

**JOHNSON COUNTY GOVERNMENT
FLEXIBLE BENEFIT PROGRAM
(As Amended Effective January 1, 2009)**

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**ARTICLE I.
OUTLINE OF THE PLAN DOCUMENT**

1.1 Introduction. This is not just a summary of the Plan, but the actual Plan document, written so that it can be used by Participants, the County, and the Plan Administrator in determining Participant benefits under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125 and will be construed in a manner consistent with that Section. The Medical Reimbursement Program is intended to qualify as a Code Section 105 medical expense reimbursement plan, and the Dependent Care Program is intended to qualify as a Code Section 129 dependent care assistance plan. Although included in this document, the Medical Reimbursement Program and the Dependent Care Program are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code and all applicable provisions of ERISA.

In addition to this Article, which explains how to use the Plan document, the Plan has eight (8) other Articles. A brief summary of what can be found in each of them is provided below.

1.2 Claims Procedures. Article II sets forth the Plan's claims and appeals procedures. These procedures apply to claims relating to an employee's eligibility to participate in the Plan and to claims under the Medical Reimbursement Program and the Dependent Care Program. The claims and appeals procedures set out in Article II, however, do not govern claims under the Health Plan. Participants with claims under the Health Plan must file those claims in accordance with the procedures applicable to that plan.

1.3 Participation. Article III explains who is eligible to participate in the Plan and when an individual's eligibility to participate begins and ends. The participation provisions in Article III apply only to an employee's eligibility to make pre-tax contributions under the Plan to pay for Optional Benefits selected and to participate in the Medical Reimbursement Program and the Dependent Care Program.

1.4 Benefits Available and Contributions. Article IV describes the benefits which may be purchased under the Plan, including certain tax aspects of participation in the Plan.

1.5 Participant Accounts and Elections. Article V explains the establishment of Participant accounts and how Participants elect to purchase benefits under the Plan.

1.6 Medical Reimbursement Benefits. Article VI describes the Medical Reimbursement Program.

1.7 Dependent Care Benefits. Article VII describes the Dependent Care Program.

1.8 General Provisions. Article VIII sets forth general provisions important to the administration of the Plan.

1.9 Definitions. Capitalized terms used in this Plan are defined in Article IX.

ARTICLE II. CLAIM PROCEDURES

2.1 Filing a Claim. In order to be reimbursed for claims under the Medical Reimbursement Program or the Dependent Care Program, a Participant must complete an application for payment. Application forms are available from the Personnel/Payroll Representative, from the County's Office of Financial Management or on the OFM web page. Completed forms should be returned to the OFM Benefits Division, 111 South Cherry Street, Suite 2400, Olathe, Kansas 66061-3441.

The application for payment must be accompanied by a receipt or bill indicating the type of expense incurred, the date the service was provided and the amount of that expense. In the case of a medical expense, the application must also provide the person for whom the service was provided and that person's relationship to the Participant, and the Participant will be required to sign a statement indicating that he or she has not been reimbursed for the expense from any health plan and is not entitled to reimbursement of such expense from any health plan. In the case of a dependent care expense, the Participant must provide the name, address and social security number (or taxpayer identification number in the case of a corporation or other organization) of the person providing the care for the Participant's dependent.

Claims relating to an employee's eligibility to participate in the Plan or claims relating to any other Plan matters should be filed with the OFM Benefits Division. These claims will also be reviewed in accordance with the procedures described in this Article.

2.2 Payment of Claims. The Plan Administrator or his or her designee will decide each claim within a reasonable time after it is received. The Participant will be notified of all payments and will receive an explanation of how the payments were calculated. If a claim is wholly or partially denied, the Participant will be furnished a written notice setting forth:

- (a) the specific reasons for the denial;
- (b) a specific reference to pertinent provisions on which the denial was based;
- (c) a description of any additional material or information necessary to process the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if the Participant wishes to appeal the denial of the claim.

The notice will be furnished to the Participant within thirty (30) days after receipt of the claim by the OFM Benefits Division, unless special circumstances require an extension of time for processing the claim. No extension will be for more than thirty (30) days after the end of the initial thirty (30)-day period. If an extension of time for processing is required, written notice of the extension shall be furnished to the Participant before the end of the initial, thirty (30)-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a final decision will be made.

2.3 Appealing a Claim. If a claim is denied, the Participant may appeal the denial by filing a written appeal with the OFM Benefits Division. The Participant may review documents pertinent to the appeal and may submit issues and comments in writing as part of the appeal. No appeal will be considered unless it is received by the OFM Benefits Division within sixty (60) days after the Participant receives written notification of the denial of his or her claim. In most cases, the Plan Administrator or his or her designee will decide the appeal within sixty (60) days after it is received. However, if special circumstances require an extension of time for processing, a decision will be rendered as soon as possible, but not later than one hundred twenty (120) days after the appeal is received. If such an extension of time for deciding the appeal is required, written notice of the extension will be furnished to the Participant before the commencement of the extension. The Plan Administrator or his or her designee will make his decision in writing and will include specific references to the pertinent provisions upon which the decision is based.

ARTICLE III. PARTICIPATION

3.1 Eligibility to Participate. Each Eligible Employee, as defined in Section 9.5, is eligible to participate in the Plan, including the Medical Reimbursement Program and the Dependent Care Program, on the day coincident with or next following the date he or she becomes an Eligible Employee according to uniform procedures established by the Plan Administrator or his or her designee; provided, however, that an Eligible Employee may not make contributions to a Health Savings Account if he or she elects coverage under any Health Plan option for medical coverage other than the qualified high deductible health plan or if he or she elects coverage under the Medical Reimbursement Program.

Special eligibility requirements apply to participation in a Health Savings Account. Each Participant is responsible for determining whether he or she is eligible to participate in a Health Savings Account. By allowing a Participant to make pre-tax contributions to his or her Health Savings Account through this Plan and making matching contributions, the County is not assuming any responsibility to make an independent determination as to the Participant's eligibility to contribute to a Health Savings Account.

