

City of Saint Paul Cafeteria Plan Summary Plan Description



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Table of Contents

Introduction	1
General Information	2
1 What is the purpose of the Plan?	2
2 What types of benefits are available through the Plan?	2
3 Who can participate in the Plan?	2
4 When am I eligible to participate in the Plan?	2
5 How do I become a participant?	2
6 How do I benefit from reducing my compensation in order to make pre-tax contributions to the Plan?	3
7 If I elect to reduce my compensation, will this affect my Social Security and/or other retirement benefits?	4
8 What happens if I don't complete the election process by the deadline?	4
9 Can I change or revoke my election during the Plan Year?	4
10 What happens to my elections if I am no longer able to participate in the Plan?	5
11 How long will the Plan remain in effect?	5
12 Can I stay in the Plan if I am on an approved Family and Medical Leave Act leave?	6
13 How does the Plan affect my rights as an employee?	6
14 What happens if a claim for benefits is denied?	6
Health Care Reimbursement Account	8
15 Why should I participate in the Health Care Reimbursement Account if I already have health insurance offered by The City?	8
16 What health expenses qualify for reimbursement?	8
17 What is the maximum amount that I can receive per year in health care reimbursements?	8
18 How will funds flow into and out of my Health Care Reimbursement Account?	9
19 How do I submit health care expenses for reimbursement?	9

City of Saint Paul Cafeteria Plan Summary Plan Description

20	Can I receive a refund of any balance remaining in my Health Care Reimbursement Account at the end of the Plan Year?	10
21	What if the balance in my Health Care Reimbursement Account is not enough to cover the reimbursement requested?	10
22	What happens if I terminate my employment with the City or I become ineligible to participate in the Health Care Reimbursement Account for any other reason?	10
Dependent Care Reimbursement Account		13
23	Who qualifies as a dependent?	13
24	What type of dependent care expenses can be reimbursed under the Plan?	13
25	Can payments made to a relative qualify as dependent care expenses?	14
26	What is the maximum amount that I can receive per year in Dependent Care Reimbursement Account payments?	14
27	How will I be reimbursed for my dependent care expenses?	14
28	How do I submit dependent care expenses for reimbursement?	15
29	Can I receive payment for any balance remaining in my Dependent Care Reimbursement Account at the end of the Plan Year?	15
30	What if the balance in my Dependent Care Reimbursement Account is not enough to cover the reimbursement requested?	15
31	Will I receive any kind of report showing the amount I received in dependent care reimbursement during each calendar year?	16
32	What happens if I terminate my employment with the City or I become ineligible to participate in the Dependent Care Reimbursement Account for any other reason?	16
33	Are there any other tax-favored opportunities available for the payment of dependent care expenses?	16
Legal Notice.....		17
34	How do I claim my rights under the Plan?	17
Important Information.....		18

Introduction



The City of Saint Paul sponsors the City of Saint Paul Cafeteria Plan (the “Plan”) for you and your fellow employees. The Plan provides you with the opportunity to use pre-tax dollars to pay your portion of the cost of certain benefits. In addition, you may elect to set aside pre-tax dollars to pay for: (i) medical expenses not covered by insurance and (ii) dependent care. These pre-tax dollars are placed in individual “reimbursement accounts” on your behalf.

After submitting your medical expenses to your health care plan you can submit a claim and receive reimbursement for the amounts you have paid out-of-pocket from your pre-tax health care “reimbursement account.” In the same fashion, you can submit a claim and receive reimbursement for the many of the expenses you have incurred for dependent care from your pre-tax dependent care “reimbursement account.” These arrangements help you because they provide the opportunity to pay your group health insurance contributions, medical expenses not paid by insurance and/or your dependent care expenses with pre-tax dollars. As a result, you save both income tax and social security tax on these amounts.

