

**SUMMARY PLAN DESCRIPTION**  
**for**  
**City of Knoxville**  
**Flexible Benefit Plan**

**Introduction**

City of Knoxville is pleased to announce that it has established a Flexible Benefit Plan for you and other eligible employees. Under this program, you will be able to pay for certain insurance/benefit coverage(s) that the City of Knoxville makes available to you, as well as other qualifying, eligible expenses for health care and dependent care (child or adult daycare) expenses with a portion of your pay before income and social security taxes are withheld. This means that you will pay less tax and have more money to spend and save. You can do this by entering into a salary reduction arrangement by which you elect to pay for these benefits on a pretax basis instead of receiving a corresponding amount of your regular pay. Alternatively, you may choose to pay for any of the available benefits with after-tax contributions on a payroll reduction 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. This is only a summary of the key parts of the Plan and a brief description of your rights as a Participant; it is not the official Plan Document. If there is a conflict between the Plan Document and this Summary Plan Description, the Plan Document will control.

**General Information**

Name of Plan:	Flexible Benefit Plan
Type of Plan:	Section 125 Cafeteria/Flexible Benefit Plan
Funding:	Employee contributions by salary reduction
Plan Number:	N/A
Initial Effective Date of the Plan:	January 1, 2006
Amended and Restated Date:	January 1, 2007
Plan Year:	January 1 through December 31

**Employer Information**

City of Knoxville  
400 Main Street, Room 599  
Knoxville, TN 37902  
(865)215-2111  
Employer Tax ID Number: 62-6000326

The Employer keeps records for the Plan and is responsible for the administration of the Plan. The Employer will answer any questions that you may have about the Plan. You may contact the Employer at the above address for further information about the Plan.

## **Plan Administrator Information**

City of Knoxville  
400 Main Street, Room 599  
Knoxville, TN 37902  
(865)215-2111

## **Service of Legal Process**

City of Knoxville  
400 Main Street, Room 599  
Knoxville, TN 37902  
(865)215-2111

## **Claims Administrator**

PayFlex™ Systems USA, Inc.  
P.O. Box 3039  
Omaha, NE 68103-3039  
[www.mypayflex.com](http://www.mypayflex.com)  
FAX: (402) 231-4310  
(402) 345-0666  
(800) 284-4885

**1. What is the purpose of the Plan?**

The purpose of the Plan is to allow eligible Employees to use funds provided through employee salary reductions to pay for certain benefits under the Plan with pretax dollars.

**2. What benefits are provided under the Plan?**

Before the start of each Plan Year, you are able to elect to have some of your upcoming pay paid to the Plan on a pretax basis. You can choose from the following options:

- 1) *Premium Conversion.* This option allows you to pay your share of the cost of premiums for certain health insurance/benefit coverage(s) that the City of Knoxville is offering you on a pretax basis;
- 2) *Health Care Flexible Spending Account (FSA).* This option allows you to pay for your qualifying health care expenses that have not been reimbursed and are not otherwise reimbursable by insurance or any other source, with pretax dollars; or
- 3) *Dependent Care Flexible Spending Account (FSA).* This option allows you to pay for your qualifying dependent care (child or adult daycare) expenses with pretax dollars.

The portion of your pay that is contributed to the Plan in order to pay insurance/benefit premiums or to be deposited into spending accounts to pay for qualifying, eligible expenses is not subject to income or social security taxes. In other words, the Plan allows you to use tax-free dollars to pay the premium expenses for insurance/benefit coverages and other eligible expenses you would otherwise normally pay for with out-of-pocket, taxable dollars.

You can purchase plan benefits from your regular pay on a pretax basis or receive your regular pay in cash on a tax basis. If you do not participate in this plan you are considered to have elected to receive your regular pay in cash on a taxable basis.

**3. Who can participate in the Plan?**

Regular employees are eligible to participate in the Plan provided they work at least 30 hours per week and are eligible the first day of the calendar month following 90 days of continuous employment. Judges are eligible if they work at least 24 hours per week, but they must satisfy the same waiting period.

Employees who actually participate in the Plan are called “Participants.”

**4. What happens to contributions made to the Plan?**

If you participate in the City of Knoxville health insurance/benefit plans, the City will automatically set aside your portion of the premium for insurance/benefit coverages on a pretax basis. Before each plan year begins, you must designate the amount of money to be set aside for unreimbursed health care and dependent care expenses for that plan year; this is called your “plan year election.” The money you have set aside will be available for payment of your qualifying unreimbursed health care and dependent care expenses.

