Franklin County Cooperative
Health Improvement Program

Franklin County Cooperative Health Improvement Program
Summary Plan Description (SPD)

Flexible Spending Accounts

Effective January 1, 2025

BENEFITS
614.525.5750
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FRANKLIN COUNTY BENEFITS & WELLNESS OFFICE
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This document, along with any other applicable benefit descriptions, is the summary plan description (SPD) for the Flexible Spending Accounts for the Franklin County Cooperative Health Improvement Program.

The Flexible Spending Accounts allow eligible Employees and Elected Officials to elect to make ore-tax contributions to reimburse qualified Medical Care and Dependent Care expenses incurred by eligible Employees and their family members.

You should retain this SPD as part of your permanent records. However, remember that it is only a summary. Ther SPD summarizes who is eligible for benefits and the nature of the benefits available. The SPD does not change the provisions of any benefit plan documents, or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the FSAs.

For additional information, you should contact Benefits & Wellness at 614.525.5750 or contact WexHealth at 866.451.3399.

General Plan Information

Type of Plan:	Health Flexible Spending Account (HCFSA)
	Dependent Care Flexible Spending Account (DCFSA)
Plan Year:	Twelve-month period ending December 31
Plan Year Close:	July 10 of the following year
Plan Sponsor:	Franklin County Board of Commissioners
	373 S. High St. 25th Fl
	Columbus, OH 43215
Plan Administrator:	Franklin County Cooperative Health Improvement Plan
Claim Administrator:	WexHealth
	866.451.3399

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Important Notice

The Flexible Spending Accounts (FSA) plan is established by Franklin County Cooperative Health Improvement Program (Cooperative) voluntarily and may be amended or terminated at any time by the Cooperative, in its sole discretion. Amendments may, among other things, affect eligibility, contribution rates, benefits coverage, reimbursement rates, procedures, participation, etc., at any time, regardless of whether the individual is participating in the benefit plans at the time of the amendment. The Plan Administrator has the discretionary authority to interpret the provisions of the Plan and SPD, and its decisions are final and binding. Nothing in the SPD or the Plan gives or is intended to give any person the right to be retained in the employment of Franklin County or any agency participating in the Cooperative or to interfere with these Employers right to terminate the employment of any person.

Eligibility

You are in an eligible class for coverage under this Plan if you are:

- A benefit eligible employee as defined by the health plan (see the health plan SPD for more details)

You can sign up for the Healthcare FSA, the Dependent Care FSA, both FSAs, or neither FSA. Participation is completely voluntary; it is up to you to decide which FSA (if any) meets your needs. Only employees can enroll in the Flexible Spending Accounts, but the FSAs can be used to reimburse your dependents' eligible expenses, as well as your own.

Enrolling in the Plan

Enrolling is easy and available 24 hours a day through the benefit administration system during your new hire enrollment period (30 days), the annual open enrollment period and during enrollment periods following a qualifying life event. You must enroll during these enrollment periods. Your completed enrollment authorizes your employer to withhold a portion of your earnings before taxes are deducted and credit that same amount into your FSA(s). Federal law requires that whatever election you make is locked in throughout the applicable calendar year unless you have a qualifying life event. Federal law also requires that any amounts you do not use for eligible reimbursements be forfeited, so it is important to plan carefully.

New Employees

You must enroll within 30 days of your date of hire (or the date you become eligible to participate) to participate in FSA(s).

Annual Enrollment

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

If you already enrolled in an FSA(s) and wish to continue participating, you must re enroll each year to continue your participation.

Making Changes

The IRS requires that your FSA elections stay in effect throughout the full Plan year. Once made, you cannot change your election during the year unless you experience a "qualifying life event."