This summary plan description (“SPD”) describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The SPD only contains a summary of the key elements of the Plan and a brief description of your rights as a participant. It is not a part of the official Plan document. **If there is a conflict between the Plan document and this booklet, the Plan document will rule.**

General information

1. What is the purpose of the Plan?

The Plan allows you to use your benefit dollars in the most cost effective manner possible. Certain provisions of the Internal Revenue Code allow the City of Saint Paul to offer you the opportunity to participate in select benefit plans on a tax-favored (pre-tax) basis.

2. What types of benefits are available through the Plan?

Benefits are purchased through the Plan with pre-tax dollars. The benefits from which you may choose include:

- ▶ Premium Payment Program
- ▶ Health Care Reimbursement Account
(Also known as the “health - flexible spending account” or “FSA”)
- ▶ Dependent Care Reimbursement Account

Each benefit under the Plan has separate rules governing benefits and plan administration. These rules are explained in more detail in the plan documents which have been prepared solely for the purpose of describing each particular benefit in detail. A copy of this information is available from Risk Management.

3. Who can participate in the Plan?

If you are eligible to participate in a medical benefit plan offered by the City you are eligible to enroll in this Plan.

4. When am I eligible to participate in the Plan?

Generally, an eligible employee may enroll in the Plan on the first day of the month coincident with or next following thirty (30) days of continuous employment with the City.



5. How do I become a participant?

When first eligible, and every year thereafter, you must specify which of the three optional benefits available under the Plan (See Q&A 2 above) you desire. The opportunity to make this election will be available to eligible employees: (i) at the time of their employment, and (ii) prior to the start of each plan year during the open enrollment period.

6. How do I benefit from reducing my compensation in order to make pre-tax contributions to the Plan?

Reducing your compensation through the Premium Payment Program, the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account all operate in the same manner. This can best be shown by the following example:

John and Jane Jones are married and have two children. John is an employee at Example Company and earns \$20,000 a year.

John decided to enroll in the Example Company Flexible Benefits Plan. He elects to reduce his current compensation by \$1,500 (\$125 per month) and direct this amount into the plan to purchase health insurance for him and his family.

Under the Flexible Benefits Plan, John is able to pay his health insurance contribution with pre-tax dollars. Without the plan, John would pay his health plan contribution with after-tax dollars. John's disposable income with and without the Flexible Spending Account plan is shown below.

	With Pre-Tax Contributions	With After-Tax Contributions
Gross salary	\$20,000	\$20,000
Less: Compensation reduction for employee contribution for health insurance	\$1,500	n/a
Taxable Income	\$18,500	\$20,000
Less: Federal Income Tax	\$2,775	\$3,000
Less: Social Security Tax	\$1,415	\$1,530
Total taxes paid	\$4,190	\$4,530
Income after taxes	\$14,310	\$15,470
Health insurance contribution	n/a	\$1,500
DISPOSABLE INCOME	\$14,310	\$13,970
NET SAVINGS WITH PLAN	\$340	

John Jones receives \$340 (\$14,310 minus \$13,970) more per year in disposable income if he elects to purchase his health insurance on a pre-tax basis through the Flexible Benefits Plan. There may be additional state income tax savings, also.

7. If I elect to reduce my compensation, will this affect my Social Security and/or other retirement benefits?

Selection of pre-tax contributions under the Premium Payment Program, the Health Care Reimbursement Account or the Dependent Care Reimbursement Account will normally result in both you and the City making lower contributions to the federal Social Security system. In many situations, this will reduce your Social Security contributions and could slightly reduce your benefits. However, electing to participate in the Premium Payment Program, the Health Care Reimbursement Account or the Dependent Care Reimbursement Account will not affect your benefits under the State retirement program in any way.

8. What happens if I don't complete the election process by the deadline?

If you fail to fully complete the election process when you are first eligible to participate, you will be automatically enrolled for employee-only coverage under the lowest cost medical option offered by the City. If you want to enroll in a different medical option... or want to enroll your eligible dependents for coverage... or want to contribute to either the Health Care Reimbursement Account or the Dependent Care Reimbursement Account... or even if you simply want to opt-out of coverage under the City's plans, you must complete the election process.

