City of Spokane
Section 125 Flexible Benefits Plan

Summary Plan Description

Effective Date: June 1, 1989

Revised and Restated: January 1, 2013

Administered by:
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SECTION I: INTRODUCTION

City of Spokane is pleased to sponsor an employee benefit program that allows you to choose from several different insurance and fringe benefit programs according to your individual needs. City of Spokane provides you the opportunity to use pre-tax dollars to pay for them by entering into a salary reduction arrangement. This helps you because the benefit(s) you elect are nontaxable; you save social security and income taxes on the dollars in your salary reduction. Alternatively, you may choose to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The booklet is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. It is not a part of the official plan documents. If there is a conflict between them and this booklet, the plan documents will apply.

SECTION II: GENERAL Q&A

What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to use funds provided through employee salary reduction, to choose one or more of the Benefit Plans or Policies offered through the Plan, and enable them to pay for the selected coverage(s) with pre-tax dollars.

What is the Plan Year for this Plan?

The Plan Year is January 1 through December 31.

What benefits are provided by the Plan?

The Plan includes the following benefit plans:

- Insurance Premium Payment Benefit: permits an employee to pay for his or her share of insurance premiums with pre-tax dollars.
- Health Care FSA: also called a health flexible spending arrangement (health FSA) – that permits an employee to pay for his or her qualifying medical expenses (that are not otherwise reimbursable by insurance) with pre-tax dollars.
- Dependent Care FSA: permits an employee to pay for his or her qualifying dependent care expenses with pre-tax dollars.

What tax advantages are available through the Plan?

You save both Federal Income Tax and FICA (Social Security) taxes by participating. Let's take a look at two typical examples. While everyone is different, they all enjoy big tax savings.

YOUNG COUPLE WITH TWO CHILDREN	
Co-pays to Doctors and pharmacies	$ 250.00
Over-the-Counter Drugs	600.00
Eye Exams	200.00
Glasses & Contacts	500.00
Dental Cleanings	240.00
Chiropractic & podiatrist fees	710.00
After School and Summer Child Care	5,000.00
Total Budgeted Expenses	**$ 7,500.00**
*** ESTIMATED ANNUAL SAVINGS OF $2,250.00**	

SINGLE PARENT WITH ONE CHILD	
Co-Pays To Doctors & Pharmacies	$ 180.00
Over-The-Counter Drugs & Supplies	250.00
Eye Exams	80.00
Dental Cleanings	130.00
Massage Therapy	200.00
Braces	1,000.00
Before & After School Child Care	2,500.00
Total Budgeted Expenses	**$ 4,340.00**
*** ESTIMATED ANNUAL SAVINGS OF $1,302.00**	

* Annual savings are determined by multiplying your total budgeted expenses by the percentage of payroll taxes you pay. In these examples, the savings is based on a 30% tax rate.

Who can participate in the Plan?

An individual is eligible to participate in this Plan if the individual is an Employee of City of Spokane and is regularly scheduled to work at least thirty (30) hours per week. Those employees who actually

participate in the Plan are called "Participants". An employee continues to participate until the end of the Plan Year or the Employee:

(a) elects to no longer participate in accordance with plan guidelines;

(b) is no longer employed by City of Spokane or

(c) Continuation Coverage (as described below) is no longer in effect.

How do I become a participant?

For the Insurance Premium Payment Benefit, you become a Participant by signing an Enrollment/Salary Reduction Form when first eligible to participate in the Plan. If you do not elect or complete the enrollment form when you are first eligible, you will have to wait until the next Open Enrollment Period to enroll for the following Plan Year or until such time that you have a Change in Status. In future years, a new Enrollment form will be made available to you during each Open Enrollment Period, and you will be given the opportunity during Open Enrollment to make a change in your coverage for the next Plan Year. A Participant who fails to complete, sign and file a new Election Form/Salary Reduction Agreement shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and (except for a Change in Status) will not be permitted to modify his election until the next Open Enrollment Period.