**5. When must I decide whether or not to participate?**

You are required by federal law to decide whether you want to participate before your initial eligibility period, and thereafter before each plan year begins. This is called the “election period”.

- a) *Premium Conversion.*  
Election for certain health insurance/benefit coverage(s) premiums will be automatic and remain in effect until you officially revoke it by signing a waiver.

b) **Health Care and Dependent Care FSAs.**

To become a plan participant, you are required to complete an Enrollment Form each year. On this form you will authorize which of the optional benefits you desire and the specific amount of your salary you wish to set aside for each account.

If you fail to complete the Enrollment Form during the designated election period, you will not be a participant in the FSAs for the following Plan Year, and you will have to wait for the next election period (unless a qualifying Change in Status occurs) to once again select the FSA options under this Plan.

**6. When is the election period for the Plan?**

Your election period begins on your date of hire and ends on the date you first meet the Plan's eligibility requirements. Then, for each Plan Year following the Plan Year during which you first became a participant, the election period is established by the City of Knoxville and applied uniformly to all participants. It will normally be a period of time prior to the beginning of each Plan Year.

**7. May I change my elections during the Plan Year?**

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change under the following circumstances:

1. **Change in Status.** If one or more of the following Changes in Status occurs, you may revoke your old election and make a new election, provided that both the revocation and new election are 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, death of your spouse, divorce, legal separation or annulment);
  - a change in the number of your tax dependents (as defined in Code Section 152) such as birth or adoption of a child, placement for adoption or the death of a dependent;
  - a change in employment status by you, your spouse, or your dependent that affects the benefit eligibility under a cafeteria plan or other employee benefit plan of the employer of you, your spouse, or your dependents (such as termination or commencement of employment; a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly or union to nonunion or vice versa, incurring a reduction or increase in hours of employment (e.g., going from part-time to full-time), or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;
  - your dependent's satisfying or ceasing to satisfy the dependent eligibility requirement for a particular benefit; (such as attaining a specified age, getting married, or ceasing to be a student); and
  - a change in your, your spouse's or your dependent's place of residence that affects the benefit eligibility under a cafeteria plan or other employee benefit plan of the employer of you, your spouse, or your dependents.
  - Medicare eligibility.

If a Change in Status occurs, you must inform the Plan Administrator and apply for a change by completing a new election form and a Request for Change in Election form within 60 days of the occurrence.

A Participant may change or terminate his or her election under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status that affects coverage eligibility of a Participant, a participant's Spouse, or a Participant's Dependent (referred to as the general consistency requirement.) The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on that change.

- a. *Loss of Dependent Eligibility.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel cancer or health insurance coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant's Spouse (not ex-spouse) or the Participant's Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's Plan, the Participant may increase his election to pay for such coverage.
  - b. *Gain of Coverage Eligibility under Another Employer's Plan.* For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's Dependent gains eligibility for coverage under this Employer's plan or another employer's cafeteria plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the other employer's plan.
  - c. *Dependent Care FSA Expense Reimbursement Benefits.* With respect to the Dependent Care FSA Expense Reimbursement benefit plan, a Participant may change or terminate his or her election only if (i) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (ii) the election change is on account of and corresponds with a Change in Status that affects eligibility of dependent care expenses for the tax exclusion available under Code §129.
  - d. *Group Term Life Insurance, Accidental Death & Dismemberment, and Disability Income Coverage (if offered under the plan).* For any Change in Status involving a Participant's legal marital status or the employment status of a Participant's Spouse or Dependent (disregarding the requirement that the event cause a loss or gain of eligibility), a Participant may elect either to increase or to decrease group term life insurance, accidental death & dismemberment or disability income coverage offered under the Plan.
2. **HIPAA 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 to correspond with the special enrollment right. For example, if you declined enrollment in medical coverage for yourself or for your eligible dependents because of outside medical coverage, and if eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), then you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly-acquired dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights.
  3. **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, legal separation, annulment or legal custody change (including a qualified medical child support order) requires your child to be covered under this Plan 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 your election to revoke coverage for the child provided other coverage is actually procured.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's cancer or health coverage. Furthermore, if you, your Spouse, or a Dependent loses eligibility for such coverage, you may elect to commence or increase that person's accident or health coverage.
5. **Changes in Cost. (These rules do not apply to health care flexible spending accounts.)**
  - a. *Automatic Increase or Decrease for Insignificant Cost Changes.* If the cost of a benefit coverage increases or decreases during a Plan Year by an insignificant amount, then the pretax contributions or after-tax contributions (as applicable) under each affected Participant's election shall be prospectively increased or decreased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in affected employees' elective contributions in accordance with such cost changes. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).
  - b. *Significant Cost Increases/Decreases.* If the Plan Administrator determines that the cost of a Participant's benefit coverage significantly increases by 20% during a Plan Year, the Participant may either make a corresponding prospective increase in his or her contributions, or revoke his or her election, and in lieu thereof, receive coverage under another Plan option which provides similar coverage. If the Plan Administrator determines that the cost of a Participant's benefit plan(s) significantly decreases by 20% during a Plan Year, the participant may revoke his or her election, and in lieu thereof, receive coverage under the decreased Plan option which provides similar coverage. In the event of a decrease, Participants who were not previously enrolled could elect the decreased Plan option. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.
  - c. *Limitation on Change in Cost Provisions for Dependent Care FSA Expense Reimbursement.* The above "Change in Cost" provisions apply to Dependent Care FSA Expense Reimbursement *only* if the cost change is imposed by a dependent care provider who is not a "relative" of the employee by blood or marriage (as that term is defined in Proposed Treas. Reg. §1.125-4(f)(2)(iii) or other IRS guidance).
6. **Changes in Coverage (These rules do not apply to health care flexible spending accounts.)**
  - a. *Significant Curtailment.* If the Plan Administrator determines that a benefit coverage under this Plan is significantly curtailed or ceases during a Plan Year, the Participant may revoke his or her election under the Plan. In that case, each affected Participant may prospectively elect coverage under another benefit coverage option which provides similar coverage but cannot drop coverage. If the Plan Administrator determines that a Participant benefit coverage under this Plan is significantly curtailed that results in a loss of coverage, the Participant may elect coverage under another benefit coverage option which provides similar coverage, or can drop coverage if no other similar option is available. Coverage under a cancer or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a substitute benefit coverage constitutes "similar coverage" based upon all the surrounding facts and circumstances.

- b. *Addition or Significant Improvement of Benefit Package Option.* If during a Plan Year the Plan adds a new benefit plan or significantly improves an existing benefit plan, you may revoke your election and make a new election on a prospective basis for coverage under the new or improved benefit plan. This is so even if you previously waived coverage under the Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether there has been a “significant improvement” in a benefit plan.
- c. *Change in Coverage of Spouse or Dependent under Their Employer’s Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under any employer plan (including the plan or the Spouse’s, former Spouse’s, or Dependent’s employer), so long as (a) the cafeteria plan or qualified benefits plan of the Spouse’s, former Spouse’s, or Dependent’s employer permits its participants to make an election change that would be permitted under IRS regulations; or (b) the Plan permits Participants to make an election for a Plan Year period of coverage which is different from the plan year period of coverage under the cafeteria plan or qualified benefits plan of the Spouse’s, former Spouse’s or Dependent’s employer. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the Spouse’s, former Spouse’s, or Dependent’s employer.

Additionally, the Plan Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

A Participant entitled to make a new election under this Section must do so within 30 days of the event. An Employee who is eligible to elect benefits and declined to do so during the initial election period or during a subsequent open enrollment period, may file a pretax contribution election change within 30 days of the occurrence of an event described in this section, but only if the election under the new salary reduction agreement is made on account of and corresponds with the event. Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly adopted Dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to 30 days. All other new elections shall be effective prospectively immediately following the date the Participant files his new salary reduction agreement with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

## **8. How do leaves of absence affect my benefits?**

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the City of Knoxville will continue to maintain your medical and dental insurance benefits and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the premium to the extent you opt to continue coverage). The City may elect to continue all medical and dental insurance benefits and Health FSA Benefits coverage for Participants while they are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the premiums by the method normally used during any paid leave (for example, on a pretax salary reduction basis if that is what was used before the FMLA leave began).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), and you opt to continue your medical and dental insurance benefits and Health FSA Benefits, then you may pay your share of the premium in one of three ways:

- (1) with after-tax dollars while on leave;
- (2) with pretax dollars to the extent you receive compensation during the leave on a pretax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation would normally be

- available to you, but note that prepayments with pretax dollars may not be used to pay for coverage during the next Plan Year); or
- (3) by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue medical and dental insurance benefits and Health FSA Benefits during the unpaid FMLA leave, you may discontinue paying your share of the required premium until you return from leave. Upon returning from leave you must pay your share of any required premiums that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pretax or after-tax basis, as you and the Plan Administrator may agree.

If your medical or dental insurance benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be entitled to re-enter such Benefits, as applicable, upon return from such leave on the same basis as you were participating in the Plan before the leave, or otherwise required by the FMLA. You are entitled to have coverage for such Benefits automatically so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be entitled to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay premium. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, your election for non-health benefits will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave. If that policy permits Participants to discontinue contributions while on leave, Participants will upon returning from leave be required to repay the premiums not paid by the participant during leave. Payment will be withheld from your compensation either on a pretax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

*Non-FMLA Leaves of Absence.* If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the premium due for you will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator.

## **9. What happens if my employment terminates?**

If your employment terminates during the Plan Year, your active participation in the Plan will cease as of that date and you will not be able to make any more contributions to the Plan. 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. You must complete the eligibility waiting period again before you can participate in the Plan unless you were laid off. The City of Knoxville does not permit an individual to be rehired within 30 days.

Upon termination of employment or cessation of participation, you may continue to submit Dependent Care claims up to the amount of the cash balance (plan year contributions less prior reimbursements) in your account for qualifying dependent care expense INCURRED during your period of coverage and up through the Plan Year.

Upon termination of employment or cessation of participation, you may continue to submit Health Care claims up to the amount of the plan balance (plan year election less prior reimbursements) in your account for qualifying health care expenses INCURRED during your period of coverage and up through your termination date. Expenses INCURRED after your termination date are ineligible. In order to continue



participation in the Health Care FSA account you must elect to continue your coverage through “Continuation Coverage” (COBRA). This will allow you to continue to participate through the end of the plan year. When COBRA is elected, all contributions to your Health Care FSA account are made on an after-tax basis, except to the extent compensation may be available to pay pre-tax.

#### **10. What is “Continuation Coverage” and how does it work?**

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain instances where coverage under a group health plan would otherwise end. Your employer can tell you if this law applies to the plan and if continuation coverage is available to you.

A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that the Employer may maintain and that provides medical care. In this case, continuation coverage may be available for the Health FSA benefit. Continuation coverage means your right to continue the same coverage that was in place the day before a Qualifying Event if participation by you would otherwise end due to the occurrence of such Qualifying Event. A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- Your death;
- Divorce or legal separation from your spouse;
- Your becoming entitled to receive Medicare benefits; or
- Your dependent’s ceasing to be a dependent.

For Qualifying Events other than a change in your employment status or death, you and your qualified beneficiaries are obligated to inform the Administrator of the qualifying event within 60 days of its occurrence. The Administrator will furnish you with a written option to continue the coverage provided at the stated premium costs with respect to the plan. The notification will explain all terms and conditions of the continued coverage. You may pay premiums for continuation coverage on a pre-tax basis to the extent compensation is available, but not beyond the current Plan Year. Otherwise, premium payments are made on an after-tax basis. Your Employer will provide you with any notice regarding COBRA continuation coverage applicable to your plan.

If you have any questions about COBRA continuation coverage, contact your Employer.

#### **11. What insurance/benefit coverage(s) may I purchase?**

You can choose to pay your share of premiums on a pretax basis for the group benefit plans as offered by the City of Knoxville from year to year, by entering into a salary reduction agreement with the Employer. Your Employer will notify you each year of the available insurance/benefit coverages. By paying your share of the premiums on a pretax basis, you save income and Social Security taxes on the amount of your contribution.

#### **12. Will my social security benefits be affected?**

Your social security benefits may be reduced if you participate, because when you receive tax-free benefits under the Plan, it reduces the amount of contributions that you make to the federal social security system as well as the Employer’s contribution to the social security system on your behalf. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

#### **13. Will I pay any administrative costs under the Plan?**

Generally the Employer pays the cost of administering the Plan. However, this is subject to change each year and the Employer may decide at any time to pass on certain costs to Plan Participants.

#### **14. How long will the Plan remain in effect?**

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly. The Plan will also automatically terminate if the Employer

- 1) is legally dissolved,
- 2) files for liquidation under the Bankruptcy Code,
- 3) merges or consolidates with any other entity and it is not the surviving entity, or if it reorganizes, sells or transfers substantially all of its assets, or goes out of business, unless the Employer's successor in interest agrees to assume the liabilities under this Plan as to the participants and eligible dependents.

#### **15. Are my benefits taxable?**

Since the Plan is intended to meet certain requirements of federal tax laws, the benefits you receive under the Plan are not currently taxable to you under present law. However, neither the Employer nor the Claims Administrator can guarantee the tax treatment to any given participant, as individual circumstances may produce differing results.

The tax benefits that you receive depend on the validity of the claims you submit. For example, to qualify for tax-free treatment, your health care and dependent expenses must meet the definition of health care and dependent care as defined in the Code.

In addition, to qualify for tax-free treatment of your dependent care expenses, you are required to file IRS Form 2441 (Child and Dependent Care Expenses) with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers of any persons who provided you with dependent care services during the Plan Year for which you have claimed a tax-free reimbursement.

If you are reimbursed for a claim that is later determined to not be for a qualifying expense, you will be required to repay the amount to the plan.

Ultimately, it is your responsibility to determine whether each payment to you under this Plan is excludable for tax purposes. In case of doubt, you should consult your own qualified tax adviser.

#### **16. What are Health Care FSA benefits?**

If you elect Health Care FSA benefits, you provide a source of pretax funds to reimburse yourself for qualifying health care expenses by completing an enrollment form and entering into a salary reduction agreement with your Employer. You agree to a salary reduction to fund the Health Care FSA instead of receiving a corresponding amount of your regular pay. This means that the contributions ("premiums") you pay will be paid with pretax funds. In return, you may be reimbursed from the Plan for certain eligible health care expenses.

If you elect Health FSA Benefits, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you make a contribution (pay a premium) for such coverage by having an equal portion of the annual election amount deducted from your paycheck on a schedule established by your Employer. A health FSA account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA is a record-keeping account; it is not funded, and it does not bear interest.

Health Care FSA benefits are intended to pay benefits solely for health care expenses not previously reimbursed or reimbursable elsewhere. The Health FSA is not considered to be a group health plan for coordination of benefits purposes, and Health FSA benefits shall not be taken into account when determining benefits payable under any other plan.

**17. What are the maximum and minimum Health FSA Benefits that I may elect?**

The minimum election amount is \$120; the maximum election amount is \$5,000 per Plan Year.

**18. What amounts will be available for Health FSA reimbursements at any particular time during the Plan Year?**

The full plan year election amount (reduced by prior reimbursements) will be available to reimburse you for qualifying, eligible health care expenses incurred during the Plan Year, regardless of the amount you have contributed when you submitted the claim (so long as you remain a participant and have continued to make contributions).

**19. What are Health Care expenses?**

Qualifying Health Care expenses are those expenses incurred by you, your spouse or eligible dependents for “medical care” as defined in Code Section 213. Generally, this means an item for which you could have claimed a medical care expense deduction on an itemized federal income tax return (without regard to any threshold limitation or time of payment) for which you have not otherwise been reimbursed or would not seek to be reimbursed from insurance or from some other source.

Medical care expenses include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part of function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses for solely cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to one’s general health are not expenses for medical care. However, medical care for this purpose includes expenses for over-the-counter (OTC) drugs and medicines. In some cases, you will be required to provide a letter or further documentation from your attending physician in order to substantiate your claim.

For information about what items are, and are not, deductible health care expenses, consult IRS Publication 502-Medical and Dental Expenses. Use the Publication with caution since it is intended only to help taxpayers figure out their tax deductions and not to explain what is reimbursable under a Health FSA. Although the Publication indicates you may get a deduction based on when you pay for an expense, this rule does not apply to your Health FSA. Your Health FSA requires that you incur the expenses (have the service provided that gives rise to the expense) during the Plan Year, regardless when you pay for it or are billed for it. The Publication also refers to health insurance premiums, founders’ fees, lifetime care, long-term contracts/services; these are not eligible expenses under the Health FSA. In addition, OTC drugs and medicines are eligible under the Health FSA.

Be sure to contact your Employer if you have questions about what expenses are, and are not, eligible. You can also go online at [www.mypayflex.com](http://www.mypayflex.com) for more information.

**20. When are Health Care Expenses incurred?**

A health care expense is incurred when the service that gives rise to the expense is provided, and not when you pay for the expense, or when you are billed for it. If you have paid for the expense but the service has not yet been rendered, then the expense has not been incurred and is not eligible. You cannot be reimbursed for an expense that has not been incurred (service rendered). Also, you may not be reimbursed for expenses arising before the Plan was effective or before your effective date of coverage under the Plan; or for expenses incurred after the end of the Plan Year’s grace period (if your Employer has elected to offer the grace period) or after your coverage ends. The grace period, if so offered, immediately follows the end

of each Plan Year and runs for 2 ½ months. As a result of the grace period, you have until the fifteenth day of the third calendar month following the immediately preceding plan year to incur an eligible expense. For example: If the plan year ends December 31, you have until March 15 to incur an eligible expense. In other words, you may have as long as 14 months and 15 days to incur eligible expenses.

## **21. What are Dependent Care Benefits?**

If you elect Dependent Care Benefits, you provide a source of pretax funds to reimburse yourself for qualifying, eligible Dependent Care expenses by completing an Enrollment Form and entering into a salary reduction agreement with your employer. You agree to a salary reduction to fund the Dependent Care FSA instead of receiving a corresponding amount of your regular pay. This means that the contributions (“premiums”) you pay will be with pretax funds. In return, you may be reimbursed from the Plan for certain eligible Dependent Care expenses.

If you elect Dependent Care Benefits, you specify the amount of Dependent Care Benefits that you wish to pay for with your salary reduction. From then on, you make a contribution (pay a premium) for such coverage by having an equal portion of the plan year election amount deducted from your paycheck on a schedule established by your Employer. A Dependent Care FSA account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Dependent Care FSA is a record-keeping account; it is not funded and it does not bear interest.

## **22. What are the maximum and minimum Dependent Care Benefits that I may elect?**

The amount of Dependent Care Benefits that you elect cannot exceed the maximum amount specified in Code Section 129. There is a \$120 per plan year minimum election amount. The maximum amount is currently \$5,000 for a calendar year if you:

- Are married and file a joint return;
- Are single.

If you are married and you file a separate federal income tax return, then the maximum Dependent Care Benefit that you may elect is \$2,500 for a calendar year. A special rule permits a \$5000 maximum for certain married individuals who file separate returns but who are living apart for the last six months of the year.

The maximum (\$5,000 or \$2,500 for a calendar year) applies to the amount that you may elect under this Plan and any plan of your Spouse. (The election amount that applies to you may be less than the above maximum because of other limitations.)

## **23. What amounts will be available for Dependent Care reimbursement at any particular time during the Plan Year?**

The amount of year-to-date contributions (premiums paid), reduced by prior reimbursements, will be available to reimburse you for qualifying, eligible Dependent Care Benefits during the Plan Year.

## **24. What are Dependent Care Expenses?**

Dependent Care Expenses means employment-related expenses incurred on behalf of any Dependent who meets the requirements of a Qualifying Individual. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

- (a) Each Dependent for whom you incur the expense must be a Qualifying Individual as follows:
  - your child under age 13 who has lived with you for more than half of the taxable year and does

- not provide over half of his own support (if you are a divorced parent, a child is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
  - your Spouse, if he or she is physically or mentally incapable of self-care and has the same principal place of abode as you for more than half of the taxable year; or
  - any person who qualifies as a Dependent and who is physically or mentally incapable of self-care, receives over half of his support from you, lives with you for the entire year, and meets all other requirements of a Qualifying Individual as described under Code Section 21 (b).
- (b) No reimbursement will be made to the extent that such reimbursement would exceed the cash balance in your account. No reimbursement will be made to the extent that such reimbursement, when combined with the total amount of reimbursements made for the Plan Year, would exceed the applicable statutory limit, as amended. Your statutory limit is the smallest of the following amounts:
- your earned income for the calendar year (after your salary reductions under the Plan);
  - the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of \$250 (\$500 if you have two or more Qualifying Individuals), for each month in which your Spouse is (1) physically or mentally incapable of self-care; or (2) a full-time student); or
  - the contribution limit of \$5,000 for the calendar year.
- (c) The expenses are incurred for services rendered after the effective date of your election and during the Plan Year to which the election applies; and are not for services to be provided in the future.
- (d) The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. (This does not include unpaid volunteer work, or volunteer work for a nominal salary.)
- (e) The expenses are incurred for the care of a Qualifying Individual.
- (f) If the expenses are incurred for services outside your household, they are incurred for the care of (1) a person under age 13; or (2) your Spouse or a person who is your Dependent under federal tax law, is physically or mentally incapable of self-care, regularly spends at least eight hours per day in your household, and meets any income limitations required by the IRS.
- (g) If the expenses are incurred for services provided by a dependent care center (that is, 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.
- (h) The person who provided care was not your Spouse or a person for whom you are entitled to a personal exemption under Code Section 151. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- (i) The expenses are not paid for services outside your household at a camp where the dependent stays overnight; for transportation services; for education/tuition costs (kindergarten or higher); for food, clothing, entertainment; for registration/reservation fees; or for amounts incurred while you are off work because of illness/injury or vacation.