Health Care Reimbursement Account elections and Dependent Care Reimbursement Account elections cannot roll from one year to the next.

During annual re-enrollment, if you fail to complete the election process, your prior year's election under the Premium Payment Program will be continued for another year.

However, if you are participating in the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account and you fail to complete the annual re-enrollment process before the specified due date, you will be considered to have elected cash compensation in lieu of continued participation in one or both of these programs. Neither Health Care Reimbursement Account elections nor Dependent Care Reimbursement Account elections can roll from one year to the next...that is, you must re-submit your elections for each Plan Year, even if your desired election remains unchanged.

9. Can I change or revoke my election during the Plan Year?

In general – No. However, there are a number of exceptions that permit a change or revocation of certain elections under certain circumstances. The following are examples of the types of life events that are considered changes in status under federal law:

- ▶ Changes in legal marital status (through marriage, death of spouse, divorce, legal separation, or annulment)
- ▶ Change in number of dependents (through birth, adoption, placement for adoption or death of a dependent)

- ▶ Change in employment status (through termination or commencement of employment by you, your spouse or your dependent)
- ▶ Change in work schedule (through a switch between part-time and full-time work, commencement or return from an unpaid leave of absence or an increase or reduction in hours of employment by you, your spouse or your dependent)
- ▶ Change in dependent status (through satisfying or ceasing to satisfy the age or other requirements to qualify as a covered dependent under the plan)
- ▶ A “significant” increase or decrease in the cost of health coverage or a “significant” expansion or reduction in the level of coverage provided, affecting either the City’s medical benefits or the medical benefits of another employer’s plan where you are enrolled as a dependent or where your spouse or dependent child is enrolled (does not apply to Health Care Reimbursement Account elections)
- ▶ Relative to your Dependent Care Reimbursement Account election, a change in the day care provider’s rates



When an approved change in status occurs, federal tax law also requires that your new election be “consistent” with the nature of your status change and must be made within 30 days of the date of the qualifying change in status. For more information on status changes and the related changes in elections that are permitted, contact Risk Management for assistance.

Also note that any new election under the City of Saint Paul Cafeteria Plan will be effective at such time as the City will proscribe, but generally not earlier than the first pay period beginning after the re-election process is completed.

10. What happens to my elections if I am no longer eligible to participate in the plan?

Elections under the Plan will automatically terminate on the date you cease to be a participant in the plan. (Also see Question #22 regarding when you cease to be a participant in the Health Care Reimbursement Account and Question #32 regarding when you cease to be a participant in the Dependent Care Reimbursement Account.)

11. How long will the Plan remain in effect?

It is the City's intent that the Plan will continue indefinitely. However, the City of Saint Paul reserves the right to amend or discontinue the Plan if conditions require or if changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

12. Can I stay in the Plan if I am absent on an approved Family and Medical Leave Act leave?

If you are on an approved FMLA leave of absence, you have the right to continue your Premium Payment Program and Health Care Reimbursement Account. While on an unpaid FMLA leave of absence, there are several options available for you to continue contributions to the Plan... or you have the right to terminate coverage during the leave and reinstate it when you return from leave. Contact Risk Management for a complete explanation of your FMLA rights and responsibilities.



13. How does the Plan affect my rights as an employee?

No provision of the Plan is to be considered a contract of employment between you and the City. In addition, the City's rights with regard to disciplinary action and termination of any employee, if necessary, are in no manner changed by any provision of the Plan.

14. What happens if a claim for benefits is denied?

Claims for benefits under the Health Care Reimbursement Account and the Dependent Care Reimbursement Account are discussed below.

If your claim is denied in whole or in part, the Claim Administrator will notify you in writing within 30 days after the date the Claim Administrator received your claim. This time period may be extended for an additional 15 days for matters beyond the control of the Claim Administrator, including cases where a claim is incomplete. The Claim Administrator will provide notice of any extension, including the reasons for the extension and the date by which a decision by the Claim Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information; will allow you 45 days from receipt of the notice in which to provide the specified information; and will have the effect of suspending the time for a decision on your claim until the specified information is provided.