If you are eligible on June 1, 1989, you will be able to enter the Plan during the Initial Enrollment Period and shall become a Participant on the June 1, 1989. Otherwise, you will enter the Plan on the effective date of your coverage under the Benefit Plan(s) or Policies.

For the Health Care FSA and Dependent Care FSA, you become a Participant by signing an individual Salary Reduction Agreement in which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. You will be provided with a Salary Reduction Agreement when you first become eligible to participate. You must complete the form and turn it into the Plan Administrator within the time period specified by the Plan Administrator. If you do not elect coverage into the Health Care FSA or Dependent Care FSA when you are first eligible, you will have to wait until the next Open Enrollment Period to enroll for the following Plan Year or until such time that you have a Change in Status. During each Open Enrollment Period, a new Salary Reduction Agreement will be made available to you and you will be given the opportunity to elect your coverage for the next Plan Year. A participant who fails to complete, sign and file (or timely file) Salary Reduction Agreement for the annual elections to participate in the Health Care FSA and/or the Dependent Care FSA prior to the beginning of each Plan Year, will not be reenrolled and must wait to participate until the next Open Enrollment Period, or until there is a qualifying Change in Status.

What is the Open Enrollment period?

The Open Enrollment period will generally begin at least 30 days before the beginning of the Plan Year.

Can I change my election during the Plan Year?

You generally cannot change your election to participate in the Plan or vary the salary reduction amounts you have selected during the Plan Year. However, your election will terminate if you are no longer working for City of Spokane.

There are several important exceptions to this general rule: You may change or revoke your previous elections if you have a "change in status" which affects your eligibility as described below.

A. Change in Status. If one or more of the following Changes in Status occurs and the change affects you and/or your dependent's eligibility for plan benefits, you may revoke your old election and make a new election, either increasing or decreasing coverage. Both the revocation and the new election must be caused by and are consistent with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below and any other events that the Plan Administrator (in its sole discretion) determines to be within prevailing IRS guidance:

   - a change in your legal marital status (such as marriage, divorce, legal separation, annulment or death of your spouse);
   - a change in the number of your dependents (such as birth or adoption of a child or placement of a child for adoption, or the death of a dependent);
   - termination or commencement of employment by you, your spouse, or your dependent;
   - a change in your, your spouse's or your dependent's work hours (including switch between full and part-time status);
   - your dependent's satisfying or ceasing to satisfy an eligibility requirement for a particular benefit and
   - a change in your, your spouse's or your dependent's place of residence or work.

   If a Change in Status occurs, you must inform the Plan Administrator and complete a new election form within 30 days of the occurrence.

   If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and is consistent with a change in status and subsequent change in eligibility. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and is consistent with a Change in Status.

B. Special Enrollment Rights. If you, your spouse and/or a dependent are entitled to special enrollment rights under a group health plan, you may change your election under the Premium Payment Benefit under the Plan, but not the Health Care FSA or the Dependent Care FSA benefits of the Plan. Please refer to the group health plan description for an explanation of special enrollment rights.

C. Certain Judgments and Orders. If a judgment, decree or Order from a divorce, separation, annulment or custody change requires your child to be covered under this Plan or your former spouse's plan, if the Order requires you to cover the child, you may change your election to provide coverage for the child. If the Order requires that your former spouse cover the child, you may change coverage for the child under the Premium Payment and Health Care FSA of the Plan, but not the Dependent Care FSA.

D. Entitlement to Medicare or Medicaid. If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may change coverage for that person's coverage under the Premium Payment Benefit and Health Care FSA of the Plan, but not the Dependent Care FSA.

E. Significant Changes in Cost or Coverage. If an independent, third-party provider of medical benefits significantly increases premiums or significantly curtails coverage, you may revoke your election under the Premium Payment Benefit and elect coverage under another health option with similar coverage, provided that you notify the Plan Administrator within 30 days of receiving written notice of the change. Under the Dependent Care FSA, if a dependent care provider increases the monthly fee, you may increase your election accordingly to reflect the new fee. No election changes are allowed if the dependent care provider is your relative. No changes under the Health Care FSA are allowed for Significant Changes in Cost or Coverage.

