Summary Plan Description

Foothill-De Anza Community College District
Flexible Spending Account Plan

Effective: July 1, 2010
Group Number: 709593

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FLEXIBLE SPENDING ACCOUNT PLAN

Notice To Employees

This booklet describes the Employer-sponsored Flexible Spending Account Plan ("Plan") as of July 1, 2010.

Foothill-De Anza Community College District has entered into an arrangement with UnitedHealthcare Insurance Company, Hartford, CT ("UnitedHealthcare") under which UnitedHealthcare will process reimbursements and provide certain other administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this booklet.

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PLAN HIGHLIGHTS

Under the Plan, you can elect to establish two Flexible Spending Accounts ("FSAs"). These accounts let you make before-tax contributions from your salary, which can then be used to reimburse yourself for Eligible Expenses.

If you are a Qualified Reservist called to active duty, this Plan includes a special distribution rule to assist such reservists as described in Sections, *Health Care Spending Account - Qualified Reservist Distribution* and *Requesting a Reimbursement or Qualified Distribution from your Flexible Spending Accounts*.

The **Health Care Spending Account ("HCSA")** is a type of FSA used for reimbursement of Eligible Health Care Expenses (defined in the ***Health Care Spending Account*** section), including certain medical and dental expenses for you, your spouse, your dependent children, and any other dependents you can claim on your federal tax return.

The **Dependent Care Spending Account ("DCSA")** is a type of FSA used for reimbursement of Eligible Dependent Care Expenses (defined in the ***Dependent Care Spending Account*** section), such as day care.

You can elect to participate in either the HCSA, the DCSA, or both.

Each Plan year (July 1 through June 30) you can contribute to your HCSA and/or DCSA, and then, during the Plan year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth as described under Section, *Contributions*.

WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT

Who is Eligible

A regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 24 hours per week is eligible to participate in the Plan.

When You May Enroll

You may elect to participate in the Plan during your first 31 days of employment or during any subsequent annual enrollment period. If timely elected, the Plan will be effective on your date of hire. If you do not elect to participate in the Plan during your first 31 days of employment, you must wait until the next annual Open Enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status. (Refer to the Section, *Changing Your Contribution Amounts*.) You will need to enroll each year, even if you enrolled in the Plan the year before.

How to Enroll

You elect to participate in the Plan by completing an enrollment form and submitting it to Human Resources. You must specify the amount of before-tax dollars you wish to contribute to the HCSA, the DCSA, or both.

To enroll, call Human Resources or log onto http://fhda.edu/benefits within 31 days of the date you first become eligible to participate in the Plan. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to participate in the Plan.

Each year during annual Open Enrollment, you have the opportunity to review and change the amount of before-tax dollars you wish to contribute to the HCSA, the DCSA, or both. Any changes you make during Open Enrollment will become effective the following July 1.

CONTRIBUTIONS

Each year, you must decide on the amount of before-tax dollars you want to contribute to the accounts. Please note that these accounts are not "funded". Rather, the amount you elect to "contribute" remains in the employer's general assets until claims are reimbursed. You may contribute to the HCSA or DCSA, or both, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses", for the upcoming Plan year because IRS regulations require that you forfeit any unused funds remaining in either account after the end of the Plan year.

You have until September 30 of the next year to request reimbursement for Eligible Expenses incurred during the Plan year. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account termed. Any such Eligible Dependent Care expenses must be submitted on or before September 30 of the Plan year following your termination.

For the Health Care Spending Account, you may elect to contribute between $0 and $3000 a year.

For the Dependent Care Spending Account, you may each elect to contribute between $0 and $5,000, or if you are married and filing separately for federal income tax purposes, you may each elect to contribute up to $2,500 a year. If you or your spouse's earned income is less than $5,000 per year, the amount that you can contribute is reduced to the amount of your or your spouse's earned income.

CHANGING YOUR CONTRIBUTION AMOUNTS

IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan year, unless you meet one of the following conditions:

A. With regard to both a HCSA and a DCSA, one of the following changes in status events occurs:

- An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
- An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
- An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence.
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age, student status or any similar circumstances, as provided under the HCSA or DCSA.

B. For individuals who participate in a HCSA, the following additional events will enable you to change your election:

- If you become entitled to Medicare or Medicaid, you may elect to revoke your HCSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
- If the FSA Plan Sponsor and/or Foothill-De Anza Community College District receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator and/or Foothill-De Anza Community College District may:
    - ♦ Change your election to provide coverage for that child, if the order requires you to provide coverage for the child under the HCSA, or
    - ♦ Permit you to cancel your child's coverage under the HCSA, if the order requires your former spouse to provide coverage.