3.2 When Participation Terminates. A Participant's eligibility to participate in the Plan terminates on the earlier of:

- (a) The date the Participant ceases to be an Eligible Employee;
- (b) With respect to any Optional Benefit, the date the Participant ceases to be eligible to purchase such Optional Benefit;
- (c) The effective date of the Participant's election not to participate in the Plan; or
- (d) The date the Plan is terminated;

subject to the Participant's right to make claims for expenses incurred prior to the date of such termination as provided in Section 6.6 or 7.8. Distributions from a Participant's Health Savings Account (whether before or after termination of employment) and all other matters relating to a

Participant's Health Savings Account are outside this Plan and are to be handled by the Participant and his or her trustee/custodian in accordance with the agreement between them.

3.3 Change of Employment Status. If an employee whose Plan participation ceased under Section 3.2 because his or her employment status changed from full-time to part-time again becomes an Eligible Employee, the Participant will become a Participant as provided in Section 3.1.

3.4 Special Rules for Returning Employees. If a Participant ceases to be an Eligible Employee due to a termination of employment or other change in employment status, and again becomes an Eligible Employee, he or she will be treated as a new Eligible Employee with respect to all Optional Benefits and will become eligible to participate at the times described in Section 3.1; provided, however, that if the Participant again becomes an Eligible Employee within the same calendar year as his or her termination of employment or change in employment status, the maximum amount that the Participant may contribute to his or her Medical Reimbursement Account or Dependent Care Account for the remainder of the year will be equal to the maximum specified in Section 5.2, reduced by the amount of any claims that were previously reimbursed to the Participant during that calendar year. See Section 5.10 for special rules if a Participant takes FMLA Leave or Military Leave.

ARTICLE IV. BENEFITS AVAILABLE AND CONTRIBUTIONS

4.1 How the Plan Saves Participants Money -- Some Tax Consequences of Plan Contributions.

- (a) Federal Income Tax. The Plan is intended to be a "cafeteria plan" under Section 125 of the Internal Revenue Code. By structuring the Plan in this manner, Participants should realize substantial tax savings on the amounts they contribute to purchase the benefits described in Section 4.2. In general, those amounts will not be subject to federal or state income taxes or federal social security taxes.

Although the County believes the Plan complies with Section 125, and that it offers certain benefits which are free of federal income and social security taxes pursuant to other provisions of the Code, there is currently no procedure whereby the Plan can be submitted to the Internal Revenue Service for its approval. Thus, there cannot be, nor is there, any guarantee that the intended tax benefits will be available to Participants.

- (b) Effect of Social Security Benefits. By electing to make contributions under this Plan on a pre-tax basis, the amount of a Participant's social security benefits may be affected to a small degree. This is because the amount of a Participant's social security benefits partially depends upon his or her taxable income. Because it is intended that a Participant's Plan contributions will be excluded from his or her taxable income, the amount of his or her social security benefits may be affected. For more details, Participants should contact the local social security office.

4.2 Benefits Available. Participants may elect to have a portion of their compensation, which they would otherwise be entitled to receive in cash as part of their paycheck, applied by the County toward the cost of one or more of the following benefits (the “Optional Benefits”):

- (a) Benefit options available to the Participant under the Health Plan; and
- (b) Coverage under the Medical Reimbursement Program described in Article VI; and
- (c) Coverage under the Dependent Care Program described in Article VII; and
- (d) Coverage under a Health Savings Account. (See Section 4.3(b) below.)

4.3 Description of Benefits.

- (a) Although the election to purchase one or more of the Optional Benefits is made under this Plan, only the Medical Reimbursement Program and Dependent Care Reimbursement Program are described in this document. Health Plan benefits are not provided by this Plan, but by the Health Plan itself. The types and amounts of benefits available under the Health Plan, the requirements for participating in the Health Plan, the terms and conditions of coverage, and benefits under the Health Plan are determined in accordance with the plan document(s), contracts, or other written materials evidencing the existence of the Health Plan which, as in effect from time to time, are incorporated by reference into this Plan.
- (b) Participation in a Health Savings Account, to the extent available to a Participant, is entirely voluntary and is governed entirely by the terms and conditions of each Participant’s agreement with his or her trustee/custodian. A Participant’s Health Savings Account is not an Employer-sponsored benefit plan. The County has no authority or control over the funds deposited in a Participant’s Health Savings Account. By allowing a Participant to make pre-tax contributions to his or her Health Savings Account and making matching contributions through this Plan, the County is not endorsing the Account.

4.4 Participant Contributions. Each calendar year, a Participant may elect pursuant to Section 5.2 or 5.3 to have a portion of his or her Compensation, which would otherwise be paid to the Participant in cash, applied toward the purchase of one or more Optional Benefits listed in Section 4.2. The amount a Participant elects to contribute to his or her accounts for a year will be divided into equal monthly contributions, with one-half of the monthly amount taken from the Participant’s first bi-weekly paycheck of the month and the balance taken from the Participant’s second bi-weekly paycheck of the month. Please note that the amount contributed to the Medical Reimbursement Account or the Dependent Care Account must be at least ten dollars (\$10) per paycheck. The amount the Participant elects to contribute to his or her Health Plan Account will be adjusted automatically if the cost of coverage under the Health Plan changes during the year.