If a claim is denied, the Claim Administrator will inform you of:

- ▶ the specific reason or reasons for the denial;
- ▶ the specific Plan provision on which the denial is based;
- ▶ a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
- ▶ information on the steps you need to take if you wish to appeal the Claim Administrator's decision, including your right to submit written comments and have them considered and your right to review (upon request and at no charge) relevant documents and other information.

Appeals

Any expert involved in deciding your appeal will be different from and not subordinate to any expert involved with the initial claim denial.

If your claim is denied in whole or in part, you (or your authorized representative) may request a review upon written application to the Claim Administrator. Your appeal must be made in writing within 180 days after you receive notice that the claim was denied. Your request for appeal should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review

Your appeal will be reviewed and decided by the Claim Administrator or other entity designated in the Plan in a reasonable time not later than 60 days after the Claim Administrator receives your request for review. The Claim Administrator may, in its discretion, hold a hearing on the denied claim.

Any expert involved in deciding your appeal will be different from and not subordinate to any expert involved with the initial claim denial. The identity of the expert consulted in connection with your appeal will be provided. If the review decision supports the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review describing:

- ▶ the specific reason(s) for the denial;
- ▶ the specific Plan provision on which the decision is based;
- ▶ a statement of your right to review (upon request and at no charge) relevant documents and other information; and
- ▶ 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 criterion will be provided free of charge to you upon request.

Health Care Reimbursement Account

NOTE: Your Health Care Reimbursement Account election does not roll from one year to the next. You must submit a new election during each enrollment period.

15. Why should I participate in the Health Care Reimbursement Account if I already have health insurance offered by the City of Saint Paul?

The Health Care Reimbursement Account offers pre-tax reimbursement for health and dental care expenses not covered under your other health and dental care plans.

16. What health expenses qualify for reimbursement?

Health care expenses paid by you, your spouse or dependents that qualify for reimbursement include, by way of example:

- ▶ Any applicable deductibles, co-payments and coinsurance
- ▶ Prescription drugs and other items and services not covered, or not fully covered by the health care plan
- ▶ Hearing aids
- ▶ Dental and orthodontia services, the cost of which exceeds dental plan limits
- ▶ Vision care costs



All of the above are examples of qualifying health care expenses, but only to the extent that you or other persons in your family unit incurring the expense are not reimbursed for the expense through insurance or otherwise.

More information on eligible medical care expenses is available in through the Internal Revenue Service in Publication #502, Medical and Dental Expenses, which is available from your local IRS office and on the IRS website at <http://www.irs.gov>.

17. What is the maximum amount that I can receive per year in health care reimbursements?

A maximum of \$4,000 per Plan Year. Effective January 1, 2013, the maximum amount is \$2,500.

18. How will funds flow into and out of my Health Care Reimbursement Account?

The amount of your compensation reduction directed to the Health Care Reimbursement Account each pay period during the year will be credited to an individual account. At any point during the year, you will be reimbursed for qualifying health care expenses up to the full amount of your annual Health Care Reimbursement Account election less prior reimbursements received during the year.

19. How do I submit health care expenses for reimbursement?

There are two ways in which eligible health care expenses can be submitted to your Health Care Reimbursement Account.

First, each participant in the Health Care Reimbursement Account will receive a Debit Card that can be used for otherwise un-reimbursed health care expenses at:

- ▶ Doctor's or dentist's offices, clinics, hospitals or other approved health care providers,
- ▶ Approved drug stores and pharmacies,
- ▶ Stores that have implemented inventory approval systems and have been approved by the Plan.