C. For individuals who participate in a DCSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider.
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify Foothill-De Anza Community College District within 31 days of above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your HCSA election). As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.

Changes in contribution amounts made during the Plan year are effective as of the first of the month following the date that you timely notify Foothill-De Anza Community College District of the change in status.

HEALTH CARE SPENDING ACCOUNT

Eligible Health Care Expenses

To be eligible for reimbursement from your HCSA, the health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body;.
- Incurred while you are participating in the HCSA.
- Incurred during the Plan year.

Please note
Any reimbursement you receive through your HCSA can not be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCSA. Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

A more comprehensive list of eligible expenses are available at **myuhc.com.** Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, or IRS website www.irs.gov. or by phone at 1-800-TAX-FORM (1-800-829-3676). However, there are certain expenses which are listed as deductible in IRS Publication 502, but which cannot be reimbursed by the HCSA because of IRS rules (e.g., insurance premiums).

Eligible Medical Expenses

- Copayments, Coinsurance and Deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization unless prohibited by law;

- Other qualified 213(d) medical expenses not covered by the underlying medical plan.

Eligible Vision Expenses

- Routine eye examinations;
- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.

Eligible Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses

- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

Eligible Prescription Drugs

- Copayments, Coinsurance and Deductible amounts;
- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers).
- Cost for allowable prescription drugs.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your HCSA cannot be claimed as deductions on your income tax return.

Qualified Reservist Distribution

In accordance with the "Heroes Earning Assistance and Relief Tax Act of 2008" ("HEART Act") a qualified reservist distribution (QRD) is permitted of all or part of any unused HCSA amounts if you are a reservist called to active duty provided that: (1) you are called up for a period of 180 days or more or for an indefinite period of time, and (2) the request for a distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the HCSA for that Plan year.

To receive a QRD of all or part of any unused HCSA amounts, you must give notice to Foothill-De Anza Community College District by contacting Human Resources as soon as you receive your orders or are called to active duty. For additional details on how to request a qualified distribution, refer to Section, *Requesting a Reimbursement or Qualified Distribution from your Flexible Spending Account.*

DEPENDENT CARE SPENDING ACCOUNT

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses that can be reimbursed from your DCSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13; or
- A spouse of a participant, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year; or

- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you cannot use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.

REQUESTING A REIMBURSEMENT OR QUALIFIED DISTRIBUTION FROM YOUR FLEXIBLE SPENDING ACCOUNT

To be reimbursed from your HCSA and/or DCSA simply submit a reimbursement form to the Claims Administrator, called a request for withdrawal, for the Eligible Expenses that have been incurred. A request for withdrawal form is available from Foothill-De Anza Community College District or can be found on **www.myuhc.com**. However, if the automatic reimbursement (auto-rollover) feature as described under Section, *Automatic*

Reimbursement (Auto-Rollover) is turned "on" you will not have to submit a reimbursement form for certain HCSA expenses.

For reimbursement from your HCSA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental/vision plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical, dental and vision plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental/vision plans are made.

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

To receive a qualified reservist distribution (QRD), you must give notice to Foothill-De Anza Community College District by contacting Human Resources as soon as you receive your orders or are called to active duty and request a QRD. Foothill-De Anza Community College District will notify the Plan Administrator (if other than Foothill-De Anza Community College District) of the request for a QRD.

The amount available as a QRD will be the amount contributed to the HCSA as of the date of the QRD request, less any HCSA reimbursements received as of that date.

Once your Plan Administrator has determined your eligibility for a QRD, you will see your qualified distribution included as part of your paycheck, subject to taxation, within 60 days of the request.

You should call the Plan Administrator if you have questions about your rights to receive a QRD under the Plan.

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from a Flexible Spending Account. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account termed. In addition, expenses which are incurred during one Plan year cannot be reimbursed from funds contributed to your HCSA or DCSA during another Plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as daily. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least $50, except for reimbursement with respect to the last month of the Plan year. Amounts below $50 will be accumulated and processed with future payments. However, if the automatic reimbursement (auto-rollover) feature as described under Section, *Automatic Reimbursement (Auto-Rollover)* is turned "on" you will not have to submit a reimbursement form for certain HCSA expenses.

If you have established a HCSA, your total annual contribution amount is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

Requests for withdrawal will be accepted and processed through September 30 of the following year for expenses incurred during the Plan year. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or end of the Plan year] following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account termed. Any such Eligible Dependent Care expenses must be submitted on or before September 30 of the Plan year following your termination.

In accordance with IRS regulations, amounts contributed to your HCSA or DCSA during the Plan year but remaining in your account at the end of the processing period (September 30 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited.