4.5 County Contributions. If a Participant is eligible for and elects to make contributions to a Health Savings Account for a calendar year, the County may, in its sole discretion:

- (a) Make a contribution to his or her Health Savings Account coincident with the first payroll of the calendar year to pre-fund one-half of the amount the Participant elects to contribute to such Account for the calendar year. In order to receive such contribution, the Participant must agree to repay the amount of the accelerated contribution by payroll withholding or other method acceptable to the County by the end of the year or in the event of his or her termination.
- (b) Make a matching contribution to his or her Health Savings Account coincident with the first payroll of the calendar year. Such matching contribution shall equal one hundred percent (100%) of the first two hundred fifty dollars (\$250) contributed to the Health Savings Account by a Participant with employee-only coverage under the qualified high deductible health plan and one hundred percent (100%) of the first five hundred dollars (\$500) contributed to the Health Savings Account by a Participant with any other level of coverage under the qualified high deductible health plan. Notwithstanding the preceding, if a Participant first becomes a Participant during: (1) April through June of the year, he or she will be eligible for up to seventy-five percent (75%) of the matching contribution specified in the preceding sentence for such year, (2) July through September of the year, he or she will be eligible for up to fifty percent (50%) of the matching contribution specified in the preceding sentence for such year, and (3) October through December, he or she will be eligible for up to twenty-five percent (25%) of the matching contribution specified in the preceding sentence for such year.

**ARTICLE V.
PARTICIPANT ACCOUNTS AND ELECTIONS**

5.1 Participant Accounts. Each Participant will have four (4) bookkeeping accounts established to keep track of the number of benefit dollars available to the Participant for reimbursement of covered expenses. “Benefit dollars” refers to that portion of the Participant’s compensation which he or she elects to contribute to purchase the Optional Benefits.

- (a) One account will be used to keep track of the number of benefit dollars available to pay contributions for the Health Plan coverage elected by the Participant. This is referred to as the Health Plan Account.
- (b) A second account will be used to keep track of the number of benefit dollars available to the Participant for the reimbursement of medical expenses covered under the Medical Reimbursement Program. This is referred to as the Medical Reimbursement Account.
- (c) A third account will be used to keep track of the number of benefit dollars available to the Participant for the reimbursement of dependent care expenses covered under the Dependent Care Program. This is referred to as the Dependent Care Account.
- (d) A fourth account will be used to keep track of benefit dollars the Participant elects to contribute to his or her Health Savings Account and the Employer’s matching contribution on those benefit dollars. As noted in Section 4.3(b), a

trustee/custodian maintains the Participant's Health Savings Account. The County will only maintain records to keep track of a Participant's pre-tax contributions and matching contributions to the Account under this Plan. This is referred to as the Health Savings Account.

5.2 Annual Enrollment Period. Approximately forty-five (45) days prior to each year, Participants will be provided one or more election forms and compensation reduction agreements. Elections made on such forms will be effective as of the first day of the following year. If the Participant desires to purchase for the following year one or more of the Optional Benefits, he or she must so specify on the appropriate election form or forms and agree to a reduction in his or her compensation in an amount sufficient to pay for the benefit options elected. Each election form and corresponding compensation reduction election must be completed and returned to the OFM Benefits Division on or before the date specified by the Plan Administrator, which in any event will not be later than the beginning of the first pay period to which the Participant's compensation reduction agreement, if any, will apply.

On the election form(s), Participants will be required to specify the amount, if any, to be contributed to each of their accounts. The maximum amount that Participants may contribute (or that may be contributed on their behalf) each calendar year to their accounts is as follows:

- (a) Health Plan Account - the Participant's cost of the Optional Benefits elected;
- (b) Medical Reimbursement Account - Four thousand dollars (\$4,000);
- (c) Dependent Care Account - Five thousand dollars (\$5,000) (twenty-five hundred dollars (\$2,500) if the Participant is married and files a separate return); and
- (d) Health Savings Account - the maximum amount a Participant may contribute to his or her Health Savings Account under Code Section 223. The maximum amount is pro-rated if the Participant does not participate in the Health Savings Account for the entire year. Other special rules may also apply. (It is the Participant's responsibility to make sure that he or she does not exceed the maximum set by law. By allowing a Participant to make pre-tax contributions to his or her Health Savings Account under this Plan, neither the Plan Sponsor nor any Employer is assuming any responsibility for ensuring the Participant does not exceed the maximum.)

5.3 Initial Enrollment Period -- New Eligible Employees. As soon as practicable before an Eligible Employee becomes eligible to participate in the Plan under Section 3.1, he or she will be provided the written election forms and compensation reduction agreements described in Section 5.2. The election forms with respect to dependent care and medical reimbursement benefits will be effective as of the date the Eligible Employee becomes eligible to participate in the Plan. With respect to the Health Plan, the election forms will be effective on the first day of the calendar month coincident with or next following the date the Eligible Employee becomes a Participant. If the Participant desires to elect one or more of the Optional Benefits for the year (or the balance of the year if he or she became eligible to participate during the year), the Participant must so specify on the election forms and, if applicable, agree to a reduction in compensation as provided in Section 5.2. The election forms must be completed

and returned to the OFM Benefits Division on or before the date specified by the Plan Administrator, which in any event will be no later than the beginning of the first pay period for which the Participant's compensation reduction agreement, if any, will apply. Contributions for any retroactive periods of coverage may be made on an after-tax basis.

5.4 Failure to Elect. If a Participant does not return a completed election form during his or her initial enrollment period or an annual enrollment period, the Participant will be deemed to have elected single coverage under the Health Plan for the following year and will be treated as having agreed to a reduction in compensation equal to the Participant's cost of such coverage.

5.5 Irrevocability of Election During the Year (Other than Health Savings Account). Federal tax law requires that an election made under the Plan (or deemed to be made under Section 5.4), other than elections with respect to a Health Savings Account, must remain in effect without modification for the entire calendar year for which the election is made. A Participant may, however, revoke an election for the balance of a calendar year and file a new election if the revocation and new election are on account of, and consistent with, the "change in status" or in certain other special situations, as described below.

