METROPOLITAN LIBRARY SYSTEM OF OKLAHOMA COUNTY FLEXIBLE BENEFITS PLAN

COMBINED PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

EFFECTIVE: JULY 1, 2021

CONTENTS

I. ESTABLISHMENT OF PLAN

A. Purpose

This Plan is a voluntary employee benefit plan that affords a participant the opportunity to take advantage of tax savings currently available. A participant sets aside a portion of income each pay period before it is taxed for uses described in this Plan Document. Participants should read this entire Plan Document to ensure that all requirements and conditions of the Plan are fully understood.

The Plan is intended to qualify as a cafeteria plan which meets the requirements of Section 125 of the Code. The Dependent Care Flexible Spending Account portion of the Plan is intended to qualify as a dependent care assistance program under Section 129 of the Code. The Health Care Flexible Spending Account portion of the Plan is intended to qualify as an accident or health plan under Sections 105 and 106 of the Code.

B. Introduction to Plan

Any eligible employee may elect to participate in the Metropolitan Library System of Oklahoma County Flexible Benefits Plan. Participation in the Premium Only option, the Health Care Flexible Spending Account, and/or the Dependent Care Flexible Spending Account is optional and requires completion of an enrollment form.

This document serves as both the written Plan Document and Summary Plan Description.

C. Terms of Participation

Under federal regulations which govern the Plan, an eligible employee may change elections regarding participation once a year during the open enrollment period established by the employer. Such changes may be made for any reason and will become effective on the first day of the next plan year. During the remainder of the plan year, an eligible employee may not change elections unless they experience a qualifying change in status that is on account of and consistent with the change as set forth in this document.

Any balance in a participant's account at the end of a plan year must be forfeited. Under IRS rules for flexible spending account plans, that balance cannot be paid to an employee in cash, carried over to the next plan year, nor be made available to an employee in any way. Forfeited funds may be used to offset costs of the plan.

Note: As permitted by the Heroes Earnings Assistance and Relief Tax Act of 2008 (the "HEART Act"), unused amounts in the Health Care Flexible Spending Account may be distributed if requested prior to the end of the plan year.

By accepting coverage under this Plan, a participant and their dependents agree to supply information about medical conditions and records when requested by the Plan. All private health information will be kept confidential and will be used on a need only basis for purposes of administering Plan benefits.

D. Compliance

This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. Should any part of this document for any reason be declared invalid, such decision shall not affect the validity of any remaining portion, which

remaining portion shall remain in effect as if this document had been executed with the invalid portion thereof eliminated.

II. PREMIUM ONLY OPTION

Participants who enroll in certain health care benefit plan(s) sponsored by the employer can choose to have their payroll deductions for contributions, including any change in the cost of the benefit during a period of coverage under the terms of the Plan, to be taken before or after income is taxed for federal, applicable state and social security purposes, as allowed by law. The participant's election for those contributions will not continue year-after-year; the participant must affirmatively elect to participate each year during the open enrollment period or pursuant to a mid-year election-change event recognized by the Plan.

Information regarding the employer-sponsored welfare plan(s) is contained in the plan documents and/or insurance contracts for those plans. Coverage and claims procedures for such health benefits are governed by said documents.

III. HEALTH CARE FLEXIBLE SPENDING ACCOUNT OPTION

A. Contributions

Participants may choose to have a portion of their compensation applied toward the HCFSA. The amount of such salary reduction contributions to the HCFSA shall not exceed the maximum annual limit permitted by the Internal Revenue Service.

B. Eligible Expenses

In general, health care expenses for a participant and their dependents are eligible for reimbursement from the Health Care Flexible Spending Account if they meet all of the following requirements:

- The expenses were incurred on or after the effective date of the employee's participation in the Plan;
- They would qualify as medical expenses for federal income tax purposes under Section 213 of the Code;
- They have not been and will not be paid by the participant's health benefit plan(s) or by another employer's group health benefit plan or by any other insurance policy or program; and
- They have not and will not be deducted on the Participant's tax return.

Eligible reimbursable expenses under this Plan include, but are not limited to, out-of-pocket expenses for:

- Deductibles and copayments for hospital, physician, prescription and over-the-counter drugs, dental and vision care;
- Uncovered health services such as hearing aids, vision care, routine physicals and well-baby care, counseling therapy and long-term rehabilitation services (alcoholism and drug abuse); and
- Fees in excess of plan limits, including those for orthodontia and psychiatric services.

Under current laws, the contributions a spouse makes for health insurance, and the expenses for elective cosmetic surgery, are expenses which are not eligible for reimbursement from the participant's Health Care Flexible Spending Account. The above are just two examples of ineligible expenses.

Further information on the types of health care expenses eligible for reimbursement from a participant's Health Care Flexible Spending Account is available from the IRS in Publication 502. (Call 1-800-TAXFORM.) However, Publication 502 provides information relating to tax-deductible expenses on the federal income tax return, and, therefore, includes some provisions that conflict with this Plan. For purposes of filing a claim for reimbursement, all other terms and conditions of this Plan shall apply in determining the benefits available to a participant.

C. Over-the-Counter Drugs

Notwithstanding the eligible expense requirements set forth above, over-the-counter (OTC) drug expenses for a participant and their dependents are eligible for reimbursement from the

Health Care Flexible Spending Account if they are medicines or drugs that are used for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Items that are used to promote the general good health of an individual, such as vitamins, are not eligible for reimbursement. OTC drug medical expenses must be properly substantiated when filing a claim for reimbursement. Different levels of substantiation may be required depending on the facts and circumstances of the claim.

As permitted under the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and Code Section 106(f), expenses incurred for menstrual care products shall be treated as incurred for medical care (as defined in Code Section 223(d)(2)(D)) and deemed an eligible expense.

