

**SUMMARY PLAN DESCRIPTION OF THE
COUNTY OF SUFFOLK EMPLOYEE CAFETERIA PLAN
UPDATE 11/01/2008**

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INTRODUCTION

The County of Suffolk has adopted SUFFOLK F-L-E-X, a "flexible benefits plan" for the exclusive benefit of its permanent employees. The Plan is a lengthy document which sets forth the provisions and requirements of the program. However, we have condensed the major provisions of the Plan into a series of questions and answers, which summarize and explain the major circumstances affecting your benefits and other rights under the program.

You should read this Summary Plan Description carefully as it gives you a detailed description of your Plan, how it works, what benefits it provides, how they may be obtained and how they may be lost. If the summary does not answer your questions or if you need further information, please contact the Plan Administrator or the Plan Agent as indicated in the section "Identifying Information."

IMPORTANT NOTICE

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.

Copies of the Plan documents are available for inspection at the office of the Plan Administrator, during regular business hours or by request from the Plan Agent by phone: 800-836-8100 or e-mail: info@flexbene.com

The information in this SPD may be modified by a "Summary of Material Modification" ("SMM"). Check to see if there are any SMM's attached when you refer to this SPD.

IDENTIFYING PLAN INFORMATION

Plan Name: SUFFOLK F-L-E-X

Employer Name & Address: County of Suffolk
Department of Civil Service/Human Resources
Employee Benefits Unit
P.O. Box 6100
Hauppauge, NY 11788

Plan Number: 503

Employer ID: 11-6000464

Plan Year: January 1 through December 31.

Original Effective Date: May 28, 1990

Amendment Dates: March 1, 2002; November 1, 2008

Plan Administrator: County of Suffolk
Department of Civil Service/Human Resources

Type of Plan Administration: The Plan is administered by the County through a Plan Agent appointed by the County. All benefits are paid from the general assets of the County. The County is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting the minimum and maximum amount of participant contributions. The Plan Administrator and the Plan Agent are the primary source for information about these aspects of the Plan.

Service of Legal Process: The Plan Administrator

Plan Agent: The County may appoint and retain a Plan Agent to handle all bookkeeping, claims adjudication and reimbursement functions of the Plan. This Plan Agent may also provide communication and interpretation services on behalf of the County.

The current Plan Agent is:
Marketing Associates & Ltd Cos Inc. dba MA Services
P.O. Box 587
Pittsford, NY 14534

QUESTIONS AND ANSWERS

ESSENTIALLY, HOW DOES THE PLAN WORK?

Upon initial employment and annually, thereafter, an eligible employee will submit a written or electronic election form authorizing the County to contribute a portion of the employee's gross pay for the forthcoming calendar year to selected benefit options. The total amount the employee elects and authorizes the County to withhold, if any, will be divided among one or more of the following accounts as the employee elects: (1) an account established to pay for group out-of-pocket health insurance premiums offered by the County and purchased by the employee; (2) an account established to reimburse the employee for qualifying individual health and/or disability insurance plans purchased by the employee; (3) an account which will be used to reimburse the employee for dependent care expenses incurred by the employee; (4) an account established to reimburse the employee for uninsured health care expenses; (5) an account established to reimburse the employee for qualifying adoption assistance expenses. The "accounts" are bookkeeping entries and actual claims are paid from the County's general assets.

Amounts, which an employee elects to allocate to the Plan for any one or more of these purposes, are not subject to social security, Medicare, NYS or other federal income tax. In essence then, the Plan enables employees to pay for medical, dependent care, adoption assistance and qualified insurance expenses with tax-free dollars thereby decreasing the net cost of these benefits to the employee.