- (a) A Participant may revoke an election for any Optional Benefit for the balance of a year and file a new election if a "change in status" occurs and the election is consistent with and due to the "change in status." For example, the election change may be a change from family to individual coverage, or a change from individual coverage to family coverage. A change of plans can only be made during Open Enrollment or if the Participant moves out of the current plan's network area. A "change in status" includes changes relating to:
 - (1) the Participant's marriage or divorce;
 - (2) the death of the Participant's spouse or child;
 - (3) the birth or adoption of the Participant's child;
 - (4) the termination or commencement of the spouse's employment;
 - (5) the switching from part-time to full-time employment status (or from full-time to part-time) by the Participant's spouse; or
 - (6) a significant change in the health coverage for the Participant or the Participant's spouse attributable to the spouse's employment.
- (b) A Participant may modify an election for Optional Benefits (other than the medical reimbursement benefit) and make a new election to select a benefit package option providing similar coverage if coverage under an Optional Benefit is significantly curtailed (for example, if there is a significant increase in the deductible, the co-pay or the out-of-pocket cost sharing limits). A Participant may not revoke his or her election and cease coverage entirely under the Optional Benefit.

- (c) A Participant may revoke an election for Optional Benefits (other than the medical reimbursement benefit) and make a new election to select a benefit package option providing similar coverage or, if no similar coverage is available, to drop coverage entirely, if coverage under an Optional Benefit is substantially curtailed so as to constitute a cessation of coverage (including, for example, if there is a substantial decrease in medical care providers available under the option or a reduction in the benefits for a specific type of medical condition with regard to which the Participant or his or her spouse or dependent is currently in a course of treatment).
- (d) A Participant may revoke an election for Optional Benefits (other than the medical reimbursement benefit) and make a new election if another benefit package option is added or if coverage under an existing benefit package option is significantly improved. In the case of the Dependent Care Program, a change of child care providers is a change in coverage for this purpose.
- (e) A Participant may revoke an election for Optional Benefits (other than the medical reimbursement benefit) and make a new and corresponding election if the cost of the Optional Benefit or benefit package option of the County significantly increases or decreases. In the case of the Dependent Care Program, this applies only if the Participant's child care provider is not a relative.
- (f) A Participant may revoke an election for Optional Benefits (other than the medical reimbursement benefit) and make a new election to add coverage for himself or herself and his or her spouse or dependents if the Participant or his or her spouse or dependents lose coverage under any group health coverage sponsored by a governmental or educational institution, including a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization, a state health benefits risk pool, or a foreign governmental group health plan.
- (g) A Participant may revoke an election related to the Health Plan for the balance of a calendar year and file a new election if the revocation and new election relate to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires the Participant to provide coverage for the Participant's child under this Plan or requires the Participant's former spouse to provide coverage and the former spouse actually does provide such coverage (thus permitting the Participant to make an election to cancel coverage for the child).
- (h) A Participant may revoke an election related to the Health Plan and file a new election if a "special enrollment period" is available to the Participant under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, a Participant is generally afforded the opportunity to elect health coverage for himself or herself and/or his or her dependents where coverage was either declined because: (A) the Participant and/or his or her dependents had COBRA continuation coverage and such COBRA continuation coverage has since been exhausted (nonpayment of premiums or contributions is not sufficient

for this purpose); or (B) the Participant and/or his or her dependents had non-COBRA health coverage and the other coverage has been terminated due to loss of eligibility for coverage (for example, loss of student-only coverage available through a college due to the individual ceasing to be a student) or employer contributions towards the other coverage have terminated. HIPAA also provides a special enrollment period where the Participant previously declined coverage either for himself or herself and/or his or her dependents and the Participant subsequently acquires a new dependent by marriage, birth, adoption or placement for adoption.

- (i) A Participant may cancel or reduce coverage under the Health Plan for the Participant or his or her spouse or dependents to the extent the Participant or his or her spouse or dependents become entitled to Medicare or Medicaid coverage and the Participant may commence or increase coverage for himself or herself and his or her spouse or dependents to the extent that any such individual loses eligibility for Medicare coverage.
- (j) A Participant and his or her spouse or dependents who are not currently enrolled may enroll for coverage under the terms of the Health Plan upon either: (1) termination of Medicaid or state children's health insurance program ("SCHIP") coverage because of a loss of eligibility, and the Participant requests coverage under the Plan within sixty (60) days of the termination of Medicaid or SCHIP coverage; or (2) becoming eligible for a Medicaid or SCHIP premium assistance subsidy and the Participant requests coverage under the Plan within sixty (60) days after such eligibility.

Except as otherwise specifically provided in Section 5.5(j), to be given effect, a new election under this Section 5.5 must be filed with the OFM Benefits Division within thirty (30) days of the date of the change in family status or other event permitting the new election, except that, in the case of a leave of absence, the new election must be returned within thirty (30) days of the Participant's return to work. Such an election will be effective the first pay period beginning after the election form is completed and returned to the OFM Benefits Division. The Participant may be required to provide supporting documentation establishing that one of the above events permitting an election change has in fact occurred.

5.6 Election Changes under Health Savings Account. Elections to contribute to a Health Savings Account generally can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed, or as soon thereafter as administratively practicable. For more information regarding changes in election under a Health Savings Account, the Participant should refer to his or her agreement with the trustee/custodian.

5.7 Automatic Termination of Election. Elections made under this Plan (or deemed to be made under Section 5.4) automatically terminate on the date the Participant becomes ineligible to participate in the Plan. See Section 3.2. Coverage under the Health Plan, or medical reimbursement or dependent care benefits, continue only to the extent provided under the Health Plan, Article VI with respect to medical reimbursement benefits, or Article VII with respect to dependent care benefits. For example, under the Health Plan, the Participant (or the

Participant's spouse or dependent) may be entitled to continue coverage by making self-pay contributions. In that event, such contributions will not be made on a pre-tax basis as described in Section 4.1 and such coverage will generally not be governed by this Plan, but rather the terms of the Health Plan. However, individuals continuing Health Plan coverage generally may change health plan coverage during an annual enrollment period to the extent similarly-situated Eligible Employees may do so. Please refer to the Health Plan, and summaries thereof, for more information concerning such continuation privileges.

