choose to re-instate the election as it was immediately prior to the leave. However, such Participant shall have no greater rights to coverage or election changes than had the Participant not been on such leave.

## **ARTICLE VII. PAYMENT OF CLAIMS**

- 7.1 **Determination of Status of Eligible Expenses.** After receiving an appropriately submitted claim and the information required under section 7.4 or 7.5, the Claims Administrator shall determine whether such expenses are Qualified Health Care Expenses or Qualified Dependent Care Expenses.
- 7.2 **Payment of Claims.** The Claims Administrator will pay properly submitted claims for reimbursement at such intervals as it may consider appropriate.
- 7.3 **Expenses.** All administrative expenses incurred prior to the termination of the Plan that arise in connection with the administration of the Plan shall be paid by the employer.
- 7.4 **Claims Reimbursed for Qualified Health Care Expenses.**

The Participant must submit a properly completed claim form to the Claims Administrator along with written evidence from an independent third party stating the Health Care Expense has been

incurred, the amount of such expense, and such other information as the Claims Administrator may find necessary.

The Participant must submit with other required documents, a signed statement in such form as determined by the Claims Administrator certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Health Care Expenses and are not reimbursable from any other source.

The Claims Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Health Care Expenses.

At the end of each plan year, participants have an additional 2-month 15-day grace period to incur health care claims for unused benefits from the previous plan year. This additional period is January 1 through March 15. All claims for reimbursement must be submitted not later than March 31 following the end of the Plan Year in which the expense was incurred.

7.5 **Claims Reimbursement for Qualified Dependent Care Expenses.** To make a claim for reimbursement of Qualified Dependent Care Expenses, the Participant shall submit a properly completed claim form to the Claim Administrator that contains the following information:

- a. the Qualifying Individual(s) for whom the Qualified Dependent Care Expenses were incurred;
- b. the nature of the services which will generate the Qualified Dependent Care Expenses
- c. written evidence from an independent third party stating the expenses have been incurred, the amount of such expenses, and such other information as the Claims Administrator in its sole discretion may request; and
- d. a statement that the Qualified Dependent Care Expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.

The Participant must submit with other required documents a signed statement in such form as determined by the Claims Administrator certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Dependent Care Expenses.

The Claims Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Dependent Care Expenses.

All claims for reimbursement must be submitted not later than March 31 following the end of the Plan Year in which the expense was incurred.

## **ARTICLE VIII. ADMINISTRATION**

8.1 **Claims Administrator Powers and Duties.** The Claims Administrator shall manage and administer the Plan. The Claims Administrator shall interpret the Plan and decide all matters arising there under, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Claims Administrator with respect to any matter under the Plan shall be conclusive and binding on all persons. The Claims Administrator shall:

- a. Require any person to furnish such information as it may request for the purpose of the proper administration of the Plan and as a condition to receiving any benefits under the Plan.
- b. Make and enforce administrative rules and prescribe the use of such forms as it considers necessary for the efficient administration of the Plan.
- c. Decide questions concerning the Plan and the eligibility of any Employee to Participate in the Plan, in accordance with the provisions of the Plan.
- d. Determine the amount of benefits which are payable to any person in accordance with the provisions of the Plan; and provide a review to any Participant whose claim for benefits has been denied in whole or in part.

8.2 **Additional Operating Rules.** The Claims Administrator makes no guarantee as to the taxability of a Participant's salary reduction amount.

Salary reduction amounts under this Plan shall not reduce salary or wage amounts for purposes of any other Employer-sponsored employee benefit programs unless the provisions of those programs otherwise provide.

## **ARTICLE IX. APPEALS PROCEDURE**

9.1 **Notice to Employee.** Any person who claims he/she has been denied a benefit under the Plan shall be entitled, upon written request to the Claims Administrator to receive, within 30 days of receipt of such request, a written notice of such action, together with a full and clear statement of the specific reasons therefore, citing pertinent provisions of the Plan and a statement of the procedure to be followed in requesting a review of his or her claim.

9.2 **Appeal of Denial of Benefit.** If the claimant wishes further consideration of his/her claim, he/she may request a review. The Claims Administrator shall schedule a review on the issue within thirty (30) days following receipt of the claimant's request for such review. The decision following such review shall be communicated in writing to the claimant and, if the claim is denied, shall set forth the specific reasons for such denial, citing the pertinent provisions of the Plan. The decision of the Claims Administrator as to all claims shall be final.

## **ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN**

The Claims Administrator or Employer reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Code) to modify or amend, in whole or in part, any or all of the provisions of the Plan provided, however, that no such modifications or amendment shall divest a Participant of a right to a benefit to which he becomes entitled in accordance with the Plan. The Employer reserves the power to discontinue or terminate the Plan at any time. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine.

## **ARTICLE XI. GENERAL PROVISIONS**

- 11.1 **No Right to be Retained in Employment.** Nothing contained in the Plan shall give any Employee the right to be retained in the employment of any Employer or affect the right of the Employer to dismiss any Employee.
- 11.2 **Alienation of Benefits.** No benefit under the Plan is subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so is void.
- 11.3 **Use of Form Required.** All communications in connection with the Plan made by a Participant are effective only when duly executed on forms provided by and filed with the Claims Administrator.
- 11.4 **Applicable Law.** The provisions of the Plan shall be construed, administered and enforced according to applicable Federal Law and the laws of the State of Texas.