STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
MEDICAL FLEXIBLE SPENDING ACCOUNT PLAN

SUMMARY PLAN DESCRIPTION

June 1, 2014

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MEDICAL FLEXIBLE SPENDING ACCOUNT PLAN

INTRODUCTION

This Summary Plan Description (SPD) outlines the key features of the Medical Flexible Spending Account Plan (MEDFLEX) and the rules for joining.

The MEDFLEX allows you to pay for qualifying medical and dental expenses not covered by insurance by setting aside a portion of your pay that is not subject to federal income or Social Security taxes. This effectively reduces the cost of these services to you.

This SPD contains a non-technical description of the Plan's benefits and operations, which are governed by the formal Plan document. The Plan document is written in more technical language in order to comply with IRS requirements. If the language in this SPD conflicts with any provision in the Plan document, the Plan document will control. You can download a copy of the Plan document and the SPD from the Office of the State Comptroller web site at www.osc.state.ct.us and/or the third party administrator web site at www.ctpbs.com

The Plan is designed to comply with the Internal Revenue Code (IRC) and other federal and state laws. The provisions of the Plan are subject to revision due to a change in laws or interpretations issued by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate the Plan. If the Plan provisions described in this SPD should change, we will notify you.

We have attempted to answer most of the questions you may have regarding your MEDFLEX benefits. If this SPD does not answer all of them, please contact the Third Party Administrator (or other plan representative). The name and address of the Third Party Administrator can be found in the Article VIII of this SPD.

I
BENEFITS

1. How does MEDFLEX work?

The MEDFLEX, a valuable part of the State of Connecticut employee voluntary benefit program, is regulated by the IRS. It allows you to set aside a portion of your income on a pre-tax basis to pay for qualifying medical and dental care expenses that are not covered by your health plans. The money you pay into the MEDFLEX is not taxed. This saves you money on every dollar set aside.

Your MEDFLEX account can only be used to cover qualified medical care expenses (defined by IRS Publication 502) as amounts paid for: (1) the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body; (2) the cost of medical services rendered by physicians, surgeons, dentists, and other medical practitioners, including the cost of equipment, supplies, and diagnostic devices needed for these purposes; (3) medical care expenses must be primarily to alleviate or prevent or treat a physical or mental defect or illness and do not include expenses that are merely beneficial to

general health, such as vitamins; (4) medical expenses include transportation amounts incurred primarily for and essential to medical care.

Out-of-pocket medical expenses for the employee, a spouse and IRS eligible dependents may be reimbursed so long as: (1) expenses are qualified under IRS Code Section 105 and 213; (2) all other sources of reimbursement, such as your health insurance plan, are exhausted; (3) reimbursement will not be sought from any additional source; and (4) documentation to substantiate expenses is maintained and submitted for verification.

Only the cost of medical products and services allowed under the IRS Code Section 213 and the State of Connecticut MEDFLEX Plan Document are eligible for reimbursement. If these medical products and services include expenses that can be provided for both a medical and cosmetic use, capital expenditure, personal, living and/or family purpose, a Medical Necessity Form Letter must be submitted along with your MEDFLEX Claim Reimbursement Form.

II

ELIGIBILITY

1. What are the eligibility requirements for the Plan?

The MEDFLEX will be made available to any individual employed by the State of Connecticut at a Connecticut location, as long as the employee is working at least half-time (0.5 full time equivalent) and is not classified as a sessional, temporary, durational, or seasonal worker, graduate assistant, or adjunct faculty member. Employees who are out on unpaid leave—including those classified as “Paid Leave—Unpaid Workers Compensation” cannot enroll in the Plan until they return to work.

2. When can I become a participant in the Plan?

MEDFLEX participation is only available to active employees that meet the eligibility requirements. You can only join the Plan on an "eligibility date," as defined in Question 3 below. You will need to complete the MEDFLEX Enrollment/Change Form before you can enroll in the MEDFLEX.