Although clearly the most convenient way to pay eligible health care expenses directly from your Health Care Reimbursement Account, it is important to remember that you may only use the health Debit Card for eligible health care expenses and that you must retain sufficient supporting information (*e.g.*, invoices, receipts, etc.) for any health care expenses purchased by use of the card. You must also be aware that the Plan has established a series of steps that will be used to recover the full amount of ineligible expenses that are improperly purchased with the Debit Card. For this reason care must be taken that the health Debit Card is only used for payment of eligible health care expenses.

Additional information on the proper use of the Health Care Reimbursement Account Debit Card is available on the Knowledge Base at: <http://www.BenefitReady.com>,

The second way to receive reimbursement for eligible health care expenses is by submitting a Health Care Reimbursement Account claim to the Claim Administrator. This submission may be made either by mail, by fax or by email. Along with the completed claim form, you must also submit: a statement from the health care provider showing the expenses that have been incurred; the amount and date of the expense; the name of the health care provider; and the name of the person for whom the expenses were incurred. The City reserves the right to request copies of any additional documentation that may be required to substantiate the claim.

Health Care Reimbursement Account claim forms are available on the Knowledge Base at: <http://www.BenefitReady.com>.

20. Can I receive a refund of any balance remaining in my Health Care Reimbursement Account at the end of the Plan Year?

Any balance remaining in your Health Care Reimbursement Account at the end of a Plan Year will be forfeited and cannot be carried over to reimburse you for health care expenses in the next Plan Year.

No! Federal law requires that the amount deposited into your Health Care Reimbursement Account for any Plan Year only be used to reimburse you for health care expenses incurred during that Plan Year, and only if you apply for reimbursement no later than February 15th following the end of the Plan Year. Any balance remaining in your Health Care Reimbursement Account after that point in time will be forfeited and cannot be carried over to reimburse you for health care expenses in the next Plan Year.

For this reason, it is important to carefully estimate your expenses for the coming year at the time you submit your Health Care Reimbursement Account election.

21. What if the balance in my Health Care Reimbursement Account is not enough to cover the reimbursement requested?

You will be reimbursed for the entire amount of your expense, up to the amount you have elected to contribute to the Health Care Reimbursement Account for the current year less prior reimbursements in that year.

22. What happens if I terminate my employment with the City or I become ineligible to participate in the Health Care Reimbursement Account for any other reason?

Your compensation reduction agreement and participation in the Plan will end. You are, however, entitled to reimbursement for health care expenses incurred while you were an active participant in the Plan during the current Plan Year. Your maximum reimbursement will not exceed the amount you elected to deposit into your Health Care Reimbursement Account during the Plan Year, less any amounts you have already received during the same Plan Year.



Remember, your request for reimbursement must be submitted by you (or your estate) no later than February 15th following the end of the Plan Year.

Under the terms of the Plan you may have the right to elect a temporary extension of health coverage (called “Continuation Coverage”) at group rates when coverage under a group health plan would otherwise end due to certain life events. This notice is intended to inform you in a summary fashion of your potential future options and obligations under the Continuation Coverage provisions of the Plan with respect to the Health Care Reimbursement Account. For information regarding your Continuation Coverage rights under any of the City of Saint Paul’s other group health plans, refer to those plan documents.

Should a recognized life event occur in the future, the City will send you additional information and the appropriate election notice at that time.

Eligibility for Continuation Coverage

With respect to the Health Care Reimbursement Account, a covered employee will be eligible for Continuation Coverage upon the occurrence of any of the life events described below if:

- ▶ at the time of the event such employee was participating in the Health Care Reimbursement Account; and
- ▶ the remaining balance in his or her Health Care Reimbursement Account exceeds the amount of contributions he or she would be required to make to the Account for the remainder of the Plan Year, assuming the employee continued to participate until the end of the Plan Year.

The City reserves the right to verify your eligibility for Continuation Coverage and terminate the coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

Election Period and Contributions for Continued Coverage

Once the City learns that a qualifying life event has occurred, you will be notified of your right to elect Continuation Coverage. You will have 60 days to elect Continuation Coverage. If you do not elect Continuation Coverage within this period of time, your right to continue coverage will be lost.