D. Debit Card Privileges

All eligible employees that elect to participate in the Health Care Flexible Spending Account benefit option may use a debit card to pay for eligible expenses that are incurred during the plan year. The card is a prepaid debit card that may be used for purchases at certain merchant locations that accept debit cards. The card should only be used to pay for qualified health care expenses. The card cannot be used to get cash or to obtain cash back in any purchase transaction. If the card is used to pay for ineligible expenses, the participant must repay those amounts to the Plan. For more detailed information about using the card, see the cardholder agreement with the debit card company.

E. Estimating Eligible Health Care Expenses

To determine how much a participant should contribute, the participant should estimate the unreimbursed health care expenses that are expected to be incurred in the plan year ahead. Careful consideration should include anticipated medical, dental, and vision care out-of-pocket expenses. Any balance in a participant's account at the end of a plan year must be forfeited. Under IRS rules for Flexible Spending Account plans, that balance cannot be paid to a participant in cash, carried over to the next plan year, nor be made available to a participant in any way. Forfeited funds may be used to offset costs of the Plan.

Note: As permitted by the HEART Act, unused amounts in the Health Care Flexible Spending Account may be distributed if requested prior to the end of the plan year.

F. Limited Purpose Flexible Spending Account Option

HSA-eligible participants may choose to have a portion of their compensation applied toward the Limited Purpose Flexible Spending Account (rather than the HCFSA). The amount of such salary reduction contributions to the Limited Purpose Flexible Spending Account shall not exceed the maximum annual limit permitted by the Internal Revenue Service.

In general, only vision and dental care expenses for a participant and their selected dependents are eligible for reimbursement from a Limited Purpose Flexible Spending Account if they meet all of the following requirements:

- The expenses were incurred on or after the effective date of the employee's participation in the Plan;
- The expenses relate to vision or dental services, and they would qualify as medical

expenses for federal income tax purposes under Section 213 of the Code;

- They have not been and will not be paid by the participant's health benefit plan(s) or by another employer's group health benefit plan or by any other insurance policy or program; and
- They have not and will not be deducted on the participant's tax return.

Eligible reimbursable expenses under this Plan include, but are not limited to, out-of-pocket expenses for:

- Deductibles and copayments for dental and vision care; and
- Uncovered dental and vision services.

Under current laws, the contributions for health insurance, and the expenses for elective cosmetic surgery, are expenses which are not eligible for reimbursement from any flexible spending account. The above are just two examples of ineligible expenses. For purposes of the particular Limited Purpose Flexible Spending Account option, expenses that are not related to vision or dental services are also ineligible for reimbursement.

G. Order of Benefit Payment

Benefits must first be reimbursed from any health insurance plan before any benefits are payable from this Plan.

IV. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT OPTION

A. Contributions and Limitations

Contributions to a participant's Dependent Care Flexible Spending Account are limited by federal regulations. A Participant may elect to contribute a maximum to a Dependent Care Flexible Spending Account for a plan year that is the **lesser of:**

1) **$5,000** if the Participant is single and files an individual tax return or if the participant is married and files a joint tax return;
2) **$2,500** if the participant is married and files a separate tax return; **or**
3) The Participant's taxable income or the spouse's taxable income, whichever is less. (For example, if the employee earns $25,000 per year and their spouse earns $3,000, then the Employee's contribution to a Dependent Care Flexible Spending Account can be no more than $3,000 for the year.)

Important: Contributions to all employer-sponsored Dependent Care Flexible Spending Account plans cannot exceed $5,000 on a combined basis in any calendar year.

The payroll deductions will begin as of the first payroll of the plan year following submission of the employee's election form (unless the eligible employee is eligible for mid-year enrollment), and the annual amount will be divided among the remaining paychecks for the plan year.

If a participant's spouse is a full-time student or cannot care for themselves, the spouse may be considered to have an income of **$250 per month** if there is one qualified dependent or **$500 per month** if there are two or more qualified dependents.

Note: The Child Care Tax Credit on a participant's federal income tax statement provides a dollar-for-dollar write-off against the participant's taxes. The Child Care Tax Credit cannot be used for expenses paid by the Dependent Care Flexible Spending Account. The Tax Credit amount may range from 20% to 35% of child care costs dependent upon the participant's adjusted gross income. The credit cannot be claimed on more than the amount allowed under current Federal law. Participants should consult a tax advisor for specific questions.

B. Eligible Expenses

Eligible Dependent Care expenses are work-related expenses incurred for qualifying individuals (see next subsection). Expenses are for the care of a qualifying person only if their main purpose is the person's well-being and protection, and must be incurred to enable the participant (and spouse, if applicable) to be gainfully employed. These expenses include:

- Work-related babysitting (*i.e.*, not social) and licensed daycare center costs;
- After-school* day care costs;
- Incidental housekeeping services in the Participant's home included with day care.

*Expenses for care do not include amounts for education. The IRS provides an example of a 5-year old child who goes to kindergarten in the morning. In the afternoon, the child attends an after-school day care program at the same school. The total cost of

sending the child to school is $3,000, of which $1,800 is for the after-school day care program. Only the $1,800 qualifies as non-educational care with the primary purpose of providing for a child's well-being and protection.

Note: The provider's name, address, and taxpayer identification are required to be provided on the participant's tax return. A participant may not claim an exclusion for reimbursement of dependent care expenses unless they provide on the tax return the name, address and taxpayer identification number (TIN) of the service provider. (No TIN is necessary for tax-exempt organizations.) If the caregiver is an individual, the TIN is the individual's social security number.

A participant may claim reimbursement for payments made to a relative; however, they may not be reimbursed for payments make to one of their tax-eligible dependents or any of their children age eighteen (18) or younger.

C. Ineligible Expenses

Expenses which are ineligible for reimbursement include, but are not limited to:

- Babysitting for social reasons;
- Expenses incurred on or after a child's 13th birthday;
- Overnight camp;
- Education, food, or clothing expenses that are not incidental to and inseparably part of the care;
- Costs of transportation;
- Tuition for children in the first grade or above and for kindergarten education; and
- Payments made for care provided by someone eligible to be claimed as a dependent on the participant's income tax form (although payment to another relative is permissible) or to any of their children age eighteen (18) or younger.

