Summary Plan Description

Note to Employer: The United States Department of Labor requires this summary or a copy of it be given to eligible employees.

Plan Sponsor (Employer), Plan Administrator and Agent for Legal Service

Susan Zenzen
Superior Court of California, County of San Bernardino

247 W Third St
1st Floor
San Bernardino CA 92415-0312
Plan Administrator accepts service of legal process.

Phone Number: 909-521-3635
Plan Number:
Federal Tax ID: 33-0939001

Employer's Plan Name: Flexible Compensation Plan for Superior Court of California, County of San Bernardino

Plan Year: 01/01/2019 - 12/31/2019

Medical FSA Carryover Maximum: $500.00

Runout End Date: 03/30/2020

Client TASC ID: 4213-2582-3934

Group Name: Superior Court of California, County of San Bernardino

PURPOSE
Your Employer has adopted this Flexible Compensation Plan to allow you to select from among benefit options made available under the Flexible Compensation Plan and pay for the selected benefits for yourself, your spouse, and your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" benefits in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code, and the benefits you elect will be excluded from your income under Section 125(a).

BENEFITS OFFERED TO EMPLOYEES:	**Maximum Participant Salary Reduction**	**Grace Period End Date**
Dependent Care Expenses	$ 5000.00	N/A
Medical (Out-of-Pocket) Expenses	$ 2650.00	N/A

This Flexible Compensation Plan allows you to reduce your taxable income in direct proportion to (a) your contribution to the cost of your elected benefits and (b) your contribution to any account based tax advantaged plan or fringe benefit plan offered by your Employer that is governed by the Internal Revenue Service (IRS) Code.

ELIGIBILITY REQUIREMENTS: The benefits offered above are available to the following employees as stipulated below**:**

Part-time Employees	Included
Members of Bargaining Unit	Included

This Plan defines a Plan-eligible employee to be an individual classified by the Employer as a common-law employee who is on the Employer's W-2 payroll. Employees do not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Existing Employees. If you are employed by the Employer on the Plan's effective date, you shall be eligible to participate on the later of the Plan's Effective Date or on the date you satisfy the Eligibility Requirements stated above.

New Employees. If your employment begins after the Plan's Effective Date, you will be eligible to participate on the entry date noted above for Probationary Employees, following the date you satisfy the Eligibility Requirement stated above.

Re-employment of Former Employees.
Based on the Reinstatement Policy

Age Requirement. No maximum age requirement may be imposed for participation in the Plan.

GENERAL INFORMATION
This Flexible Compensation Plan allows you to pay your cost for the benefit plans you elected that are sponsored by your Employer through a Salary Reduction Agreement. This lowers your federal and state taxes. Under this Flexible Compensation Plan two types of benefit plans offered by your Employer may be funded by your salary reduction: premium benefits and reimbursement benefits. Premium benefits are the actual payments made to secure your participation in insurance plans. These are payments made from your Employer's general assets to an insurance company or a third-party administrator. Reimbursement benefits are benefits paid under an agreement to reduce your salary by the amount you elected to defer and pay you tax free benefits for certain qualified medical and dependent care expenses, as authorized under the Internal Revenue Code.

Administration. Your Employer or appointed Plan Administrator is responsible for the administration of your Employer Sponsored General Welfare Plans. Should you need to see any records or have any questions regarding these Plans, contact the Plan Administrator. The Plan Administrator has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. A health insurance issuer is not responsible for the Plan's administration (including payment of claims).

The Plan Administrator appoints TASC as a Service Provider to maintain certain Plan records and to be responsible for the Plan's day-to-day administration. TASC is not a Plan Administrator and has no discretionary authority regarding the Plan.

Plan Termination or Amendment. The Employer, or appointed Plan Administrator, has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time. Upon the termination or partial termination of the Plan, Participants have no Plan benefits except with respect to covered events giving rise to benefits occurring prior to the date of Plan termination or partial termination, except as otherwise expressly provided in writing by the Employer.

Excess Payments. Upon any benefit payment made to a Participant in error under the Plan, said Participant will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Participant's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid claim upon request is not provided. The Employer may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and subtracting from future benefit reimbursement(s) the amount paid in error.

No Continued Employment. No provisions either of the Plan or of this Summary shall grant any employee any rights of continued employment with the Employer or shall in any way prohibit changes in the terms of employment of any employee covered by the Plan.

Non-Assignment Of Benefits. No Participant or beneficiary may transfer, assign or pledge any Plan benefits except as may be required pursuant to (a) a "Qualified Medical Child Support Order" (which provides for Plan coverage for an alternate recipient), (b) other applicable law, or (c) electronic payment made directly to a healthcare provider.

CONTRIBUTIONS AND ENROLLMENT

Participant Contributions. By participating in the Plan, you agree to have your annual compensation reduced by the total cost of the Plan benefits you elected.

Employer Contributions and Enrollment Elections. At its election, your Employer may pay part of the insurance premiums or other qualified benefits made available through this Plan. The annual enrollment materials will include: (1) the amount of any Employer contributions for the various Plans offered by the Employer that allow you to make pre-tax contributions, (2) the rules defining how the Employer contributions may be used, and (3) the enrollment procedures to make annual elections for your pretax contributions. These enrollment materials are incorporated in this Summary Plan Description by reference.

The various benefit plans offered by your Employer may operate under different plan years. For instance, an Employer may enter into an annual contract with an insurance company (to provide benefits to employees) under a contract year that differs from the Plan Year established for this Flexible Compensation Plan. If this is the case, different Plan benefit entry dates will apply.

If you are not eligible to participate in this Plan but are allowed to participate in another benefit plan offered by your Employer, under the eligibility terms of that Plan, your costs will be paid with taxable income, and your compensation will not be reduced by the Employer.