Participants will have 60 days to elect Continuation Coverage.

If you elect Continuation Coverage, you will be required to continue to make contributions to the Health Care Reimbursement Account on an after-tax basis. In addition, you may be required to pay an additional 2% administrative fee. Contributions must be made on a monthly basis, subject to a maximum grace period of thirty (30) days.

Length of Continuation Coverage – Remainder of the Plan Year

If you are eligible for and elect Continuation Coverage with respect to the Health Care Reimbursement Account as described above, you will have the opportunity to continue coverage until the end of the Plan Year in which the loss of coverage occurred.

Notification of Address Change

To ensure that all affected individuals receive information properly and efficiently, it is important that you notify the City of any address change as soon as possible. Your failure to do so may result in delayed notification or a loss of Continuation Coverage options.

Any Questions?

Remember, this notice is simply a brief summary of your potential future right to Continuation Coverage. Should a recognized life event occur and it is determined that you are eligible for Continuation Coverage; you will be notified of your rights at that time. If you do not understand any part of this summary or if you have any questions regarding this information, simply contact Risk Management for assistance.



Dependent Care Reimbursement Account

NOTE: Your Dependent Care Reimbursement Account election does not roll from one year to the next. You must submit a new election during each enrollment period.

23. Who qualifies as a dependent?

A dependent means any individual that is:

- a) your dependent who is under the age of 13 and with respect to whom you are entitled a tax exemption; or
- b) your dependent or spouse who is physically or mentally incapable of caring for himself/herself.

24. What type of dependent care expenses can be reimbursed under this plan?

Expenses for dependent care services are covered by the Plan only if the services are performed:

- a) In your household; or
- b) Outside your household for:
 - ▶ the care of a dependent as described above, or
 - ▶ the care of any other qualifying individual who spends at least eight hours a day in your household.

The expenses incurred for services that are performed by a dependent care center qualify under the Plan only if the center:

- a) Complies with all applicable state and local laws and regulations
- b) Provides care for more than six individuals (other than individuals who reside at the center)
- c) Receives a fee, payment, or grant for providing such services (regardless of whether the facility is operated for a profit)



Other services that can be reimbursed through this plan include:

- a) Services of a housekeeper whose duties include, in part, providing for a qualified dependent
- b) Summer day camp

However, in order to be eligible for reimbursement under the Plan, the dependent care expenses must be necessary for you (and your spouse, if married) to be gainfully employed, or for you to be gainfully employed and your spouse to be a full-time student or be seeking full-time employment.

More information on eligible dependent care expenses is available through the Internal Revenue Service, in Publication #503, Child and Dependent Care Expenses.

25. Can payments made to a relative qualify as dependent care expenses?

Payments to your relatives or members of your household are covered by the Plan only if the person to whom the payments were made is not your dependent, your spouse, or your child who is under the age of 19.

26. What is the maximum amount that I can receive per year in Dependent Care Reimbursement Account reimbursement?

The most you can receive under the Plan is the lesser of:

- a) Your earned income (after all compensation reduction elections)
- b) Your spouse's earned income
- c) \$5,000 if married and filing jointly or single, \$2,500 if married and filing individually

In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for him/her self, such spouse shall be deemed to have earned income of \$250 per month if you have one dependent and \$500 per month if you have two or more dependents.



The following example illustrates the maximum amount you can receive for dependent care:

John and Jane have two children. John earns \$20,000 per year and Jane is a full-time student. The most John can receive under the plan is the lesser of:

- a) John's salary of \$20,000 (less all compensation reduction elections)
- b) Jane's income, which is deemed to be \$6,000 since she is a full-time student and they have two children (\$500 x 12 months)
- c) \$5,000 if married and filing jointly or single, \$2,500 if married and filing individually

27. How will I be reimbursed for my dependent care expenses?

The amount of your compensation reduction directed to the Dependent Care Reimbursement Account for each pay period during the year will be credited to an account. You will be reimbursed, up to the then current balance in your account, for your dependent care expenses incurred during the year.