D. Qualifying Individuals

Individuals who qualify as dependents for the purpose of this Plan are:

- Children, grandchildren, and siblings who are under the age of 13 and for whom the participant is entitled to claim an exemption under Section 151(c) of the Code (*Note: A Dependent Care election may be canceled when a dependent child turns age 13 in the middle of a plan year and is no longer a qualifying individual for purposes of the Dependent Care Flexible Spending Account rules)*; and
- A spouse or dependent of the participant who is physically or mentally incapable of caring for themselves and meets the income exemption amount required by the IRS.

For purposes of Dependent Care Flexible Spending Account provisions, including contribution limits, eligible dependents shall not include an individual legally separated from the employee under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the employee, files a separate federal income tax return, maintains a separate principal residence from the employee during the last six (6) months of the taxable year and does not furnish more than one-half the cost of maintaining the principal

place of residence. However, if an employee is divorced or legally separated, they can generally have dependent care expenses reimbursed if they are the custodial parent (i.e., if they have custody of the child for a longer period of time during the plan year than the other parent). The following exceptions would override the custodial parent rule and permit the employee, as a non-custodial parent, to have their Dependent Care expenses eligible for payment from the Dependent Care Flexible Spending Account:

- The custodial parent formally releases claim to the federal income tax dependent care exemption for the year; or
- The employee provides over half the support of the child under a multiple support agreement.

E. Federal Reporting Requirement

A participant is required to report on their federal income tax return the name(s) and tax identification number(s) or social security number(s) of the providers of dependent care services.

Note: The tax identification number is not required if the provider of dependent care services is a tax-exempt organization (i.e., a church-sponsored nursery school or a county daycare center).

F. Understanding Dependent Care Benefit Options with the Spending Account and the Federal Income Tax Credit

The federal government provides an income tax credit for dependent care expenses such as those described earlier. While a participant may take advantage of the tax benefits available under both the Dependent Care Flexible Spending Account and the federal income tax credit, they cannot use both the tax credit and the spending account for the same dependent care expenses, and expenses eligible for the tax credit are reduced, on a dollar-for-dollar basis, by the amount they contribute to a Dependent Care Flexible Spending Account.

The practical effect of contributing dollars to a Dependent Care Flexible Spending Account which would otherwise be received in salary is that the income which is reported for federal, applicable state and FICA (Social Security) taxes is reduced, as may be allowed by applicable law. The amount of this contribution will not be reported on the employee's W-2 form as part of earnings. There will be no taxes due on this amount.

The amount which a participant can save in taxes depends on the amount of contribution and their taxable income with and without the contribution. A participant can approximate this amount of savings by determining marginal, i.e., top, tax rate. The higher a participant's marginal tax rate, the greater amount they can save in taxes with this spending account.

In deciding whether to use the Dependent Care Flexible Spending Account or the federal tax credit, a participant needs to evaluate which will be more advantageous. In most cases, the spending account will provide the greater tax savings.

Since the spending account advantage may change as revisions are made in the tax rules, a participant will want to monitor their personal situation and may also wish to consult a tax advisor.

G. Debit Card Privileges

All eligible employees that elect to participate in the Dependent Care Flexible Spending Account benefit option may use a debit card to pay for eligible expenses that are incurred during the plan year provided that the dependent care expenses are not reimbursed before the expenses are incurred. Dependent care expenses are treated as having been incurred when the dependent care expenses are provided and not when the expenses are formally billed, charged for, or paid by the participant. If a dependent care provider requires payment before the dependent care services are provided, those expenses cannot be reimbursed at the time of payment, even through the use of a debit card.

V. HEALTH SAVINGS ACCOUNT BENEFIT

Each participant who is enrolled in a qualifying high deductible health plan and has no other impermissible coverage may elect to have salary reductions contributed to a health savings account, as defined in Code § 223. The amounts contributed shall be subject to the terms of the health savings account as established. Such an election may be increased, decreased, or revoked prospectively at any time during the plan year to be implemented as soon as administratively practicable. The employer may make discretionary contributions to HSA accounts as it deems desirable in its sole discretion.

The health savings account benefit is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow pre-tax salary reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the employer.

VI. ELIGIBILITY AND PARTICIPATION

A. Eligibility Provisions

Any active employee of the employer who satisfies the eligibility conditions of the employer's group medical plan is eligible to participate in this Plan, subject to the provisions stated in this article.

B. Participation

If an eligible employee wishes to open a Flexible Spending Account and contribute a portion of their salary to such an account to pay for eligible costs which will be incurred during a plan year, an eligible employee must make such an election by completing an election form and processing it as directed by the plan administrator or its authorized representative. This initial election may be made prior to the effective date but must be made no later than thirty (30) days after the date of eligibility. The effective date shall be the later of the original date of eligibility or the date that the election form is signed by the eligible employee.

Subsequent elections may be made annually during the open enrollment period generally held during the month of June. Such open enrollment elections will become effective on the first day of the next plan year.

If an eligible employee does not complete the election form on a timely basis, they will be considered to have elected not to participate in the Flexible Spending Account Option(s) of this Plan.

If an eligible employee wishes to participate in the Premium Only Option offered in this Plan, they must complete the required enrollment or election process as described in Article II of this document.

C. Change in Elections

Under federal regulations which govern the Plan, a participant may change their elections regarding participation once a year during the open enrollment period established by the employer, except with respect to the HSA benefit described above. Such changes may be made for any reason and will become effective on the first day of the next plan year.

During the remainder of the plan year, an eligible employee may not change their elections unless they experience a qualifying change in status that is on account of and consistent with the change, as discussed below under Section D, "Consistency Rule."

