Summary Plan Description

of the

KENT COUNTY
FLEXIBLE BENEFITS PLAN

May 2015

INTRODUCTION

The County of Kent, Michigan (the "County") maintains the **Kent County Flexible Benefits Plan** ("Plan") for the benefit of its employees. The Plan allows you to design your own benefits package to suit your individual needs.

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of the Plan. The Summary Plan Description is based upon the Plan provisions in effect as of January 1, 2015.

You should carefully read this Summary Plan Description and keep it for future reference. This Summary Plan Description does not replace the provisions of the Plan document. The Plan document governs the operation of the Plan. Every effort has been made to make this Summary Plan Description as complete and accurate as possible, without making it overly technical. In the event of any difference between the Summary Plan Description and the Plan document, the terms of the Plan document will control.

If you have any questions about the Plan, please contact the Human Resources Department.

KENT COUNTY

May 2015

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WHAT IS THE FLEXIBLE BENEFITS PLAN?

The Flexible Benefits Plan is a plan which allows you to design a benefits package to suit the individual needs of you and your family. You have the following benefit choices under the Plan:

- You may elect to pay your portion of the premium for health coverage under the County's group health plan on a pre-tax basis.

- You may reduce your compensation on a pre-tax basis to pay the premium for any supplemental insurance coverages (excluding life insurance) that the County makes available to employees.

- You may waive the County-provided health coverage and receive additional compensation from the County. In order to waive coverage, the County may request that you certify that you are enrolled in other health coverage (for example, through your spouse's employer).

- You may elect to reduce your pay to be reimbursed on a pre-tax basis for certain qualifying medical expenses.

- You may elect to reduce your pay to be reimbursed on a pre-tax basis for certain qualifying dependent care expenses.

More information regarding the types of tax-free benefits which you may choose and the procedures for making your benefit elections are explained in the following sections of this Summary Plan Description.

References are made throughout this Summary Plan Description to the "plan year." Benefits under the Plan are elected on a plan year basis. The plan year is the 12-month accounting period for the Plan which is January 1 through December 31. Any references to "calendar year" also mean the 12-month consecutive period beginning January 1 and ending on December 31.

References are also made throughout this Summary Plan Description to your "spouse" and your "dependents." For purposes of paying premiums for health and other coverage which includes spouses and dependents, the Plan relies on the definitions of those terms in the underlying documents for that coverage. For purposes of obtaining reimbursement for qualifying expenses from your flexible spending accounts, the definition of spouse means your legally married spouse, based on the laws of the state or jurisdiction where the marriage occurs. For other purposes under the Plan, such as determining whether required contributions for coverage can be paid pre-tax, and the maximum contribution limits for dependent care spending accounts, these terms are defined in accordance with the Internal Revenue Code and federal regulations.

ELIGIBILITY AND PARTICIPATION

Eligibility and Beginning of Participation

You are eligible to participate in the Plan if you are an active regular full-time employee of the County who is regularly scheduled to work at least 80 hours per pay period or if you are an active regular part-time employee of the County who is regularly scheduled to work at least 40 hours per pay period. Only employees who are eligible for the County-provided medical coverage are eligible to participate in the medical flexible spending account.

If you are an eligible employee, your participation in the Plan begins on your date of hire provided it occurs on the first day of the month, or on the first day of the month immediately following your date of hire. County Commissioners will be eligible for the Plan.

Termination of Participation

If you terminate employment with the County, or otherwise become ineligible to participate in the Plan, your participation in the Plan will terminate on the last day you are an eligible employee. Subject to the terms of any applicable collective bargaining agreement (for example, extending benefits in the event of layoff), your termination will have the following consequences:

- You will no longer be eligible to use pre-tax income to pay for coverage under the County's group health plan or for any supplemental insurance coverages made available by the County.

- You will no longer be eligible to receive additional compensation from the County for waiving the County-provided health coverage.

- You will no longer be eligible to set aside additional pre-tax income to pay for the reimbursement of certain medical expenses or dependent care expenses.

    - If you have an amount remaining in your medical flexible spending account when you stop participating in the Plan, you may continue to turn in claims for reimbursement of expenses incurred before you terminated participation. You are generally not eligible to be reimbursed for claims occurring after you terminated participation. If you have an amount remaining in your medical flexible spending account when you stop participating in the Plan you may be eligible to continue participation pursuant to COBRA (see the "Other Rules Regarding Your Flexible Spending Accounts" subsection later in this Summary Plan Description).