3. When is my eligibility date?

If you meet the eligibility requirements, you can you can join the MEDFLEX:

(1) During the annual open enrollment period or;
(2) Within 31 days of your date of hire with the State of Connecticut or
(3) Within 31 days of a change in family status, such as: marriage or divorce; birth or adoption of a child; death of a dependent or spouse; a change in dependent eligibility requirements for health benefits (example. loss of other coverage, meeting maximum age requirements, etc.); a change in employment status that affects health benefits eligibility for you, your spouse or your dependent, or
(4) Within 31 days of your return from an unpaid leave of absence.

4. Are there any employees who are not eligible?

Certain employees are not eligible to enroll in the Plan. They are:

- Per Diem, sessional, durational, temporary or seasonal workers, adjunct faculty members, graduate assistants, and employees who are working, or are expected to work, less than 0.5 full time equivalent (FTE).
- Employees on unpaid leave for any reason.
- Former employees and rehired retirees.

5. What must I do to enroll in the Plan?

Before you can join the MEDFLEX, you must complete the MEDFLEX Enrollment/Change Form authorizing us to set aside some of your earnings to pay for MEDFLEX claim reimbursements. If you sign up for MEDFLEX, but are ineligible to participate, your enrollment will be cancelled and any contributions made will be returned to you on an after-tax basis.

III
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year (See Article VIII for the definition of "Plan Year."), you must elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to reimburse your MEDFLEX claims. The portion of your pay that is contributed towards your MEDFLEX is not subject to federal income or Social Security taxes. This allows you to use tax-free dollars to pay for eligible medical and dental care expenses that are not covered by your health insurance plan. If you receive a reimbursement for an expense under the MEDFLEX, you cannot claim that same amount as a federal income tax credit or deduction on your income tax return.

IV
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

The maximum contribution limit is $2500 and the minimum is $520. Before each Plan Year begins, you select your MEDFLEX annual election amount. In order to choose the appropriate amount to set aside, you should estimate your family's yearly medical expenses that are not covered under the State's healthcare plan. Be conservative, because any monies that are not spent during the plan year may be forfeited.

Throughout the year, the amount chosen will be deducted evenly from your paychecks based on your anticipated pay frequency (example. 26 pays, 24 pays, 12 pays). Your per paycheck deduction may be adjusted if the number of pay periods you actually work during the Plan Year

changes. Faculty members who are paid for 10 months will have their contributions equally distributed over the number of paychecks received during the Plan Year.

Members who will be retiring during the Plan Year will have their per paycheck contribution amount calculated based on the number of pay periods to be worked in the year. For example, Employee A plans to retire on July 1, 2014 and wants to contribute $2400 for the Plan Year. He is paid on a 24-pay cycle. His per paycheck deduction will be $200 per pay period. Had he worked the full year, his per paycheck deduction would have been $100.

2. What happens to contributions made to the Plan?

Contributions are accumulated in your MEDFLEX account and may be used during the Plan Year to pay for eligible expenses incurred between January to December or during your period of coverage, if you joined mid-year due to a qualified family status change event.

3. When must I decide if I want to participate?

Federal law requires that you decide whether you want to participate in the upcoming year, and if so, to establish what your MEDFLEX annual election will be before the Plan Year begins. You must make this election during the annual open enrollment period (defined below).

4. When is the election period for our Plan?

The annual open enrollment period will be held during the month of October. The Administrator will inform you when each year's election period will begin and end. (See the Article entitled "General Information about Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

During the Plan Year you can only make a change within 31 days of a family status change that affects benefits eligibility, such as: marriage or divorce; birth or adoption of a child; death of a dependent or spouse; a change in dependent eligibility requirements for health benefits (such as loss of other coverage, meeting maximum age requirements, etc.); a change in employment status, which results in a benefits eligibility change for you, your spouse or your dependent. For example, if you have an unpaid leave of absence after the Plan Year begins you can suspend your contributions while you are away from work or elect to continue your contributions on an after tax basis.

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6. What happens if I go out on unpaid leave after the Plan Year starts.

You can either continue or suspend your participation in the Plan during an unpaid leave of absence. You must notify the Third Party Administrator if you want to continue participation before going out on unpaid leave. Otherwise, your participation in the Plan will be automatically suspended and you will not be entitled to be reimbursed for claims incurred during unpaid leave.