BENEFITS AND QUALIFYING CHANGE IN STATUS EVENTS

The laws governing Flexible Compensation Plans generally do not allow you to change your benefit and contribution elections during a Plan Year (except for Health Savings Account plans; see below). Your elections are irrevocable and any balance in your account at the close of the Plan Year is forfeited and becomes the property of your Employer (refer to your open enrollment materials if your Plan has a Grace Period or a Carryover); this irrevocable election rule does not apply if you experience a qualifying change in status event, in which case the election change requested must be on account of and consistent with the qualifying event.

Any request to change your election must be submitted in writing within 30 days of any applicable qualifying event. The new benefit elections may start only after your change in status has taken place and the new paperwork has been filed.

A qualifying change in status event may be one of the following:

- A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
- The adoption, birth, or death of a child or dependent.
- Dependent satisfies or ceases to satisfy dependent eligibility requirements.
- The change in employment status of you, your spouse or dependent.
- Change in your residence.*
- Beginning or ending adoption proceedings.
- Automatic changes upon cost increases or decreases.*
- Significant cost increases.*
- Significant curtailment of coverage.*
- Addition or elimination of similar benefits package option.*
- Change in coverage of a spouse or dependent under an employer plan.*
- FMLA.
- HIPAA special enrollment rights.*
- COBRA qualifying event.
- Loss of group health coverage sponsored by governmental or education institution.*
- A judgment, decree or order requiring coverage for a spouse or child.
- Medicare or Medicaid entitlement.
- Termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage.*
- Eligibility for Employment Assistance under Medicaid or SCHIP.*
- Exchange Event – a loss of eligibility under the terms of the plan due to a reduction in hours (less than 30) – even when the Employer allows the coverage to continue in effect during the 'Stabilization Period' to satisfy the Affordable Care Act coverage requirements.*
- Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period.*

* These qualifying events do not apply to the Medical Expenses Reimbursement Plan.

If you are making tax free contributions to a Health Savings Account (HSA) under this Plan, you do not need a 'change in status' event to change your HSA election. You may prospectively change your HSA election at any time during the Plan Year.

Under the qualifying events of Termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

THE REIMBURSEMENT PLANS

If the BENEFITS OFFERED TO EMPLOYEES Section of this Summary Plan Description lists Medical (Out-of-Pocket) Expenses, Dependent Care Expenses and/or Non-Employer Sponsored Premiums, then your Plan includes that Reimbursement Plan.

The Participant Reference Guide, incorporated by express reference into this Summary Plan Description, includes all of the information you need to access your reimbursement accounts and submit claims for reimbursement. By visiting the Account Manager link addressed in this Guide you may access information about your reenrollment, your available funds, annual election, total contributions, and total reimbursements. These plans provide tax free benefits for medical, dependent daycare and/or non-employer sponsored health insurance premium claim reimbursements in accordance with IRS guidelines and protocols.

Medical (Out-of-Pocket) Expenses Reimbursement Plan. All medical claim expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, with certain limitations described under Services Not Covered; (b) incurred by an employee who has made a valid pre-tax election to participate in the Plan, such employee's spouse, or tax dependent for healthcare purposes as defined in Section 105(b), (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit program.

A medicine or drug that is available for purchase without a prescription is considered an over-the-counter medicine. Under new federal law, an over-the-counter medicine obtained on or after January 1, 2011 may be reimbursed tax free only if a Participant obtains and submits a prescription with their claim for reimbursement. A Participant must submit a 'prescription' that meets all state law requirements of the state in which the prescription was written. The person who wrote the prescription must be allowed to prescribe drugs under applicable state law. A medicine is any over-the-counter item the IRS determines is purchased for the primary purpose of applying the drug or biological contained in the item. Insulin will continue to be reimbursed without a prescription.

The following examples—even those recommended by a doctor—do not qualify as expenses eligible for reimbursement under the Medical Expenses Reimbursement Plan: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for a Participant's general wellbeing; items the Participant would have purchased even if the Participant had no medical condition (for example, a toothbrush); vacation and travel expenses even if for rehabilitation or prescribed by a doctor; long-term care expenses that are not for actual medical care; expenses incurred in stockpiling over-the-counter items in quantities that could not reasonably be used during the current Plan Year.

If you contribute to a Health Savings Account (HSA) then you may additionally enroll in a limited *Medical Expenses Reimbursement Plan* only. Qualified expenses under a limited Medical Expenses Reimbursement Plan are limited to dental and vision services or supplies excluded from coverage under your high deductible health plan. The limited Medical Expenses Reimbursement Plan will not provide reimbursement for any other service or supply regardless of whether that service or supply is allowed by the IRS as a medical expense, or allowed under a full Medical Expenses Reimbursement Plan.

Dependent Care Expenses Reimbursement Plan. This Plan provides employees with tax free dependent care assistance only when the assistance is necessary for the Participant to leave the home to engage in activity directly related to his/her employment. Qualified expenses under the Dependent Care Expenses Reimbursement Plan include any expenses that you could take as a credit against tax on your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of your payroll deduction on the date the claim is processed. The tax laws further limit how much you may contribute to this Plan. Under the law and the terms of the Plan, you may defer no more than the lesser of your actual (or, if you are married and if less, your spouse's) income for the year or $5000 per year to this Program. A married Participant who files separate tax returns is limited to $2500 per year.

Non-Employer Sponsored Premiums Reimbursement Plan. This account provides reimbursement for premiums you paid for employee-owned health insurance policies. Employer provided insurance plans do not qualify. Premiums eligible for reimbursement are for a period in which you were a covered Participant under this Plan.