Defining a Qualifying Life Event

The following are examples of qualifying life events for FSA:

- Marriage
- Divorce, legal separation or annulment
- Birth, placement for adoption, or adoption of a child
- Death of a spouse or a child
- Termination of your spouse's employment
- Commencement of your spouse's employment affecting eligibility
- Transition from part-time to full-time work, or from full-time work to part-time work, by you or your spouse that affects eligibility
- An unpaid leave of absence taken by you or your spouse affecting eligibility
- Change in provider or cost for Dependent Care FSA (does not apply if the provider is your relative)
- A child ceasing to qualify as a dependent (such as turning age 13 with respect to Dependent Care FSA elections)

If You Have a Qualifying Life Event

You have 30 days from the qualifying life event to change your Healthcare and/or Dependent Care FSA election. **The change in your FSA election must be due to and consistent with the change in your family status and otherwise be allowed by the Plan Administrator.**

For Example:

- Upon the birth or adoption of your child, you could increase the amount you are contributing to your Healthcare FSA, but you could not decrease or stop your FSA contributions.
- If you divorce, you could terminate or decrease your Healthcare FSA contributions, but you could not increase the amount you elect for the year.

You should immediately enter the qualifying life event information in the Benefit Administration system to give yourself time to make any allowable changes to FSA elections. If you have questions about what changes are allowed following a qualifying life event change, please contact the Benefits and Wellness Department.

If you do not report the qualifying life event change and enter election changes in the benefit administration system within the 30-day period, you will not be allowed to make the change until the next annual enrollment period.

If You Take a Leave of Absence

Paid Leave of Absence

Your participation in FSA(s) will not be affected if you are granted a paid leave of absence. Payroll deductions will continue, and you can still use your FSA(s) to reimburse yourself for eligible expenses. However, you could choose to decrease or stop your contributions to the Dependent Care FSA.

Note: You can continue to be reimbursed from your Dependent Care FSA for eligible expenses you incurred while you were actively at work; but you will not be reimbursed for expenses incurred while on paid leave. Any balance in your Dependent Care FSA account from contributions made before your leave can be used for claims incurred upon your return to work.

Unpaid Leave of Absence-Healthcare FSA

While on unpaid leave of absence

1. You can continue your Healthcare FSA by making payments on an after-tax basis (contact the Benefits Department for details). If you fail to make the required payments

during your leave, you will be required to pay the missed payments when you return to work in the same calendar year of the Healthcare FSA election.

2. If you elect to discontinue your participation in the Healthcare FSA during your unpaid FMLA leave of absence or military (USERRA) leave of absence and you return to work during the same plan year, you may either have your same pay period withholding apply (with a corresponding reduction in the total amount available to reflect the period during which no contributions were made) or you can choose to have your pay period withholding increased as increased as necessary to make up the contributions you missed while out on leave. If you elect to discontinue your participation in the Healthcare FSA during your unpaid FMLA leave of absence, you will not be eligible to be reimbursed for expenses incurred during your leave. If you have had a change in status, you may be eligible to make changes to your election within 30 days of your return from the unpaid leave of absence.

Unpaid Leave of Absence-Dependent Care FSA

If you are on an unpaid leave of absence, your contributions and participation in the Dependent Care FSA will end. You can continue to be reimbursed from your Dependent Care FSA for eligible expenses you incurred while you were actively at work; you will not be reimbursed for expenses incurred while on unpaid leave. Any balance in your account from contributions made before your leave can be used for claims incurred upon your return to work.

When you return from an unpaid leave, it is considered a family status change, and you may elect to participate in the Dependent Care FSA so long as you complete the family status change within 30 days of your return to work.

When Your Employment Ends

Healthcare FSA

If you terminate employment during the year or lose benefit eligibility for another reason:

- Your ability to use your card and fund will end effective on your termination date. The account will remain active until the end of the month and employees still have the option to be reimbursed only for services incurred on or before the termination date. The run-out period for mid-year terminations is 90 days post termination date of benefits.
- Unused funds will be forfeited to the Plan
- If you have used more funds that you have contributed, it will result in a loss to the Plan

Dependent Care FSA

If you terminate employment during the year or lose benefit eligibility, your contributions to your Dependent Care FSA will end. However, you can still be reimbursed for eligible expenses you incur through your last day worked. You have until 90 days after the date of termination to submit claims.

If You Are Rehired

If you terminate employment and you are rehired as a benefit eligible employee, the following special rules apply to your FSA elections.