The following events are changes in status:

LEGAL MARITAL STATUS.

Events that change an eligible employee's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.

NUMBER OF DEPENDENTS.

Events that change an eligible employee's number of dependents, including the following: birth; death; adoption and placement for adoption; and court ordered change in custody or Qualified Medical Child Support Order (QMCSO).

EMPLOYMENT STATUS.

Any of the following events that change the employment status of the eligible employee, the eligible employee's spouse, or the eligible employee's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the cafeteria plan or other employee benefit plan of the employer of the employee, spouse, or dependent depend on the employment status of that individual, and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under that plan, then that change constitutes a change in employment (e.g., if a plan only applies to salaried employees, and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan, then that change constitutes a change in employment status).

DEPENDENT SATISFIES OR CEASES TO SATISFY ELIGIBILITY REQUIREMENTS.

Events that cause an eligible employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of age, student status, or any similar circumstance.

RESIDENCE.

A change in the place of residence of the eligible employee, spouse, or dependent.

D. Consistency Rule

An election change satisfies the consistency rule only if the election change is **on account of and corresponds with a change in status** that affects eligibility for coverage under an employer's plan.

If an employee experiences a change in status, they will be permitted to change their election in a manner that is consistent with the change in status, provided that they do so within thirty-one (31) days. Any such change will become effective on the date of the occurrence, the date that the change of election is received or the first of the month following the date of the change in election, as permissible by law.

E. Special Application of Consistency Rule to Dependent Care

IRS regulations provide that the consistency rule is satisfied for a Dependent Care Flexible Spending Account if the election change is on account of and corresponds with a change in status that affects eligibility of dependent care expenses for tax exclusions. The following examples illustrate the effect of change in status and consistency rule requirements for a Dependent Care Flexible Spending Account change in elections:

- A dependent child's turning age 13 would affect eligibility for dependent care expenses. Therefore, a dependent care election may be canceled when a dependent child turns age 13 in the middle of a plan year and is no longer a qualifying individual for purposes of the Dependent Care Flexible Spending Account rules.
- An employee's or spouse's leave of absence (paid or unpaid) or change in employment status (part-time to full-time or vice versa) would also represent a special application of the consistency rule under a Dependent Care Flexible Spending Account. A change in

the number of hours of work performed by the employee or the employee's spouse is a change in coverage. Thus, the dependent care election may be changed to correspond with the change in coverage.

- Another special application of the consistency rule under a Dependent Care Flexible Spending Account provides that significant changes in the cost for the services of the child care provider represent a change in status that will permit a corresponding change in the dependent care election. However, no change based on a significant increase or decrease in cost can be made to a Dependent Care Flexible Spending Account when the cost increase for dependent care is imposed by a dependent care provider who is a relative of the employee.

F. Medicare or Medicaid Entitlement

If the employee, the employee's spouse or qualified dependent becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the employee may prospectively reduce or cancel their election. Likewise, if the employee, the employee's spouse or qualified dependent loses eligibility to Medicare or Medicaid coverage, then the employee may prospectively elect to commence or increase their election.

G. Significant Cost or Coverage Changes (Not Applicable for Health Care Flexible Spending Account Option)

If a participant's cost for coverage under the employer-sponsored health plan changes significantly during a plan year, the employee may choose to revoke their election under the Premium Only Option and in its place receive on a prospective basis coverage under another plan providing similar coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and whether a substitute plan provides similar coverage. If the change in cost is deemed to be insignificant, each employee's election shall be prospectively decreased or increased to reflect the change. Similarly, if a change in cost is significant but the employee chooses not to revoke their election, that employee's election shall be changed accordingly.

Furthermore, an eligible employee may revoke their election or make a prospective election change during the plan year if the change corresponds with an open enrollment period change made by the employee's spouse or qualified dependent, provided that the employee's election change is consistent with the changes made under the other group benefits plan and the other group benefits plan permits such an election change. Similarly, the Plan Administrator (in its sole discretion) will determine, based upon prevailing IRS guidance, whether the requested change is on account of and corresponds with a change made under the group benefits plan of the spouse or qualified dependent.

Furthermore, an eligible employee may revoke their election or make a prospective election change during the plan year if the coverage under their employer-sponsored health plan is significantly curtailed or ceases during a period of coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether coverage has been significantly curtailed.

Finally, an eligible employee who loses group health coverage under plans of governmental or educational institutions (including state children's health insurance programs, state health

benefits risk pools, and health plans sponsored by foreign or Indian tribal governments and organization) may be permitted to enroll in the employer's health care plan and make a prospective election change during the plan year. This applies to the Premium Only Option.

If an employee's cost for dependent care changes significantly during a plan year, the employee may increase or decrease the contribution election to reflect the new fee, switch to an alternative or similar coverage option (i.e., a new provider) and make a corresponding election change or revoke the election if no similar alternative coverage option is available. If a cost change is imposed by a dependent care provider who is a relative (as defined in the regulations), no election change will be permitted.

If an eligible employee changes dependent day care providers during a plan year, a new election may also be permitted.

VII. FILING A CLAIM

A. Claims under the Health Care Flexible Spending Account

Claim forms for expenses covered under the Health Care Flexible Spending Account Plan should be accompanied by:

(1) A written, dated statement from an independent third party stating the Health Care expense has been incurred and the amount of the expense. (This means that an employee is required to submit an explanation of benefits (EOB); or, if the expense is totally ineligible for reimbursement, a statement from the service provider rather than just a proof of payment, such as a canceled check.) The following information must be set forth on the claim for reimbursement:

- patient's name
- nature of incurred expense
- amount of requested reimbursement
- date of service

(2) A written statement that the health care expense has not been reimbursed under any other health plan coverage (included on claim form).