HEALTH SAVINGS ACCOUNT (HSA)

If you elect Medical Expenses Reimbursement benefits, you cannot also elect HSA benefits (or otherwise make contributions to an HSA) unless you elect the Limited (Vision/Dental) Medical Expenses Reimbursement Benefit. In addition, when the Medical Expenses Reimbursement Benefit includes a grace period and you have a Medical Expenses Reimbursement Benefit that is not a Limited Benefit, you cannot elect HSA benefits or make contributions to an HSA until the first day of the month following the last day of the grace period, unless the balance in your Medical Expenses Reimbursement Benefit is $0 as of the last day of that Plan Year.

If you have a Medical Expenses Reimbursement benefit with the Carryover feature that is not a Limited Benefit, you will need to elect the limited Medical Expenses Reimbursement Plan for the new Plan Year. Claims with service dates in the new Plan Year can only be reimbursed if they are covered under the Limited Benefit. In any event, you cannot contribute to an HSA in any month in which you are eligible for a Medical Expenses Reimbursement Benefit that is not a Limited Benefit.

QUALIFIED RESERVIST DISTRIBUTION
A Participant who is called to active duty in the US Armed Services and enrolled in the Medical Expenses Reimbursement Plan may elect to receive a Qualified Reservist Distribution of all or a portion of the unused balance in his/her individual Medical Expenses Reimbursement Plan subject to the requirements of Code Section 125(h) and the applicable regulations thereunder. The Employer may limit this distribution to the amount you have contributed to the Plan that has not been used to reimburse you for claims submitted.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of a Participant in a group health plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits. Participants may obtain, without charge, a copy of the Plan's procedures from the Plan Administrator.

LEAVE OF ABSENCE
Family and Medical Leave Act (FMLA). If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your benefit package options providing health coverage (including the Medical Expenses Reimbursement Plan) on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contribution to the extent you opt to continue coverage). Your Employer may require you to continue coverage while you are on paid leave (as long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave.

If your coverage ceases while on FMLA leave, you will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as you had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which you did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave. If you are going on unpaid FMLA leave and you opt to continue your Medical and Dental Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways:

(1) Prepay. Your share of contributions due during your leave may be paid either pre-tax or after-tax before your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.
(2) Pay-as-you-go. Your share of contributions will be paid on the same schedule as if you were not on leave or under another schedule. Per the Department of Labor regulations, if you fail to make payments under this option, your Employer is not required to continue coverage. If your Employer chooses to make payment and thereby continue coverage, your Employer is entitled to recoup these amounts from you after you return from leave.
(3) Catch-up. Your Employer may advance your share of contributions while you are on leave. Upon your return from leave, your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with your Employer to determine if this option is available under your Plan.

Non-FMLA Leave. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave. If you take a leave of absence due to military service, you may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

TERMINATION OF PARTICIPATION
Participants are enrolled in the Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be a Participant on the earliest of the following dates:
a. Your death, resignation or termination of employment with the Employer;
b. The date the Plan terminates;
c. The date on which you fail to pay any required premium (including payment by salary reduction) under the Plan;
d. The date you no longer meet the requirements for eligibility in the Plan; or,
e. The date you revoke your election under a qualifying change in status event.

When participation has terminated, you are eligible to incur claims against any positive account balance through the eligibility end date.

Positive Balance: Upon termination your annual election amount will be limited to the greater of the amount paid for coverage (total contributions) less previously paid reimbursements or the total of paid reimbursements from the Plan.

As a terminated Participant, you are not eligible for carryover.

When your participation has terminated, you may submit eligible claims for reimbursement through your run out end date as noted in the Claims Procedure section of this document.

CLAIMS PROCEDURE
Unless otherwise noted in this section, if you have elected reimbursement coverage, you may submit eligible claims for reimbursement through the Plan's runout period which ends on: 03/30/2020

All other claim procedures for the Plan are provided in a separate administrative document upon the original enrollment in the Plan. An additional copy may be provided without charge upon request.

CLAIM DENIALS
Medical and Dental Insurance Benefits. The applicable insurance company will determine your claim in accordance with its claims procedures.

Claims Under the Medical (Out-of-Pocket) Expenses, Dependent Care Expenses or Non-Employer Sponsored Premiums Reimbursement Benefits. The claims procedure described below will apply if (a) a claim for reimbursement under the Medical (Out-of-Pocket) Expenses, Dependent Care Expenses or Non-Employer Sponsored Premium components of the salary reduction plan is wholly or partially denied, or (b) you are denied a benefit under the salary reduction plan due to an issue germane to your coverage under the Plan.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete.) The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected. When a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will detail:

- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) 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.

Appeals. If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision on Review. Your appeal will be reviewed and determination made within a reasonable time, defined as not later than 60 days after receipt of your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA §502(a) (where applicable).

NOTICES REQUIRED BY LAW

Special Rights on Childbirth. Under Federal law, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for (either mother or newborn child) to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean 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 the above period. In any case, under Federal law a provider may not be required (by Plan or insurer) to obtain authorization from the plan for prescribing a length of stay up to 48 hours (or 96 hours).

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") continuation shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than twenty (20) Employees on a typical business day during the preceding calendar year. Government entities are subject to the same continuation coverage under the Public Health Services Act. This Summary Plan Description describes your rights for the Medical Reimbursement Plan. Your rights under any of the other Qualified Benefits Plans offered by your Employer are described in the Summary Plan Description(s) for that Plan and may be obtained from your Plan Administrator.

If you elect to participate under the Medical Expenses Reimbursement Plan and are considered a Participant on the day before experiencing a qualifying event, COBRA continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, COBRA continuation coverage will not be offered if on the day of your qualifying event, the amount of your annual election less any reimbursed claims is less than the amount of premium required to continue the Medical Expenses Reimbursement Plan until the end of the Plan Year. COBRA continuation under an excepted Medical Expenses Reimbursement Plan is available until the end of the Plan Year in which the qualifying event occurs.