- If you are rehired within 30 days or less and during the same calendar year that you terminated employment, your prior FSA election(s) will be reinstated upon reemployment.
- If you are rehired after 30 days and in the same calendar year, you will be treated like a new hire. This means you will be given 30 days to enroll in the FSA. If you do not enroll during that period, you will not participate in the FSA for the remainder of the year. You will be allowed to elect up to the annual IRS allowed maximum minus the amount you elected during your prior election for that Plan Year.
- If you are rehired after 30 days and in a different calendar year, you will be treated like a new hire. This means you will be given 30 days to enroll in the FSA. If you do not enroll during that period, you will not participate in the FSA for the remainder of the year.

Expenses incurred while you were not participating in the FSA are not reimbursable. These same rules apply if you lose or gain eligibility to participate in the FSAs during the same year for another reason (meaning a reason other than termination of employment).

Summary of Benefits

A Flexible Spending Account (FSA) allows you to set aside a portion of your salary on a pre-tax basis, which is reflected, in a special bookkeeping account. You can then use the money in your account(s) to reimburse yourself for qualified healthcare and/or dependent care expenses (but you cannot use money in your Healthcare Account for dependent care expenses or vice versa). Your taxable salary is reduced by the amount you contribute to your account(s), so you pay lower income taxes and Social Security taxes. Participation in a FSA(s) is voluntary. You decide whether you would like to participate and how much money you would like to contribute based on the minimums and maximums shown below.

Contribution	Healthcare Account	Dependent Care Account
Annual Minimum	120	120
Annual Maximum	$3,300	$5,000**

** Please see below for additional limits that apply, such as if you are married but file taxes separately or based on you or your spouse's earned income.

How the Flexible Spending Account Works

You decide how much you want to contribute to one or both FSA(s) through pre-tax amounts can only be used to pay for qualifying expenses incurred while you participate in the account(s). These are bookkeeping accounts only (there is no actual account in your name, and the account does not earn interest). You cannot deposit cash directly into your account(s). Once you decide how much you will contribute for the year, you cannot change your election unless you have a qualified family status change, nor can you transfer money from one FSA to another.

How Much You Can Contribute

You can contribute from $120 to $3,300 (or such other amount indicated in the enrollment material) to your Healthcare FSA each year.

In general, you can contribute from $120 to $5,000 a year to your Dependent Care FSA. However, there are a few additional rules that may affect the maximum available to you. Please see the section below entitled "Additional Limits on Dependent Care FSAs" for other rules that may affect the maximum you can contribute to the Dependent Care FSA.

Carefully calculate the amount you contribute to your Flexible Spending Account(s). The IRS imposes a "use it or lose it" rule on FSA plans' you forfeit any money that remains in your account after reimbursement of your eligible expenses for the year. In addition, you cannot transfer amounts from one account to the other. See ***Limits and Restrictions for more information.***

Limits and Restrictions

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

- An FSA is what is known as a "use it or lose it" arrangement, which means if you do not spend all the money in your account, you lose the unspent balance. You must decide how much to deposit for the year before each year begins. Once you decide your contribution amount, you cannot change it during the year unless you experience a

qualifying life event; so, you should plan to contribute only as much as you expect to spend in the current (if new hire) or upcoming year.

- Having a Healthcare FSA limits your tax deductions for healthcare expenses. However, keep in mind that you can deduct unreimbursed healthcare expenses from your federal income tax only if they exceed the threshold established by the Internal Revenue Service.
- To be eligible for reimbursement from the Healthcare FSA, the expenses must be for you, your child or a tax qualified dependent. A tax qualified dependent is someone for whom you can claim a tax exemption, such as a spouse.
- Having a Dependent Care FSA limits the tax credits you may be able to take for dependent care expenses. You can use both Dependent Care FSA and tax credit, provided you do not claim the same expenses for both. However, federal regulations required that your dependent care tax credit be reduced dollar for dollar, by whatever you put in your FSA.
- You should ask your tax advisor to help you choose the right alternative for your tax bracket.
- You cannot transfer funds between the Healthcare and Dependent Care FSAs.
- You cannot carry over unclaimed Dependent Care FSA balances from one year to the next. Any funds remaining in your Dependent Care FSA on December 31 will be forfeited unless they are used to cover expenses incurred during that calendar year and WexHealth receives your claim for reimbursement by March 15 of the following calendar year.
- The risk of forfeiting money from your Healthcare FSA is reduced by a grace period. You can use your remaining balance available as of December 31 (up to a maximum of $3,300.00) to pay for expenses incurred through March 31 of the following calendar year. Claims must be filed by March 31 of the following calendar year.