    - If you have an amount remaining in your dependent care flexible spending account when you stop participating in the Plan, the

amount in your account may continue to be applied toward the reimbursement of claims for eligible expenses incurred through the date your participation terminated.

In addition, the County may terminate your participation in the Plan for cause, which includes a termination for fraud or misrepresentation in an application for enrollment or a claim for benefits.

If you are rehired during the same plan year in which you terminate employment, there are special rules which may apply to you. If you become eligible to participate in the Plan again during the same plan year, you should contact the Human Resources Department for the details regarding these special eligibility rules.

BENEFIT CHOICES

For each plan year, you may choose from the following benefits:

Health Insurance Benefits

The County maintains a group health plan which provides you and your dependents with health coverage. You may be required to pay a portion of the cost of the health coverage if you decide to participate. You have two choices with regard to the health coverage for you and your dependents:

- You may elect to receive the health coverage and pay your share of the cost with your pay reductions. The cost of your coverage may depend on various factors, such as whether coverage is elected for you only or you and one or more of your dependents.

- You may elect to waive the health coverage if you have other health insurance coverage (for example, from your spouse's employer). If health coverage is waived, you may be required to certify that you have alternate health coverage. The certification shall be on a form provided by the County for this purpose. Depending on your job classification, the County may pay additional compensation to you if health insurance coverage is waived. You will receive this additional pay in your paychecks during the plan year for which health insurance coverage was waived. The County will inform you of the time table for paying the additional compensation (for example, in equal installments over each pay period or quarterly, in a lump sum at year end, etc.). The additional compensation is subject to tax withholdings.

Supplemental Insurance Benefits

The County may make supplemental insurance coverages available to you. If you want to purchase any of these other insurance coverages, you may pay the cost with your pay reductions.

Flexible Spending Accounts

You may use your pay reductions to obtain reimbursement of qualifying medical expenses and/or dependent care expenses (see the "YOUR FLEXIBLE SPENDING ACCOUNTS" section for details).

YOUR PAY REDUCTIONS

You may select different types of tax-free benefits under the Plan by reducing your pay to purchase the benefits. For each plan year, you may elect to reduce your pay for each pay period in an equal amount. Your W-2 Form (which you use to compute your income taxes) will be reduced by the total amount of your pay reductions so you will not pay income taxes on this portion of your pay. In addition, your pay reductions are not subject to FICA.

The advantage to you is that, unlike money you receive in your paycheck, there is no income tax or FICA withheld on the benefits you receive. Therefore, if you know you will need health coverage under the County's group health plan, or coverage under one of the supplemental insurance coverages the County makes available to you, or will incur an expense which may be reimbursed through your flexible spending accounts, you could reduce your pay and obtain the coverage or pay the reimbursable expense with "before-tax" income rather than "after-tax" income.

The only disadvantage is that the pay reductions reduce the amount of your pay that is reported to the Social Security Administration. This may cause a small reduction in the amount of your Social Security benefits.

You may elect to reduce your pay as provided in the election process. The election procedures will be provided to you during the open enrollment period (see the "CHOOSING YOUR BENEFITS" section below).

CHOOSING YOUR BENEFITS

This section describes the procedure for choosing benefits under the Plan. You may generally not change your election during the plan year, except as described below.

Initial Benefit Selection

Generally, you must make an election within four days of becoming eligible to participate in the Plan. The County will inform you of the election procedures. The election process may require the completion and return of a written election form and/or may require you to make your election electronically such as through an online computer system or telephone system. After you make your choice, you may change your election only during an open enrollment period or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

If you do not make an election before the date that you become a participant in the Plan, you will not be eligible to pay your cost of coverage under the County's group health insurance plan or for any supplemental insurance coverages available through the County on a pre-tax basis for the remainder of the plan year. You will not be eligible to receive any additional compensation for waiving health coverage. Your right to reimbursement from the flexible spending accounts will also be waived for the remainder of the plan year. Instead, you will receive your regular pay for the remainder of the plan year through the County's payroll system.

There is an exception to these rules if you are a new employee who becomes eligible to participate in the Plan on your date of hire. In this situation, if you make your election within the next 30 days after you start working, the election will be retroactively effective to your first day of employment.