5.8 Forfeitures.

- (a) This Section 5.8(a) is not applicable with respect to a Participant's Health Savings Account. Federal law requires that amounts a Participant elects to contribute to this Plan for any given year (or portion thereof if the Participant became eligible to participate during a year) be used only to purchase benefits for that year (or if the Participant became eligible to participate during a year, only for the period commencing on the effective day of the Participant's election and ending on the last day of the year). Amounts contributed for a given year (or portion thereof) may not be carried over to provide benefits or coverage for a subsequent year. This means, for example, that to the extent a Participant has amounts remaining in his or her accounts for a given year, after the reimbursement of all likely claims for covered expenses incurred during that year, such amounts will be forfeited by the Participant. Any amounts so forfeited will be used by the County to defray the administrative costs of the Plan.
- (b) Distributions from a Participant's Health Savings Account and all other matters relating to a Participant's Health Savings Account are outside this Plan and are to be handled by the Participant and his or her trustee/custodian in accordance with the agreement between them.

5.9 Nondiscrimination Rules. If the Plan Administrator determines, before or during any Plan Year, that the Plan or any Optional Benefit fails to satisfy any nondiscrimination requirement or any limitation on benefits provided to highly compensated employees or individuals imposed by the Code, the County may take such action as it deems appropriate, under rules uniformly applicable to similarly situated employees or individuals, to assure compliance with any such requirement or limitation. Such action may include, without limitation, a modification of an election by a highly compensated employee or individual, with or without the consent of such employee or individual.

5.10 Participation During or Upon Return From FMLA or Military Leave of Absence.

Special rules apply if a Participant takes an FMLA Leave or Military Leave. These rules are very complex and, in part, depend upon whether the leave is paid or unpaid and the terms of the County's leave policy. The Participant's rights during or upon return from FMLA Leave or Military Leave under this Plan will be determined in accordance with the County's leave policy, to the extent consistent with the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act, as may be amended.

In general, however, if the Participant is on a paid FMLA Leave or paid Military Leave, the Participant's elections under this Plan will automatically continue, so long as he or she remains eligible for the Optional Benefits during the leave in accordance with the County's leave policy. To the extent provided in the County's leave policy, the County's contributions towards the cost of such Optional Benefits will continue as if the Participant had remained actively employed with the County.

Different rules apply if the FMLA Leave or Military Leave is unpaid. With respect to an unpaid FMLA Leave, the Participant will have the opportunity to discontinue his or her contributions towards the Optional Benefits. If the Participant does so, his or her coverage under such benefits will terminate while the Participant is on leave. While on unpaid FMLA Leave, the Participant has the right to continue health-related coverage, including the Health Plan and the Medical Reimbursement Program. The County's contributions towards such health benefits will continue, if the Participant elects to continue such coverage, on the same basis as if the Participant was actively employed with the County. In some cases, the County's leave policy may also allow the Participant to continue participation in the Dependent Care Program while on unpaid FMLA Leave.

If the Participant elects to continue coverage while on unpaid FMLA Leave, the County's leave policy may allow the Participant to continue contributions on an after-tax "pay as you go basis," which generally means that to continue such coverage the Participant will be required to make payments to the County at the times payments would otherwise be withheld from the Participant's pay. Alternatively, the County's leave policy may permit the Participant to make special pay arrangements, including the payment by the County of the Participant's contributions for the period while the Participant is on FMLA Leave, with the understanding that the Participant will repay such contributions at the conclusion of his or her leave. It might also allow the Participant at his or her request to pay the amounts that will become due during the leave out of his or her paychecks preceding the leave where there is no overlap of calendar years.

If the Participant is on an unpaid Military Leave, his or her rights are very similar to those described above. However, in these circumstances, the County's obligation to make contributions towards health-related benefits generally ceases if the Military Leave exceeds thirty-one (31) days. In that event, however, the Participant may still continue health-related benefits, including the Health Plan and the Medical Reimbursement Program, by paying the full cost of such coverage in accordance with the methods described above.

Upon the Participant's timely return to active employment from FMLA Leave or Military Leave, the Participant will have the opportunity to be reinstated in any Optional Benefits (to the extent available to other employees) which he or she had previously elected, without evidence of insurability or the new imposition of a waiting period. If the Participant incurred a "change in status," he or she will be able to file a new election under the "change in status" rules described in Section 5.5. Unless the Participant continued coverage during the leave, the coverage to which the Participant is reinstated will not be given retroactive effect. As a result, if the Participant discontinues coverage in the Medical Reimbursement Program while on leave, and subsequently elects to be reinstated upon return from such leave, the Participant's coverage for the remainder of the calendar year (assuming the Participant returns to employment in the same calendar year) is equal to the Participant's initial election for the calendar year, prorated for the

period during the FMLA or Military Leave for which no contributions were paid, reduced by prior reimbursements.

ARTICLE VI. MEDICAL REIMBURSEMENT PROGRAM

6.1 In General. If a Participant elects to purchase medical reimbursement benefits, the Participant may submit claims for the reimbursement of Covered Medical Expenses. A Participant who elects to make contributions to a Health Savings Account may not participate in the Medical Reimbursement Program.