Additional Limits on Dependent Care FSA Contributions

If Your Spouse Also Contributes to a Dependent Care FSA, You File Taxes Separately or Based on Earned Income

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

- You are limited to a combined Dependent Care FSA contribution of $5,000 in a calendar year. This limit applies whether you have one or more dependents receiving care.
- If you file separate federal income tax returns, the most you can contribute is $2,500 a year.

- If you file a joint return, you cannot contribute more than you earn (or what your spouse earns, if it is less than what you earn for the year, with a $5,000 limit).

If You or Your Spouse is Either Disabled or a Full-Time Student

If your spouse is disabled or a full-time student, the IRS considers your spouse's earnings to be $2,500 a month if you have one eligible dependent, and $5,000 if you have more than two eligible dependents.

How Participating in the FSA(s) Affects Taxes and Other Benefits

Establishing an FSA can also affect your tax strategy when you file your income tax return. You should consult with a tax advisor before signing up for an FSA(s) - you cannot change your election once you have made it, unless you have a qualified life event (as explained in **Making Changes**.

The Tax Advantages

The Internal Revenue Code Section 125 allows your employer to take the money you direct to your FSA(s) out of your pay before federal income tax and state income tax are deducted. In turn, your taxable income is lower, and you pay less federal and state taxes. The Cooperative has the right to adjust elections as it deems reasonable to comply with IRS nondiscrimination rules.

Any reimbursements you receive from your FSA(s) are exempt from federal tax as long as you have not taken (or do not intend to take) a tax deduction or credit for related expenses when you file your federal tax return.

Impact on Other Benefits

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

Your Flexible Spending Account Statements

You can access information about your FSA account status 24 hours a day, 7 days a week by registering and logging in to https://benefitslogin.WexHealth.com. Once logged in you can see your account information.

Your Healthcare FSA

The Healthcare FSA lets you pay many of your otherwise unreimbursed healthcare expenses with tax-free dollars. Since not every healthcare expense you incur is eligible for reimbursement through your FSA, it is important to know which are reimbursable and which are not.

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

Eligible Healthcare Expenses

You can use your Healthcare FSA to reimburse yourself for certain expenses that are considered "medical care" under Section 213(d) of the Internal Revenue Code, as long as the expenses are not reimburse by any other medical, dental or vision plan. Tax rules change, so you should check with your tax advisor about the eligibility of specific expenses. You can get additional information about eligible healthcare expenses from IRS Publication 502, "Medical and Dental Expenses," which is available from your local IRS office and the IRS website at http://www.irs.gov/. Keep in mind that not all expenses listed in the Publication are eligible for reimbursement (such as premiums for coverage).

Ineligible Healthcare Expenses

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

- Expenses for which you have already been reimbursed by other healthcare plans or for which you could be reimbursed from those plans, if you submitted a claim (including Medicare, Medicaid, or any other Medical, Dental, or Vision Plan)
- Expenses incurred by anyone other than you or your qualified dependents
- Expenses that are not excludable from federal income tax
- Babysitting, childcare and nursing services for a normal, healthy baby. This includes the cost of a licensed practical nurse (L.P.N.) to care for a normal and healthy newborn.
- Controlled substances
- Cosmetic dental work
- Cosmetic surgery
- Custodial care in an institution
- Diaper service
- Electrolysis

- Funeral and burial expenses
- Healthcare plan contributions or premiums, including those for Medicare, your spouse's employer's plan, COBRA, or any other private coverage
- Health club dues
- Household help, even if such help is recommended by a physician
- Illegal medical services or supplies
- Maternity clothing
- Medical savings account (MSA) contributions
- Medical plan expenses prior to meeting the deductible, if you are enrolled in a Limited Healthcare FSA
- Over the counter health aids or medication, not for medical care (example: vitamins, weight loss aids)
- Nutritional supplements
- Personal use items, unless the item is used primarily to prevent or alleviate a physical or mental defect or illness
- Prescription drugs for cosmetic purposes
- Weight-loss programs not prescribed by a doctor for a specific disease
- Special schooling for a child, even if the child may benefit from the course of study or disciplinary methods
- Transportation to and from work, even if a physical condition requires special means of transportation
- Up-front patient administration fees paid to a physician's practice
- Vitamins or minerals taken for general health purposes

Your Dependent Care FSA

You can use the Dependent Care FSA to reimburse yourself with tax-free funds for certain employment-related dependent care expenses.