F. Changes in Coverage Attributable to Spouse's Employment. If there is a significant change in your or your Spouse's health coverage that is attributable to your Spouse's employment, you may change your election under the Premium Payment and Dependent Care FSA of the Plan provided that the change is consistent with the change in coverage. No changes under the Health Care FSA are allowed.

To make a change, you must file a written request for change with the Plan Administrator within 30 days of the event permitting the change.

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code (the Code), if necessary to prevent the Salary Reduction Plan from becoming discriminatory within the meaning of the federal income tax law. If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator will correct the mistake in the manner and to the extent that it deems administratively possible and otherwise permissible under applicable law. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

How are my Premium Payments made?

When you become a participant, your premiums will be paid with that portion of gross income that you have elected to forego through pre-tax salary reductions.

What if I terminate my employment during the Plan Year?

If your employment with City of Spokane is terminated during the Plan Year, your active participation in the Plan will cease and you will not be able to make any more contributions to the Plan. You have up to 90 days after your termination dated to turn in any claims which have been incurred prior to the date of your termination. See Question 15 of this summary and the your insurance booklets for information on your right to continued or converted group health coverage after termination of your employment.

If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year.

Will I have any administrative costs under the Plan?

City of Spokane is currently bearing the entire cost of administering the Plan.

How long will the Plan remain in effect?

Although City of Spokane expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

What happens if a claim for benefits is denied?

Any claim for Benefits shall be made to the Administrator. If the Administrator denies a claim in whole or in part, the Administrator shall notify the Participant or beneficiary, in writing, within 30 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Administrator does not notify the Participant of the denial of the claim within the 30-day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- The specific reason or reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes;
- Specific reference to pertinent Plan provisions or IRS rules and regulations on which the denial is based;
- A description of available internal appeals processes, including information regarding how to initiate an appeal pursuant as stated below.

What are my appeal rights?

Any claimant whose request for benefits has been denied, in whole or in part, or such claimant's authorized representative, may appeal said denial of Plan benefits by submitting to the Third-party Administrator a written request for a review of such denied claim. Any such request for review must be delivered to the Third-party Administrator no later than one hundred and eighty (180) days from the date the claimant received written notification of the Third-party Administrator's initial denial of the claimant's request for benefits or from the date the claim was deemed denied, unless the Third-party Administrator, upon the written application of the claimant or his authorized representative, shall in its discretion agree in writing to an extension of said period.

During the period for filing a request for review of a denied claim, the Third-party Administrator shall permit the claimant to review pertinent documents and submit written issues and comments concerning the claimant's request for benefits.

Upon receiving a request by a claimant, or his authorized representative, for a review of a denied claim, the Third-party Administrator shall deliver the complete file to the Administrator, who shall consider such request promptly, and shall advise the claimant of its decision within thirty (30) days from the date on which said request for review was received by the Third-party Administrator, unless special circumstances require an extension of time for reviewing said denied claim. In the event special

circumstances require an extension of time for reviewing said denied claim, the Administrator shall, prior to the expiration of the initial 30-day period referred to above, provide the claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Administrator expects to render its decision. In no event shall such extension exceed a period of forty-five (45) days from the date on which the claimant's request for review was received by the Third-party Administrator. The Administrator's decision shall be furnished to the claimant and shall:

- Be written in a manner calculated to be understood by the claimant;
- Include specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes; and
- Include specific references to the pertinent Plan provisions or IRS rules on which the decision is based;
- A description of available external review processes, including information regarding how to initiate an appeal as stated below; and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

The Administrator may, in its discretion, determine that a hearing is required in order to properly consider the claimant's request for review of a denied claim. In the event the Administrator determines that such hearing is required, such determination shall, in and of itself, constitute special circumstances permitting an extension of time in which to consider the claimant's request for review.