If you elect to continue participating in the Plan during your unpaid leave, you must make all required payments to the Third Party Administrator on an after-tax basis on the same schedule as your regular payroll contributions. If you continue your participation (and make the required contributions), you will be eligible to submit claims incurred during your unpaid leave for reimbursement.

7. What happens when I return from unpaid leave?

When you return from unpaid leave during the same Plan Year, you will be automatically reinstated in MEDFLEX for your original annual election amount, and your election amount will be divided equally over the remaining calendar year pay periods. Within 31 days of returning to

work, you may elect to reduce your election amount by the contributions missed during the unpaid leave, in which case, your per payroll deduction will remain the same as before your unpaid leave. Keep in mind that if your account is "overspent you cannot reduce your Election Amount by your missed contributions.

Note: Your account is deemed overspent if your Plan Year contributions (together with any carryover amount from the prior Plan Year) are less than amounts you have already received as Plan Year reimbursements as of the date you went out on unpaid leave. You cannot reduce your election amount by contributions missed during your unpaid leave if the anticipated Plan Year contributions would be insufficient to pay for benefits already received.

8. **Can you provide examples of how unpaid leave adjustments might work?**

a. Sally elected to contribute $1200 for the Plan Year. She is on a 24-pay schedule and her deductions are $50 per pay period. She has already received $100 in Plan Year reimbursements. In April she suspends her Plan participation during her unpaid maternity leave. When Sally returns to work in July, she elects to reduce her overall Plan Year election amount by the $300 missed contributions from April through July. Sally's adjusted election amount is $900 and her remaining contributions will continue to be $50 per pay period.

b. Andy elected to contribute $1200 for the Plan Year. He is on a 24-week pay schedule with deductions of $50 per pay period. In February he gets reimbursed $1200 for his daughter's orthodontia. In April he goes on unpaid leave and suspends participation. He returns in July and asks to reduce his original election amount by $300. Andy's account is "overspent"; therefore, he cannot reduce his election amount. ;. Andy retains his original election amount of $1200 and the balance of his remaining $900 contributions will be will be $75 per pay period to make up the missed contributions.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

Health care services must be "incurred" before you file a claim for reimbursement. IRS guidelines stipulate that "expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expense and not when the patient is formally billed, charged for or pays for the medical care." The date of medical service must be within the plan year of participation. If expenses are for orthodontia, an orthodontia contract must be submitted with your first plan year claim. If your payment plan is monthly, you may submit a reimbursement request after each monthly payment is due. If your entire treatment is pre-paid, the amount will be pro-rated and reimbursed over the course of the orthodontia treatment.

You can use the Benny™ Prepaid MasterCard® Card at qualifying medical merchant locations where a MASTERCARD™ credit card is accepted. The Benny Prepaid Benefits Card may only be used at those locations that have a health-care related merchant category code.

Examples of qualified locations include those who use an Inventory Information Approval System (IIAS), such as: physician offices, pharmacies, dental offices, grocery and discount stores, hospitals and vision centers. Qualified locations that use an IIAS only allow the Card to purchase items identified as eligible expenses. If your purchase has both eligible and ineligible expenses, the location will only accept the Benny Card for the eligible expenses. Ineligible expenses must be paid via another method. You can not use your Prepaid Benny Card at locations that do not use an IIAS.

Regardless of the form of reimbursement (Prepaid Benefits Card or other form of payment) IRS provisions require all expenses to be substantiated; however, many transactions are automatically substantiated by the card system using one of the below IRS-approved substantiation methods:

- ✓ Recurring Expense – Recurring transactions will be processed and approved without recurring documentation after the initial transaction's substantiating receipts or other documentation have been reviewed and approved. Documentation requests will not be required so long as the subsequent recurring expense equals the same amount, duration and provider as the initial transaction.
- ✓ Co-pay Matching – The expense specifically matches your health plan's co-pay. For example, if the healthcare provider office visit co-pay is $10 and your payment for the office visit was $10, a substantiating receipt may not be required.
- ✓ IIAS Approved – Your FSA-eligible products are purchased at a location that uses the IIAS. In the unlikely event that your card payment is denied at a location that uses the IIAS, you will be required to submit substantiating documentation in order to receive reimbursement.