6.2 Definitions. For purposes of this Article, the following special definitions apply:

- (a) “Dependent” means any person who is: (1) the Participant’s natural, adopted, foster or stepchild; or (2) the Participant’s spouse, unless the Participant and his or her spouse are legally separated, in which case the Participant’s spouse would not be considered the Participant’s Dependent.
- (b) The term “Medical Expenses” means medical and dental expenses incurred by the Participant or the Participant’s dependents for medical care, as defined in Code Section 213(d)(1)(A) and (B). The term “Covered Medical Expenses” means Medical Expenses incurred while the Participant has an effective election to purchase medical reimbursement benefits for a year or, if the Participant became an Eligible Employee during a year, the Medical Expenses incurred after the first pay day on which the Participant’s compensation is reduced by reason of his or her election, but before the last day of the year. For this purpose, an expense is “incurred” when the Participant or the Participant’s dependent is furnished the medical care or services giving rise to the claimed expense. Covered Medical Expenses do not include, however, an expense incurred for the payment of contributions or premiums under a health insurance plan not sponsored by the County, an expense which is reimbursable through insurance or otherwise (other than this Plan) or for which the Participant is not obligated to pay.

6.3 Maximum Amount of Coverage. The amount of medical reimbursement benefits during any year may not exceed four thousand dollars (\$4,000). Also, a Participant may not elect to contribute less than ten dollars (\$10) per paycheck to his or her Medical Reimbursement Account. When completing election forms for a year, a Participant should be careful not to exceed the maximum amount or contribute less than this minimum.

6.4 Medical Reimbursement Account. There will be credited to the Participant’s Medical Reimbursement Account an amount equal to the reduction (if any) in the Participant’s compensation in accordance with his or her election under Article V. The Participant’s Medical Reimbursement Account for each year will be debited from time to time in the amount of any reimbursement for Covered Medical Expenses. At any time during a year, the Plan will reimburse the Participant for Covered Medical Expenses up to the amount he or she has elected to contribute for the year, less prior reimbursements for that year.

6.5 Forfeiture of Account. The amount credited to a Participant's Medical Reimbursement Account for any year may be used only to reimburse the Participant for Covered Medical Expenses incurred during such year, and only if the Participant applies for reimbursement (in accordance with Article II) on or before the March 15 following the close of the year in which the claimed expense is incurred. If any balance remains in the Participant's account for any year after all permissible reimbursements, such balance will not be carried over to reimburse the Participant for Covered Medical Expenses incurred during a subsequent year and will not be available to the Participant in any other form or manner. The Participant will forfeit all rights with respect to such balance. Forfeitures will be used to help defray the administrative costs of the Plan.

6.6 Termination of Benefits: Special Rules for Former Eligible Employees. A Participant's coverage will automatically terminate as of the date he or she ceases to be eligible to participate in the Plan under Section 3.2, unless the Participant elects to continue coverage under Section 6.7 below. The Participant may continue to file claims for Covered Medical Expenses incurred through the date his or her eligibility ceased. Claims for reimbursement must be filed before the earlier of: (a) the March 15 following the year in which the Participant's participation ceased; or (b) within sixty (60) days of the date such participation ceased.

6.7 Continuation Coverage. Participants and their dependents may be entitled to continue this medical reimbursement benefit under the rules described in Appendix A.

ARTICLE VII. DEPENDENT CARE PROGRAM

7.1 In General. If a Participant elects to purchase benefits under this Program, the Participant may submit claims for the reimbursement of Covered Dependent Care Expenses.

7.2 Definitions. For purposes of this Article, the following special definitions apply:

- (a) "Dependent" means (1) a dependent under the age of thirteen (13) and with respect to whom the Participant is entitled to claim as a dependent on his or her federal income tax return; or (2) the Participant's spouse or other tax dependent if he or she is physically or mentally incapable of caring for himself or herself.
- (b) "Dependent Care Expense" means amounts paid or incurred by the Participant for "household services" or for the care of a dependent, either inside or outside of the Participant's home, subject to the limitations in Section 7.5, in order to enable the Participant to be gainfully employed for any period for which the Participant has one or more dependents. In the case of dependent care provided outside of the Participant's home, where the person or facility providing the care cares for more than six (6) individuals, expenses will be considered Dependent Care Expenses only if the person or facility complies with all applicable laws and regulations or any state or unit of local government and the benefits are provided: (1) for the care of the Participant's dependent child under the age of thirteen (13); or (2) any other dependent who regularly spends at least eight (8) hours each day in the Participant's household.

- (c) “Household Services” means expenses paid for the performance in and about the Participant’s home of ordinary and usual services necessary to the maintenance of the Participant’s household. Such expenses must also be attributable to the care of a dependent, as defined above. As an example, amounts paid for the services of a cook may be reimbursed if they are provided to a dependent and enable the Participant to be gainfully employed. Expenses will not be reimbursed for the services of a chauffeur, bartender or gardener.

7.3 Covered Expense. The Program will reimburse only Dependent Care Expenses incurred during the Plan Year the Participant elected dependent care benefits, or if the Participant became an Eligible Employee during a Plan Year, such expenses incurred after the first pay day on which the Participant’s compensation is reduced by reason of his or her election, but before the last day of the year. Dependent Care Expenses will be considered incurred when the dependent care is provided and not when the Participant is formally billed, charged for, or pays the Dependent Care Expenses.

7.4 Further Limitations. The amount of dependent care benefits during any year may not exceed the lesser of:

- (a) Five thousand dollars (\$5,000) (twenty-five hundred dollars (\$2,500) if the Participant is married and files a separate return),
- (b) the Participant’s earned income for the year (after all reductions in pay to provide dependent care benefits under this Program), or
- (c) the actual or deemed earned income of the Participant’s spouse for the year.

For purposes of Section 7.4(c), if the Participant’s spouse is a full-time student at an educational institution or physically or mentally incapable of caring for himself or herself, the spouse is deemed to have earned income of two hundred dollars (\$200) per month if the Participant has only one dependent, and four hundred dollars (\$400) per month if the Participant has two or more dependents.

A Participant may not elect to contribute less than ten dollars (\$10) per paycheck to his or her Dependent Care Account. When completing elections for the year, Participants should be careful not to exceed the permissible amount described in this Section or to contribute less than this minimum.