28. How do I submit dependent care expenses for reimbursement?

As with the Health Care Reimbursement Account, there are two ways in which eligible dependent care expenses can be submitted to your Dependent Care Reimbursement Account.

Each participant in the Dependent Care Reimbursement Account will receive a Debit Card that can be used for eligible dependent care expenses. But again, although the most convenient way to pay eligible dependent care expenses, it is important to remember that you may only use the dependent care Debit Card for eligible dependent care expenses and that you retain sufficient supporting information (*e.g.*, invoices, receipts, etc.) for any dependent care expenses you pay for with the card. Also keep in mind that the Plan has a series of steps that will be used to recover the full amount of ineligible expenses that are improperly purchased with the dependent care Debit Card. Additional information on the proper use of the Dependent Care Reimbursement Account Debit Card is available on the Knowledge Base at: <http://www.BenefitReady.com>.

The second way to receive reimbursement for eligible dependent care expenses is by submitting a Dependent Care Reimbursement Account claim to the Claim Administrator. This submission may be made either by mail, by fax or by email. Along with the completed claim form, you must also attach a statement from the dependent care provider showing the amount and date of the expense; the name, address and taxpayer identification number of the dependent care provider; and the name of each qualifying dependent for whom the expenses were incurred. The City reserves the right to request copies of any additional documentation that may be required to substantiate the claim.

Dependent Care Reimbursement Account claim forms are available on the Knowledge Base at: <http://www.BenefitReady.com>.

29. Can I receive payment for any balance remaining in my Dependent Care Reimbursement Account at the end of the Plan Year?

No! Under federal law, funds deposited in your Dependent Care Reimbursement Account can only be used to reimburse you for eligible dependent care expenses incurred during such Plan Year, and only if you submit your claim for reimbursement no later than February 15th following the end of the Plan Year. Any balance remaining after that point in time cannot be carried over to reimburse you for dependent care expenses incurred in the next Plan Year. You forfeit all rights with respect to any balance remaining in your account at the end of the Plan Year.

For this reason, it is important to carefully estimate your expenses for the coming year at the time you submit your Dependent Care Reimbursement Account election.

30. What if the balance in my Dependent Care Reimbursement Account is not enough to cover the reimbursement requested?

The un-reimbursed expense will be carried over to subsequent pay periods until the balance in the account permits reimbursement. However, the un-reimbursed expense will not be carried over from one Plan Year to the next.

31. Will I receive any kind of report showing the amount I received in dependent care reimbursement during each calendar year?

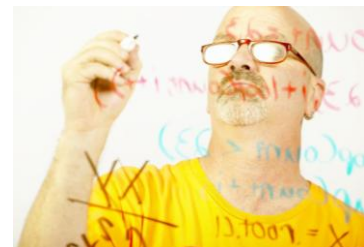
Yes, the amount reimbursed to you through the Dependent Care Reimbursement Account will be reflected on your Form W-2 by January 31st of each year.

32. What happens if I terminate my employment with the City or I become ineligible to participate in the Dependent Care Reimbursement Account for any other reason?

Your compensation agreement will terminate. You are entitled to reimbursement for dependent care expenses incurred on or before the date of your termination of employment. Your request for reimbursement will be granted only if you (or your estate) submit your claim for reimbursement no later than February 15th following the end of the Plan Year. Keep in mind, your reimbursement for the Plan Year will not exceed the balance in your Dependent Care Reimbursement Account at the point in time you ceased to be a participant.

33. Are there any other tax-favored opportunities available for the payment of dependent care expenses?

Under federal law, you may be eligible for a Dependent Care Tax Credit for amounts you pay someone to care for your dependents. The rules regarding eligible dependents and qualifying expenses are similar to those explained earlier. The amount of credit you may be allowed to take will depend on your adjusted gross income (AGI) and other factors. However for any given dependent care expenses, you cannot take advantage of both the Dependent Care Reimbursement Account and the Dependent Care Tax Credit.