Annual Benefit Selection

For each type of benefit, there will be an open enrollment period before the start of each plan year. You may make a new election during the open enrollment period for each plan year. The new election will become effective as of the first day of the next plan year and will remain in effect through the last day of the plan year. After the plan year begins, you may change your election only during the next open enrollment period for that particular benefit or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

If you do not make a new election during the open enrollment period, your prior elections regarding the health insurance plan and any supplemental insurance coverages made available by the County will be continued. You will be considered to have agreed to pay the appropriate premium for the subsequent plan year for this coverage. If the current health insurance election in which you are enrolled is not being offered during the subsequent plan year, you will be enrolled in the designated replacement option. However, no pay reductions will be credited to your flexible spending accounts unless you make a new election for each plan year.

CHANGING YOUR ELECTION DURING A PLAN YEAR

As a general rule, you may only change your benefit election annually during an open enrollment period. However, you may change your election during a plan year in certain situations for which federal law permits a new election. The next sections describe these situations.

Change In Status

A change in status is an exception to the rule prohibiting any change during a plan year in your benefit election. A change in status is limited to situations where your status has changed during the plan year and this change affects the benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment;

- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;

- An event affecting the employment status of you or your spouse or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status which affects an individual's eligibility for benefits;

- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, or any similar circumstance; or

- A change in the place of residence of you or your spouse or dependent that affects your previous election.

If you have a change in status, you may change your election under the Plan only if the election change is on account of, and corresponds with, the change in status that affects eligibility for coverage. However, the following special rules apply:

- If you want to decrease or cancel the County-provided health coverage because you become eligible for coverage under the plan of the employer of your spouse or dependent due to a legal marital or employment change in status, the change will only be permitted if coverage is or will be actually obtained under the other plan.

- With respect to any supplemental group term life insurance benefit election, an election to increase or decrease coverage will be permitted.

- With respect to your medical spending account, you may elect to decrease your annual contribution amount, but not below the amount that has already been reimbursed to you for the plan year.

- With respect to your dependent care spending account, an election change may be made if your dependent attains age 13 or becomes or ceases to be totally disabled.

If you have a change in status during a plan year, you may make a new election within 30 days after the change in status occurs. The new election will be effective at the time determined by the plan administrator. If you do not make a new election within 30 days after the change in status, you must wait until the next open enrollment period to change your election. Further, any new election involving a third party insurer will only be approved to the extent permitted by the third party insurer.

Changes to Coordinate with Health Care Reform

Under Health Care Reform, you may become eligible for the County-provided group health coverage for a period of time and not lose eligibility even if you have a change in employment status where your hours of service will be reasonably expected to be reduced to an average of less than 30 hours of service per week. If this occurs, you can elect to cancel the County-provided group health coverage even if the reduction in hours does not result in you ceasing to be eligible for the coverage. You may revoke coverage in this situation for yourself and any affected family members provided that you enroll in another plan that provides "minimum essential coverage" (as that term is defined under Health Care Reform) which is effective no later than the first day of the second month following the month that includes the date your County-provided group health coverage is revoked.

Similarly, if you are eligible to enroll in a "qualified health plan" (as that term is defined under Health Care Reform) through an Exchange during a special enrollment period or annual open enrollment period, you can elect to cancel the County-provided group health coverage. This election is permitted provided that the revocation corresponds to the intended enrollment of you and your family members, if applicable, in a qualified health plan which is effective no later than the day immediately following the date your County-provided group health coverage is revoked.

FMLA Leaves and Other County-Approved Leaves of Absence

If you go on an FMLA leave, you may continue or revoke your elections regarding group health coverage and/or your medical spending account even if you do not otherwise have a change in status. If you go on an FMLA leave, the following rules apply:

- Generally, the maximum FMLA leave period is 12 weeks per 12-month period (as that 12-month period is defined by the County). However, if you take an FMLA leave to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA leave is 26 weeks per 12-month period.

- You may continue or revoke your election of these benefits when you begin your FMLA leave.

- If you continue all or a portion of your election, you must continue making the necessary contributions for the benefits. You should contact the Human Resources Department to discuss the procedures for making the contributions.

- If you terminated coverage during the FMLA leave, your coverage may be reinstated when you return to work. Reinstatement will occur immediately.

- You have the same election rights as an actively working participant during an open enrollment period and if a new or significantly improved benefit or coverage option is offered.

- If you take an unpaid FMLA leave and you receive additional compensation from the County for waiving health coverage, you will not receive this additional compensation for the time period when you are on the unpaid leave.