A Participant who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the COBRA Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan Administrator of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan Administrator does not receive notification within this time period, you will lose your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the Plan would have occurred.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of your monthly contribution. The Employer may require the COBRA payments be apportioned for the remainder of the Plan Year.

Listed below are qualifying events.

(1) Termination of employment (for reason other than "gross misconduct"); and
(2) Reduction of employee's work hours.

Questions

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

FlexSystem®

Participant Reference Guide

Welcome to FlexSystem and to the tax saving benefits of a Section 125 Cafeteria Plan.

We hope you will find FlexSystem to be an efficient and valuable service. Our Participant website is **www.tasconline.com** and is referred to as MyTASC throughout this Guide. This Guide will walk you through the initial login process, how to use your TASC Card, how to request a reimbursement, and how to change your election(s), as well as how to use several other Participant web tools. Please retain this Guide for future reference. If you have additional questions, log in to MyTASC and select Contact Us or call Customer Care at 608-241-1900 or toll-free at 800-422-4661.

- Participant forms, guides, and videos: www.tasconline.com/flexsystem-participant-documents/
- MyTASC Web Portal: www.tasconline.com/mytasc

Here's what you'll find inside:

TASC®

FX-3991-100117

FlexSystem Overview

What is FlexSystem?

"FlexSystem" is the brand name for a selection of tax-advantaged Section 125 Cafeteria Plans administered by TASC. These plans (also called Flexible Spending Accounts or FSAs) allow you to set aside pre-tax dollars to pay for eligible expenses incurred when enrolled in the benefit. The benefits options in your FlexSystem Plan may include:

- Healthcare FSA
- Dependent Care FSA
- Transit and/or Parking Reimbursement Accounts
- Non-Employer Sponsored Premium Plan (NESP)

Employees may choose to participate in any of these benefits accounts when offered by your employer as part of your specific FlexSystem Plan.

Tax-Advantages
The amount deducted from your salary to pay for eligible expenses is called an "election." These **pre-tax** payroll deductions allow you to be taxed on a ***lower gross salary***, thereby saving you money that would otherwise be spent on federal, state, and FICA taxes.

Plan Enrollment

During your enrollment period, you must choose which benefits to participate in (as offered by your Employer) and make annual election(s) for each (the dollar amount to be contributed pre-tax). Elections are specific to each benefit type, meaning that dollars set aside for dependent care can only be used for dependent care and not for healthcare expenses, etc.

Steps to prepare for enrollment:

- Review the list of ***Eligible Expenses*** for each FlexSystem benefit (visit the participant resources page at: www.tasconline.com/eligible-expenses/
- Estimate your total out-of-pockets expenses for the Plan Year to determine your contributions. Use our savings calculator for help: www.tasconline.com/tasc-flexsystem-calculator/
- Complete the enrollment process per your employer's enrollment instructions.

Plan Contributions and Limits

Your elected contributions are deducted from your payroll on a **pre-tax basis** throughout the Plan Year in equal amounts and deposited into your FlexSystem account(s). This is done on your authorization by enrolling in the FlexSystem Plan.

Contributions to an FSA are subject to annual limits set by the IRS. View current limits online at:
www.tasconline.com/benefits-limits

Dependent Care FSA

The **Dependent Care FSA** requires certain criteria be met. Refer to the specific procedures outlined in the *Dependent Care FSA Qualifications Flyer* (FX-3166).

To determine whether it is more beneficial for you to participate in the Dependent Care FSA or take the tax credit (cannot do both), please review the *Dependent Care FSA vs Tax Credit Flyer* (FX-5571).

For information regarding dependent care expenses that are eligible for reimbursement, please review the ***FlexSystem Eligible Expenses Flyer*** (FX-4248), or IRS Publication 503.

Use-It-or-Lose-It Rule

It is important to be conservative in making elections because any unused funds left in your benefits account at the close of the Plan Year are not refundable to you (see exceptions below). You are urged to take precautionary steps to avoid having funds remaining in your account at year-end and risk forfeiture.

FlexSystem provides tools to make it easy for you to monitor/check your account balances in order to avoid having a leftover balance at the end of a Plan Year:

- MyTASC Web Portal
- MyTASC Mobile App and Text Message
- FlexSystem Interactive Voice Response (IVR) Phone System (608-241-1900 or 800-422-4661)

Exceptions *(as offered by your Employer)*
Up to $500 (or less, as determined by your Employer) of any leftover **Healthcare FSA funds** may be carried over into the next Plan Year with no cost or penalty. **Carryover is only available for Healthcare FSA funds and does NOT apply to Dependent Care FSA.**

If your employer elects the Rollover option for your **Transit or Parking Plan**, the entire amount remaining in your Transit or Parking account may rollover to the next Plan Year (no maximum).

Availability of Funds by Benefit Type

Healthcare FSA Funds: The full annual election is available for reimbursement at the start of the Plan Year. Eligible healthcare expenses will be reimbursed up to your total Plan Year election, less prior reimbursements.

Dependent Care FSA, Transit/Parking, and NESP Funds: You may only access funds **as** they are contributed to your benefits account (pay in-pay out).

Benefits and Change of Elections

The laws governing FSA plans generally do not allow changes to benefit elections during a Plan Year. Your elections are irrevocable and any balance remaining in your account at the close of the Plan Year is forfeited (refer to your Plan-specific details if a Grace Period or Carryover is included).

You may only change your FSA elections during the Plan Year if you experience a *change of status* such as:

- a marriage or divorce
- birth or adoption of a child, or
- a change in employment status

Refer to the ***Change of Election Form*** (available from your employer) for a complete list of circumstances acceptable for changing elections mid-year.