IMPORTANT NOTICE

ONCE THE EMPLOYEE ALLOCATES DOLLARS TOWARDS AN ACCOUNT, AN EMPLOYEE WHO DOES NOT USE THE AMOUNTS IN THE VARIOUS ACCOUNTS FOR QUALIFIED EXPENSES BY THE END OF THE PLAN YEAR WILL FORFEIT THESE AMOUNTS TO THE PLAN. THESE FORFEITED DOLLARS SHALL BE DISTRIBUTED EQUALLY, THE FOLLOWING YEAR, TO PLAN PARTICIPANTS WHO MAINTAIN REIMBURSEMENT ACCOUNTS THAT YEAR. THEREFORE, IT IS IMPORTANT FOR YOU, PERSONALLY, TO ESTIMATE YOUR INSURANCE, HEALTH CARE, ADOPTION ASSISTANCE AND DEPENDENT CARE EXPENSES CAREFULLY AND CONSERVATIVELY. THE ONLY EXCEPTION TO THIS RULE INCLUDES QUALIFIED CHANGES IN FAMILY STATUS (SEE "***MAY I TERMINATE MY PARTICIPATION IN THE PLAN AND, IF SO, WHEN?***")

WHO MAY PARTICIPATE IN THE PLAN?

All permanent employees of the County, who have completed their initial probationary period as of the beginning of any Plan Year (that probationary period not to exceed 6 months) are eligible to participate in the Health Care Reimbursement program. Permanent employees may participate in the Dependent Care Assistance and the Adoption Assistance programs upon completing sixty (60) days of continuous service to the County. Your entry date, assuming you have completed the required enrollment election form will be the first day of the payroll period nearest the date you have completed the eligibility requirements. Participation in the Plan is voluntary.

**AM I REQUIRED TO PARTICIPATE?
WILL I AUTOMATICALLY PARTICIPATE?**

No. Participation in the Plan is voluntary. In addition, you will need to complete the required enrollment form and submit it to the Plan Agent in order to participate. This can be done electronically through www.flexbene.com Password: SUFFOLK

**IF I LEAVE THE COUNTY MAY I REQUEST IMMEDIATE PAYMENT OF
ANY UNUSED BALANCE IN MY ACCOUNT?**

No. But, you may submit claims for amounts held by the Plan for your benefit during the current Plan Year through your termination date, provided you file a written claim for valid reimbursement within ninety (90) days after your termination date. If you have purchased insurance coverage through the Plan you will continue to receive any coverage under the insurance contract during the period for which the premiums were paid prior to your termination of employment even if that coverage extends beyond your termination date. There will be no required adjustment in this case.

MAY I TERMINATE MY PARTICIPATION IN THE PLAN AND, IF SO, WHEN?

Generally, once you enroll for a Plan Year you may not terminate your participation in the Plan until January 1st of the following year. Exceptions are included in the following question **“Can I Increase or Decrease the Amount of My Contribution to the Various Accounts?”**

**CAN I INCREASE OR DECREASE THE AMOUNT OF MY CONTRIBUTION
TO THE VARIOUS ACCOUNTS?**

Generally, no. Elections under the Plan are irrevocable until January 1st of the following year. However, if there is a change in family status or other qualifying events occur, you may be able to change a benefit election after the Plan Year has commenced and make a new election for the balance of the Plan Year. In summary, federal tax laws permit you to change your elections only when one of the following “changes in status” occurs:

- You exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- You, your spouse or dependent becomes eligible for continued health coverage under federal law (COBRA) or similar state law under a group health plan of your Employer.
- A court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage.
- A leave under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act

- You, your spouse or dependent becomes entitled to or loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines).
- Your premium increases significantly. (However, if there is an ordinary increase or decrease in premiums, your contributions will automatically be adjusted to reflect the change.) Note, a significant increase in premiums allows you to change the amount of those premiums you pay through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

You may also make a change if:

- There is a significant curtailment in, or cessation of your group coverage. (In the case of group health coverage, there must be reduced coverage for employees generally.) Note, that a significant curtailment in, or cessation of your group coverage allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.
Please note: this is generally applicable ONLY to those employees who must contribute towards their group health insurance coverage through the County.
- A new group coverage option is added or a group coverage option you have selected is eliminated. Note that the addition or elimination of a coverage option allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.
Please note: this is generally applicable ONLY to those employees who must contribute towards their group health insurance coverage through the County.
- Your legal marital status changes (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).
- The number of your dependents changes (including a change resulting from a birth, death, adoption or placement for adoption of a child).
- There is a change in your employment status, or in the employment status of your spouse or dependent, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes you, your spouse or dependent to become or cease to be eligible for coverage under the Plan or other employer plan providing the same type of benefits. However, if your employment terminates and resumes in the same Plan Year within a period of thirty (30) days or less, your elections in effect before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in your elections.
- A change in your place of residence, or the place of residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for group coverage at the new place of residence. Note, a change in residence allows you to change the