For more information about what items are, and are not, deductible Dependent Care Expenses, consult IRS Publication 503 (Child and Dependent Care Expenses). Use the Publication with caution since it was meant only to help taxpayers figure out whether they can claim the Dependent Care Credit, not to explain what is reimbursable under the Dependent Care FSA. Regardless of what the Publication says, you must incur the expense during the Plan Year to be reimbursed for it.

Be sure to contact your Employer if you have questions about what expenses are, and are not, eligible. You can also go online at [www.mypayflex.com](http://www.mypayflex.com) for more information.

## **25. When must Dependent Care Expenses be incurred?**

Dependent Care Expenses must be incurred during the Plan Year. Dependent Care expenses are incurred when the service is provided that gives rise to the expenses, regardless when you pay for or are billed for the service. If you have paid for expenses but the services have not yet been rendered, the expense is not considered incurred and is not eligible.

**26. If I elect Dependent Care Benefits, can I still claim the Dependent Care Credit on my federal income tax return?**

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan. The amount of any Dependent Care Credit you may have available will be offset by any Dependent Care Benefits received under this Plan. Amounts contributed to your Dependent Care FSA Benefits account will be shown on your Form W-2 statement, and must be reported on your personal income tax return.

The Dependent Care Credit is an allowance for a percentage of your annual Dependent Care Expenses as a credit against your federal income tax liability. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as a person'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.

For more information review IRS Publication 503-Child and Dependent Care Expenses and IRS Form 2441, and consult a qualified tax advisor.

**27. How do I submit a claim for health care or dependent care FSA benefits?**

A claim for benefits is a request for a plan benefit made by the claimant/Participant in accordance with the plans' procedure for filing benefit claims. When you incur expenses that qualify under the plan as a benefit,

claims must be made in writing sent through the mail or fax or on the web evidencing that the claim has actually been INCURRED during the Plan Year. Application for such expense reimbursement may be made at any time during the Plan Year in which the expense was INCURRED. An "autopayment" feature is another option for reimbursement of medical claims only. Any out-of-pocket liability of the employee is then automatically reimbursed via direct deposit or check. This process allows the reimbursement of medical insurance claims without requiring the employee to submit a claim for reimbursement.

**Health Care FSA Benefits.** If you have insurance, submit the expense to the insurance carrier first, and then retain the insurance carrier's Explanation of Benefits (EOB) as documentation to submit with your claim. If you do not have insurance, obtain an itemized statement from the provider that includes all of the following information:

- provider name and address;
- date service or supply was provided (regardless when paid for or when you are billed for it);
- patient name receiving the service or supply;
- detailed description of the service or supply; and,
- dollar amount charged for the service.

In some cases, you will also be required to provide a letter or further documentation from your attending physician in order to substantiate your claim.

**Dependent Care FSA Benefits.** Obtain an itemized statement from the dependent care provider that includes:

- provider name, address, and Social Security/tax identification number;
- date services were provided (regardless when paid for or when you are billed for it);
- dependent's name and age; and,
- dollar amount charged for the services.

In lieu of an itemized statement, the dependent care provider can sign the claim form where indicated.

An expense is INCURRED on the date the service is provided. The date of payment or billing is immaterial in determining when an expense is INCURRED. For prescription drugs or other medical goods ordered, the incurred date is the date the order is placed or filled, that gives rise to the expense.

Claims for reimbursement may be made in writing on a Claim Form. The Claim Form must be completed in full and signed by the Plan Participant and submitted to the Claims Administrator, accompanied by third party documentation of the incurred expenses such as itemized bills, invoices, or receipts; or explanation of benefits or other itemized statements as described above. (Cancelled checks, credit card receipts, balance forward statements, paid on account or received on account statements are not eligible documentation.)

Claims are processed according to a schedule established by the Employer and Administrator. Reimbursements will be processed no less frequently than monthly or when the total is at least a specified minimum amount (as established by your Employer). Claims will be accepted for a period of time (as determined by your Employer) following the end of each Plan Year.