- If you terminate coverage in your medical spending account during the FMLA leave, your account cannot be used to reimburse expenses incurred during the FMLA leave. Also, your total benefits during the plan year may be reduced on a pro rata basis for the time period in which your coverage was not in effect.

- If you do not return to work at the end of an FMLA leave, your participation in the Plan will terminate.

The rules described above will also apply if you go on a non-FMLA County-approved paid leave of absence.

Special Enrollment Rights Under HIPAA

You may have special rights under HIPAA to enroll in the County's group health plan in these situations:

- You have lost other group health coverage. This could occur if your COBRA rights under the other plan were exhausted or you became ineligible for the other plan for a reason other than the nonpayment of premiums. You must make your new election within 30 days after the event occurs.

- You acquire a new dependent by marriage, birth or adoption. You must make your new election within 30 days after the event occurs.

- Your Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or you become eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under the County's group health plan. ("CHIP" is a state children's health insurance program.) You must make your new election within 60 days after the event occurs.

Court Order

You may change your election regarding the County's group health plan because of a court order resulting from a divorce, legal separation or change in legal custody that requires health coverage for one or more of your children. Specifically, you may:

- Elect coverage for the child if the court order requires you to add the child to the County-provided health coverage in which you are enrolled; or

- Cancel coverage for the child if the court order requires the spouse, former spouse or other person to provide coverage and the other coverage is actually provided.

Medicare or Medicaid Coverage

If you or one of your dependents becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce coverage for that individual under the County's group health plan. In addition, if you or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase coverage for that individual under the County's group health plan.

Cost and Coverage Changes

If the cost of coverage under the County's group health plan or one of the County's supplemental insurance plans in which you participate changes during the plan year, your compensation reductions may be automatically adjusted. However, if the cost increase is significant, you may either, agree to the increase, change your election to another comparable benefit option, or drop coverage if no other comparable benefit option is available. However, coverage may be dropped only if you certify that you have other health coverage. Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease is significant, you may elect the reduced cost option even if you did not previously elect it for the plan year.

With respect to your dependent care spending account, if the cost of your dependent care provider changes during the plan year you may adjust your election. However, this opportunity is not available if the dependent care provider is your relative.

If coverage under the County's group health plan or one of the County's supplemental insurance plans in which you participate is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. However, coverage may be dropped only if you certify that you have other health coverage. Further, if the County offers a new or significantly improved benefit or coverage option, you may prospectively elect the new or significantly improved option.

Finally, if you or your spouse or dependent has a change in coverage under another group health plan where the change is as a result of one of the circumstances described in this section or where the change is made during the annual open enrollment period of the other plan, you may make a corresponding election change under this Plan.

YOUR PREMIUM PAYMENTS

If you elect to receive coverage under the County's group health plan or a supplemental insurance plan provided by the County, your pay will be reduced by the amount stated in your election. Your premiums will automatically be paid when they come due. However, if your employment is temporarily interrupted and you do not receive pay, you must make arrangements with the County to pay your share of the premiums in order to continue coverage.

YOUR FLEXIBLE SPENDING ACCOUNTS

There are certain medical expenses that you or your family may incur that are not covered under the County's group health plan. Also, if you have children or other dependents, you may have to pay others to provide care for them while you are at work. You may be reimbursed for these medical and dependent care expenses under your flexible spending accounts. Your flexible spending accounts allow you to pay certain qualifying expenses using "before-tax" income rather than "after-tax" income. Your pay reductions are converted into the tax-free reimbursement of certain qualifying expenses.

The flexible spending accounts operate as follows. The County will establish a separate bookkeeping account in your name for each tax-free reimbursement benefit you choose for a plan year. For example, if you choose both of the tax-free reimbursement benefits available under the Plan, the County will establish the following accounts in your name:

- Medical spending account; and
- Dependent care spending account.

The County will allocate your pay reductions to each account in the amount indicated in your election. When a claim for reimbursement is paid, the amount paid will be subtracted from the applicable flexible spending account. You may not use amounts allocated to one account to receive reimbursement for another type of benefit.

Medical Spending Account

What Amount of Pay Reductions Should I Allocate to My Medical Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your medical spending account and, if so, how much to reduce your pay. The County will inform you during the open enrollment period of the maximum amount you may have credited to your medical spending account for the plan year. Federal law does not allow you to contribute more than $2,550 to your medical spending account per plan year. This is the limit for 2015. This amount may be adjusted in future taxable years for changes in the cost of living.