A request to change your election must be submitted in writing within 30 days of any applicable qualifying event

Parking and/or Transit Plans may be updated on a monthly basis for the upcoming month, and submitted to TASC from your employer.

Additional Information & Resources

www.tasconline.com/flexsystem-participant-documents

Dependent Care FSA Qualifications Flyer (FX-3166)
Dependent Care FSA vs. Tax Credit (FX-5571)
Carryover Education Flyer (FX-4942)

Managing Your Account

MyTASC: Online Account Management

TASC offers a variety of ways to manage your Flexible Spending Account (FSA)! These include an online portal called MyTASC at www.tasconline.com, the MyTASC Mobile app, and text messaging using any SMS compatible device.

NOTE: A valid email is required to access each of these tools.

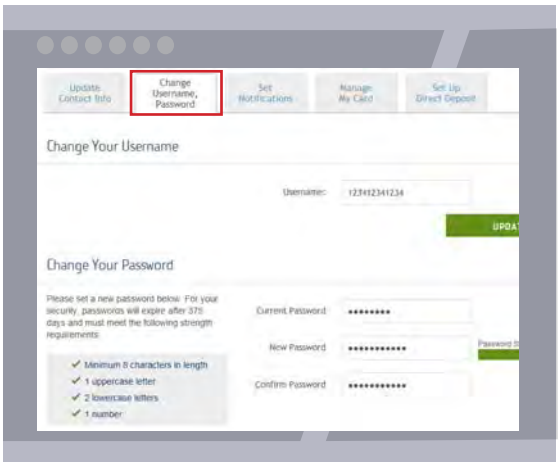
If you or your employer provided your email address upon your initial enrollment, you will receive a ***Welcome New FlexSystem Participant*** email with instructions about how to set up your MyTASC account for the first time. You will be asked to set your password, and once logged in, you may create your own Username. If you do not change your Username, it will remain as your **12-digit TASC ID** (found on your TASC Card and personalized Request for Reimbursement Form).

If you did not receive the Welcome email with access instructions, please call Customer Care at 608-241-1900 or toll-free at 800-422-4661 to provide your email address so we may enter it in your online Profile. After this update, you will be able to access your account online. (NOTE: If you have no email address, we suggest one of many email hosting services that are free, including Gmail, Hotmail, etc.)

Profile Settings

To access your profile settings, click on ***Profile*** from the MyTASC home page.

All Participants are obligated to maintain up-to-date contact information in MyTASC; this includes email and mailing addresses, and phone numbers. TASC periodically sends important Plan notifications (regarding balances, deadlines, and/or Plan changes). We are not responsible for any consequences resulting from communications not received due to inaccurate contact information.



To change your Username (not required): Select *Change Username* in your Profile, enter your **new** Username, and click Update. Usernames must be at least 10 characters and unique to our system. To avoid possible Username duplication, you may use your email address for your new Username. NOTE: If you do not change your Username, it will remain as your 12-digit TASC ID.

To change your Password: Choose from two options:

1. Select *Change Password* in your Profile page, enter a new password, and click Update. Or…
2. Before you log in to MyTASC, click *Can't Access Your Account*. In the next screen, click "I don't know my password," then enter your Username and email address, to which we will send an email. (If you do not receive the message within a few minutes, it may have been blocked as spam by your email provider; please check your spam or junk folder to retrieve the message). **To ensure that you receive important notifications, please add the following email addresses to your list of trusted contacts or approved senders:**
   - **TASConline@tasconline.com**
   - **Notification@tasconline.com**
   - **Service@tasconline.com**
3. Select the link in the email and enter your new password.

Password requirements: must be a minimum of eight (8) characters and must contain at least one (1) upper case letter, two (2) lower case letters, and one (1) number. Passwords will expire periodically.

Managing Your Account

Set Email and Text Notifications: Sign up to receive notifications concerning your account balances, reimbursement requests, and payments.

Only benefits-related emails/texts specific to your account are sent; no SPAM or other notifications will be sent.

Follow these steps to setup your notifications:

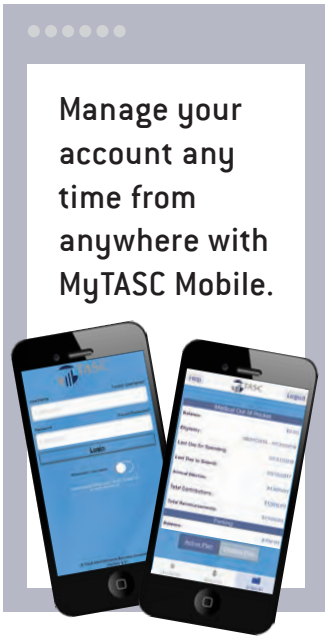
1. From your Profile page, validate your email address and enter your mobile phone number (a valid email address must be entered to receive text messages).
2. Select the text and/or email notifications you wish to receive (check sent, direct deposit sent, MyCash deposit sent, Request for Reimbursement received or denied).
3. A text message with a verification number will be sent to your mobile phone.
4. Enter the verification number in your Profile under Notifications and select Save. The verification process must be completed to authenticate your settings.

Account Overview

You can see your current benefits and available funds immediately on the home page of MyTASC. To return to the home page from any window, click the Home icon in the blue navigation bar. For more details on each benefit, click View Account Overview on the home page or click My Benefits in the main blue navigation bar.

A separate display for each benefit provides these details for you: annual election, carryover, total reimbursements, available balance, Plan Year and helpful dates, (last day for spending, last day to submit) recent activity, requests, and contributions.

Select Recent Activity to view date, activity, name, status, amount, and details. Select the Requests tab to view method, date, name, description, provider, status, amount, and details. Select the Contributions tab to view the date, status, amounts, and details of contributions to your benefits elections.