Eligibility

If you are married, you may be reimbursed for expenses from the Dependent Care FSA only for expenses incurred while your spouse works or is actively looking for work, or if your spouse:

- Has no earned income for the year; and
- Is a full-time student for at least five months of the year; or
- Is incapable of caring for themselves or for the dependent.

Who Qualifies as a Dependent

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

- Children who are under age 13 when the care is provided and for whom you can claim an exemption on your federal income tax return;
- Your spouse or other dependent who is mentally or physically incapable of self-care, who lives with you for more than half of the year, and whom you claim as a dependent on your federal tax return (or who you could have so claimed except such individual's earnings exceed the amount permitted for IRS tax exemption purposes).

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

Eligible Dependent Care Expenses

The Dependent Care FSA is strictly monitored by the IRS, and only those expenses that comply with Section 129 of the Internal Revenue Code of 1986 are covered. Keep in mind that the expenses must be work-related to qualify as eligible expenses. The IRS considers expenses "work-related" only if they meet both of the following rules:

- They allow you (and your spouse) to work or look for work; and
- They are for the care of a qualified dependent.

You can pay the following work-related expenses through your Dependent Care FSA:

- Wages paid to a babysitter, unless you or your spouse claims the sitter as a dependent.
- Care can be provided in or out of your home.
- Services of a Dependent Care Center (such as a daycare center or nursery school) if the facility provides care for more than six individuals (other than those who reside there), receives a fee, payment or grant for providing its services, and complies with all applicable state and local laws and regulations.
- Cost for adult care at facilities away from home, such as family daycare center, as long as your dependent spends at least 8 hours at home.
- Wages paid to a housekeeper for providing care to an eligible dependent. Household services, including the cost to perform ordinary services needed to run your home that are at least partly for the care of the qualifying individual, are covered as long as the

person providing the services is not your dependent under age 19 or anyone you or your spouse claim as a dependent for tax purposes.

If you have any questions about what is considered an eligible expense under the Dependent Care FSA, you may call WexHealth Participant Services at 866.451.3399. You may also contract your local IRS office or visit the IRS website and review Publication 503 at http://www.irs.gov/.

Ineligible Dependent Care Expenses

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

- Allow you to participate in leisure-time activities;
- Allow you to attend school part-time;
- Enable you to attend educational programs, meetings or seminars; or
- Are primarily medical in nature (such as in-house nursing care).

In addition, expenses for education (such as kindergarten fees) can not be reimbursed from this account, nor can expenses for overnight camp.

Claiming Reimbursement

When You Can File Claims

Expenses must have been incurred during the Plan Year (or portion of the year during which you participate in that account). An expense is incurred when the service that gives rise to the expense is provided. When the expense is billed, charged or paid is irrelevant.

You may not be reimbursed for any expense arising before the plan becomes effective or for any expense incurred after the close of the plan year (other than due to the grace period), or after a separation from service or other loss of coverage.

For example, orthodontia payments, even if billed, will not be considered a healthcare expense under this plan until after the service has been provided. Orthodontia expenses will be reimbursed by this plan only if the expense has been incurred within the plan year. Lump sum payments or services paid in advance of the service being rendered are not reimbursable under this plan except as provided below.

Orthodontia expenses may also be reimbursed if a reasonable payment schedule or service contract with expense detail is provided with the claim. A reasonable payment schedule or service contract must be prepared by your dentist and must illustrate what orthodontia services are to be provided, when the services are planned to be provided

(identified by month and year) and the corresponding projected expenses associated with those services. An example of a reasonable payment schedule or service contract may include a down payment for initial services provided, and subsequent proportional payments in anticipation of follow up services. Lump sum payments or services paid in advance of services being rendered are not reimbursable under this plan in absence of a reasonable payment schedule or service contract.