If your expense is not automatically substantiated, PBS will request additional supporting documentation via an email or letter request. Acceptable supporting documentation includes:

- An Explanation of Benefits (EOB) from the insurance carrier indicating the patient name, date of service, and out-of-pocket expenses associated with claim.
- An itemized statement from the service provider for expenses not covered by insurance. The statement must include: (1) the patient's name; (2) date of service; (3) description of procedure; (4) physician name and (5) the service charge.
- Prescription Drugs – A statement from the pharmacy indicating: (1) pharmacy name; (2) patient name; (3) date of prescription fill; (4) patient cost (i.e. co-pay); (5) Rx number and; (5) name of drug.
- Eligible Over-the-Counter (OTC) Medications – A completed Letter of Medical Necessity Form including an itemized cash register receipt indicating: (1) medication name; and (2) OTC purchase date.

In order for your claim to be reimbursed you must retain copies of all itemized receipts

for eligible expenses. It is recommended that all receipts be retained for at least 3 years after the close of the plan year in which the expense has been incurred. Keep in mind that IRS regulations stipulate that cancelled checks, balance forward statements, and credit card and/or cash receipts cannot be used to substantiate expenses (itemized cash register receipts are acceptable substantiation for eligible over-the-counter expenses not requiring a Letter of Medical Necessity Form).

Note that missing or lost receipts will result in a claim denial. If you are unable to secure a replacement receipt or use your Prepaid Benefits Card for expenses that are deemed ineligible, your claim will be denied and you will be required to reimburse the plan with post-tax dollars. If you fail to do so, your Benny Prepaid Card will be de-activated and/or the Administrator will offset the amount of the ineligible expense from your later substantiated claims until the full amount is repaid.

In those cases where you are unable to use your Prepaid Benefits Card or if you prefer the manual reimbursement method, you must first pay for your MEDFLEX expenses, then submit a Claim Reimbursement Form to PBS for processing.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Because it is possible to forfeit excess Plan contributions, it is important that your estimates of eligible expenses be conservative. You have until March 31st to submit claims for expenses incurred during the previous Plan Year. If you don't spend all of your contributions by March 31st you can carry over up to Five Hundred Dollars ($500) to your Medical Flexible Spending Account for the next plan year. Unused amounts in excess of $500 will be forfeited after March 31st. If you have not enrolled in the MEDFLEX for the current Plan Year and have $25 or less in unclaimed funds that amount will be forfeited after March 31st.

3. Do carryover funds affect the Plan Year Maximum or Minimum Contributions?

The maximum and minimum contribution amounts apply only to Plan Year election amounts. If you carried over $500 from Plan Year 2013 you can still contribute the maximum amount of $2500 for Plan Year 2014, which means that you would have a total of $3000 to reimburse eligible claims incurred in 2014. If you have $400 in carryover amounts from Plan Year 2013 but didn't sign up for the MEDFLEX for Plan Year 2014, you can still use the $400 remaining in your account to pay for eligible 2014 expenses.

4. What happens if I terminate employment?

If you terminate employment during the Plan Year, you can request reimbursement from your MEDFLEX account for eligible medical and dental care expenses incurred up to your date of termination. No salary redirection contributions can be made after your date of separation. Any contributions taken in error after the date of termination will be reimbursed on an after-tax basis. You must submit eligible claims for reimbursement within 90 days after termination of employment; otherwise any remaining balance will be forfeited.

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) you and/or your qualified beneficiaries may be eligible to continue participation in the Plan, following a

qualifying event, such as the death of the participant, the divorce or legal separation, a loss of dependent status, or the participant's termination of employment (other than for gross misconduct). If there is a positive balance in the participant's MEDFLEX account at the time of the qualifying event (taking into account all claims submitted before the date of the event), the participant or a qualifying beneficiary, may be permitted to continue participation in the Plan for the remainder of the Plan Year, unless the maximum benefit available under the Plan for the remainder of the Plan Year is not more than the maximum benefit the Plan could require as payment for the remainder of the year. You or your qualifying beneficiary will be eligible to elect the full amount elected by the Participant minus any claims incurred for that individual.