TASC Mobile Tools

For the ultimate convenience, you can access your account information from anywhere, at any time with the MyTASC Mobile app and text messaging option.

MyTASC Mobile App: The app provides mobile access to the same features available through your online account.

The MyTASC Mobile app provides the simplest and quickest method to submit **Requests for Reimbursement** along with any substantiation documents directly to FlexSystem. Simply enter the required information as prompted and attach your receipt to the Request for Reimbursement by taking a photo using your mobile device camera.

To download the MyTASC Mobile App, visit the Apple App Store or Android Market and search for TASC.

Text Messaging (SMS): Real-time account balance information may also be retrieved via text message. Once you've entered your mobile number in your account profile, simply send a text to **41411** with the message **TASC BAL**. Almost immediately, you will receive a text back with your current balance. Note: You must Set Notifications by entering your mobile phone number in your Profile to use this feature.

IVR Phone System

FlexSystem also offers an Interactive Voice Response (IVR) phone system to easily check your account balance, recent transactions, and obtain other account information by calling one of the automated phone lines below:

IVR: (608) 241-1900 or (800) 422-4661

Additional Information & Resources

www.tasconline.com/flexsystem-participant-documents

TASC Mobile Education Flyer (FX-4688)
TASC Mobile App Guide (FX-4808)

TASC Mobile Site: www.tasconline.com/mobile/

Access to FSA Funds

FlexSystem offers two methods for a Participant to access their FSA funds for eligible expenses:

1. **TASC Card (benefits debit card)**
2. **Request for Reimbursement (claim)**

The TASC Card

The TASC Card is the preferred and most convenient method to access available account funds for eligible FSA expenses. It automatically pays for and substantiates most eligible expenses at the point-of-purchase, eliminating the need to submit requests for reimbursement and wait for payment.

The TASC Card is only available for the following FlexSystem Plan Types (as offered by your Employer):

- **Healthcare FSA**
- **Dependent Care FSA**
- **Transit and/or Parking Benefit Accounts**

Card purchases are limited to the Plan Type(s) elected and will only pull from available funds in the account from which the expense is eligible. For example, a purchase for bandages will only be paid from your available Healthcare FSA funds.

When are TASC Cards Issued?
You will receive a TASC Card within 10 days following the completion of your Plan enrollment. It will be mailed directly to your home address along with the Cardholder Agreement in a plain envelope. Please watch for this mailing.

In the meantime, you may submit a Request for Reimbursement for expenses incurred prior to receiving your TASC Card.

Your TASC Card is good for four (4) years, so hang on to it! Even if you deplete the current year's benefits funds, you'll be able to use the TASC Card again next year when you re-enroll in your Plan.

How the TASC Card Works

The TASC Card operates under two separate accounts to serve as both a benefits debit card as well as a cash card:

1. MyBenefits - all elected FlexSystem benefit accounts.
2. MyCash - cash reimbursement payments.

The TASC Card is smart enough to know that eligible expenses are paid from the MyBenefits account and ineligible expenses are withdrawn from MyCash.

MyBenefits

The TASC Card works like a typical debit card, but is used as a credit card for eligible FSA expenses, based on the funds available in your benefits account.

Rather than paying out-of-pocket and waiting to be reimbursed, the TASC Card allows you to pay for eligible expenses when the service is provided (or when an eligible product is purchased).

When using your TASC Card, the amount of the expense is automatically deducted from your available account balance and paid directly to the authorized provider. **All TASC Card transactions and services must occur within the Plan Year.**

Remember to **save your receipts** as you must retain records and documents to validate your TASC Card transactions. In some cases, FlexSystem may require additional information or documentation regarding the TASC Card transaction.

Where to Use the TASC Card
The TASC Card may only be used at merchants who accept Mastercard and who also have an inventory information approval system (IIAS) in place to identify FSA-eligible purchases. At the point of purchase, the IIAS automatically approves the purchase of eligible items and payment is made automatically to the authorized merchant from your benefits account.

MyCash

The TASC Card features a separate cash account known as MyCash where reimbursement payments are deposited (faster than ACH bank deposit) and available via the TASC Card for purchases or ATM withdrawal.

Additional Information & Resources
www.tasconline.com/flexsystem-participant-documents

- TASC Card Tips (FX-4619)
- TASC Card Education Flyer (FX-4249)
- MyCash Manager Guide (FX-4660)
- MyCash Education Flyer (4875)

TASC Card FAQs: www.tasconline.com/tasc-card-faqs

Access to FSA Funds

MyCash funds can be spent any way and anywhere Mastercard is accepted. *NOTE: Currently MyCash purchases may not be made at CVS Pharmacy, ShopKo, or Walmart.*

Access your MyCash funds in any of the following ways:

1. Swipe your TASC Card at a merchant that accepts Mastercard;
2. Withdraw cash at ATM (with a PIN) using the TASC Card (request a PIN online via MyTASC portal);
3. Transfer funds to a personal bank account via MyTASC online.

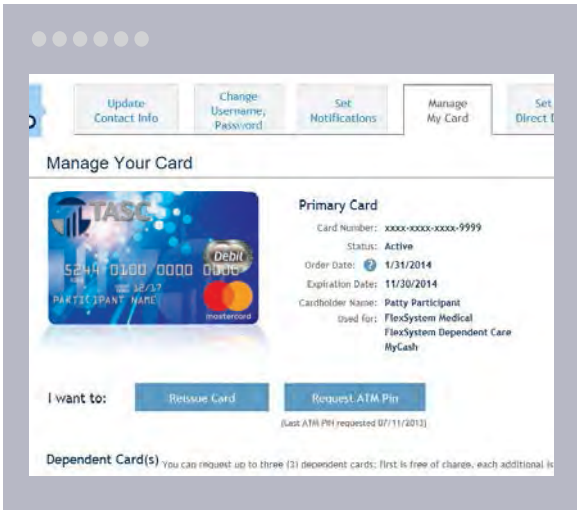
MyCash funds can also be relied upon to cover eligible FSA expenses if no funds are available in your MyBenefits account (avoid embarrassing declines at checkout).