7.5 Prohibition of Certain Payments. No benefits will be paid to a Participant during any taxable year for Dependent Care Expenses paid to an individual:

- (a) with respect to whom, for such taxable year, the Participant or his or her spouse is entitled to a personal tax exemption as a dependent; or
- (b) who is the Participant’s spouse or child under age nineteen (19).

7.6 Dependent Care Account. There will be credited to a Participant’s Dependent Care Account an amount equal to the reduction (if any) in the Participant’s compensation in accordance with his or her election under Article V. The Participant’s Dependent Care Account

for each year will be debited from time to time in the amount of any reimbursement for Covered Dependent Care Expenses. Reimbursement from a Participant's Dependent Care Account for Covered Dependent Care Expenses may never exceed the amount then remaining in the account

7.7 Forfeiture of Account. The amount credited to a Participant's Dependent Care Account for any year may be used only to reimburse the Participant for Dependent Care Expenses incurred during such year, and only if the Participant applies for reimbursement (in accordance with Article II) on or before the January 31 following the close of the year in which the claimed expense is incurred. If any balance remains in the Participant's account for any year after all permissible reimbursements, such balance will not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent year and will not be available to the Participant in any other form or manner. The Participant will forfeit all rights with respect to such balance. Forfeitures will be used to defray the administrative costs of the Program.

7.8 Termination of Benefits: Special Rules for Former Eligible Employees. If a Participant ceases to be eligible to participate in the Plan under Section 3.2, the Participant's coverage under this Program will automatically terminate as of that date. A Participant may continue to file claims for Dependent Care Expenses incurred through the date his or her eligibility ceased. Claims must be filed before the earlier of: (a) the January 31 following the year in which the Participant's participation ceased; or (b) within sixty (60) days of the date such participation ceased.

7.9 Divorced or Separated Parents. Special rules apply in the case of dependent care or household services for a child of parents who are divorced, legally separated, or separated under a written separation agreement. For such a child, expenses for dependent care and household services may be reimbursed from a Participant's Dependent Care Account only if the child:

- (a) is under age thirteen (13) or is physically or mentally incapable of caring for himself or herself,
- (b) receives over half of his or her support during the year from his or her parents,
- (c) is in the custody of one or both of his or her parents for more than half of the year, and
- (d) is in the Participant's custody for a longer period during the year than in the custody of his or her other parent.

7.10 Important Reporting Requirements. Federal law requires that in order for a Participant to exclude such expenses from his or her federal taxable income, the Participant must include certain information on his or her federal tax return. In particular, a Participant will have to report the correct name, address, and taxpayer identification number of the dependent care provider. If the dependent care provider is an individual, the taxpayer identification number is the individual's social security number. Special reporting rules apply if the provider is tax-exempt for federal tax purposes. Participants should consult their personal tax advisers for more information concerning these reporting requirements.

7.11 Alternative Tax Credit. In some circumstances, it may be to a Participant's advantage not to contribute to the Dependent Care Account because there is a dependent care "tax credit" which is an alternative to the dependent care benefits provided under this Plan. Although the tax credit is an alternative -- a Participant cannot use both this Program and the tax credit for the same dollar spent on dependent care -- it is possible to use this Program for a portion of dependent care expenses and the tax credit for another portion. Use of this Program does, however, reduce the amount of dependent care expenses for which a Participant may claim the tax credit. Before enrolling in the Dependent Care Reimbursement Program, Participants may wish to consult with their tax advisors.

ARTICLE VIII. GENERAL PROVISIONS

8.1 Any Questions? If a Participant has questions or needs additional information about this Plan, he or she should contact the OFM Benefits Division in writing or by telephone. The address and telephone number are:

111 South Cherry Street
Suite 2400
Olathe, Kansas 66061-3441
(913) 715-0700

8.2 Administrator. The administration of the Plan, the Medical Reimbursement Program and the Dependent Care Program is the responsibility of the Plan Administrator. The Plan Administrator has the power to carry out their provisions and to resolve any disputes or conflicts relating to them. For a more detailed explanation of the powers and duties of the Plan Administrator, see Appendix B.

8.3 Governing Law. The Plan and Program are established in the State of Kansas. To the extent federal law does not apply, any questions arising under the Plan or Program will be determined under the laws of the State of Kansas.

8.4 Alienation. No benefits under this Plan or Program may be assigned or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for a Participant's debts or obligations. If a person who is entitled to receive a payment under the Plan or Program is, in the Plan Administrator's opinion, incapable of giving a valid receipt for the payment and if no guardian has been appointed for that person, payment may be made to the person or persons who in the Plan Administrator's opinion have assumed the obligations of caring for the person on whose behalf the payment is made.

8.5 Termination and Amendment. The County or the Plan Administrator has the authority to terminate the Plan or Program at any time or to amend and modify them from time to time as it deems proper. Any amendment or modification will be in writing and as formal as the Plan and Program. If the Plan or Program is terminated, the Plan or Program, as the case may be, will make payments to Participants from their accounts for covered expenses incurred during the remainder of the Plan Year based on applications for payment filed after the Plan or Program is terminated.

8.6 General Information. The Plan is funded through compensation reductions made by Eligible Employees. Amounts contributed to purchase coverage under the Health Plan are held by the County as part of its general assets until paid to the Health Plan or its insurers as premiums become due. Amounts contributed to purchase medical reimbursement or dependent care benefits are held by the County as part of its general assets until requests for payment of covered expenses are approved.

8.7 Plan Not in Place of Workers' Compensation. This Plan is not in place of and does not affect any requirement for coverage by Workers' Compensation insurance.

8.8 Effective Date. The original effective date of the Plan and Program is January 1, 1988. The Plan was most recently amended and restated by this document effective January 1, 2009.

8.9 Plan Not Employment Contract. This Plan and Program do not constitute an employment contract between the County and any individual, nor should they be considered as an inducement for the employment or continued employment of any individual. Nothing herein should be interpreted to give any individual the right to be retained by the County or to interfere with the right of the County to discharge any individual at any time regardless of the effect which such discharge may have upon his or her participation under the Plan or Program.