amount of the premiums you pay through the Plan for the group coverage for which you, your spouse or dependent is no longer eligible, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- Your dependent's eligibility for health coverage changes due to the dependent's age, student status or marital status or similar circumstance.
- There is a change in your dependent care provider or a change in the cost of services provided by a dependent care provider who is not a relative.
- A person's status as a dependent for purposes of your dependent care election changes.
- Your spouse, former spouse or dependent makes a change under another plan which is either (i) consistent with one of the events described above, or (ii) for the normal election period under the other plan and that election period is different from the Plan Year of this Plan.
- You, your spouse or dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 770 l (a) (40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan. Note, loss of such coverage allows you to change the amount of premiums you pay through the Plan for dental, medical and vision coverage, but does not allow you to change the amount of any other premiums you pay through the Plan or any other elections.

Note that any election change must be made within thirty (30) days of an event described above, and must conform to and be consistent with that event.

Also, even if you are allowed to change your health care expense reimbursement election, you may not reduce the annual contribution elected to less than the amount of health care expenses already reimbursed to you for the Plan Year.

CAN I TRANSFER AMOUNTS FROM ONE ACCOUNT TO ANOTHER?

Generally, no. For example, money from a dependent care account can only be used for dependent care expenses and money from the health care reimbursement account can only be used for qualified health care expenses. However, new elections may be permissible if there is a change in family status or the occurrence of a qualifying event, as defined above.

WILL THE COUNTY CONTRIBUTE TO THE PLAN?

NO, the Plan will be funded with employee salary reduction contributions, only.

**IF THERE IS MONEY IN MY ACCOUNT AT THE END OF A YEAR
MAY I WITHDRAW IT FROM THE PLAN OR CARRY IT OVER TO THE
FOLLOWING YEAR?**

No. Any unused balance in your account at the end of the year after all premiums are paid and all reimbursements have been made to you, is forfeited and reverts to the Plan. These funds will be equally distributed amongst the current reimbursement plan participants of the Plan as an offset to each participant's selected reimbursement account the next Plan Year. Should a participant maintain more than one reimbursement account, only one of these accounts will be credited with the offset dollars. Therefore, it is important that you budget carefully and conservatively in determining the amount you, personally, contribute to the Plan. In other words, before you allocate any money to a benefit account, be sure you will be able to spend all of it for that benefit during the year.

CAN I PARTICIPATE IN THIS PLAN ONE YEAR AND NOT THE NEXT?

Yes. During each enrollment period, which is generally towards the end of a year, you will elect whether or not to participate during the following year. *HOWEVER, if you have enrolled in the Plan for County sponsored group health insurance premium payments, directly through the Plan, your enrollment in this portion of the Plan ONLY will remain in place from year to year, whether or not you have completed a new enrollment form. The amount of the pre-tax deduction for the coverage will increase or decrease with the cost, from year to year, of the selected group insurance program.*

WHAT BENEFITS MAY I CHOOSE UNDER THE PLAN?

The benefits include a Group Health Insurance Premium Payment Program, an Individual Health and Disability Insurance Premium Reimbursement Program, an Unreimbursed Health Care Expenses Reimbursement Program, a Dependent Care Assistance Program, and an Adoption Assistance Program.

1. GROUP HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

If you elect to participate in the Group Health Insurance Premium Payment Program you will be allowed to directly pay the cost of any group health premiums, offered by the County, pre-tax, through the Plan.

**2. INDIVIDUAL HEALTH AND DISABILITY INSURANCE PREMIUM
REIMBURSEMENT PROGRAM**

If you elect to participate in the Individual Health and Disability Insurance Premium Reimbursement Program, you will be reimbursed for qualified individual health and disability insurance premiums incurred for yourself, your spouse and/or your other legal dependents. Qualified premiums include premiums NOT sponsored by another employer organization.