Important
Myuhc.com includes many features such as the options to:
- View Explanation of Benefits/Health Statements
- Utilize a savings calculator for FSA
- View your FSA summary page detailing contributions and amount left in your FSA
- View your FSA Claims Summary including claim transaction details

Automatic Reimbursement (Auto-Rollover)

Your employer has elected to have Eligible Expenses for medical, pharmacy, dental and vision claims which are not covered under your UnitedHealthcare administered plans automatically submitted to your HCSA for reimbursement. This eliminates extra paperwork and makes it more convenient for you to use your HCSA. Automatic Reimbursement (Auto-rollover) is turned "on" at the start of the Plan year. You can turn automatic reimbursement (auto-rollover) of claims "off" or back "on" by going on to **www.myuhc.com**. All claims must still be verified and UnitedHealthcare may request additional substantiation.

However, if you have coverage administered through another carrier, the automatic reimbursement (auto-rollover) feature does not apply. Further, the automatic reimbursement (auto-rollover) feature does not apply to your domestic partner covered under your employer's group health plan, unless your domestic partner is your federal tax dependent for health coverage purposes, as defined under Section 105(b) of the IRS Code. An FSA withdrawal request must be submitted for any other types of expenses such as dependent care expenses and any health expenses not submitted to your health benefits carrier.

A Qualified Reservist Distribution will be distributed in accordance with any Plan year grace period.

CLAIMS PROCEDURES

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. UnitedHealthcare will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

UnitedHealthcare – Appeals
Attn Appeals
P.O. Box 981512
El Paso, TX 79998-1512

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Foothill-De Anza Community College District within 60 days from receipt of the first level appeal. Foothill-De Anza Community College District must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Foothill-De Anza Community College District will review all claims in accordance with the rules established by the U.S. Department of Labor. Foothill-De Anza Community College District's decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Foothill-De Anza Community College District must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date your employment with the Company ends.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.
- The date you retire, unless the plan is available for retired persons and you are eligible for the plan.

Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan year of employment termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before September 30 of the next Plan year.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Care Spending Account Plan. You should call Foothill-De Anza Community College District to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

Optional Continuation Coverage Under Your Health Care Spending Account (COBRA)

This optional continuation coverage only applies if it has been made available by Foothill-De Anza Community College District. Foothill-De Anza Community College District may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Ask Foothill-De Anza Community College District to find out if and how this continuation coverage and continuation coverage under USERRA described below applies.

In no event will UnitedHealthcare be obligated to provide continuation coverage to a participant if Foothill-De Anza Community College District or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying UnitedHealthcare in a timely manner of the participant's election of continuation coverage.

In general, COBRA continuation coverage must be offered with respect to a participant's HCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the Plan year in which the qualifying event occurs and coverage cannot be continued into the next Plan year. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by Foothill-De Anza Community College District on a uniform and consistent basis plus a 2% administrative fee or other cost as permitted by law.

Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the HCSA. If an employee 's Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the HCSA.

An employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the employee's absence from work; or
- the day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues the HCSA, if the employee returns to a position of employment, the employee's HCSA and that of the employee's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue the HCSA under USERRA.

UnitedHealthcare is not Foothill-De Anza Community College District's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

Dependent Care Spending Account

You may submit claims for the Eligible Expenses you have incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date, against what is in your DCSA balance at the time of termination. Any such claims must be submitted on or before September 30 of the Plan year following your termination.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Please note
The DCSA is not subject to ERISA. Only the HCSA is subject to ERISA.

Claims Administrator:

The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

UnitedHealthcare Insurance Company
Attn: Claims
185 Asylum Street
Hartford, CT 06103-3408

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Foothill-De Anza Community College District, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

SUMMARY OF MATERIAL MODIFICATIONS

A Summary Plan Description (SPD) was published effective July 1, 2010. The following are modifications and clarifications that are effective January 1, 2011 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

Section: HEALTH CARE SPENDING ACCOUNT	
Under Heading:	**The Following Should be Noted:**
Eligible Health Care Expenses	**Replace the first bullet in the first paragraph from the list with the following.** ■ Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code, for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.
Eligible Health Care Expenses	**Replace the third paragraph with the following.** A more comprehensive list of Eligible Expenses are available at **www.myuhc.com**. Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, IRS website **www.irs.gov** or by phone at 1-800-TAX-FORM (1-800-829-3676). However, there are certain exceptions, e.g. over-the-counter medicine or drugs prescribed by a health care provider may be reimbursable from your HCSA, but insurance premiums are not.
Eligible Health Care Expenses	**Remove the following bullet from the list in the third paragraph.** **Over-the-Counter Medications** ■ Over the counter non-prescription drugs and

	medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers).
Ineligible Expenses	**Add the following bullet to the list.** ■ Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider.