INFINISOURCE BENEFIT SERVICES

KABEL BUSINESS SERVICES

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Warren County

January 1-December 31

FLEXIBLE BENEFIT PLAN

Summary Plan Description

Summary Plan Description

COMPANY INFORMATION

Name of Plan	Warren County **Flexible Benefit Plan**
Employer	Warren County
Federal Tax ID Number	42-6004798
Mailing Address	301 N Buxton, #1 Indianola, IA 50125
Plan Administrator	Warren County
Agent for Service of Legal Process	Peg Hutchison

PLAN SERVICE PROVIDER

Provider Name	**Kabel Business Services** Powered by Infinisource Benefit Services
Mailing Address	1454 30th Street, Suite 105 West Des Moines, IA 50266
Phone	(515) 224-9400 or (800) 300-9691
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Website	www.kabelbiz.com

PLAN TYPES

The following are applicable to Warren County's plan.

☒	**Medical Flexible Spending Account**
☒	**Limited Purpose Flexible Spending Account**
☒	**Dependent Care Flexible Spending Account**
☐	**Health Savings Account**

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Basics of Flexible Spending Accounts

About this Summary Plan Description

This Summary Plan Description (SPD) describes the benefits of your Flexible Spending Account Plan. This Plan is intended to qualify as a Cafeteria Plan under Code § 125 and the regulations issued thereunder and shall be interpreted to accomplish that objective. As a Cafeteria Plan, this Plan is designed to permit eligible employees to pay for their share of contributions for certain Medical Insurance Plan, Dental Insurance Plan, and other Employer sponsored benefit plans on a pre-tax Salary Redirection basis and to contribute on a pre-tax Salary Reduction basis to an eligible employee's Health Savings Account, to a Medical Flexible Spending Account, to a Limited Purpose Flexible Spending Account, and to a Dependent Care Flexible Spending Account.

Please read this SPD carefully so you understand the benefits of your Plan. Your Employer has official documents for each benefit type in the Plan. In case of a conflict between those documents and this SPD, the official documents will govern. You may view or request copies of the official plan documents by contacting your Employer. If laws change regarding any provision in this SPD, that provision will be changed to meet the minimum requirements of the law.

Premium Payment Component of this Plan

The Premium Payment Component of this Plan offers benefits under the Medical Insurance Plan, providing major medical benefits (including a High Deductible Health Plan option and such other options as may from time to time be offered by your employer), and other such benefit options offered by your employer on a pre-tax basis through a Salary Reduction Agreement. Under the Premium Payment Component of this Plan, eligible employees can (a) elect to pay their share of benefit contributions, if any, on a pre-tax basis; or (b) elect no benefits under the Premium Payment Component and pay for their share of benefit contributions, if any, with after-tax deductions outside of this Plan. Unless an exception applies that allows a change in election, such election is irrevocable for the duration of the plan year. Notwithstanding any other provision in this Plan, your Employer has official documents for your major medical benefits, and other such benefit options offered by your employer on a pre-tax basis under this Plan, and in case of a conflict between those documents and this SPD, the official documents will govern.

What is a Medical Flexible Spending Account?

A Medical Flexible Spending Account (Medical FSA) allows the employee to set aside before-tax dollars to pay for medical expenses that are not paid by insurance, the employer, or reimbursed by any other source. The annual election maximum is based on the plan's design. The annual election that the employee determines is irrevocable once the employer's open enrollment period is over unless the employee experiences a qualifying event or status change. The election must be requested for reimbursement for services within the plan year and/or while actively participating in the plan.

The maximum annual contribution or election amount an employee may have for a Medical FSA is the IRS Medical Maximum.

What is a Limited Purpose Flexible Spending Account?

A Limited Purpose Flexible Spending Account (LPFSA) is much like a Medical FSA, however, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents.

The maximum annual contribution or election amount an employee may have for a Limited Purpose FSA is the IRS Medical Maximum.

What is a Dependent Care Flexible Spending Account?

A Dependent Care Flexible Spending Account (DCFSA) provides payment by the employer to individuals who elect Dependent Care Assistance as defined in IRS Section 129. Individuals will be reimbursed for the care of eligible dependents by a qualified provider only to the extent that such amounts have not been previously claimed as a credit on the individual's personal income tax return.

The maximum amount an employee may elect for the DCFSA per benefit plan year is $5,000 if the employee is married and filing a joint income tax return or is a single parent and $2,500 if the employee is married but filing an income tax return separately.

Important Points to Remember for Medical FSA and LPFSA

- Elections made under the plan are irrevocable during the plan year and subject to a qualifying event or status change.
- Medical FSA and LPFSA reimbursements can only be made for eligible services or expenses incurred from January 1-December 31.
- Eligible expenses must have been incurred for you, your spouse, children, or any other person who is your qualified dependent under the Internal Revenue Code.
- Expenses are incurred when care is provided rather than when you are billed or pay for the care; except for orthodontia.
- For mid-year enrollments, expenses incurred prior to your effective date are not eligible.
- Expenses incurred after participation ends or after employment is terminated are not eligible unless the plan is eligible for and elected under COBRA.
- A run-out period is the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the plan year. You will have a run-out period of 90 days after the plan year end date in which to submit claims for payment of eligible expenses incurred during the plan year that were not yet reimbursed.

Important Points to Remember for DCFSA

- DCFSA expenses must be incurred to enable you (and your spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: if your spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care.
- DCFSA reimbursements can only be made for eligible services or expenses incurred from you January 1-December 31.
- Eligible expenses must have been incurred for a child under the age of 13 who is a dependent on your federal income tax return or a dependent who is incapable of self-care.
- Expenses are incurred when the care is provided rather than when you are billed or pay for the care.
- Elections made by you under the plan are irrevocable during the plan year and subject to a qualifying event or status change.
- For mid-year enrollments, expenses incurred prior to your effective date are not eligible.
- Expenses incurred after participation ends or after employment is terminated are eligible for reimbursement until the end of the plan year.
- A run-out period is the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the plan year. You will have a run-out period of 90 days after the plan year end date in which to submit claims for payment of eligible expenses incurred during the plan year that were not yet reimbursed.
- If you fail, or are unable, to fully utilize the pre-tax dollars you have set aside during the plan year, or do not submit claims incurred during the plan year within the applicable grace period and run-out period, your unused election dollars will be forfeited.

What is a Health Savings Account?

A Health Savings Account (HSA) is an individual trust or custodial account that is separately established and maintained as a savings account of the employee governed by the trust/custodial agreement set forth in the employee's HSA, and is to be used primarily for reimbursement of qualified eligible medical expenses as set forth in Internal Revenue Code, Section § 223(d)(2). Benefits under this Plan consist of the ability of eligible employees to make contributions to the HSA on a pre-tax salary reduction basis and for the employer to forward contributions to be deposited into the employee's HSA. Terms and conditions of the HSA are governed by the trust/custodial agreement applicable to each eligible employee who elects to participate in an HSA.

The maximum annual contribution an employee can make is subject to the statutory maximum amount for HSA contributions for the calendar year in which the contribution is made ($3,500 for single and $7,000 for family are the statutory maximum amounts for 2019). An additional catch-up contribution of $1,000 may be made for participants who are age 55 or older. In addition, the maximum annual contribution shall be reduced by any matching employer contribution made on the employee's behalf and prorated for the number of months in which the participant is an HSA-eligible individual.

Important Points to Remember for HSA

- In order to be eligible to enroll in an HSA:
  - You must be enrolled in the High Deductible Health Plan.
  - You must not be covered by any other medical plan other than an IRS-qualified high deductible medical plan, even if it is another family member's coverage. If you are covered by any other non-high deductible medical insurance, such as your spouse's employer's PPO plan, or HMO plan, you cannot contribute to an HSA, even if you are enrolled in your employer's High Deductible Health Plan.
  - You must not be enrolled in, be eligible for reimbursement under, or receive reimbursement from a Medical Flexible Spending Account, including as a dependent under your spouse's Medical Flexible Spending Account. However, you or your spouse can be enrolled in a Limited Purpose Flexible Spending Account.
  - You and your spouse must not have a Retirement Reimbursement Account with another employer that covers you, or an outstanding balance in a Retiree Reimbursement Account.
  - You must not be enrolled in Medicare or TRICARE.
  - You must not be claimed as a dependent on anyone else's tax return.
- Unlike the Medical Flexible Spending Account, Limited Purpose Flexible Spending Account, and Dependent Care Flexible Spending Account, any funds remaining in your HSA at the end of the plan year roll over, and you can add more money or spend the money on eligible expenses in future years. The funds in your HSA are always yours even if you change medical plans, leave your employer, or retire.
- You can rollover funds from other HSAs.
- You can use your HSA to pay certain health care expenses incurred by you or any of your dependents. You or your dependents do not have to be enrolled in your employer's medical plan in order to receive reimbursement for eligible health care expenses from your HSA, however, you must be enrolled in your employer's High Deductible Health Plan option in order to make contributions to your HSA.
- Eligible expenses must have been incurred for a child under the age of 13 who is a dependent on your federal income tax return or a dependent who is incapable of self-care.
- Expenses are incurred when the care is provided rather than when you are billed or pay for the care.

Plan Information

Eligibility Requirements

Existing Employees: If you are in the Employer's employment on the plan's effective date and have satisfied the waiting period, you shall be eligible to become a participant on the plan's effective date, subject to the exclusions noted below.

New Employees: If your employment by the Employer begins after the plan's effective date, you will become eligible to participate when eligible for group health coverage.

Re-employment of Former Employees: A re-employed former employee shall be treated the same as a new employee in determining eligibility, unless rehired within 30 days or less during the same plan year, then your prior elections will be reinstated.

Exclusions:
- ☐ None – All employees eligible
- ☒ Part-time employees working less than 40 hours per week
- ☐ Seasonal employees
- ☐ Employee waiting period
- ☐ Members of the bargaining unit

When to Enroll

- You may enroll within 30 days of when you first become eligible as a new employee.
- You may enroll each year during open enrollment.
- You may enroll during the year within 30 days of a qualifying life event. Your election change must be consistent with the qualifying event or status change.

How to Enroll

Your employer will provide enrollment materials upon eligibility and each year upon open enrollment.

When Coverage Begins

If you enroll when first eligible or after a qualifying event, your coverage starts immediately following your enrollment, subject to payroll deadlines, unless the change is the addition of a dependent through birth or adoption, which may be made retroactive to the date of event if the request is timely made. If you elect coverage during Open Enrollment, the effective date is January 1.

Benefit Payments

Claims under the plan are paid from salary reductions taken on a pre-tax basis. Amounts withheld are held in a trust account or with the general assets of the employer.

Plan Administration

As the Plan Administrator, your employer is ultimately responsible for the management of the plan. Plan Administrators may employ or contract with persons or firms to perform the day-to-day functions such as processing claims and performing other plan-related services. Kabel Business Services, as the Plan Manager, provides administrative services for the Plan Administrator in connection with the operation of the plan, including the processing of claims and other such functions as may be delegated to Kabel Business Services by the Plan Administrator.

Who Can Be Covered Under the Plan

Medical and Limited Purpose FSA Eligible Dependents

You can use your FSA when expenses are incurred for yourself or eligible dependents, even if they are not covered through your employer's health plan. The following individuals would be considered eligible dependents:

- Spouse
- Child who has not attained age 27 as of the end of the calendar year
- Qualifying Tax Dependent

Dependent Care FSA Eligible Dependents

Eligible dependents for Dependent Care FSA include:

- A child under the age of 13 who is a dependent on your federal income tax return.
- A spouse who is incapable of self-care
- A dependent who is over the age of 13, parent, sibling, or in-law who is incapable of self-care, provided that they have the same principal abode as you for more than half of the year and for whom you claim as a dependent on your tax return.
- For the children of divorced/separated parents, see final IRS rules for a "Dependent Child of Divorced or Separated Parents Who Live Apart." To determine how the rules may apply, you must consult a tax advisor.

For more information on dependent care qualifying dependents, refer to IRS Publication 503.

Changing Elections

Once the plan year starts, changes in the elections are not allowed unless a qualified change in election event is experienced. If you experience a change in election event, you may be able to make certain election changes that are on account of, consistent with the change in election event, and allowable under IRS guidelines. If one of the following events applies to you, inform your employer within 30 days of the occurrence (within 60 days for Medicaid/State Children's Health Insurance Plan); you may be required to submit a new Election Form/Salary Reduction Agreement. The change will be effective as of the first of the month following the date of the election request, except in the cases of birth, adoption, or placement for adoption, when coverage for the new dependent will be effective as of the date of the qualifying event. Only claims incurred while actively participating are eligible for reimbursement.

The irrevocability rules described above do not apply to HSAs. You may start, stop, increase or decrease the amount of your HSA contribution at any time, and regardless of whether or not you have experienced a qualified change in election event as long as all other eligibility provisions applicable to HSAs apply, and as long as you do not exceed the annual maximum contribution. Your change request will be effective as soon as administratively feasible, typically the first or second pay period following the date you submit your request.

Events for Which You May Change Your Enrollment Election

These are examples of qualifying change in election events:

- Change in status
  - Legal marital status (such as marriage, death of a spouse, divorce, legal separation, or annulment)
  - Number of dependents (such as the birth of a child, adoption or placement for adoption of dependent, or death of a dependent)
  - Employment status change that makes the individual become or cease to be eligible for the applicable benefit (such as termination or commencement of employment, change in the number of hours worked, strike or lockout, switch between part-time and full-time, or the beginning or end of an unpaid leave of absence by you, your spouse, or your dependent)
  - Event causing your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or similar circumstances
  - Residence change for you, your spouse, or your dependent resulting in gain or loss of eligibility under a group insurance plan
- Special enrollment rights
  - In certain circumstances, special enrollment rights for major medical plans under the Health Insurance Portability and Accountability Act of 1996, may allow you to change your election to correspond with your special enrollment right.
- Court order event
  - Allows you to change your Medical FSA election in accordance with a court order regarding the health coverage of your child. This does **not** apply to DCFSA.
- Entitlement to Medicare or Medicaid
  - If you, your spouse, or your dependent becomes entitled to and enrolled in Medicare or Medicaid, you may reduce or cancel that person's accident or major medical coverage under the medical or dental insurance plan and/or your Medical FSA coverage may be canceled completely, but not reduced.
- Significant change in the cost of dependent care
  - If your dependent care provider increases or decreases the cost of care, you may make a corresponding change to your DCFSA election. This does **not** apply to the Medical FSA or LPFSA.

Examples of Eligible and Ineligible Expenses

Medical FSA Expenses

The Internal Revenue Code, Section §213(d), set the rules determining which expenses can be paid with your FSA funds. Generally, eligible expenses are those not covered by your medical, dental, or vision plans. They must be meant to diagnose, cure, mitigate, treat or prevent illness or disease.

Some examples of eligible Medical FSA expenses include:

- Co-payments, deductibles, and other eligible expenses not covered by insurance
- Payments for prescription drugs
- Over-the-counter medications, dietary supplements and vitamins
- Dental services, orthodontics, and dentures
- Contact lenses, eyeglasses, and vision correction procedures
- Weight-loss programs to treat a specific disease
- Chiropractic services
- Psychiatric care and psychologists' fees
- Durable medical equipment like crutches and wheelchairs
- Transportation for medical care

Some examples of ineligible Medical FSA expenses include:

- Insurance premiums
- Personal use items like toothpaste and cosmetics
- Over-the-counter medications that are not prescribed by a doctor or other legally prescribing provider
- Family or marriage counseling

Expenses reimbursed under your Medical FSA cannot be deducted on your tax return. Likewise, you cannot use the Medical FSA to be reimbursed for expenses that are eligible for reimbursement through another plan or program.

Limited Purpose FSA Expenses

LPFSA covers qualified out-of-pocket expenses for dental or vision care provided to you, your spouse or qualified dependents.

Some examples of eligible LPFSA expenses include:

- Dental check-ups and cleanings
- Fillings
- Crowns
- Braces
- Contact lenses
- Eyeglasses
- Eye exams
- Vision correction procedures

Some examples of ineligible LPFSA expenses include:

- Insurance premiums
- Medical expenses, including deductibles, co-insurance, and co-pays
- Dental whitening procedures and kits
- Prescription medications
- Over-the-counter medications
- Medical equipment
- Personal use items such as toothpaste, razors, and shampoo

Expenses reimbursed through your LPFSA cannot be deducted on your tax return. Likewise, you cannot use the LPFSA to be reimbursed for expenses that are eligible for reimbursement through another plan or program.

Dependent Care FSA Expenses

DCFSA reimbursements are those incurred to enable you (and your spouse, if you are married) to be gainfully employed, which generally means working or looking for work. The maximum reimbursement you may receive is equal to the current balance in your DCFSA. If your reimbursement request is more than your available balance, the remaining amount will be placed in a pending status and will be paid when additional funds are posted to your account. Any funds left at the end of a plan year are forfeited if claims are not submitted for reimbursement within 90 days of the close of the plan year.

Some examples of eligible DCFSA expenses include:

- Before-school and after-school care
- Expenses for preschool/nursery school
- Extended day programs
- Babysitter (in or out of the home)
- Nanny services (amounts paid for the actual care of the dependent)
- Summer day camp for a qualifying child under the age of 13
- Elder day care for a qualifying individual

Some examples of ineligible DCFSA expenses include:

- Services provided by your dependents
- Nursing homes or residential care centers
- Educational expenses
- Tuition for kindergarten and above
- Food expenses (unless inseparable from care)
- Incidental expenses (such as extra charges for supplies, special events, or activities unless inseparable from care)
- Overnight camp

You will be reimbursed for the dependent care of your eligible dependents by a qualified provider. The care provider must have a Social Security Number, Employer Identification Number (EIN), Individual Taxpayer Identification (ITIN), or a Taxpayer Identification Number (TIN).

Expenses reimbursed through a DCFSA cannot be deducted or used as a credit on your tax return.

Health Savings Account Expenses

Only allowable medical expenses under IRS rules that are adequately documented and not covered by insurance are eligible to be reimbursed.

Some examples of eligible HSA expenses include:

- Limited types of insurance premiums, including COBRA and qualified long-term care
- Deductibles/co-insurance/copayments under the medical plan, dental plan, vision plan, or any other health plan under which you have coverage
- Payments for prescription drugs
- Over-the-counter medications, dietary supplements and vitamins
- Dental services, orthodontics, and dentures
- Contact lenses, eyeglasses, and vision correction procedures
- Weight-loss programs to treat a specific disease with proven medical necessity
- Chiropractic services
- Psychiatric care and psychologists' fees
- Durable medical equipment like crutches and wheelchairs
- Transportation for medical care

Some examples of ineligible HSA expenses include:

- Cosmetic surgery and procedures
- Cosmetics and toiletries
- Expenses claimed on your income tax return
- Meals
- Most insurance premiums, including premiums for plans maintained by the employer of your spouse

Expenses reimbursed under your HSA cannot be deducted on your tax return. Likewise, you cannot use your HSA to be reimbursed for expenses that are eligible for reimbursement through another plan or program.

Claims Processing and Reimbursements

Medical FSA and Limited Purpose FSA Claims Processing and Reimbursement

When you incur an eligible expense, you can be reimbursed in one of following ways:

- Use the Kabel Business Services debit card as you would any other debit card for IRS eligible medical expenses at a qualified medical merchant for instant payment using your FSA funds. The Kabel Business Services debit card is limited to providers with a qualified medical Merchant Category Code (MCC) and for purchases that are IRS eligible medical expenses. Payment can only be made using the debit card during the plan year for which the expenses are incurred. You can use your Kabel Business Services debit card to pay for expenses on the date of service or when you receive a bill from your provider, as long as both the debit card payment for the expense and the date of service of the expense (not the date you received the bill from your provider) is within the same plan year and funds are available for that plan year.
- Pay the provider by logging into your account or through the mobile application.
- Pay with cash or check, then submit a claim to Kabel Business Services with appropriate

documentation of the eligible expense. You can submit a claim and/or required documentation to Kabel Business Services the following ways:

- Log into your account at https://kabelparticipant.lh1ondemand.com
- Use the mobile application available for Apple or Android devices
- Fax your claim and supporting documentation to 515-224-9256
- Mail your claim and supporting documentation to Kabel Business Services

Debit Card Claims

In accordance with IRS guidelines, and to maintain the plan's pre-tax eligibility, Kabel Business Services must request documentation from participants for certain debit card transactions that are not able to be auto substantiated. In some instances, you may be required to provide documentation or additional information regarding your debit card purchase. If you do not provide enough information to allow Kabel Business Services to substantiate a Medical or LPFSA claim, Kabel Business Services will suspend the debit card and the reimbursement of claims from the applicable account until provided with the documentation requested by Kabel Business Services, or until the amount in question is repaid or offset by unreimbursed eligible expenses.

We contact participants directly via email, or postal mail if no email address is on file, for any claims that require documentation. Participants are contacted three (3) times for each transaction requiring documentation and are given a sixty (60) day window from the date of transaction to submit documentation to substantiate the transaction before their card is suspended.

Claims Filed for Reimbursement

Kabel Business Services will review your claim and supporting documentation, including Explanation of Benefits statements or other appropriate documentation. Supporting documents must list the type of service or product you purchased, the date of the purchase, and the name of the covered individual the purchase was for. You must also include the name of the person or organization providing the service or product and the cost of the expense. For orthodontic expenses like braces, include a copy of the treatment plan or provider contract. You may include cash register receipts for standard medical copays or over-the-counter items, as long as the receipt includes the name of the provider, date, purchase amount and description of the item purchased (if applicable).

IRS regulations mandate reimbursement eligibility. Once Kabel Business Services receives and accepts your claim form and documentation, you will be reimbursed via direct deposit or check if you did not use the Kabel Business Services debit card. Usually, Kabel Business Services will process your claim within three (3) business days. Kabel Business Services has the authority to deny a claim that is not consistent with the terms of the plan; for example, if the claim is for an ineligible expense or if the claim is submitted after the deadline.

The IRS may request itemized receipts from individuals to verify expenses. As such, individuals should keep their receipts and other supporting documentation related to their expenses and reimbursement requests, including the insurance plan's Explanation of Benefits statement for an office visit or a pharmacy statement (with the patient's name, the prescribing physician, the prescription number, name of the drug, its cost and the date the prescription was filled).

Dependent Care FSA Claims Processing and Reimbursement

Reimbursement for DCFSA claims is only available up to the dollar amount you have contributed to your DCFSA account through pre-tax deductions from your paycheck for dependent care services that have

already been provided. This means you cannot be reimbursed for more than the amount in your DCFSA account at any given time, nor for any service that has not yet taken place, even if billed in advance. When you incur an eligible dependent care expense, you can be reimbursed in one of the following ways:

- Pay with cash or check, then submit a claim to Kabel Business Services with appropriate documentation of the eligible expense. You can submit a claim and/or required documentation to Kabel Business Services the following ways:
  - Log into your account at https://kabelparticipant.lh1ondemand.com
  - Use the mobile application available for Apple or Android devices
  - Fax your claim and supporting documentation to 515-224-9256
  - Mail your claim and supporting documentation to Kabel Business Services
- Pay the dependent care provider by logging into your account or through the mobile application.
- Pay with the Kabel Business Services debit card to pay for DCFSA services that have already been provided, as long as the merchant category code on the dependent care provider's card transaction machine is set as a dependent care provider, and the amount of the transaction is consistent with, or less than, the amount in your DCFSA account.

Kabel Business Services will review your claim and supporting documentation. IRS regulations mandate reimbursement eligibility regarding qualifying dependents, qualified providers, and eligible dependent care expenses. DCFSA claim documentation must include: the provider name, provider contact information, dependent name, date(s) of care, a description of the service(s), and the amount paid. Once Kabel Business Services receives and accepts your claim form and documentation, you will be reimbursed via direct deposit or check. If your reimbursement request is more than your available balance, the remaining amount will be placed in a pending status and paid when additional funds are posted to your account. Usually, Kabel Business Services will process your claim within three (3) business days. Kabel Business Services has the authority to deny a claim that is not consistent with the terms of the plan; for example, if the claim is for an ineligible expense of if the claim is submitted after the deadline.

The IRS may request itemized receipts from individuals to verify select expenses. As such, individuals should keep their receipts and other supporting documentation related to their expenses and reimbursement requests.

Leaves of Absence

Special rules can apply to FSA participation when you are on a leave of absence, to the extent required by federal or state law. Please contact your employer for details about your rights and responsibilities during your leave and your return to work. If your unpaid leave of absence is covered under the Family and Medical Leave Act (FMLA), you can continue your Medical FSA participation during your period of leave as long as you make after-tax contributions equal to the amount you were contributing on a pre-tax basis.

The plan provides for reinstatement of coverage for persons returning to employment after military service to the extent required by federal law. If you are rehired after a period of uniformed service that entitles you to rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA), you will be eligible for reinstatement under the plans. Contact your employer for further information.

How to Appeal a Claim Denial

If Kabel Business Services denies a claim in whole or in part, a written explanation will be sent by email or postal mail within three (3) business days of receiving your request for reimbursement. If the claim was denied because it is not consistent with the terms of the plan – for example, because the expense was ineligible or the claim was submitted after the deadline – Kabel Business Services will handle the appeal. You will need to request an appeal within 180 days of receiving the denial by writing to:

Kabel Business Services
Attn: Flex Claims Appeals
1454 30th Street, Suite 105
West Des Moines, IA 50266
515-224-9400
flexteamkb@infinisource.com

You should state all the reasons and supporting facts upon which your appeal is based, along with any other information you consider relevant. Generally, Kabel Business Services will respond within 30 days of receiving your request or within 30 days of receiving additional materials Kabel Business Services requests from you, your employer, or another relevant party. It is possible, however, that Kabel Business Services may require a longer period of review.

If your first level of appeal was denied, you may submit a final written appeal within 180 days of receiving your first level of appeal denial. You should include all relevant documents, issues, comments and additional information for review regarding your final appeal to Kabel Business Services at the address above. Kabel Business Services will submit all relevant claim appeal documentation to the Plan Administrator for final determination. Generally, the Plan Administrator will review and provide final determination of the appeal within 30 days.

Termination

Once the plan year commences or the newly eligible election period is over (for newly eligible employees), your election is irrevocable except when legislation requires termination of or substantial amendment to the plan, the Plan Administrator terminates the plan and/or coverages, or subject to the qualifying event status change rules. The plan or any portion of the plan is subject to termination at any time by the employer/Plan Administrator.

If you terminate employment and have funds left in your Medical FSA or LPFSA, you can submit claims for any eligible expenses you had prior to your termination. You have 90 days from the date of your termination to submit claims that were incurred on or prior to your date of termination or you will lose any remaining funds, absent an election in Continuation Coverage through your employer, based on eligibility and Continuation Coverage rules.

If you terminate employment and have funds left in your DCFSA, you will have 90 days to submit claims for eligible dependent care expenses that are incurred during the plan year or you will lose any remaining funds you contributed to your DCFSA account.

Continuation of Coverage Under COBRA or through State Continuation Coverage

Continuation of Coverage means the right under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) to continue the Medical FSA or LPFSA that was in place the day before a COBRA qualifying event took place, if participation by the plan member would otherwise terminate due to the COBRA qualifying event.

If you terminate employment or have another COBRA qualifying event and your employer is subject to COBRA or certain State Continuation Coverage that obligates them to offer continuation of Medical FSA or LPFSA coverage, you may be entitled to the offer of continuation of Medical FSA or LPFSA coverage through the end of the plan year.

Only participants who have positive balances (elected to contribute more money than they have taken out in claims) in their Medical FSA or LPFSA account at the time of a qualifying COBRA event will be eligible for COBRA coverage. For example, a participant who elected to contribute an annual amount of $1,000 to his or her Medical FSA account, and, at the time of termination of employment had contributed $600 but only claimed $200, may elect to continue applicable Medical FSA account. In this example, the participant would be able to continue to receive reimbursements for eligible claims up to the remainder of the annual election amount. However, the participant would have to continue to pay for the coverage, at the contribution costs stated by the Plan Administrator or through their designated COBRA administrator on an after-tax basis.

If required to be offered continuation of Medical FSA or LPFSA coverage, you should receive additional information regarding your Medical FSA or LPFSA coverage within your COBRA or State Continuation election notice.

Your Rights Under ERISA

As a participant in the company's medical and dental expense reimbursement 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 and union halls, all plan documents including insurance contract, 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.

Receive a summary of the plan's annual financial report when such a report is required by law.

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 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 administrator review and 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 materials and pay you up to $100 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 as above. 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 or if it finds your claim is frivolous. 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. Labor-Management Services Administration, Department of Labor.

Access to Records and Confidentiality
(Applies to Medical FSA and Limited Purpose FSA Plans)

The Plan Administrator complies with applicable state and federal laws governing the confidentiality and use of protected health information and medical records. The Plan Administrator is also allowed to use your protected health information when necessary, for proper administration of the plan.

In the event that protected health information is disclosed to the Plan Administrator, the Plan Administrator may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated there under and as amended including, certain plan administrative functions such as: claims review, subrogation, quality assurance, auditing, monitoring and management of carve out plans. Information may only be disclosed to the Plan Administrator upon receipt, by the plan, of a certification from the Plan Administrator to the amendment of the plan documents and that your Plan Administrator agrees to:

- Not use or further disclose information except as listed above or as required or permitted by law;
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your employer or Plan Administrator and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;
- Not use or disclose any information for employment-related actions or decisions;
- Not use or disclose any information in connection with any other employee benefit plan of your employer or Plan Administrator;
- Report to the plan any security incident it becomes aware of and any use or disclosure of the information that is inconsistent with the uses or disclosures described above;
- Make information available to fulfill your right to access your protected health information;
- Make information available for amendment or to incorporate applicable amendments;
- Make information available in order to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of information received from the plan available to the Department of Human Services to determine compliance with HIPAA;
- Return or destroy all protected health information received from the plan, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure only certain classes of employees designated by your employer are permitted access to your protected health information for plan administration functions;
- Implement an effective mechanism for handling noncompliance by the employees designated access to your protected health information;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that is created, received, maintained or transmitted on behalf of the group health plan;
- Ensure adequate separation between the plan and your Plan Administrator is supported by reasonable and appropriate security measures.