What is "Continuation Coverage" and how does it work?

A. This is your notice of Continuation Coverage Rights Under COBRA for yourself, your spouse and your dependents.

    a. You are receiving this notice in the SPD because you have recently become covered under the City of Spokane Flexible Benefits Plan. This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator or from third party administrators: Rehn & Associates, PO Box 5433, Spokane, WA, 99205, (509) 534-0600 or 800-872-8979. The Plan Administrator is responsible for administering COBRA continuation coverage.

B. COBRA Continuation Coverage:

a. COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event" and you have a positive balance in the Health Care FSA of your Flexible Benefits Plan. Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

b. If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

    (a) Your hours of employment are reduced, or

    (b) Your employment ends for any reason other than your gross misconduct.

c. If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

    (a) Your spouse dies;

    (b) Your spouse's hours of employment are reduced;

    (c) Your spouse's employment ends for any reason other than his or her gross misconduct;

    (d) You become divorced or legally separated from your spouse.

d. Your dependent will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

    (a) The parent-employee dies;

    (b) The parent-employee's hours of employment are reduced;

    (c) The parent-employee's employment ends for any reason other than his or her gross misconduct;

    (d) The parents become divorced or legally separated; or

    (e) The dependent stops being eligible for coverage under the plan as a “dependent.”

C. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

D. For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent’s losing eligibility for coverage as a dependent), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Rehn & Associates.

E. Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

F. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts until the end of the current Plan Year. COBRA premiums paid by the former Participant are not reimbursable through their Health Reimbursement Account.

G. If you have questions about your COBRA continuation coverage, you should contact Rehn & Associates or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

H. In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g. pension, disability and life insurance), which are based on taxable compensation.

What is the Family and Medical Leave Act?

Under the Family and Medical Leave Act (FMLA), if you are on eligible paid leave, then nothing happens to your benefits; they continue to be in effect as if you were still at work. If you are on unpaid leave and wish to continue with your current benefits, then you may continue to pay for your insurance coverage on an after-tax basis or by other arrangements (such as prepaying on a pre-tax basis via extra salary reductions before you go on leave). If you are on unpaid leave and are required to keep your benefits active by your employer, you can discontinue paying your share of your benefits while on leave and repay your share once returning to work. If your employer pays a portion of your insurance premiums, then they must continue those payments. However, if you do not return from FMLA, you may be required to repay the Employer-paid portion of the insurance premiums. You should be provided with a complete explanation of your FMLA rights and responsibilities.

SECTION III: INSURANCE PREMIUM PAYMENT BENEFIT

What are "Premium Payment Benefits"?

As described above, if you elect Premium Payment Benefits you will be able to pay for your share of contributions for eligible Insurance Benefits with pre-tax dollars. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

How do I pay for my "Premium Payment Benefits?"

If a Participant elects the pre-tax option, the Participant's share (as determined by the Employer) of the premium for the Insurance Plan benefits the employee elects will be financed by Salary Reductions. Salary Reductions are applied by the Employer to pay for the Participant's share of the premium. For the purpose of this Plan and for Code compliance, such Salary Reductions are considered Employer contributions. The Employer will pay under this Plan its share of the premium for Participants who elect to participate in the pre-tax feature of this Plan. For those who elect the after-tax option, the employee portion of the premium will be paid outside of this Plan.

SECTION IV: HEALTH CARE FSA BENEFIT

What are "Health Care FSA Benefits?"

Under the Health Care FSA, you purchase a specific level of Health Care Reimbursement benefits, paying for coverage through the Salary Reduction Agreement with City of Spokane, in lieu of a corresponding amount of current pay, which means that the premiums you pay will be with pre-tax funds. In return, you may be reimbursed from the Plan for certain eligible Health Care Expenses. This arrangement helps you because the level of coverage you elect is non-taxable, thereby saving you social security and income taxes on the amount of your salary reduction.

What is my "Health Care Expense Reimbursement Account"?