If you no longer participate in FlexSystem, you may maintain an active TASC Card to access your remaining MyCash funds. Per the Cardholder Agreement, you will be charged a $5 monthly Cash Account Access Service fee, deducted from your MyCash account each month until all funds are depleted.

Manage your TASC Card Online

Easily manage your TASC Card and MyCash account via MyTASC online and perform any of the following functions:

- View card transactions
- View card details (number, status, expiration date)
- View allowed benefits
- Transfer MyCash funds
- Request ATM PIN for MyCash withdrawals
- Request additional card for spouse/dependent
- Report lost/stolen card and request replacement card



Report a Lost or Stolen Card

Participants must notify FlexSystem immediately to report a lost or stolen TASC Card, and request a replacement card.

Online Instructions:

(a) log in to MyTASC
(b) click ***Manage My Card***, and then ***Reissue Card***
(c) select ***Lost/Stolen*** as the reason for reissue

If you are unable to access MyTASC online, please call Customer Care at 608-241-1900 or toll-free 800-422-4661.

A new card will arrive within 7-15 days and a $10 reissue fee will be withdrawn automatically from your FlexSystem account (pre-tax).

Request an Additional Card for Spouse/Dependent

Give your spouse or dependent the flexibility of his/her own TASC Card with the same convenience and advantages you enjoy! You will receive **one additional card** for your spouse or dependent free of charge. A $10 fee will apply for each subsequent TASC Card generated. This fee will be deducted from your FlexSystem account upon the issuance of the card(s).

To request a TASC Card for your spouse or dependent, log in to your MyTASC account and click ***Manage My Card***, ***Issue Dependent Card***, and follow the prompts.

TASC Card for Exclusive MyCash Access Only

If your employer has not elected the TASC Card for your FlexSystem Plan and you have not elected bank direct deposit for your reimbursements, you will receive a special TASC Card with exclusive MyCash access.

This card serves as a reimbursement card only. It has no access to benefits funds.

Reimbursements for eligible benefits expenses will be deposited into your MyCash account. You can access your MyCash funds with the swipe of your TASC Card at any merchant that accepts Mastercard, Maestro, or NYCE cards, or at an ATM (with a PIN). Or you can setup a transfer from the MyTASC home screen (select ***Schedule MyCash Transfer***).

Access to FSA Funds

Request for Reimbursement

If you pay for an eligible expense out-of-pocket (without the TASC Card), submit a **Request for Reimbursement (RFR)** along with substantiation through one of the following methods:

- Online Request for Reimbursement Wizard
- MyTASC Mobile App
- Mail or Fax personalized paper request form (download via MyTASC online)

You may request reimbursement any time a qualified expense has been incurred. The service related to the expense needs only to have taken place; it need not be paid before requesting reimbursement.

You may only claim reimbursement for:

(a) eligible expenses incurred during the applicable Plan Year, or subsequent Grace Period (if applicable);

(b) expenses incurred by eligible Plan Participants; and

(c) for expenses that have been neither previously reimbursed under this or any other benefit Plan, nor claimed as an income tax deduction.

It is your responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible claims.

RFR - Online Wizard

It's easy to submit reimbursement requests *along with substantiation* online! Follow these steps:

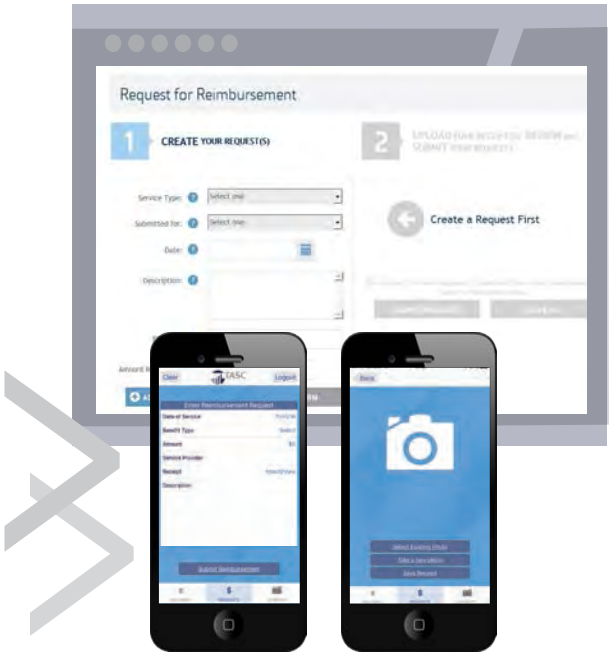
1. Log in to your MyTASC account and select ***I Want to Request a Reimbursement*** from the home page.
2. Enter all required information.
3. Add documentation by "drag and drop" or upload receipts (attach a scanned document: jpg, png, tif, or pdf).
4. Review your request carefully to ensure its accuracy, then *Add Another Request* or click Submit Request(s).

You may also upload documentation for previously submitted claims that are missing substantiation.

Transit Requirement: Effective for expenses incurred after 12/31/15, the IRS **no longer allows manual cash reimbursements** for pre-tax transit benefits. Participants are required to use their TASC Card for transit expenses. ***This requirement does not apply to Parking benefits.***

RFR - Mail or Fax Paper Form

Download a personalized ***Request for Reimbursement form*** from MyTASC, complete, and submit with substantiation to TASC.