PLEASE NOTE:

Certain disability insurance plans paid for with pre-tax dollars will pay TAXABLE dollars as benefits in the event of disability. Other health insurance plans providing more than basic health care coverage may also provide TAXABLE benefits upon benefit claim. This includes the AFLAC program offerings at the County. Please see the Agent of your plan to determine the ultimate taxability of the Plan you have purchased. In addition, you should contact your tax advisor.

3. UNREIMBURSED HEALTH CARE EXPENSES REIMBURSEMENT PROGRAM

If you elect the Health Care Reimbursement Program, you will be reimbursed for medical and hospital expenses not covered or paid for by insurance, plus expenses incurred for medical care, for yourself, your spouse, and/or your dependents which are not covered or paid for under any other plan or policy. Medical care means medical treatment, the payment for which is normally deductible for federal income tax purposes. It includes care for the diagnosis, cure, treatment or prevention of disease.

Expenses for medical care include expenses for routine and extraordinary physical, medical and dental examinations, surgery, psychiatric care, hospitalization, drugs and medicines, therapeutic, orthopedic and prosthetic aids and devices, accident and health insurance, and transportation primarily for and essential to medical care.

****NOTE****

The amount of your health care reimbursement for the Plan Year is limited to the lesser of \$6,000.00 or the amount you elect for the Plan Year. Therefore, for each Plan Year you may not allocate more than \$6,000.00 of your compensation to this reimbursement account.

4. DEPENDENT CARE ASSISTANCE PROGRAM

If you select the Dependent Care Assistance Program, you will be reimbursed for qualified dependent care expenses that you incur during the Plan Year. Under the Plan, you will be reimbursed only for dependent care expenses, which meet all of the following conditions:

1. The expenses are incurred for services rendered after the date of Participation.
2. Each individual for whom you incur the expenses is an IRC Section 152 (as modified by Code Section 105(b) and Code Section 105(e)) dependent.
3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 2 above, and who regularly spends at least 8 hours per day in your household.
5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.

7. The expenses are not paid or payable to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

Reimbursements under the Dependent Care Assistance Program may not exceed the least of the following limits: (a) \$5,000 (\$2,500 if you are a married individual and file a separate return), (b) your taxable compensation (after the reduction agreed to under the Plan), or (c) if you are married, your spouse's actual or deemed earned income. For purposes of (c), your spouse will be deemed to have earned income of \$200 (\$400 if you have two or more dependents described in paragraph 2 above), for each month in which your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student at an educational institution.

IMPORTANT NOTICE

Under current tax laws, qualified dependent care expenses that you pay on an after-tax basis may qualify as an itemized credit on your Federal income tax return. Therefore, the tax savings for some people may be greater if they pay for dependent care on an after-tax basis rather than a before-tax basis under a dependent care account. For others, the tax savings will be greater under a dependent care account. For tax years beginning in 1989, any contribution to your dependent care account will be a direct offset against any Federal income tax credit for which you might be eligible. That credit was increased effective 1/1/2002.

For more information you should check with a financial advisor or a tax professional.

5. ADOPTION ASSISTANCE PROGRAM

If you elect the Adoption Assistance Program, you will be reimbursed for qualified adoption expenses incurred by you and your spouse as provided under Section 137 of the Internal Revenue Code. Adoption expenses must be incurred while you are a participant in this Plan. Please note that adoption is a valid reason for a change in status, which would allow you to participate in this portion of the Plan.

Adoption Assistance is limited to \$10,000 per child.

**HOW DO I OBTAIN REIMBURSEMENT FOR
UNINSURED HEALTH CARE, DENTAL, ADOPTION ASSISTANCE
OR DEPENDENT CARE EXPENSES I INCUR?**

To secure reimbursement for any of the benefits allowed under the Plan, you must submit a voucher and receipt bill, a canceled check, a list of expenses, an unpaid bill, or a signed affidavit indicating the expense incurred. It is your responsibility to maintain adequate records to verify these expenses. A voucher envelope and claim form may be obtained from your Plan Representative, the Plan Administrator or from www.flexbene.com/forms. One is attached to this SPD.

You must apply for reimbursement on or before the 90th day following the close of the Plan Year, assuming you are currently employed. If you are no longer employed by the County, you will have ninety (90) days from your termination date to apply for reimbursement of valid expenses incurred while you were employed with the County. Upon receiving a timely claim and proper documentation from you, the Plan Agent will distribute to you or your beneficiary the amount to which you are entitled.