If you know you will have qualifying medical expenses during the plan year which will not be covered by the County's group health plan or another health

plan in which you participate, you should consider putting enough in your medical spending account to cover these planned-for expenses. The amount in your account will be used to pay all the qualifying medical expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the amount to put in your medical spending account, it is wise not to put in too much. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year (December 31) and the 2½-month grace period (March 15), all unused amounts must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Medical Spending Account?

Qualifying Individuals

Your qualifying medical expenses may be reimbursed under the Plan. Qualifying medical expenses may be incurred for:

- You;
- Your legally married spouse;
- Your natural child, your adopted child, a child placed with you for adoption, your step-child or your foster child through the end of the month in which the child turns age 26; or
- Other children, relatives and members of your household who are your "qualifying child" or "qualifying relative" under IRS guidelines.
    - A qualifying child is your child or other relative who is younger than you, who lives with you, who does not provide more than half of his or her own financial support and who meets certain other requirements. Such an individual will be your qualifying child until the end of the calendar year in which the individual turns 18 or 23 (if a full-time student). However, this age requirement is waived for a qualifying child who is totally disabled.
    - A qualifying relative is your child, other relative, or member of your household for whom you provide over half the individual's financial support and the individual is not the qualifying child of you or any other individual.

Qualifying Medical Expenses

Qualifying medical expenses are generally those types of medical expenses normally deductible on your federal tax return (without regard to the adjusted gross income limitation which is generally 10%). They include, for example, expenses you have incurred for:

- Copays and deductibles you must pay before your group health plan begins to pay benefits.
- Vaccines, medicine and drugs that require a prescription (for example, birth control pills).
- Over-the-counter drugs and medicines specifically prescribed by a physician or if the drug is insulin.
- Medical supplies such as bandages and crutches.
- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
- Medical examinations, x-rays and laboratory services, insulin treatments and whirlpool baths the doctor ordered for a specific medical condition.
- Lasik (laser) eye surgery.
- Nursing help. If you pay someone to do both nursing and housework, only the nursing help may be reimbursed as a qualifying medical expense. However, housework may qualify for reimbursement under your dependent care spending account.
- Hospital care (including meals and lodging), clinic costs and lab fees.
- Medical treatment at a center for the treatment of alcohol or other substance abuse.
- Medical aids such as hearing aids (and batteries), dentures, eyeglasses, contact lenses, braces, orthopedic shoes, wheelchairs, guide dogs and the cost of maintaining these aids.
- Ambulance service and other travel costs to get health care. If you used your own car, you may claim what you spent

for gas and oil to go to and from the place you received the care, or you may claim the mileage reimbursement rate allowed by federal law. You may add parking and tolls to the amount you claim under either method.

- Expenses for weight-loss programs as a treatment for obesity. This includes the fees to join the program, but not the cost of food.

- Massage therapy prescribed by a physician to treat a medical condition.

- Body scans and other diagnostic procedures, including pregnancy kits, ovulation monitors and on-site health fairs that check items such as blood pressure and cholesterol.

- Teeth whitening to correct discoloration caused by disease, birth defect or injury, but not to correct discoloration caused by aging.

- Cord blood storage if a child is born with a medical condition where cord blood may be needed in the future, but not if storing it just in case of a future need.

Many of the expenses listed above are covered by the County's group health plan. Any expense covered by that plan or any other source will not be treated as a qualifying medical expense under the Plan.

Expenses are considered to be incurred when the services are rendered or supplies are provided, not when billed or paid. However, orthodontia services may be reimbursed before the services are provided but only to the extent that you have actually made payment in advance in order to receive the services. These orthodontia services are deemed to be incurred when you make the advance payment.

Special Rule for Health Savings Account Participants

A health savings account ("HSA") is a tax-favored IRA type of account established for an eligible individual who is covered only by a qualified high deductible health plan. The County currently does not offer a qualified high deductible health plan.

If you have a spouse or dependent who participates in an HSA and qualified high deductible health plan (for example, through his or her employer), you and your dependents should not participate in the medical spending account portion of this Plan for the entire plan year in which your spouse or dependent participates in the HSA in order for your spouse or dependent to be eligible for the HSA. This is because the

medical spending account portion of this Plan is not a limited purpose one for you and therefore is an ineligible, non-high deductible health plan for HSA purposes.