Continuation in the FSA after a qualifying event must be elected within 60 days from the date of the COBRA notice provided to you or your qualifying beneficiary. In no event can the total amount of the funds available under the COBRA FSA exceed the annual election amount. Continuation of participation in MEDFLEX requires that an initial contribution be made to the Plan within 45 days of the election to participate in the COBRA FSA. Thereafter, the COBRA contribution shall be one-twelfth ($1/12^{th}$) of the elected amount, plus an additional two percent (2%) administrative fee, payable monthly to Progressive Benefit Services, FBO State of Connecticut MEDFLEX Program. All contributions to the COBRA FSA must be paid on an after-tax basis. COBRA Medical FSA coverage will terminate no later that the end of the Plan Year during which the qualifying event occurs. Amounts remaining in a participant's or qualified beneficiary's account at the end of the Plan Year will be subject to the Use-It-Or-Lose-It Rule.

All unused amounts that remain in your MEDFLEX account 90 days after Termination of Employment or a change in employment status that makes you ineligible for participation will be forfeited, unless COBRA continuation was elected, in which case your unused funds will remain available for reimbursement of eligible expense until the end of the Plan Year (and after the processing of all claims for such Plan Year). All funds remaining after March 31st will be forfeited and are not eligible to be carried over to the next Plan Year.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

The Internal Revenue Code requires that the Plan as a whole must not unfairly favor highly paid employees, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under the Plan.

Highly compensated employees generally include officers, key employees or highly paid individuals. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee. If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified if you are affected by these limitations.

VII
PLAN ACCOUNTING

1. Annual Statement

Before the end of the Plan Year the Third Party Administrator will provide you with an annual statement showing your account balance. Read this statement carefully so you can manage your remaining Plan Year balance effectively.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information about the Plan.

1. General Plan Information

State of Connecticut, Office of the State Comptroller, Medical Flexible Spending Account is the name of the Plan.

Your Employer has assigned Plan Number 504 to your Plan.

The provisions of the Plan become effective on 1/1/2011, which is called the Effective Date of the Plan.

Your Plan's records are maintained on a twelve-month period, known as the Plan Year. The Plan Year begins on January 1 and ends on December 31st.

2. Employer/ Plan Sponsor Information

Your Employer's/Plan Sponsor's name and address are:

State of Connecticut
c/o Office of the State Comptroller
Healthcare Policy and Benefit Services Division
55 Elm Street
Hartford, Connecticut 06106

3. Third Party Plan Administrator Information

The State of Connecticut has appointed the following company as the Plan's Third Party Administrator:

Progressive Benefit Solutions, LLC
14 Business Park Drive #8

Branford, CT 06405
(866) 906-8023

The Third Party Plan Administrator is responsible for the day to day administration of the Plan and is responsible for the actual processing of claims on behalf of the Employer/Plan Sponsor. The Third Party Plan Administrator has the right to interpret the appropriate plan provisions in accordance with IRC Section 125 and 105 and answer any questions you may have about our Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

State of Connecticut
Office of the State Comptroller
55 Elm Street
Hartford, Connecticut 06106

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Progressive Benefit Solutions, LLC
14 Business Park Drive #8
Branford, CT 06405

FAX: (203) 974-4890
http://www.ctpbs.com/ (for claim reimbursement forms)

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

You should submit all reimbursement claims during the Plan Year. However, you have 90 days after the end of the Plan Year to submit all eligible claims from the preceding year. Claims submitted after that date will not be considered.

If a MEDFLEX claim is denied in whole or in part, you will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. Within 60 days after denial, you may submit a written request for reconsideration to the Third Party Plan Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You may review pertinent documents and submit issues and comments in writing. The Third Party Plan Administrator will review the claim and provide a written response to the appeal within 60 days (this period may be extended an additional 60 days under certain circumstances). In this response, the Third Party Plan Administrator will explain the reasons for the decision, with specific reference to the IRC and administrative provisions of the Plan on which the decision is based. The Third Party Plan Administrator has the right to interpret the appropriate plan provisions in accordance with IRC Section 125 and 105.