If you elect benefits under this portion of the Plan, a Health Care Expense Reimbursement Account will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the premiums you have paid for such benefits during the Plan Year. Your Health Care Reimbursement Account is merely a record keeping account; it is not funded (all reimbursements are paid from the general assets of City of Spokane).

Health Care Expense Reimbursement Accounts are intended to pay benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health Care Expense Reimbursement Account shall not be considered to be a group health plan for coordination of benefits purposes, and Health Care Expense Reimbursement Accounts shall not be taken into account when determining benefits payable under any other plan.

What is the annual maximum I can contribute to the Health Care FSA and what is the cost?

You may choose any amount of Plan Year reimbursement you desire, subject to a maximum reimbursement amount of $2,500.00 per year and a minimum of $10.00/month or $120.00/year. You will be required to pay the annual premium equal to the coverage level you have chosen.

How is my Health Care Expense Reimbursement benefit paid for?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay with your salary reduction. Thereafter, you must pay a premium for such coverage by having an equal portion of the annual premium deducted from each paycheck. The full amount of the coverage you have elected will be available to reimburse you for certain Health Care Expenses at any time during the Plan Year, so long as you continue to pay the premiums.

How much can I be reimbursed under the Health Care FSA?

Provided that you have continued to pay the periodic premiums due for this benefit, then the full annual amount of coverage that you have elected will be available at any time during the Plan Year or Grace Period, although reduced by the amount of prior reimbursements received during the Year. The Grace Period is the 2 ½ months immediately following the end of the Plan Year, in which you may continue to incur claims.

How do I receive reimbursement under the Plan?

You will have to take certain steps to be reimbursed for your Health Care Expenses. When you incur an expense that is eligible for payment, you must submit a claim to the Plan's contract administrator, Rehn & Associates, on a claim form that will be supplied to you. You must include written statement(s) from an independent third party(ies) stating that the Health Care expense(s) have been incurred, and the amount of such expense(s) along with the claim form. In addition, you must include an Explanation of Benefits (EOB) Form(s) from any insurance carrier(s) indicating the amount(s) that you are obligated to pay.

Claims are paid on a daily or weekly basis through the contract administrator, depending on the selection made by the Plan Administrator. Remember, though, you cannot be reimbursed for any total expenses above the annual reimbursement amount you have elected.

You have 90 days from the end of the Plan Year in which to submit a claim for reimbursement for Health Care Expenses incurred during the previous Plan Year or subsequent grace period. You will be notified in writing if any claim for benefits is denied.

Please note that it is *not necessary* for you to have actually paid the bill for a Health Care Expense – only for you to have *incurred* the expense and that it is not being paid for or reimbursed from any other source.

What is a "Health Care Expense"?

A "Health Care Expense" generally means incurred by a participant or their Spouse and/or eligible Dependent(s) for medical care, as defined by Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. Health Care Expenses are limited to generally recognized health care expenses, which are defined to mean (a) expenses incurred for diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body, and (b) for transportation primarily for and essential to such eligible expenses.

When must the expenses be incurred?

Health Care Expenses must have been incurred during the Plan Year or subsequent grace period. You may not be reimbursed for any expenses arising before the Plan became effective, before your Salary Reduction Agreement became effective, for any expenses incurred after the close of the grace period, or after a separation from service (except for Continuation Coverage).

What if I incur fewer claims during the Plan Year than my annual Health Care FSA election?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Health Care expenses you have incurred and the annual coverage level you have elected and paid for. Any unused annual coverage benefit not used before the end of the Grace Period shall be forfeited and used to offset administrative expenses and future costs.

Will I be taxed on the Health Care FSA benefits that I receive?

You will not normally be taxed on your Health Care FSA benefits, up to the limits set out in this summary. However, the Employer cannot guarantee that specific tax consequences will flow from your participation on the Plan. The tax benefits that you receive depend on the validity of the claims you submit.

SECTION V: DEPENDENT CARE FSA BENEFIT

What are "Dependent Care FSA Benefits?"