You may request a reimbursement as a check reimbursement that will be mailed to your address of record at the time of your enrollment. Along with that check you will receive a paper statement of your account. Should you wish, you may also, or instead, sign up for direct reimbursement of your dependent care claims, by completing the DEPENDENT CARE ASSISTANCE PROGRAM REIMBURSEMENT SELECTION form. Should you do this, you will have both a debit and a credit to your bi-weekly pay check. The credit will represent your reimbursement of eligible dependent care expenses, pre-tax, through payroll. In order to receive direct reimbursement of dependent care expenses, you must have substantially equal expenses throughout the Plan Year and submit regular validation of your dependent care costs. As well, your DEPENDENT CARE REGISTRATION form must be filed at the beginning of the Plan Year. Should your verification of services documentation lag for more than 30 days, you will be terminated from direct reimbursement and therefore will have to submit vouchered expenses BEFORE any reimbursement will be processed by electronic funds transfer or check. You will not be allowed to return to the DIRECT reimbursement program, through the current Plan Year.

Effective August 1, 2008, you may complete a form to receive your reimbursements as an electronic transfer of funds DIRECTLY from the Plan, to your designated checking or savings account. See the DIRECT DEPOSIT AUTHORIZATION FORM attached to this Summary Plan Description to participate. If you choose electronic funds transfer, you will receive an e-mail notice of your reimbursement statement and the date that your reimbursement will appear in your account.

WHAT HAPPENS IF MY CLAIM FOR REIMBURSEMENT IS DENIED?

If your claim for reimbursement is denied, the Plan Administrator, through the Plan Agent, should notify you in writing. He/she will give you the reasons and, if appropriate, explain what you must do to get your benefit. If you do not receive a denial or payment within ninety (90) days, you can assume that your claim has been denied. You have the right to request a review of the denial by the County's Flexible Benefits Committee. Your request for review must be in writing and must be made within ninety (90) days after the denial of your claim. You are entitled to examine all pertinent documents and to submit issues and comments in writing to the Plan Agent. The County must render a decision within sixty (60) days of your request for review. This can extend an additional sixty (60) days under certain circumstances.

A notice of an adverse determination on review will contain:

(i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; and (iv) the following statement: "You and your Plan may have other

voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.” If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

WHAT ARE THE CIRCUMSTANCES WHICH RESULT IN DISQUALIFICATION OR IN THE DENIAL, LOSS OR SUSPENSION OF MY BENEFITS?

The amounts credited to your benefit account during a Plan Year may only be used to reimburse you for the expenses incurred during that Plan Year while you were employed by the County. You must apply for reimbursement on or before the 90th day following the close of the Plan Year, if you are currently employed by the County. Should you terminate employment, for any reason, you would have (ninety) 90 days from your termination date, to apply for reimbursement. Any unused balance in your account at the end of the year or upon termination, after all proper reimbursements have been made to you, shall be forfeited and shall revert to the Plan. If you do not submit an election form on or before the due date for any Plan Year, including your initial Plan Year of participation, it will be assumed that you elect to receive your compensation in cash. Therefore, you will not be allowed to participate in the Plan for that Plan Year.

You will cease to be eligible for benefits under the Plan if you leave the employ of the County. All funds held in your account will be paid to you in the manner designated in your benefits election form in accordance with the terms of the Plan. However, the Administrator shall pay only those amounts for specified benefits for expenses incurred during the Plan Year through your termination date. The balance of your account after all qualified payments have been made will revert to the Plan. If the Plan Administrator determines before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirements imposed by the Internal Revenue Code, the Administrator may take action to assure compliance with any requirements or limitations. This action may include a modification of any election with or without the consent of the Employee.

CAN THE COUNTY TERMINATE OR CHANGE THE PLAN?

Yes. The County has the right at any time to amend, in whole or in part, any or all of the provisions of the Plan. However, no amendment may be passed which authorizes or permits any part of your account to be used or diverted for a purpose other than for you or your beneficiaries' benefits. The County also has the right at any time to terminate the Plan. In the event the Plan is terminated, no further contributions shall be made. Benefits under any insurance contract shall be paid in accordance with the terms of the contract.