Non-Qualifying Expenses

You **cannot** obtain reimbursement for the following expenses:

- The cost of health coverage. For example, you cannot obtain reimbursement for the premium you pay to obtain coverage under the County's group health plan or for the premium your spouse pays to obtain health coverage under his or her employer's group health plan. You also cannot obtain reimbursement for the premium for an individual health policy. However, you may purchase health coverage under other provisions of the Plan (see the "BENEFIT CHOICES" section above).

- Life insurance or income protection policies.

- The hospital insurance benefits tax withheld from your pay as part of the Social Security tax.

- Illegal operations or drugs.

- All non-prescription drugs and medicines unless specifically prescribed by a physician or if the drug is insulin.

- Items which are considered toiletries (such as toothpaste) or cosmetics (such as face cream).

- Travel your doctor told you to take for rest or change.

- Items purchased for cosmetic reasons.

- Cosmetic surgery, unless necessary because of injuries you receive, congenital disfigurement, or a disfiguring disease.

- Long-term care expenses.

- Health club dues.

- Expenses reimbursed by the County group health plan or any other source.

- Expenses incurred before you begin, or after you stop, making contributions to your medical spending account

except to the extent you are eligible to submit claims incurred during the 2½-month grace period.

How Do I Make a Claim for Reimbursement?

You should send your claims for reimbursement of qualifying medical expenses to the County or the benefit administrator the County has chosen. See the "ADMINISTRATION" section for the benefit administrator's name, address and telephone number.

You will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred, the name and address of the person or entity to which the expense was paid and a statement that the expense has not been paid or reimbursed by, nor will you seek payment or reimbursement under any other employer-sponsored plan, any federal, state, or other governmental plan or program, or any other source.

Your medical spending account resembles an insurance policy. You are entitled to uniform coverage throughout the plan year. For example, if you incur $100 of qualifying medical expenses during the first month of the plan year, you may be reimbursed for those expenses immediately, even if you only have $50 credited to your account during that month. However, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your medical spending account for the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after the benefit administrator receives the claim, but no less frequently than monthly. At the end of the plan year or subsequent 2½-month grace period, all claims will be paid to the extent of the balance in your medical spending account.

Claims for qualifying medical expenses incurred during a plan year or during the 2½-month grace period ending on the 15th day of the third month (March 15) of the next plan year may be reimbursed out of your account balance for the year.

If you submit a claim that was incurred during the grace period and you have an unused account balance with respect to the plan year just ended, the reimbursement will be credited against that account balance first until it is exhausted before being credited against your account balance for the next plan year. This allocation will occur after the grace period ends, to provide you with the most beneficial use of your account.

All claims for reimbursement must be filed no later than 90 days (March 31) after the end of the plan year. If you do not timely submit a claim, the claim will be denied. Any amount then remaining in your account will be forfeited (see the "Forfeitures" subsection).

Different rules apply if you terminate participation during the plan year:

- If you terminate participation before the end of the plan year, claims for expenses may only be reimbursed if the claims were incurred during the time period in which you were a participant.

- For this purpose, you will be considered not to have terminated participation during the plan year if you elect to continue participating in your medical spending account through the last day of the plan year through COBRA (see the "Termination of Participation" subsection).

Your medical spending account is not insured. Also, the benefit administrator, if one is chosen, is not an insurance company, but merely processes the claims. If for any reason the Plan or the County does not ultimately reimburse you for expenses that are eligible for reimbursement under the Plan, you may be liable for the expenses.

Your claims for benefits will be promptly processed, but in the event there are delays in processing claims, you will have no greater rights to interest or other remedies against the benefit administrator, if one is chosen, than as otherwise afforded by law.

HIPAA Privacy

The medical spending account is subject to the HIPAA privacy rules. You will receive a notice of the County's privacy practices which will explain, in detail, the HIPAA privacy rules and your privacy rights.

Dependent Care Spending Account

What is the Difference Between My Dependent Care Spending Account and the Dependent Care Tax Credit?

The Internal Revenue Code gives you two choices in the treatment of dependent care expenses for income tax purposes. First, you may pay for dependent care expenses with "pre-tax" income through the Plan. Second, you may claim a tax credit on dependent care expenses (up to $3,000 for one child and up to $6,000 for two or more children). However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the Plan.

What Amount of Pay Reductions Should I Allocate to My Dependent Care Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your dependent care spending account and, if so, how much to reduce your pay. If you know you will have dependent care expenses during the plan year, you should consider putting enough in your dependent care spending account to cover these

planned-for expenses. The amount in your account will be used to pay all the dependent care expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the proper amount to put in your dependent care spending account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation, you should take this into consideration when you determine the amount you want to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year (December 31), all unused amounts must be forfeited. (The 2½-month grace period does not apply to your dependent care spending account.)