RFR - MyTASC Mobile App

You may also access your FlexSystem account and Request a Reimbursement via the MyTASC mobile app. Here's how:

1. Log in to the MyTASC Mobile App
2. Select the "Reimbursement" tab in bottom menu
3. Enter "Date of Service"
4. Select the "Benefit Type"
5. Enter "Dollar Amount" of expense to be reimbursed
6. Enter the name of the "Service Provider"
7. Attach the Receipt/Documentation (take a picture of documentation with device camera)
8. Select "Submit Reimbursement"

Managing Your Requests

To view your submitted Requests for Reimbursements and check your payment status:

1. Log in to MyTASC online
2. Select ***View Account Overview*** and click the Requests tab
3. Click the magnifying glass under *View Details* for additional information and to attach documentation,

You can also obtain this information from your mobile device using the MyTASC Mobile App.

Reimbursement Processing & Payment

FlexSystem processes Requests for Reimbursements on a daily basis and payments are initiated within 48 to 72 hours of receipt of a complete and accurate reimbursement request. All reimbursements are deposited directly into your MyCash account, unless otherwise instructed.

You may instead choose to receive a mailed paper check. *Paper checks are issued on a limited basis and only upon request. A convenience fee may be applied per check.*

Insufficient Funds

If funds in the benefit account are insufficient to cover the entire request, a reimbursement will be issued in the amount of the available balance. The unpaid balance of the request will remain an open item until additional deposits are received, at which time an additional reimbursement payment will be issued.

MyCash Account

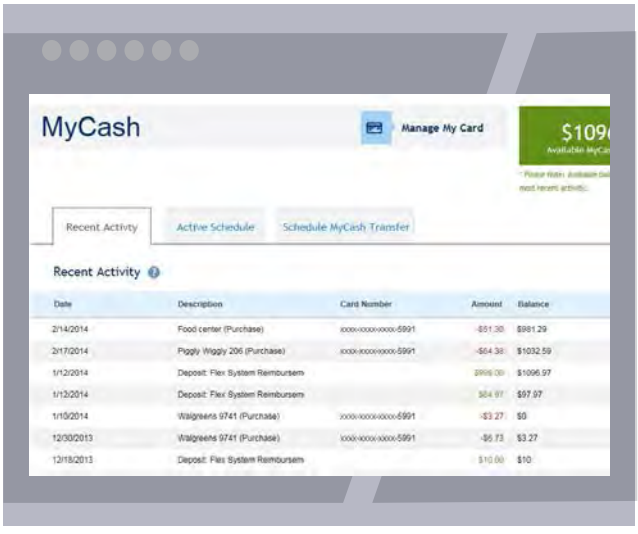
All reimbursements are directly deposited into your MyCash account and accessible via the TASC Card.

Access your MyCash funds in any of the following ways:

1. Swipe your TASC Card at a merchant that accepts Mastercard;
2. Withdraw cash at ATM (with a PIN) using the TASC Card (request a PIN online via MyTASC portal);
3. Transfer funds to a personal bank account via MyTASC online.

MyCash Manager Online

It's easy to manage your MyCash reimbursement funds from MyTASC. From MyCash, you can view recent MyCash activity and card information, save bank account information, and transfer funds to a personal bank account. You can view MyCash activity and balance via MyTASC Mobile, too.



Direct Deposit - Bank

To establish direct deposit of your MyCash funds to a personal bank account, visit MyTASC and click ***Set Up Direct Deposit***. With direct deposit, funds ($25 or more) are forwarded from your MyCash account to your bank within 48 to 72 hours of a complete submission.

Remember to verify receipt of deposits before writing checks against expected payments (check with your financial institution for availability of funds). TASC is not responsible if a Participant's bank account is assessed non-sufficient funds fees in anticipation of required deposits to cover Requests for Reimbursements.

Claim ConneX™ *(if employer elected)*

If your employer has elected Claim ConneX and you are enrolled in Claim ConneX for your Healthcare FSA Plan, your medical insurance provider **automatically** submits the unpaid portions of your medical claims to TASC for processing. Those claims will be reimbursed **automatically** to you from your Healthcare FSA Plan. **No action is required from you to receive reimbursement for those claims.**

If your employer's FlexSystem Plan has elected **Reimbursement Ordering** and you have a Healthcare FSA Plan and a TASC HRA Plan, requests submitted via the online *Request for Reimbursement form* in MyTASC or via your medical insurance provider (Claim ConneX feature) will be routed automatically to your Plan that reimburses first and next to your Plan that reimburses second.

Plan Year-End

Transitional Period

The ***transitional period*** refers to a period of time (generally three months) following the end of the Plan Year. During this time, you may continue to submit reimbursement requests for expenses incurred during the previous Plan Year or during any elected "Grace Period." Check with your employer for Plan-specific details. The Plan Year is officially closed following the transitional period, or sooner if directed by your employer.

If your employer's FlexSystem Plan includes the **Health FSA Carryover** feature or the **Transit/Parking Rollover feature**, you may **manually** move your remaining funds from those benefits into the new Plan Year during the transitional period.

- Up to $500 of your Health FSA remaining balance (refer to your Plan maximum) may be moved.
- Your entire remaining balance for Transit/Parking accounts may be moved (no maximum).

To manually move your funds:

- Log in to your MyTASC account
- Select the prior Plan Year
- Click *Carryover Funds Now* (Health FSA) or *Rollover Funds Now* (Transit/Parking)

It is important to ensure all prior Plan Year expenses have been reimbursed before moving your funds, as this option is **not reversible**.

If you do not manually move your leftover Health FSA funds, they will be automatically moved (up to the $500 maximum) into the new Plan Year after the Runout Period (even if you made no election for the new Plan Year). Any unused funds over the carryover maximum will be forfeited.

Re-Enrollment

Near the end of the Plan Year, you will have the opportunity to re-enroll in your FlexSystem Plan. Please check with your employer regarding your specific re-enrollment procedure.