Claims should be sent to: HealthSmart Benefit Solutions, Inc.
PO Box 16647
Lubbock, TX 79490-6647
Phone: 844-516-3658
Fax: 844-319-3669

B. Claims under the Dependent Care Flexible Spending Account

Claim forms for expenses covered under the Dependent Care Flexible Spending Account Plan should be accompanied by:

(1) A written, dated statement from an independent third party stating the dependent care expense has been incurred and the amount of the expense. The following information must be set forth on the claim for reimbursement:

- dependent's name
- nature of incurred expense
- amount of requested reimbursement
- date of service
- provider's name
- provider's tax identification number or social security number

(2) A written statement that the dependent care expense has not been reimbursed under any other Dependent Care Flexible Spending Account Plan (included on claim form).

Claims should be sent to: HealthSmart Benefit Solutions, Inc.
PO Box 16647
Lubbock, TX 79490-6647

Phone: 844-516-3658
Fax: 844-319-3669

C. Receiving Reimbursement

All payments for claims will be made directly to the participant and not to a provider of a service. Checks will generally be drawn on a regular basis.

D. Claims in Excess of the Employee's Account

If a participant submits a claim for more than the current balance of the applicable Health Care Flexible Spending Account, the claim will be paid up to the total elected for the plan year minus any prior payments for the plan year. However, if a "qualified reservist distribution" (QRD) is requested pursuant to the HEART Act, the amount available will be the amount contributed to the Health Care Flexible Spending Account as of the date of the QRD request minus Health Care Flexible Spending Account reimbursements received as of the date of the QRD request.

If an employee submits a claim for more than the current balance of the applicable Dependent Care Flexible Spending Account, the claim will be paid up to the balance in the account, and the remainder of the claim will automatically be paid as additional contributions are made to the account. Claims do not need to be resubmitted.

E. Claims at the End of the Plan Year

To enable an employee to use their Flexible Spending Account for expenses incurred and provided before the end of the plan year, they may continue to submit claims for up to ninety (90) days following the close of the plan year. Those claims must be for expenses incurred and provided during the appropriate plan year or coverage period.

VIII. RIGHTS OF EMPLOYEES PARTICIPATING IN THE PLAN

A. Nondiscrimination

In connection with the administration of this Plan, the Plan Administrator or representatives of the Plan Administrator will not discriminate unfairly between similarly situated individuals. The Plan Administrator shall have the authority to adjust contributions to avoid discrimination.

B. Appeal

CLAIMS UNDER THE PREMIUM ONLY PLAN, HEALTH FSA, OR DCAP - EXPLANATION OF DENIAL

The written explanation of a claim denial shall set forth, in a manner calculated to be understood by the participant, the following information:

- The reason(s) for denial.
- If the claim is denied because the Plan needs more information to make a decision, a description of any additional information necessary for the participant to perfect the claim and explanation of why such information is necessary.
- A statement that the claim and its denial shall be reviewed upon submission of a written request along with a description of the Plan's review procedures, including applicable time limits.
- A statement that the participant, the participant's attorney or other duly authorized representative shall have, as part of the review procedure, a reasonable opportunity to examine relevant plan documents and records and to submit written comments on issues.
- A statement that failure to submit a written request for review within 180 days after the receipt of the written explanation of the claim denial shall make the Plan's decision final.
- If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the participant upon request.

PROVIDING ADDITIONAL INFORMATION

As part of the review procedure, the participant or the participant's duly authorized representative shall have a reasonable opportunity to examine relevant plan documents and records and to submit written comments on the issues. Furthermore, the participant also has the right to obtain applicable determination procedures used to ascertain coverage under a Qualified Medical Child Support Order free of charge from the Plan Administrator.

DECISION ON REVIEW

The Plan shall process a claim in accordance with its reasonable claims procedures. The Plan has a right to secure independent medical advice and to require such other evidence as it deems necessary to decide the claim. If the Plan requires more than 30 days to process a claim, the claimant will be notified of the delay, the reason for the delay, and the expected date a decision will be made. If the claim is wholly or partially denied, the Plan shall furnish

the participant a written explanation for the denial. A claim and its denial shall be reviewed if a written request for appeal is filed within 180 days after receipt of the written explanation of the claim denial by the participant. Otherwise, the initial decision shall be the final decision of the Plan. The Plan shall review the request for appeal, information and comments submitted by the participant or the participant's duly authorized representative. The Plan shall furnish the participant with a written explanation of its decision with respect to the appeal within 60 days following receipt of the written appeal.

EXPLANATION OF DECISION ON REVIEW

The written explanation of the appeal decision shall set forth, in a manner calculated to be understood by the participant, the following information:

- The specific reason(s) for the decision, including a response to the information and comments, if any, submitted by the participant and their duly authorized representative.
- Specific reference to relevant Plan provisions and records, if any, on which the decision is based.
- A statement of the participant's right to review (upon request and at no charge) relevant documents and other information.
- If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the participant upon request.

LIMITATION

No action at law or in equity can be brought to recover on this Plan before exhausting the appeals procedure described above. No action at law or in equity can be brought to recover after the expiration of two years after the time when written proof of loss is required to be furnished to the Plan.

C. Health Insurance Portability and Accountability Act Privacy and Security Rules

COMPLIANCE WITH HIPAA PRIVACY AND RECOVERY STANDARDS

Certain covered individuals of the employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to protected health information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- **General.** The Plan shall not disclose protected health information to any covered individual of the employer's workforce unless each of the conditions set out in this HIPAA Privacy & Security Section is met. "protected health information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present, or future physical or mental health

or condition of an individual, including information about treatment or payment for treatment.

- **Permitted Uses and Disclosures**. protected health information disclosed to covered individuals of the employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions.

  The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of healthcare providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

- **Authorized Employees.** The Plan shall disclose protected health information only to covered individuals of the employer's workforce, who are designated and are authorized to receive such protected health information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy & Security section, "covered individuals of the employer's workforce" shall refer to all employees and other persons under the control of the employer.