What Types of Expenses Are Eligible for Reimbursement From My Dependent Care Spending Account?

Your dependent care expenses may be reimbursed under the Plan. Dependent care expenses are your expenses for certain services which your dependents need in order for you to be employed by the County.

The Internal Revenue Code defines who is considered your dependent for this purpose:

- Your dependent includes a qualifying child who is younger than you, who lives with you for more than half of the year, who does not provide over half of his or her own financial support for the year and who meets certain other requirements. A child of divorced parents who is under age 13 or totally disabled will be treated as a dependent of the custodial parent, even if the child is a dependent of the noncustodial parent for income tax purposes.

- Your dependent also includes a qualifying relative such as your parent who receives over half of his or her financial support for the year from you.

The types of services covered are:

- Care for your dependent in your home (such as babysitting), if the dependent is either:

    - Your qualifying child under age 13; or

    - Your spouse or qualifying relative who is totally disabled. A person is totally disabled if the person has a mental or physical condition which makes the person incapable of caring for his or her hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his or her personal safety or the safety of others.

- Care for your dependent outside of your home (such as in a day care center), if the dependent is either:

  - Under age 13; or

  - Totally disabled (as defined above) and regularly spends at least eight hours per day in your home.

  This also includes pay, per an agreement with your daycare provider, which is required in order to hold a place for your child(ren) during your short, temporary absence from work (for example, during vacation or your short term illness).

- Household services for the maintenance of your home (such as for a domestic maid or cook) as long as the services are performed in part for the benefit of your dependent.

May Amounts Paid to My Relatives Be Reimbursed?

You may hire whomever you want to provide services to your dependents. However, federal law provides that dependent care expenses cannot be reimbursed under the Plan if one of the following relatives provides the care:

- One of your dependents;

- Your spouse; or

- Your child (even if not your dependent), if your child is under age 19 on December 31 of the year during which the care is provided.

Are There Limits on How Much May Be Reimbursed?

Federal law limits the amount of dependent care expenses which may be reimbursed under the Plan. Generally, the limit is $5,000 per calendar year (or $2,500 if you are married and file a separate tax return).

However, if you earn less than $10,000 or your spouse earns less than $5,000, the limit is the lesser of your spouse's pay or ½ of your pay. A further limit applies if you and your spouse are filing separate tax returns. If your spouse is a full-time student or is totally disabled (as defined above) for any month in which you have dependent care expenses, your spouse will be considered to have the following pay for that month:

- $250, if you have dependent care expenses for one dependent; or

- $500, if you have dependent care expenses for more than one dependent.

How Do I Make a Claim for Reimbursement?

You should send your claims for reimbursement of dependent care expenses to the County or the benefit administrator the County has chosen. See the "ADMINISTRATION" section for the benefit administrator's name, address and telephone number. You will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the dependent care expense was paid. You will also need to provide or certify that you have obtained the taxpayer identification number (in the case of an entity) or the Social Security number (in the case of a person) of the entity or person that provided the dependent care. You are required to obtain this information in order to report your dependent care expenses with your tax return on IRS Form 2441.

A claim will only be paid to the extent of the balance in your account at the time the claim is filed. If the balance in your account is insufficient to pay the claim in full, the unpaid balance of the claim will be carried over and paid when a sufficient amount is credited to your account later in the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after the benefit administrator receives the claim, but no less frequently than monthly. At the end of the plan year, all claims will be paid to the extent of the balance in your dependent care spending account.

Claims for dependent care expenses incurred during a plan year may only be reimbursed out of your account for that plan year. Further, any amount remaining in your dependent care spending account at the time of your termination of participation may only be applied toward the reimbursement of claims for eligible dependent care expenses incurred through the date your participation terminated. All claims incurred during a plan year must be turned in no later than 90 days after the end of the plan year. If you do not timely submit a claim, the claim will be denied. Any amount then remaining in your account will be forfeited (see the "Forfeitures" subsection).

Other Rules Regarding Your Flexible Spending Accounts

Termination of Participation

If you terminate employment or otherwise become an ineligible participant under the Plan, you will be ineligible to have any additional pay reductions under the Plan credited to your medical spending account or dependent care spending account. **If you have amounts remaining in your medical spending account or dependent care spending account, you may continue to turn in claims for reimbursement of expenses incurred <u>before</u> you terminated employment.** You are not eligible to be reimbursed for claims under your medical spending

account occurring after you terminate employment unless you continue to participate in the Plan as described in the next paragraphs.