Under the Dependent Care FSA, you provide a source of pre-tax funds to reimburse yourself for your Eligible Dependent Care Expenses by entering into a Salary Reduction Agreement with City of Spokane under which you agree to a salary reduction to fund Dependent Care Expenses in lieu of a corresponding amount of your regular pay. This arrangement helps you because the coverage you elect is non-taxable, thereby saving you social security and income taxes on the amount of salary conversion

What is my "Dependent Care Expense Reimbursement Account"?

If you elect benefits under this portion of the Plan, a Dependent Care Expense Reimbursement Account will be set up in your name to keep a record of the reimbursements you are entitled to. Your Dependent Care Reimbursement Account is merely a record keeping account; it is not funded (all reimbursements are paid out of the general assets of City of Spokane).

What are the maximum Dependent Care FSA benefits I may elect?

The maximum annual benefit amount that you may elect to receive under this Plan in the form of reimbursements for Eligible Dependent Care Expenses incurred in any Plan Year shall be:

$5,000 for:

- Single employees
- Married employees filing a joint federal income tax return
- Married employees filing separate federal income tax returns that meet the following conditions (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence).

$2,500 for:

- Married employees residing with the Spouse but who files a separate federal income tax return

If you enter the Plan mid-year then you may elect coverage up to the annual maximum amount of benefit.

How is my Dependent Care Expense benefit funded?

When you complete the Salary Reduction Agreement, you specify the amount of Dependent Care FSA benefits for which you wish to pay with your salary reduction. Thereafter, your Dependent Care Reimbursement Account will be credited with the portion of your gross income that you have elected to forego through salary reduction. These portions will be credited as of each pay period. The amount

that is available for reimbursement at any particular time will be whatever has been credited to your Dependent Care Reimbursement Account, less any reimbursements already paid.

What is a "Dependent Care Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under the age of 13, who resides with you and whom you could claim as a dependent on your federal income tax return; any other dependent who is mentally or physically incapable of self-care; or your spouse, if the spouse is likewise physically or mentally incapacitated.

Generally, these expenses must meet *all* of the following conditions for them to be eligible Dependent Care Expenses:

A. the expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies:

B. Each individual for whom you incur the expenses is:

   a. A dependent under age 13 whom you are entitled to a personal tax exemption as a dependent; or

   b. A "qualifying relative" is someone who is not a "dependent" as defined above, but who meets:

      I. Specified relationship requirements (i.e., is a child, brother/sister, father/mother, etc) set forth in the Code;

      II. A support test (i.e., the taxpayer provides over one-half of the individual's support); and

      III. A gross income limitation (no more than $3,500 for 2008). the expenses are incurred for the care of a dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed;

C. If the expenses are incurred for services outside your household and such expenses are incurred for the care of a spouse or other tax dependent age 13 or older who is incapable of self-care, such individual regularly spends at least eight hours per day in your home;

D. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations;

E. The expenses are not paid or payable to a dependent of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent; and

F. This reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:

   a. $5,000;

   b. $2,500, if you are married but you and your spouse file separate tax returns;

   c. Your taxable compensation (after your Salary Reduction under this Plan); and

d. If you are married, your spouse's actual or deemed Earned Income.

G. Expenses are not paid for services outside your household at a camp where the dependent stays overnight.

For purposes of (F-d) above, your spouse will be deemed to have Earned Income of $250 ($500 if you have two or more dependents described in paragraph 2 above), for each month in which your spouse is (i) physically or mentally incapable of self-care, or (ii) a full-time student at an educational institution.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense, if you have any doubts.

How do I receive a Dependent Care Expense Reimbursement under the Plan?

If you have elected to participate in this portion of the Plan, you will have to take certain steps in order to be reimbursed for your Dependent Care Expenses. When you incur an expense that is eligible for payment, you must submit a claim to the contract administrator, Rehn & Associates, on a claim form that will be supplied to you. Your claim must include a statement from the dependent care provider showing the dates the expenses were incurred, the name of the dependent cared for, the cost of the care and the provider's taxpayer identification number. If there are enough credits in your Dependent Care Expense Reimbursement Account, you will be reimbursed for your eligible expenses.