ARTICLE IX. DEFINITIONS

9.1 Code means the Internal Revenue Code of 1986, as amended from time to time.

9.2 Compensation means the salary paid to a Participant by the County, including amounts the Participant contributed to the Plan pursuant to a compensation reduction election and amounts contributed by the County as an addition to the Participant's bi-weekly salary which may be used by the Participant to purchase Optional Benefits under the Plan.

9.3 County means the Johnson County Government.

9.4 Dependent Care Program means the Dependent Care Program adopted by the County and set forth in Article VII hereof, as amended from time to time.

9.5 Eligible Employee means a person: (a) employed with the County in a position approved by the Board of County Commissioners of Johnson County, Kansas; (b) whose normal work week is forty (40) or more hours; and (c) whose employment with the County is for an undefined period of time. The term "Eligible Employee" also includes members of the Board of County Commissioners and elected County officials.

9.6 FMLA Leave means a leave of absence that the County is required to extend, and which is taken by the Participant, in accordance with the Family and Medical Leave Act, as may be amended, and the County's FMLA leave policy.

9.7 Health Plan means the group medical and dental plans maintained by the County for its employees, as amended from time to time. A Participant may request a copy of the plans from the OFM Benefits Division.

9.8 Health Savings Account means a health savings account established under Code Section 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by a Participant with a qualified trustee/custodian.

9.9 Military Leave means a leave of absence to perform service in the uniformed services of the United States of America which is taken in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as may be amended.

9.10 Plan means the Johnson County Government Flexible Benefit Program, as herein set forth herein and as amended from time to time.

9.11 Plan Administrator means the County Manager of the Johnson County Government.

COUNTY MANAGER
JOHNSON COUNTY, KANSAS

Michael B. Press

APPROVED AS TO FORM:

Roger L. Tarbutton, Assistant County Counselor

Revised: 01/01/1991; 01/01/2003; 01/01/2004

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APPENDIX A

MEDICAL REIMBURSEMENT BENEFITS **COVERAGE CONTINUATION**

Federal law requires most employers sponsoring medical reimbursement programs to offer employees and their families the opportunity to elect a temporary extension of medical reimbursement benefits in certain instances where coverage under the program would otherwise end. This notice is to inform Participants, in summary fashion, of their rights and obligations under these provisions of the law.

A Participant in the medical reimbursement program has the right to continue coverage if he or she would otherwise lose coverage because of a reduction in his/her hours of employment or his or her termination of employment (for reasons other than gross misconduct).

The spouse of a Participant has the right to continue coverage if he or she would otherwise lose coverage for any of the following reasons:

- The death of the Participant;
- Termination of the Participant's employment (for reasons other than gross misconduct) or a reduction in the Participant's hours of employment; or
- Divorce or legal separation from the Participant.

A dependent child of a Participant also has the right to continue coverage if he or she loses coverage for any of the following reasons:

- The death of the Participant;
- Termination of the Participant's employment (for reasons other than gross misconduct) or a reduction in the Participant's hours of employment;
- The Participant's divorce or legal separation;
- The dependent child ceases to be a "dependent child" under the terms of the plan.

Under the law, the Participant or a family member has the responsibility to inform the Plan Administrator or his or her designee of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the date of the event. The Employer has the responsibility to notify the Plan Administrator or his or her designee of the Participant's death, termination, or reduction in hours of employment.

When the Plan Administrator or his or her designee is notified that one of these events has occurred, it will in turn notify the Participant and his or her dependents of the right to continue coverage. Under the law, the Participant and his or her dependents have at least sixty (60) days from the date they would lose coverage because of one of the events described above to inform the Plan Administrator or his or her designee that some or all want to continue coverage.

If the Participant and/or his or her dependents do not choose to continue coverage on a timely basis, coverage under the plan will end on the date one of the above events occurs.

If a Participant and/or his or her dependents choose to continue coverage, it will last until the end of the calendar year in which the qualifying event occurred.

Under the law, the Participant and/or dependent who elects to continue coverage may have to pay all or part of the cost of such coverage. The first required payment must be paid within forty-five (45) days of the date of continued coverage is elected .

Continued coverage will end immediately if either of the following events occurs:

- The Participant notifies the Plan Administrator that he or she wishes to discontinue coverage.
- The Participant fails to pay a required monthly contribution or premium when due or during the applicable grace period

APPENDIX B

ADMINISTRATION

1. Plan Administrator. The administration of the Plan and Dependent Care Program (“Program”) is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan and Program are carried out in accordance with their terms for the exclusive benefit of persons entitled to participate. The Plan Administrator has full power to administer the Plan and Program in all of their details, subject to applicable requirements of law. For this purpose, the Plan Administrator’s powers include, without limitation, the power:

- a. to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan and Program, including the establishment of any claims or appeal procedures that he/she may deem necessary or desirable or may be required by applicable provisions of law;
- b. to interpret the Plan and Program;
- c. to decide all questions concerning the Plan and Program and the eligibility of any person to participate in the Plan and Program;
- d. to appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan and Program;
- e. to allocate and delegate his or her responsibilities under the Plan and Program and to designate other persons to carry out any of his/her responsibilities under the Plan and Program, any such allocations, delegation or designation to be in writing; and
- f. to enter into any and all contracts and agreements for carrying out the terms of this Plan and Program and for the administration of the Plan and Program and to do all acts as he or she in his or her discretion may deem necessary or advisable, and such contracts, agreements and acts shall be binding and conclusive on the parties hereto and on the employees concerned.

Notwithstanding the foregoing, any claim which arises under the Health Plan will not be subject to review under the Plan, and the Plan Administrator’s authority under this Appendix shall not extend to any matter as to which any other entity or persons with respect to the Health Plan is empowered to make determinations.