If your Employer offers the flex debit card option, you will not have to submit a paper claim to request reimbursement. The card operates like a debit card that can simplify the process of paying for eligible expenses. It is an alternative to the traditional method of filing claims. When you use the card for eligible expenses, the card system will validate that your coverage is active and that you have available funds to cover the transaction. Although you will not need to file a paper claim for that expense, you **must** retain documentation of the expense, as you may receive a letter from our claims administrator requiring you to substantiate transactions by providing copies of the documentation. As part of the autopayment design, the debit card (which holds the balance of Health Care FSA) cannot be used at a medical provider office. The debit card can, however, be used at the pharmacy, dental providers, vision providers, etc. More information about the card is available from your Employer.

**28. What happens if I do not submit claims for the amounts credited to my health care and/or dependent care FSA accounts?**

The amounts credited to your health care FSA account for any Plan Year shall be used only to reimburse you for eligible expenses INCURRED during the plan year and up to the end of the grace period (if your Employer has elected to offer the grace period), or until the end of your applicable period of coverage. The amounts credited to your dependent care FSA account for any Plan Year shall be used only to reimburse you for eligible expenses INCURRED during the plan year. In addition, funds in one account cannot be used for expenses in another account. You must apply for reimbursement on or before the 90<sup>th</sup> day following the close of the plan year. After all claims for a plan year have been settled, according to IRS Regulations, any remaining money left in any one account (health care and/or dependent care) must be forfeited and this money would revert to the Employer (to be used to offset FSA administrative expenses and future costs.). For example, if you designate \$5,000 annually to your dependent care FSA account and by the end of the plan year you spent only \$4500, you will forfeit \$500. Unused benefits or contributions cannot be cashed out by Plan participants.

Your FSA expense account(s) will begin the new plan year with a zero balance. Because health care money is forfeited if it is left in the account at the end of the plan year's grace period, it is important that you carefully estimate what you will spend in each area of the benefit plan.

Also, any benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the expense was incurred shall be forfeited.

**29. What happens if my claim for benefits is denied?**

If a claim is denied, in whole or in part, you will receive written notice from the Claims Administrator within 30 days (may include a 15-day extension for reasons beyond the control of the plan) of the date your claim was received. This notice will state:

- 1) The specific reason for denial and plan provision on which the denial is based;
- 2) A description of any material or information necessary to perfect the claim (this information must be provided within 45 days); and

- 3) Steps to be taken if you wish to request a review of the decision, including your right to submit written comments, your right to review relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

If your claim is denied in whole or part, you may request review upon written notice. Your request for review must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not request a review on time, you will lose the right to a review and the right to file suit. Your written request for review should state the reasons that you feel your claim should not have been denied and include any additional facts and/or documents that you feel support your claim.

Your request for review will be reviewed and decided by the Plan Administrator in a reasonable time not later than 60 days after the Plan Administrator receives your request for review. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth the reason for the decision on review and plan provision on which the decision is based, a statement of your right to review relevant documents, if an internal rule, guideline or protocol, or other similar criterion is relied on in making the decision on review, a description of that rule or a statement that such rule will be provided free of charge to you upon request, and a statement of your right to bring suit under ERISA (where applicable). Such suit may be filed only after the plan's review procedures described above have been exhausted and can be filed only within 90 days after the Plan Administrator's final decision is provided.

### **30. What are my rights under the Plan?**

As a participant in the City of Knoxville's Cafeteria Compensation Flexible Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge at the Plan Administrator's office and at other specified locations, such as work-sites, all plan documents, including insurance contracts 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.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**COBRA and HIPAA.** You have a right to continue your health insurance plan(s) coverage and, in some cases, 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. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. 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 creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Qualified Medical Child Support Order.** The components of the Plan that are group health plans extend benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined. The Plan has procedures for determining whether an order qualifies as a QMCSO.



**Newborns' and Mothers' Health Protection Act of 1996.** In the case of a group health plan that provides maternity or newborn infant coverage, such group health plan and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Insurance Plan Documents.** This Summary Plan Description does not describe the Insurance Plan(s). Consult the Insurance Plan document(s) and the separate Summary Plan Description(s) for the Insurance Plan(s).

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

**Enforce Your Rights.** If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to have the plan review and reconsider your claim, all within certain time schedules. 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 which 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 lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance With Your Questions.** If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this Part of the Summary Plan Description or other rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210.