If a claim is for an amount that is more than your current Dependent Care Reimbursement Account balance, then the excess part of the claim will be carried over into the next payment cycle, to be paid out as your balance becomes adequate. Remember, though, that you cannot be reimbursed for any total expenses above the available annual credits to your Dependent Care Reimbursement Account. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

Please note that it is not necessary for you to have actually paid an amount due for Dependent Care Expenses – only for you to have incurred the expense, and that it is not being paid for or reimbursed from any other source.

You will have 90 days after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

What if I incur fewer claims during the Plan Year than my annual election amount?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Dependent Care Expenses you have incurred and the annual coverage level you have elected and paid for. Any unused annual coverage benefit not used shall be forfeited and used to offset administrative expenses and future costs.

Will I be taxed on the Dependent Care FSA benefits I receive?

You will not normally be taxed on your Dependent Care FSA benefits, up to the annual limits set forth in this document. However, to qualify for tax-free treatment, you will be required to file IRS Form 2441 or

a similar form with your annual income tax return to list the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed tax-free reimbursement.

If I participate in the Dependent Care FSA, can I anything on my federal tax return?

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

What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual dependent care expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 such expenses for one dependent, or $6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one dependent or $2,100 for two or more dependents), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one dependent or $1,200 for two or more dependents). The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

Should I participate in this Plan or claim the credit on my federal tax return?

Generally, if you are in one of the lower income tax brackets, you might come out ahead by including the Dependent Care FSA benefits in income and by claiming the credits for dependent care and earned income. On the other hand, it will generally be better to treat Dependent Care FSA benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g. married, single, head of household), number of dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits. Use IRS Form 2441 or contact a tax accountant for further guidance.

SECTION VI: ERISA

What are my ERISA Rights?

The Flexible Benefits Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act (ERISA). However, Plans with 100 or more participants in the Health Care FSA may be governed by ERISA. As a participant in an ERISA-covered benefit, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report).

What are my COBRA and HIPAA Rights?

You have a right to continue your Insurance Plan (here, major medical insurance) coverage (and, in some instances, your Health FSA coverage) for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage.

You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or insurance carrier when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of credible coverage, you may be subject to a preexisting condition exclusion(s) for 12 months (18 months for late enrollees) after your enrollment date. Under HIPAA, your enrollment date begins either on (a) the first day of the Waiting Period or (b) the day coverage begins. If you are a "late enrollee" your enrollment date is always the date coverage begins. Preexisting condition exclusion(s) have a "look back" period that cannot exceed 6 months prior to the enrollment date.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the plan, or from exercising your rights under ERISA. If your claim for a benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and have the Plan Administrator reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a

case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this Part of the Summary Plan Description or about your rights under ERISA, you should contact the nearest office of the U.S. Department of Labor, Employee Security Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Security Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W. Washington, D.C. 20210.

What other General Information should I know?

A. General Plan Information

- The Name of the Plan is City of Spokane Flexible Benefits Plan
- The Plan Number assigned to your Plan is 501.
- The provisions of the Plan described herein became effective on June 1, 1989.
- Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan year is January 1 through December 31.
- This is a welfare plan. Therefore, your benefits are not insured by the Pension Benefit Guaranty Corporation (PBGC), an agency of the federal government. The PBGC generally requires or provides insurance for certain pension plans only.

B. Employer Information

City of Spokane
808 W Spokane Falls Blvd
Spokane, WA 99201
Employer ID: 91-6001280

C. Plan Administrator Information

Teresa Collins
City of Spokane
808 W Spokane Falls Blvd
Spokane, WA 99201
(509) 625 6227

The Plan is administered by City of Spokane with the assistance of a contract administrator, A. W. Rehn & Associates, Inc. The Plan Administrator is designated as agent for all purposes of legal process.