You have the option of continuing to participate in your medical spending account after you terminate participation to the extent required by the federal law known as "COBRA." (Also known as the Public Health Services Act in the case of governmental employers.) Under COBRA, if the amount contributed to your medical spending account for the plan year exceeds the claims you have submitted for the plan year, you will generally be eligible to continue to participate for the remaining portion of the plan year and subsequent 2½-month grace period during which your participation terminated. COBRA is generally not available for a subsequent plan year unless, pursuant to federal regulations, certain requirements are met (e.g., your medical spending account is not considered an excepted benefit under HIPAA).

If you are eligible to elect COBRA with respect to your medical spending account, you may continue participation by making after-tax contributions to the Plan on a monthly basis in an amount equal to 102% of the pay reductions which were allocated to your medical spending account each month before you terminated participation. After-tax contributions for a month must be paid by the first day of that month. However, there is a 30-day grace period for timely payment. Participation will be terminated if contributions are not made on a timely basis.

In order to protect your rights to COBRA, it is important that you inform the plan administrator of any changes in your address. If you have questions regarding COBRA, you should contact the plan administrator at Kent County, Human Resources Department, County Administration Building, 300 Monroe Avenue, N.W., Grand Rapids, MI 49503-2222, telephone: (616) 632-7440 or (616) 632-7441.

For information about your rights under COBRA, HIPAA and other laws affecting the Plan, you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA's website at www.dol.gov/ebsa. (Addresses and telephone numbers of the regional and district offices are available through EBSA's website.)

If you participate in the medical spending account and you go on a military leave of absence, the County will comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 with respect to the Plan. However, these requirements will only apply to the extent they provide you with more favorable coverage than under COBRA (i.e., coverage for a longer period of time or less costly coverage).

Forfeitures

Your pay reductions for each plan year may generally only be used to reimburse qualifying expenses incurred during that plan year. The only exception is that amounts in your medical spending account at the end of a plan year may be used to reimburse qualifying medical expenses incurred during the first 2½ months of the next plan year. For purposes of the Plan, an expense is "incurred" when the service is rendered or the supply is provided. However, see the special rule regarding orthodontia services in the last paragraph of the subsection entitled "Qualifying Medical Expenses."

Federal law requires the forfeiture of amounts remaining in your flexible spending accounts after expenses incurred during the plan year or the subsequent 2½-month grace period are reimbursed. A forfeiture will occur if you fail to use the entire amount in your medical spending account and dependent care spending account. You are not allowed to transfer unused amounts from one spending account to another spending account. You should be careful not to overestimate your expected expenses when you make your election. It is better to pay some of your expenses with after-tax income than to overestimate your expected expenses and have a forfeiture.

Appeal Procedure

If your claim under the flexible spending accounts has only been partially reimbursed, or is denied, you will be provided with written notice of the partial reimbursement or denial within 90 days after your claim is received, unless special circumstances require more time for processing the claim. If more processing time is required, you will be provided with written notice of the extension before the initial 90-day period is completed. The extension will not be longer than 90 days from the end of the initial period.

You may make a written request to the plan administrator for a review of the decision. Your written request must be made within 90 days after the mailing date of your reimbursement check or notice of denial. You must refer to the Plan provisions on which your request is based and state the facts you believe justify a reversal or modification of the original decision. You must also include any information requested by the plan administrator.

You may examine pertinent documents and submit pertinent issues in writing. You may also have an authorized representative act for you. The plan administrator will review your claim within 60 days after receiving your written request.

The Plan will not be required to pay interest on any claim for benefits, regardless of when paid. Also, if a check for the payment of Plan benefits is not cashed within one year after the date it is issued, the check will be dishonored.

ADMINISTRATION

The County is the plan administrator. The plan administrator is charged with the administration of the Plan. The plan administrator has the authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The plan administrator will exercise its discretionary authority in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the plan administrator has the discretionary authority to interpret the terms of the Plan.

The benefit administrator processes flexible spending account claims. The benefit administrator is Professional Benefit Services (PBS), 2959 Lucerne SE, Suite 205, Grand Rapids, MI 49546; telephone number (616) 285-2480.

FUTURE OF THE PLAN

The County intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan at any time. However, your pay reductions which occur before the amendment or termination will continue to be used for your benefit.