WexHealth Flexible Spending Card

Participants will receive a WexHealth Flexible Spending debit card in the mail. Please activate the card when you receive it so that you will be able to use the care to use it immediately to pay for qualified expenses. Use of the card is subject to WexHealth's rules and procedures. By using the care you are certifying that you will only use the card for eligible medical expenses, that the expenses has not been reimbursed or cannot be reimburse from a medical plan, than you will not seek reimbursement from any other plan for any expenses for which you use this card and that you will retain sufficient documentation for expenses paid with the card. Each time you use the card; you are reaffirming these requirements.

Use of the WexHealth Flexible Spending Card is purely for convenience. IRS regulations still require participants to retain receipts for any eligible expense they pay using the card and to provide a copy of those receipts when requested. Failure to provide the required documentation may result in the deactivation of your card. You must obtain and retain the documentation necessary to substantiate your Healthcare FSA claim. Please note that a payment receipt may not be sufficient for medical and dental services, so check with WexHealth to determine what supporting documentation is required.

There are a few circumstances where healthcare expenses purchased with the WexHealth Flexible Spending card will be substantiated automatically. For example, payments to a healthcare provider that match the medical plan copay amount and certain recurring charges that were previously approved may not have to be substantiated. However, you should always keep documentation (such as an itemized bill or an Explanation of Benefits (EOB) necessary to support any transactions made with your debit card even if you think your expense will not require substantiation.

The FSA Plan Administrator, WexHealth, will request verification of most expenses which are purchased using the WexHealth Flexible Spending card. When you receive a request for substantiation of an expense, you must submit appropriate supporting documentation. If you do not have the required documentation or the expense is not eligible, you may submit a different eligible and previously unreimbursed Healthcare FSA expense or you may repay

the expense. If you do not timely respond to the request for substantiation, your privileges under the WexHealth Flexible Spending card may be suspended or terminated.

If an expense reimbursed by the health FSA is later determined to not be eligible for reimbursement, or you do not provide the required documentation substantiating the expense and do not take other corrective steps within the required timeframe, the excess reimbursements may be recovered by:

- Offsetting the excess against other eligible Healthcare FSA expenses submitted for reimbursement (if any are available); or
- Reporting such amount on your W-2 as income
- Withholding such amounts from your pay as an after-tax deduction (to the extent permitted under applicable law)
- Any other collection action permitted by law

Documenting Your Claim

Healthcare Expenses

If you do not use your debit card, you can file a claim for reimbursement by completing the online FSA reimbursement claim form in the WexHealth Flexible Spending portal, found under the Accounts tab (click "I want to" and click "Reimburse Myself" then choose the Medical Account in the drop-down menu.)

When you submit a claim for reimbursement from your Healthcare FSA, you must provide a copy of:

- The Explanation of Benefits (EOB) you received from your healthcare plan showing how much, if any, of your claim was paid; or
- Itemized bills from suppliers for expenses not covered by any healthcare plan. The itemized bill should include the following information:
    - Patient name;
    - Provider name;
    - Diagnosis;
    - Service or service provided;
    - Charge; and
    - Date of service

Your claim will not be accepted if the required information is not provided. If substantiating documentation is not provided within 30 days of the request for documentation, future

claims will not be reimbursed, and the flexible spending card will be suspended for further charges until appropriate substantiation has been received.

Dependent Care Expenses

Complete the online FSA reimbursement claim form in the WexHealth Flexible Spending portal, found under the Accounts tab (click "I want to" and click "Reimburse Myself" then choose the Dependent Care Account in the drop-down menu.) You must provide the following information in your claim submission:

- Dependent's name;
- Provider's name, address and tax ID (or Social Security) number;
- The cost, nature and place of the service(s) performed;
- Proof of payment; and
- An indication of whether the provider is related to you and, if so, how (if the provider is your child, you must also include the child's age)

You may ask your dependent care provider to sign the claim form as verification of payment. Detailed bills or receipts are also considered acceptable documentation for dependent care expenses. You are also required to report your provider's taxpayer identification number or Social Security number when you file your tax return.