- **Updates Required.** The employer shall amend the Plan promptly with respect to any changes in the covered individuals of its workforce who are authorized to receive protected health information.

- **Use and Disclosure Restricted.** An authorized covered individual of the employer's workforce who receives protected health information shall use or disclose the protected health information only to the extent necessary to perform duties with respect to the Plan.

- **Resolution of Issues of Noncompliance.** In the event that any covered individual of the employer's workforce uses or discloses protected health information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Official (Benefits Manager). The Privacy Official (Benefits Manager) shall take appropriate action, including:

  - Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

  - Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

  - Mitigating any harm caused by the breach, to the extent practicable; and

  - Documentation of the incident and all actions taken to resolve the issue and mitigate

any damages.

CERTIFICATION OF EMPLOYER

The Employer must provide certification to the Plan that it agrees to:

- Not use or further disclose the protected health information other than as permitted or required by the plan documents or as required by law;
- Ensure that any agent or subcontractor, to whom it provides protected health information received from the Plan, agrees to the same restrictions and conditions that apply to the employer with respect to such information;
- Not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- Report to the Plan any use or disclosure of the protected health information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- Make available protected health information to individual plan participants in accordance with Section 164.524 of the Privacy Standards;
- Make available protected health information for amendment by individual plan participants and incorporate any amendments to protected health information in accordance with Section 164.526 of the Privacy Standards;
- Make available the protected health information required to provide any accounting of disclosures to individual plan participants in accordance with Section 164.528 of the Privacy Standards;
- Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- If feasible, return or destroy all protected health information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- Ensure the adequate separation between the Plan and covered individuals of the employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

HIPAA SECURITY RULE

The employer will comply with the Standards for Security of Individually Identifiable Health Information (the "Security Rule") set forth by HHS pursuant to HIPAA. The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, or maintains electronically that is kept in electronic form ("Electronic PHI" or "ePHI") as required under HIPAA.

Definitions

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 CFR 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined in Section 164.304 of the Security Standards (45 CFR 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Employer Obligations

To enable the employer to receive and use ePHI for plan administration functions (as defined in 45 CFR 164.504(a)), the employer agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure that adequate separation between the Plan and the employer, as required by 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom the employer provides ePHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate reports to the Plan of any security incident of which it becomes aware.

IX. PLAN ADMINISTRATION, AMENDMENT, AND TERMINATION

A. Rights of the Plan Administrator

Any duly authorized officer of the employer may exercise any authority or responsibility allocated or reserved to the employer under this Plan.

The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a Claims Administrator to receive, initially review, and process claims for benefits.

The Plan Administrator shall have the authority and responsibility to call and attend the meetings at which this Plan's funding policy and method are reestablished and reviewed.

The Plan Administrator shall have the discretionary authority and responsibility to construe and interpret terms of this Plan; to make factual determinations, including all questions of eligibility; to establish the policies, interpretations, practices, and procedures of this Plan; to adopt and implement procedures; and to render final decisions on review of claims as described in this plan document. Furthermore, the Plan Administrator has the authority to delegate certain duties and responsibilities to a claims fiduciary. All interpretations under the Plan, and all determinations of fact made in good faith by the Plan Administrator will be final and binding on the participants and beneficiaries and all other interested parties.

Furthermore, the Plan Administrator shall have the right to determine the amount, manner, and time of payment of any benefits under this Plan and to change contribution rates for participants at any time and from time to time.

The Plan Administrator has a duty to maintain records and to file reports required by law.

The Plan Administrator shall forward applications to the Claims Administrator and notify the Claims Administrator in writing of changes with respect to participants and other facts necessary for determining Plan coverages and for processing claims for Plan benefits.

The Plan Administrator or any duly authorized representative of the Plan Administrator will have the right to examine any claim for benefits under this Plan.

The Plan Administrator shall perform all other responsibilities allocated to the Plan Administrator.

B. Right To Amend

The employer shall have the unlimited right to amend this Plan in any and all respects at any time and from time to time without prior notice to any participant. Any such amendment shall be documented in writing by an authorized representative of the employer and shall become effective as of the date specified in said amendment. Any such amendment shall be binding upon all employees and dependents (including those participants on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed by amendment without their written consent.

No change in this Plan will be valid unless it is approved by the Plan Administrator or the duly authorized representative of the Plan Administrator. Any such amendment must be endorsed by the Plan Administrator or the duly authorized representative of the Plan Administrator.

C. Retroactive Amendments

An amendment to this Plan may be retroactively effective, but shall not adversely affect the rights of a participant under this Plan for benefits provided after the effective date of the amendment but before the amendment is adopted.

D. Misstatement of Facts

No agent or representative of the Plan will have the authority to legally change this document or waive any of its provisions, either purposely or inadvertently. Any change must be made as stated above. If any relevant facts pertaining to any person's eligibility for benefits under this Plan are found to be misstated, an equitable adjustment of any benefits paid will be made. If such misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan, and in what amount.

E. Right To Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely; the employer reserves the unlimited right to terminate or merge the Plan at any time without prior written notice to any participant. Such termination shall be evidenced by appropriate documentation by an authorized representative of the employer that has the authority to terminate or merge the Plan. The date of the merger or termination will be the date specified in the enabling written pronouncement. Termination of the Plan shall apply to all employees and dependents (including those on continuation coverage). Additionally, the employer reserves the right to determine from time to time the level of contribution required from participants or dependents for Plan coverage.

X. MISCELLANEOUS

A. State Law

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law.

B. Status of Employment Relations

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the employer and the employees or to be consideration for, or an inducement or condition of, the employment of an employee. Nothing in this Plan shall be deemed to:

- Affect the right of the employer to discipline or discharge any employee at any time.
- Affect the right of any employee to terminate employment at any time.
- Give to the employer the right to require any employee to remain in its employ.
- Give to any employee the right to be retained in the employ of the employer.