Whether it is more advantageous for you to reduce your compensation to pay for dependent care expenses through the Dependent Care Reimbursement Account or take advantage of the Dependent Care Tax Credit will depend on your individual facts and circumstances. For this reason you may wish to consult your individual income tax advisor before you elect to participate in the Dependent Care Reimbursement Account.

LEGAL NOTICE

34. How do I claim my rights under this plan?

If you believe you are being denied any rights or benefits under the plan, you may file a claim in writing with the Claim Administrator. If any claim is wholly or partially denied, the Claim Administrator will notify you of its decision in writing. The claim denial will contain:

- a) The specific reason for the denial
- b) A reference to pertinent plan provisions
- c) A description of any additional material or information necessary for you to perfect such claim and an explanation of why such material or information is necessary
- d) Information as to the steps to be taken if you wish to submit a request for review

If you believe you are being denied any rights or benefits under the plan, you may file a claim in writing with the Claim Administrator.

You will receive the claim denial notification within 30 days after the claim is received by the Claim Administrator (or within 45 days, if special circumstances require an extension of time for processing the claim and if written notice of such extension and circumstances is sent to you within the initial 30 day period). If additional information is required by the Claim Administrator to process your claim, you have 45 days in which to provide the additional information. If you do not receive notification of denial within the specified period, you may consider the claim denied as of the last day of such period and you may at that point request a review of your claim.

Within 180 days after the date on which you receive a written notice of denied claim, you (or your duly authorized representative) may:

- a) File a written request with the Claim Administrator for review of your denied claim and of pertinent documents
- b) Submit written issues and comments to the Claim Administrator

The Claim Administrator will notify you of its decision in writing. The notification from the Claim Administrator of its decision will contain specific reasons for the decision as well as specific references to pertinent plan provisions. The decision on review will be made within 60 days after the request for review is received by the Claim Administrator. The final decision by the City on all claims, regardless of whether on an initial submission or in response to a review, will be final and binding on all parties.

IMPORTANT INFORMATION

Effective Date:	January 1, 2011 is the amendment and restatement date of the Plan. The Plan was originally effective on January 1, 1989.
Plan Year:	January 1 st through December 31 st
Plan Name:	City of Saint Paul Cafeteria Plan
Plan Sponsor:	City of Saint Paul 200 City Hall Annex 25 West 4 th Street Saint Paul, MN 55102 (651) 266-6500
Employer Identification Number:	41-600055521
Claim Administrator:	OutsourceOne 530 U.S. Trust Building 730 Second Avenue Minneapolis, MN 55402 (612) 436-2700

The City of Saint Paul is designated as agent for all purposes of legal process. The City shall have full authority and power to administer the Plan, subject to applicable requirements of law.

The City established the City of Saint Paul Cafeteria Plan for the exclusive benefit of all participating employees. The Plan's purpose is to allow you to select certain employee benefits, on a tax-favored basis. The City reserves the right to amend or terminate this plan at any time.

This material contains a summary of the benefits available through the City of Saint Paul Cafeteria Plan. While it is intended to provide you with a general description of your benefits under the Plan, it is not intended to provide medical, legal, and financial or tax advice. Complete details of the Plan can be found in the official plan documents (which are available from Risk Management) that legally govern all aspects of the Plan. In case of a conflict between the summary plan description and the provisions of the plan document, the provisions of the plan document will govern your rights and benefits. It is the City's intent that the Plan comply with all applicable federal, state and local laws. In the event of a conflict, the terms and provisions of the applicable law(s) will prevail.

Neither your eligibility for nor participation in the City of Saint Paul Cafeteria Plan constitutes a contract of employment with any individual. As a result, participation in this plan does not afford any right to continued employment nor will it interfere with the City of Saint Paul's right to discharge any employee.