Reimbursement

WexHealth processes FSA claims as they are received, and issues FSA claim payments. You can be reimbursed through your Healthcare FSA for qualifying healthcare expenses up to the annual pledge amount you elected an enrollment – even if not all of it has been deducted from your paychecks.

You can be reimbursed for dependent care expenses only up to the amount in your Dependent Care FSA when you file a claim. Any unpaid amounts still due to you will be processed in the next claim cycle when (and if) you have enough money in your Dependent Care FSA to cover them.

You may find statements and explanations of transactions, denials, payments and your current balance on the WexHealth FSA portal. Contact information for the FSA administrator is:

WexHealth Health, Inc.
PO Box 2926
Fargo, ND 58108-2926
Participant Services 866.451.3399

How to Appeal a Denied Claim

If your claim is entirely or partially denied, the reason(s) for the denial will appear in the WEXHEALTH FSA portal. See below for more information on claim denials and your right to appeal a denial. If you would like your claim reconsidered, you must submit a written appeal within the required deadline.

Healthcare FSA Claims and Appeals

If a claim for Healthcare FSA benefits is denied in whole or in part, WexHealth will notify you of an adverse benefit determination within a reasonable period, but in no event later than 30 days after receipt of a claim. An adverse benefit denial is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit. A 15-day extension may be allowed for Wex to make a determination, provided WexHealth determines that the extension is necessary due to matters beyond its control and notifies you of the need for an extension.

The denial notice will include:

- The specific reason for the adverse benefit determination
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- Documentation to support the claim must be submitted within 30 days of notice of the need for substantiation to prevent suspension of the flexible spending card and denial of future reimbursements.
- Any internal rule, guideline or protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
- Additional documentation to resolve the unsubstantiated claim or repayment of the claim will be accepted until the plan year closes.

Dependent Care FSA Claims and Claims Relating to Eligibility Under the Plan

If you submit a claim regarding eligibility under the Plan or a claim under the Dependent Care FSA and it is denied in whole or in part, you will be notified of the adverse determination within a reasonable period, but not later than 90 days after receiving the claim. This 90-day period may be extended in certain circumstances.

If you think your claim has been wrongfully denied, you have 60 days after receiving the written denial to request a review. Your request for a review, called an appeal, must be submitted to WexHealth in writing. Be sure to explain why you think you are entitled to reimbursement and attach any documentation that will support your claim. WexHealth will

respond to your written request for a review within 60 days of receiving it. If a longer response time is required, WexHealth will notify you. WexHealth's decision is final and binding. You can also follow this procedure if you do not receive any response to your claim within 90 days after you have initially filed it with WexHealth. You will lose any right to bring legal action if you do not appeal in a timely manner.

If your claim relates to eligibility or otherwise does not relate to reimbursement or benefits under the FSA, you must submit the claim, appeal and information supporting your claim and/or appeal to the Plan Administrator (not to WexHealth). The Plan Administrator has wide and absolute discretion to interpret and apply plan provisions and determine facts, benefits and eligibility. All interpretations, decisions, and determinations of the Plan Administrator are intended to be final, conclusive, and binding on all parties having an interest in the plan. Also, please refer to the section below regarding bringing legal action.

COBRA Continuation of Coverage

If coverage terminates due to a qualifying life event, you and your dependent(s) if applicable, can still contribute to the Healthcare FSA on an after-tax basis through the end of the calendar year. In certain cases (such as following termination of employment), the Cooperatives COBRA Administrator will notify you or your dependent(s) when you (or they) are eligible for continued coverage. In other situations, such as divorce, you have the obligation to provide written notice of a qualifying life event to the Cooperative at the address and/or email provided in this SPD – no later than 60 days following the date of the event so COBRA can be offered.

Even though COBRA rules allow you to take up to 60 days to notify the Cooperative about a divorce, remember that you only have 30 days to modify your election during the year. If you fail to notify the Cooperative within 30 days of the divorce (or other qualifying life event), then you will not be able to change or revoke your election under the Healthcare FSA for the remainder of the Plan Year. Of course, this will not affect your dependent's right to elect COBRA. If you of your dependents do not provide the required notice on time, you or your dependent, as applicable, will not have the right to elect COBRA.

