



State of Arizona Flexible Spending Account

Summary Plan Description

Effective January 1, 2022

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PLAN MODIFICATION, AMENDMENT AND TERMINATION

The Plan Sponsor reserves the right to, at any time, amend, change or terminate benefits under the Plan; to amend, change or terminate the eligibility of classes of employees to be covered by the Plan; to amend, change, or eliminate any other Plan term or condition; and to terminate the whole Plan or any part of it.

No consent of any Member is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any covered medical expenses incurred prior to the termination date of the Plan.

When a change or amendment happens, a Summary of Material Modification (SMM) will be attached to this Summary Plan Description (SPD). The Plan Sponsor will send you a new SPD, SMM, or Amendment.

This Plan document is effective January 1, 2022 and supersedes all Plan Descriptions and all enrollment guides previously issued by the Plan Sponsor.

PURPOSE

The State of Arizona has adopted this Flexible Spending Account Plan to allow you to pay for benefit options made available under this Flexible Spending Account Plan 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 of the Internal Revenue Code.

This Flexible Spending Account 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.

BENEFITS OFFERED TO EMPLOYEES	Maximum Participant Salary Reduction	Minimum Participant Salary Reduction
Healthcare FSA	\$2,750	\$130
Limited Purpose Healthcare FSA	\$2,750	\$130
Dependent Care FSA (day care expenses)	\$5,000	\$260

IRS rules and regulations impose annual non-discrimination testing requirements on the Plan to ensure compliance. Testing results may cause ADOA to require any participant to reduce their pre-tax contribution election if it is determined that such action is necessary.

ELIGIBILITY REQUIREMENTS

All full-time employees are eligible to participate in a FSA Plan on the 1st day of the pay period after completing a benefit enrollment form. Benefits are effective the 1st day of the pay period following the receipt of a completed enrollment. The Plan Year is the 12-month period from January 1 through December 31.

Before the start of a new plan year, members are given a certain amount of time during which they may change coverage options. Members may also elect to participate in a FSA plan at this time. This period is called open enrollment. In general, open enrollment is held in October. Action is required if you are electing a health care flexible spending and/or dependent care flexible spending account. Elections must be made before the end of open enrollment.

An employee may also enroll during the plan year if they experience a qualifying change in status and enrollment corresponds with a change in eligibility caused by that status change. See the Qualifying Change In Status Events section for more information. The Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan have slightly different rules regarding making an election change or enrolling mid-year.

New employees must enroll within 31 days to participate for the remainder of that plan year. If a new employee does not enroll within the 31-day time period, then they may not elect to participate in the Plan until the next Open Enrollment Period or until a change in status occurs that would justify a mid-year election change.

Enrollment during the plan year is effective the 1st day of the pay period following a completed enrollment.

Plan Termination

Participation will end on the last day of the pay cycle contributions were paid should an employee terminate employment with the State of Arizona. This means the employee will no longer be able to make contributions to the plan or incur services for reimbursement. Should the employee return to work within 30 days during the same Plan Year, their participation will be reinstated as it was. The employee will have the option of reinstating their coverage at the same annual level they had prior to their termination or reinstating coverage at the same per pay period amount with a reduced annual amount. Should the employee choose the same annual amount, their per pay period contributions will be adjusted so that their total contributions for the year will equal their annual coverage amount. Should an employee return to work after 31 days during the same Plan Year, they may make a new election for the remainder of the Plan Year. Except as specified in the section on Coverage Continuation (COBRA) in the Health Care Flexible Spending Account Plan Summary, expenses incurred while the employee is not a participant will not qualify for reimbursement. An employee may continue to file for Dependent Care expenses incurred during the Plan Year after the end of their participation.

GENERAL INFORMATION

This Flexible Spending Account Plan allows you to pay your cost for the benefits you elected through a Salary Reduction Agreement. This lowers your federal and state taxes. Reimbursement benefits are benefits paid under an agreement to reduce your salary by the amount you elected and pay you tax free benefits for certain qualified events such as healthcare and dependent care expenses.

Administration

The State of Arizona 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.

The State of Arizona has contracted with 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. TASC processes all claims for the Flexible Spending Account Plans.

IRS rules and regulations impose annual non-discrimination testing requirements on the Plan to ensure compliance. Testing results may cause ADOA to require any participant to reduce their pre-tax contribution election if it is determined that such action is necessary.

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.

Enrollment Elections

The Arizona Department of Administration (ADOA) will provide annual enrollment materials at the beginning of each plan year, or at the time of your enrollment in this plan. The annual enrollment materials will include the enrollment procedures to make annual elections for your pretax contributions. If the terms of the annual enrollment materials and this Summary Plan Description (SPD) are in conflict, the SPD will control for the plan year for which they were provided.

