FLEXIBLE BENEFIT PLAN
with Beniversal® MasterCard®
PLAN HIGHLIGHTS*

A. General Plan Information

1. Employer name: District of Columbia Government.
2. Plan name: District of Columbia Government Flexible Benefit Plan.
3. Plan type: The Plan is a welfare plan designed to provide benefits permitted under Section 125 of the Internal Revenue Code (IRC). The Plan name and Plan number should be used in any formal correspondence relating to the Plan.
4. Eligibility requirements: Must be an employee of District of Columbia Government who works at least 30 hours per week.
   - *If you or your spouse is reporting contributions to a Health Savings Account (HSA), you are not eligible for a Medical FSA.*
5. The effective date on which you can begin participating in the Plan: Once the eligibility requirements have been met.
6. Kinds of group insurance for which you can pay your share of premiums through the Plan: Medical, Dental and Vision Insurances.
7. The Plan Year begins on January 1 and ends on December 31.
8. Plan effective date: January 1, 2015.
9. Plan number: 501.
10. Employer ID number: 53-6001131.
11. Name, address and telephone number of the Plan Administrator:
    District of Columbia Government
    441 4th Street, NW Suite 340N
    Washington, DC 20001
    (202) 442-9623
12. Agent for service of process: District of Columbia Government.

B. Flexible Spending Accounts (FSAs)

1. Types of FSAs

Medical FSA

(a) Maximum amount you can set aside per Plan Year for reimbursement of eligible medical expenses as defined by IRC Section 213(d) except for insurance premiums: $2,700.

(b) For active participants:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year.

(c) If you become ineligible (including termination of employment) during the Plan Year:
- Eligible services must be provided:
  - after your effective date in the Plan,
  - during the Plan Year and
  - prior to the date on which you become ineligible.
- The Beniversal Card may no longer be used to access Medical FSA funds. You may submit a claim for reimbursement of eligible expenses.

Dependent Care FSA

(a) Maximum amount you can set aside per calendar year for reimbursement of eligible dependent care services, as defined by IRC Section 21(b), is limited to the smallest of the following amounts:
- $5,000 if single or if married and filing jointly; $2,500 if married and filing separately.
- The earned income of the participant.
- The earned income of the participant's spouse.

(b) For active participants:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year.

(c) If you become ineligible (including termination of employment) during the Plan Year:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year in which you become ineligible.

2. Claims for FSAs

Claim submission time frames

(a) Claims must be received by Benefit Resource, Inc. before the end of the 90 day run-out after the Plan Year ends.
(b) Claims denied during the run-out may be resubmitted, but must be received by Benefit Resource within 21 days after the run-out ends.
(c) Eligible participants are allowed to rollover up to $500 of unused Medical FSA funds to the next Plan Year after the end of the time frame in (b) is completed for the current Plan Year. The minimum amount that can rollover must be greater than $10.
(d) Any funds remaining in your Medical or Dependent Care FSA after this will be forfeited.

Claim reimbursements

(a) Complete your claim following all instructions.
(b) Claims received with proper documentation will be processed within 5 business days.
(c) Claim reimbursements are processed daily.
(d) A claim should never be submitted for an expense that has been paid for with a Beniversal Card or reimbursed from any other source.

3. Beniversal Card for Medical FSA

(a) The Beniversal Card allows you to access Medical FSA funds to pay for eligible medical services at qualified merchants.
(b) The card may only be used to pay for eligible medical services after they have been provided. The IRS allows one exception: eligibility of orthodontia expenses can be based on either date of payment, date of service or payment due date on coupons/statements.
(c) Payment of a current Plan Year medical service with the card must be completed before the Plan Year ends.
(d) Once a new Plan Year begins, only Medical FSA funds associated with the new Plan Year will be available on the card.
(e) You are advised to save all documentation related to medical expenses paid with your card, as IRS regulations require all transactions to be verified for eligibility.
(f) If a card transaction cannot be automatically verified, you will be contacted to submit documentation for that transaction.
(g) Medical expenses paid with the card should never be submitted for claim reimbursement.