Once you are notified of your right to elect COBRA, you have 60 days to respond and submit your election if you want to continue coverage. If COBRA is elected, the entire cost of coverage plus a 2% administrative fee must be paid for the duration of the COBRA continuation period. In addition, you will have 45 days from the date of your election to submit your required contribution for the first month. Future payments are due each month. Please refer to your COBRA notice for additional important information.

Non-Assignment of Benefits

You cannot assign, pledge, borrow against, or otherwise promise any benefit payment provided by the Plan before receipt of that benefit payment. However, benefits will be provided to your child if required by a Qualified Medical Child Support Order. In addition, subject to your written direct, all or a portion of benefit payments provided by the Plan may, at the option of the plan, and unless you request otherwise in writing, be paid directly to the provider rendering a service to you. Any benefit payment made by the Plan in good faith pursuant to this provision dully discharges the Plan to the extent of such payment.

In addition, you may not assign your rights to bring a lawsuit under the Plan to any providers or other persons who may provide or render any treatment or services to you or your dependents.

Legal Action and Exhaustion of Appeals

You must use and fully exhaust all your actual or potential rights under the Plan's administrative claims and appeals procedures by filing an initial claim and then filing a timely appeal of any denial before filing suit in court. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Any such suit must be filed within one year after receiving a final adverse benefit determination on appeal or two years after the date the claim arose. Failure to follow the Plan's administrative claims and appeals procedures in a timely manner will cause you to lose your right to bring legal action.

Restriction of Venue

Any claim, suit or action filed in court or any other tribunal in connection with the Plan by or on behalf of a Claimant shall only be brought or filed in the Court of Common Please Civil Division located in Franklin County, Ohio.

Discretionary Authority

The Plan Administrator and WexHealth (with respect to any matters delegated to it) have the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decision on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the plan will be paid only if the Plan Administrator or WexHealth, as applicable, decides in its discretion that a participant is entitled to them.

Amendment or Termination of the Plan

The Cooperative has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified. The establishment of an employee benefit plan does not imply that employment is guaranteed for any period or that any employee receives any non-forfeitable right to continued participation in any benefits plan.

HIPAA Privacy and Security

For important information about how the Healthcare FSA can use and disclose protected health information, and about your rights under the HIPAA privacy rule, please refer to the Plan's Notice of Privacy Practices. This notice also sets out the Plan's legal obligations concerning your protected health information and describes your rights to access and control your protected health information.

Definitions

Benefits- Your right to payment for Covered Flexible Spending Account services that are available under the Plan. Your right to benefits is subject to the terms, conditions, limitations and exclusions of the Plan.

Claims Administrator- The companies (including affiliates) that provide certain claim administration services for the Plan including WexHealth.

Claim Determination Period- The calendar year

Dependent Care FSA-A flexible spending account that may be used to pay for eligible child or adult care expenses. This includes childcare for children under the age of 13 and day care for an individual of any age who is incapable of self-care, lives with the taxpayer for more than one-half of the tax-year and is either the taxpayer's spouse or dependent.

Documentation- IRS regulations require that claims and certain card transactions be substantiated with appropriate documentation. Documentation includes the insurance carrier Explanation of Benefits (EOB), provider itemized statement or pharmacy receipt, and detailed cash register receipt with the merchant's name, product name, date and amount of purchase.

Eligible Medical or Dental Expenses-Expenses incurred by the Employee or the Employee's Spouse or Dependents that are eligible for reimbursements.

Grace Period- The period after the end of the Plan Year. During this period, unused account balances that remain at the end of a Plan Year may be used for incurred expenses. (Until March 15 for Dependent Care and March 31 for Healthcare)

Participant-A person who is an Eligible Employee and who is participating in the Plan.

Plan Year-The annual accounting period of the Plan.

Standard Healthcare FSA-A flexible spending account that may be used to pay for eligible medical, dental, vision and prescription drug expenses.

Use It or Lose It-Rule pursuant to Section 125 of the Internal Revenue Code. Under this rule, any money left unspent at the end of the coverage period is forfeited.

WexHealth Flexible Spending Card-A debit card that you may use electronically to access your flexible spending account to pay for eligible expenses. You may use the card at qualified merchants including doctor and dental offices, hospitals, pharmacies, and hearing/vision care centers.