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 request for reimbursement upon request is not provided. The State of Arizona 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.

QUALIFYING CHANGE IN STATUS EVENTS

The laws governing Flexible Spending Account Plans generally do not allow you to change your benefit and contribution elections during a Plan Year. Your elections are irrevocable and any balance in your account at the close of the Plan Year is forfeited and becomes the property of the State of Arizona; 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 31 days of any applicable qualifying event. The new benefit elections may start only after your change in status has taken place. Most coverage changes become effective on the first day of the first pay period after the new paperwork is received by the ADOA Benefit Services Division.

This plan is intended to allow any change in status event that is allowed by the IRS. A qualifying change in status event may include, but not be limited to, one of the following:

- A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
- The legal adoption, birth, death of a child or dependent, and placement for adoption.
- Dependent satisfies or ceases to satisfy dependent eligibility requirements.
- The change in employment status of you, your spouse or dependent.
- Change in coverage of a spouse or dependent under an employer plan.
- A judgment, decree or order requiring coverage for a spouse or child.
- Termination of Medicaid or Children's Health Insurance Program (CHIP) coverage.¹

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.

¹ Under the qualifying events of Termination of Medicaid or CHIP coverage and eligibility for employment assistance under Medicaid or CHIP, 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 CHIP.

REIMBURSEMENT ACCOUNTS

The *Participant Reference Guide* provided by TASC, incorporated by express reference into this Summary Plan Description, includes all the information you need to access your reimbursement accounts and submit requests for reimbursement. By signing into your online account, you may access information about your reenrollment, available funds, annual election, total contributions, and total reimbursements. These accounts provide tax-free benefits for healthcare, dependent daycare and/or non-employer sponsored health insurance premiums in accordance with IRS guidelines and protocols.

Healthcare Flexible Spending Account (FSA)

All healthcare 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 account.

A medicine or drug that is available for purchase without a prescription is considered an over-the-counter medicine. Under federal law, an over-the-counter medicine may be reimbursed tax-free under the FSA only if a Participant obtains and submits a prescription with their request 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 Healthcare FSA: 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 only enroll in a *Limited Purpose Healthcare FSA (LPHSA)*. Qualified Expenses under an LPHSA are limited to dental and vision services or supplies excluded from coverage under your high deductible health plan. The LPHSA 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 General-Purpose Healthcare FSA.

Dependent Care FSA

This account 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 FSA 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 request for reimbursement (RFR) is processed. The tax laws further limit how much you may contribute to this account.

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 \$5,000 per year to this Plan. A married Participant who files separate tax returns is limited to \$2,500 per year.

HEALTH SAVINGS ACCOUNT (HSA) RULE

If you elect the Healthcare FSA benefit (General Purpose), you cannot also elect HSA benefits (or otherwise make contributions to an HSA) unless you elect the Limited Purpose Healthcare FSA (vision/dental).

If you have a General-Purpose Healthcare FSA (not Limited Purpose), you will need to elect the Limited Purpose Healthcare FSA (LPHSA) for the new Plan Year. Expenses with service dates in the new Plan Year can only be reimbursed if they are covered under the LPHSA. In any event, you cannot contribute to an HSA in any month in which you are eligible for a Healthcare FSA that is not a Limited Purpose Healthcare FSA.

If your spouse or any dependent is not eligible for an HSA due to other prohibited coverage, they must be excluded from coverage under your HSA. You will need to submit a written statement to your employer excluding coverage. You will not be able to use your HSA to reimburse medical expenses for an excluded spouse or dependent for medical expenses incurred during the period of time they are covered by prohibited coverage.

LEAVE OF ABSENCE

Family and Medical Leave Act (FMLA)

If you go on a qualifying leave under FMLA, to the extent required by the FMLA, ADOA will continue to maintain your benefit package options providing health coverage (including the Healthcare FSA) on the same terms and conditions as if you were still active. You are required to continue coverage while you are on paid leave unless a qualifying event allows you to submit an election change request. 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 must 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.

Unpaid FMLA Leave

If you are going on unpaid FMLA leave and you opt to continue your Medical and Dental Insurance Benefits and Healthcare FSA Benefits, then you may pay your share of the contributions. Your share of contributions will be paid on the same schedule as if you were not on leave or under another schedule. If you fail to make payments under this option, your account will be terminated as of the last day which a contribution was made.

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 you with after-tax contributions while on leave, or with catch-up contributions after the leave ends. If you go on an unpaid leave that affects eligibility, then the Qualified Life Event 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.