C. Word Usage

Whenever words are used in this document in the singular or masculine form, they shall where appropriate be construed so as to include the plural, feminine, or neuter form.

D. Titles are Reference Only

The titles are for reference only. In the event of a conflict between a title and the content of a section, the content of the section shall control.

E. Information in Document

Every effort has been made to make this document as complete and accurate as possible. If any conflict should arise between any other document and this Plan, the terms of this Plan shall control.

F. Counterparts

This Plan may be executed in any number of counterparts each of which shall be deemed to be an original, but all of which together constitute an instrument which may be sufficiently evidenced by any counterpart.

G. Clerical Errors

No clerical errors made in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made.

XI. GENERAL RULES AND INFORMATION

A. Plan Year

The plan year will be a period of twelve (12) consecutive months, commencing July 1st and ending June 30th.

B. Contributions

An eligible employee may elect to contribute a portion of their salary to pay for eligible costs that will be incurred during a plan year.

C. Excess Expenses

Expenses incurred in excess of an employee's Flexible Spending Account balance(s) at the end of a plan year cannot be reimbursed or carried forward for reimbursement in the next plan year.

D. Use It or Lose It Rule

Any balance in an employee's Flexible Spending Account(s) at the end of a plan year must be forfeited. Under IRS rules for Flexible Spending Account plans, that balance cannot be paid to an employee in cash, carried over to the next plan year, nor be made available to an employee in any way. Forfeited funds may be used to offset administrative expenses of the Plan.

As permitted by the HEART Act, unused amounts in the Health Care Flexible Spending Account may be distributed if requested prior to the end of the plan year.

E. Leave of Absence

If a participant takes a leave of absence, paid or unpaid, they may still participate in the Plan. Options for continuing, suspending, or revoking participation in the Premium Only Option, Health Care, and Dependent Care Flexible Spending Accounts will vary according to the leave status as FMLA or non-FMLA.

The participant should contact the employer in advance of the leave for more information.

F. Termination of Participation

A participant will cease to be a participant in this Plan upon the earliest of:

- The expiration of the plan year for which the employee has elected to participate (unless during the open enrollment period for the next plan year the employee elects to continue participating);
- The termination of this Plan;
- The date in which the employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an employee eligible to participate; or
- The date the participant revokes their election to participate under a circumstance which such change is permitted under the terms of this Plan.

G. Termination of Employment

If an employee terminates employment during a plan year, all contributions to this Plan will cease as of the date of termination. An employee will be entitled to submit claims for a period of ninety (90) days following the date of termination for expenses incurred prior to termination. employees participating in the Plan may elect to continue to participate as described below under *Continuation of Coverage under COBRA*.

H. Health Care Flexible Spending Distributions for Reservists

In accordance with the HEART Act, an employee ordered or called to active duty may receive distributions of unused amounts in their Health Care Flexible Spending Account. A "qualified reservist distribution" (QRD) is permitted if:

- The individual is a member of a reserve component ordered or called to active duty for a period of 180 days or more or for an indefinite period; and
- The request for distribution is made during the period beginning with the order or call to active duty and ending on the last day of the plan year that includes the date of the order or call to active duty.

The employee must provide the employer with a copy of the order or call to active duty. If the order or call specifies that the period of active duty is for 180 days or more or is indefinite, the employee is eligible for a QRD, and the employee's eligibility is not affected if the actual period of active duty is less than 180 days or is otherwise changed. If the period specified in the order or call is less than 180 days, a QRD is not allowed. However, subsequent calls or orders that increase the total period of active duty to 180 days or more will qualify an Employee for a QRD.

The amount available will be the amount contributed to the Health Care Flexible Spending Account as of the date of the QRD request minus Health Care Flexible Spending Account reimbursements received as of the date of the QRD request. No further reimbursement will be made for medical expenses incurred after the date a QRD is requested for the remainder of that plan year.

I. Continuation of Coverage under COBRA

Note: Only participants in the Health Care Flexible Spending Account Option of the Plan are eligible to continue such coverage under COBRA.

Limited continuation of group health coverage for the balance of the plan year is required by federal law for Health Care Flexible Spending Account participants who have underspent their accounts as of the qualifying event date, and it is the intent of this Plan to comply with federal law.

If an employee participating in the Health Care Flexible Spending Account Option of the Plan terminates their employment or becomes ineligible because of reduced hours, they may continue to participate in a Health Care Flexible Spending Account on an after-tax basis by electing continuation of coverage under COBRA through the end of the plan year in which COBRA coverage commences. Continued participation will allow an employee to submit, for reimbursement, expenses eligible for reimbursement through the Plan according to the provisions of the Plan after termination of employment. Continued participation will provide

that an Employee be allowed the rights and privileges of similarly situated employees, except that open enrollment will not be offered for another plan year.

Qualified beneficiaries may also include the employee's spouse and/or the employee's dependents. Qualifying events for non-employees include the death of the employee; the divorce or legal separation of the employee from their spouse; the employee's dependent becoming entitled to Medicare, and as a result the loss of eligibility for coverage under the plan for the employee and their dependents; and the loss of dependent status by a dependent child under the terms of this plan. Written notice regarding the right to COBRA must be provided to the designated COBRA Claims Administrator, if applicable. The notice must include the name of the employee with identification number, plan name and number, date and type of the qualifying event and name(s) of the applicable dependent(s). Employees and Dependents who elect to continue coverage must pay the full cost of the plan, not to exceed 102% of the employer's cost.

COBRA coverage is not available for participants who have overspent their Health Care Flexible Spending Account as of the qualifying event date. If any provision of this section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is changed to comply with the law.

J. The Effect of the Plan on Other Benefits

Salary dollars contributed by an employee to their Flexible Spending Account are not subject to federal income taxes or FICA (Social Security) taxes, and will not be included in the taxable income reported on the Employee's W-2 form.