No further additions shall be made to any of the premium or reimbursement accounts selected under this Plan. All payments from such accounts shall continue to be made according to the

elections in effect until the end of the Plan Year. The County may extend this period, if required, for filing claims. Any amounts remaining in the accounts will be forfeited.

DOES PARTICIPATION IN THE PLAN AFFECT MY SOCIAL SECURITY and MEDICARE BENEFITS?

Yes. Neither you nor the County pay FICA or Medicare tax on the money which you direct into the Plan. Therefore, your social security benefits may be reduced. You should consult your tax advisor regarding the effect participation in the Plan may have on your social security benefits.

WHAT ADDITIONAL RIGHTS DO I HAVE AS A PARTICIPANT?

Federal law gives you rights with regard to coverage and certain specific benefits.

The following is a summary of those rights.

COBRA Continuation Coverage

You may have a right under “COBRA” to continue to participate in the health care expense portion of the Plan after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family when they would otherwise lose your group health coverage. Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced; or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employees employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the County must notify the Plan Administrator, the Plan representative and the Plan Agent of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you, the Employee, must notify the Plan Administrator through the Plan Representative or the Plan Agent within 60 days after the qualifying event occurs. You must provide this notice to: Margaret Ann DeMarzo, Suffolk County Department of Civil Service, Employee Benefits Division or call the Plan Agent at 800.836.8100 to obtain a form. Alternately, you may send an e-mail notice to info@flexbene.com. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage, which lasts no longer

than the last day of the Plan Year in which the qualifying event occurs. *Furthermore, COBRA continuation coverage is not available to a qualified beneficiary even for that Plan Year unless the qualified beneficiary could become entitled to reimbursement for health care expenses incurred during the remainder of that Plan Year which exceeds the amount that he or she could be required to pay for COBRA continuation coverage under this Plan for the remainder of that Plan Year.*

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan representative or to the Plan Agent. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator (through the Plan Representative) and/or the Plan Agent informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator and/or Plan Agent.

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from the Plan Representative or the Plan Agent at 800-836-8100 or e-mail info@flexbene.com.

Health Insurance Portability and Accountability Act of 1996 and Uniformed Services Employment and Reemployment Rights Act

You may be entitled to commence, continue, suspend, and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Information concerning your HIPAA and USERRA rights is available from Human Resources.

Heroes Earnings Assistance and Relief Tax (HEART) Act of 2008

The HEART Act under Code section 114 amends Code Section 125 to allow distributions of unused amounts credited to the health flexible spending accounts of reservists called to active duty. This will allow a reservist who is called to active duty and unable to fully use amounts currently credited to his/her reimbursement account, to CASH OUT the current unused benefits and not forfeit them under the "use it or lose it" provision. The distribution is subject to taxation and restricted in accordance with HEART Act subsequent guidance.

The HEART Act restricts such CASH OUT to reservists who (a) are called to active duty for a period of over 179 days or for an indefinite period and (b) the distribution is made between

the date of the order or call to active duty and the last date that reimbursements could otherwise be made for the current Plan Year.

Family and Medical Leave Act

If you are eligible for, and take, a leave of absence under the Family and Medical Leave Act (“FMLA Leave”), you may continue your contributions during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave. Coverage will continue as if you were actively employed by the County until the earlier of the date (1) the FMLA Leave ends, or (2) you notify the County that you will not return to work. If you choose not to continue coverage during an FMLA Leave, you may resume Plan contributions when the FMLA Leave expires; provided you are still an employee eligible to participate in the Plan (see Question regarding eligibility).

Information concerning your right to and obligations during a leave is available from Human Resources, or from the Plan Agent at 800-836-8100 or e-mil at info@flexbene.com.

HIPAA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act (“HIPAA”) regarding the use and disclosure of your protected health information (“PHI”). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan’s privacy notice or more information about the Plan’s privacy practices, or you want to file a privacy violation complaint, please contact the Plan Administrator who will put you in touch with the County’s current privacy officer.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for a parent to provide a child or children with health coverage. If the Plan receives a QMCSO for your child or children, you will be contacted about the procedure for the QMCSO. Copies of the Plan’s QMCSO procedures are available, without charge, from Human Resources.