Other Considerations Regarding Coverage Continuation (COBRA)

To the extent required by COBRA, you, your spouse or dependent may elect to continue the coverage elected under the Flexible Spending Account Plan even though your's or your spouse's or dependent's election to receive benefits expired or was terminated, under the following circumstances:

1. Death of the participant;
2. Termination (other than for gross misconduct) or a reduction in hours;
3. Divorce of the participant; or
4. A dependent child ceases to be a dependent under the terms of this plan.

When the Plan is notified that one of the events has occurred, the right to choose continuation coverage will be provided to each eligible person(s) if, on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments. The right to elect to continue ends 60 days from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the participant or a responsible family member to inform their agency liaison and ADOA Benefit Services Division of the occurrence of an event described in 3 or 4 above.

Continuation coverage will not extend beyond the end of the current Plan Year but may terminate earlier if the premiums are not paid within 30 days of their due dates. Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the Administrator. An administrative charge of 2% is assessed for each premium paid for continuation coverage.

Benefit Account Coverage

When participation has terminated, you are eligible to incur Qualified Expenses against your positive account balance through the date your eligibility ends for your benefit account. Funds that carried forward into your current Healthcare FSA (or LPFSA) will be included. Paid coverage and eligibility ends on the last day of the pay period in which an employee makes a contribution.

Requests for Reimbursement

When your participation has terminated, you may submit eligible requests for reimbursement through your runout period as noted in the Request for Reimbursement Procedure section of this document.

REQUEST FOR REIMBURSEMENT PROCEDURE

If you have elected reimbursement coverage, you may submit eligible requests for

reimbursement through the Plan Runout End Date of March 31, 2023. A terminated Participant may submit eligible requests for reimbursement through the runout period.

The TASC Card is the preferred and most convenient method to access available account funds for all eligible expenses. It automatically pays for and substantiates most eligible expenses at the point-of-purchase, eliminating the need to submit requests for reimbursement and waiting for payment. The TASC Card works like a typical debit card but is used as a credit card for all eligible expenses, based on the funds available in your benefit accounts.

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. Save your receipts as you must retain records and documents to validate your TASC Card transactions. In some cases, TASC may require additional documentation regarding a TASC Card transaction.

There are multiple ways to pay for an eligible expense without the TASC Card. This includes the following methods: TASC mobile app, online, or mail. TASC processes requests for reimbursement daily, and payments are initiated within 48 to 72 hours of receipt of a complete and accurate reimbursement request.

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. In addition, you may only claim reimbursement for:

- Eligible Expenses incurred during the applicable plan year, or subsequent grace period (if applicable);
- Expenses incurred by eligible plan participants; and
- Expenses that have not been previously reimbursed under this or any other benefit plan or claims as an income tax deduction.

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

How to Request a Reimbursement

1. Sign in to your account at www.tasconline.com
2. From the Overview page, select the green box **REQUEST A REIMBURSEMENT**.
3. Select who incurred the expense.
4. Select the date the expense incurred.
5. Select the expense type. Choose the appropriate category from the list, and click on the dropdown menu to the right of the chosen category, and then select the appropriate type from the displayed list.
6. Enter the expense amount, the merchant name, attach the receipt(s), and a description of the expense (optional).
7. Click **NEXT** to review your request, and then **SUBMIT** reimbursement request.

8. Your reimbursement will be deposited into your MyCash account on your TASC card.

NOTICES REQUIRED BY LAW

Newborns' and Mothers' Health Protection Act of 1996 Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with Childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or her newborn earlier. Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. If you have any questions, contact Benefit Options at 602-542-5008 or 1-800-304-3687 or email Benefit Options at BenefitIssues@azdoa.gov.

Women's Health Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because your group health plan offers coverage for mastectomies, WHCRA applies to your Plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan.

HIPAA Privacy Regulation Requirements

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor and other parties as necessary to determine appropriate processing of claims. Please refer to the Benefit Options Guide for details on the use of PHI.

Notice of Special Enrollment Rights for Health Plan Coverage

If you decline enrollment in the State of Arizona's health plan for you or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you or your Dependents may be able to enroll in the State of Arizona Employee's health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new Dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will become effective the earlier of the first of the month following your request for enrollment. In addition, you may enroll in the State of Arizona's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your Dependent becomes eligible for special enrollment rights, you may add the Dependent to your current coverage or change to another health plan.

General COBRA Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become Eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the ADOA Human Resources-Benefits.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee become entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being Eligible for coverage under the Plan as a "Dependent Child"

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Benefit Options Plan, and that bankruptcy results in a loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a

qualified beneficiary. The Retired Employee's Spouse, Surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.