Under present law, an employee's earnings, for the purpose of determining FICA earnings and eventual Social Security benefits, do not include salary reduction contributions made to the Plan. This means that if an employee earns less than the Social Security wage base, their eventual Social Security benefits will be slightly reduced. The value of the FICA and federal (and state, if applicable) income tax savings to the employee will normally exceed any reduction in eventual Social Security benefit.

XII. DEFINITIONS

CLAIMS ADMINISTRATOR

The Claims Administrator is HealthSmart Benefit Solutions, Inc.

CODE

Code shall mean the United States Internal Revenue Code of 1986, as amended.

DEPENDENT

For purposes of the Premium Only Option, dependent shall mean a dependent as defined by the employer-sponsored health plan(s), but in no circumstances (as required by Code Section 125) will such dependent exceed the definition of a dependent within the meaning of Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

For purposes of the Health Care Spending Account, dependent shall mean the following:

- The employee's spouse who (1) is recognized as a spouse under the Code, (2) has met all the requirements of a valid marriage contract of the state or country in which the marriage of such parties was performed, and (3) has not legally separated or divorced from the employee; and
- A dependent as defined in Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; and
- Any child (as defined in Section 152(f)(1) of the Code) of the employee who as of the end of the taxable year, has not attained age 27.

For purposes of the Dependent Care Flexible Spending Account, a dependent includes the participant's children who are under the age of 13 and for whom the participant is entitled to an exemption under Section 151(c) of the Code; and a spouse or dependent of the employee who is physically or mentally incapable of caring for themselves, but for purposes of Dependent Care Flexible Spending Account provisions, shall not include an individual legally separated from the employee under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the employee, files a separate federal income tax return, maintains a separate principal residence from the employee during the last six (6) months of the taxable year and does not furnish more than one-half the cost of maintaining the principal place of residence.

DEPENDENT CARE

Dependent care shall mean dependent care expenses described in Section IV(B).

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT OR DCAP

Dependent Care Flexible Spending Account shall mean the account established pursuant to Section IV.

ELIGIBLE EMPLOYEE

Eligible employee means any active employee of the employer who satisfies the eligibility conditions of the employer's group medical plan.

EMPLOYEE

An employee means an individual whom the employer compensates for personal services performed on a regular and continuous basis and for whom the employer pays employment taxes as required by the Code. "Employee" excludes self-employed individuals, independent contractors, partners in a partnership, and 2% shareholders of a Subchapter S corporation.

EMPLOYER

Employer shall mean Metropolitan Library System of Oklahoma County.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Under the Family Medical Leave Act of 1993, as amended, eligible employees may take up to twelve (12) weeks (twenty-six (26) weeks under certain circumstances) of unpaid leave in any twelve (12) month period.

HEALTH CARE COMPONENT

The portion of the Plan that is used to provide medical benefits, whether through the Premium Only Option or through the Health Care Flexible Spending Account.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT OR HCFSA

Health Care Flexible Spending Account or HCFSA shall mean the account established pursuant to Section III.

HEALTH SAVINGS ACCOUNT OR HSA

A health savings account established under Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by a participant with a qualified trustee/custodian. Although funded by salary reductions made under this Plan, the HSA is not part of or intended to be part of an ERISA-covered benefit plan.

HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time and the regulations issued thereunder.

INCURRED

Expenses are treated as having been incurred when the participant is provided with the dependent care service or the health care that gives rise to the expenses, and not when the participant is formally billed or charged for, or pays for the service or care.

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

Limited Purpose Flexible Spending Account shall mean the benefit established pursuant to Section III(F).

PARTICIPANT

Participant shall mean an employee who satisfies the eligibility and participation requirements specified in this document and is enrolled in the Plan.

PLAN

Plan shall mean the Metropolitan Library System of Oklahoma County Flexible Benefits Plan as set forth in this document.

PLAN ADMINISTRATOR

Plan Administrator shall mean Metropolitan Library System of Oklahoma County or its designee.

PLAN SPONSOR

Plan Sponsor shall mean Metropolitan Library System of Oklahoma County.

PLAN YEAR

Plan year shall mean a period of twelve (12) consecutive months, commencing July 1st and ending June 30th.

PREMIUM ONLY OPTION

Premium Only Option shall mean the benefit established pursuant to Section II.

SPOUSE

Spouse shall mean, as of the date of determination, the individual to whom the participant is legally married (a) under the laws of the state or country in which the marriage ceremony occurred or (b) pursuant to a common law marriage under applicable state law.

SUMMARY PLAN DESCRIPTION

Summary Plan Description shall mean this written description of benefits provided through the Metropolitan Library System of Oklahoma County Flexible Benefits Plan.

XIII. PLAN IDENTIFICATION

Name of Plan:	Metropolitan Library System of Oklahoma County Flexible Benefits Plan
Name and Address of Plan Sponsor:	Metropolitan Library System of Oklahoma County 300 Park Ave. Oklahoma City, OK 73102
Claims Administrator:	HealthSmart Benefit Solutions, Inc. PO Box 16647 Lubbock, TX 79490-9947 Phone: 844-516-3658 Fax: 844-319-3669
Sponsor Identification Number:	73-0747828
Administration:	Self-Funded/Third Party
Type of Plan:	Section 125 Plan
Plan Administrator/Agent for Legal Process/ Named Fiduciary:	Metropolitan Library System of Oklahoma County 300 Park Ave. Oklahoma City, OK 73102
Funding of Plan:	The Plan is funded out of the general assets of the employer based on salary reduction elections made by participating employees.
End of Plan's Fiscal Year:	June 30th

XIV. EXECUTION OF PLAN

The Metropolitan Library System of Oklahoma County Flexible Benefits Plan has been amended and restated as stated within this written document.

Executed this 20 day of October 2022.

METROPOLITAN LIBRARY SYSTEM OF OKLAHOMA COUNTY

By: _____

Name: LARRY NASH WHITE

Title: Executive Director