Summary Plan Description
Flexible Spending Accounts

Restated January 1, 2021

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About This Booklet

This booklet highlights the benefits available under the Scripps Flexible Spending Accounts effective January 1, 2021. This booklet is available on the Scripps Employee Portal. When used in this Summary Plan Description, "Scripps" shall mean Scripps Health, Inc.

Flexible spending accounts (FSAs) let you set aside pretax dollars to pay for eligible health care and dependent care expenses. There are two separate accounts you may choose to participate in — one for health care and one for dependent care expenses. You can sign up for:

- the Health Care FSA
- the Dependent Care FSA
- both the Health Care and Dependent Care FSAs

Participation is completely voluntary; it is up to you to decide which FSA (if any) meets your needs. Only employees may enroll in the Health Care and Dependent Care FSAs, but the FSAs can be used to reimburse your qualifying dependents' eligible expenses, as well as your own.

Important note - A registered domestic partner is not usually considered a tax-qualified dependent. Unless your registered domestic partner is your tax-qualified dependent, his or her expenses are not eligible for reimbursement under the Health Care FSA.

How the Accounts Work

You decide how much you want to set aside for eligible health care and/or dependent care expenses incurred during the calendar year. You make a separate annual election for each account. Regular amounts are deducted pre-tax each payday from your gross wages and deposited to your spending account(s). Reimbursements are issued to you from your spending account when you submit a properly documented claim to our Claims Administrator, HealthComp.

You can only claim reimbursement for expenses that you and your eligible dependents "incur" during the applicable plan year and while you are a participant in the flexible spending accounts. An expense is "incurred" when the services related to that expense are provided-not when you are billed for or pay for those services. If you are hired during the year or begin participating due to a qualified status change, only those services incurred after the date you start contributing to your flexible spending accounts are eligible for reimbursement.

Eligibility

As a Scripps employee, you are eligible to participate if you meet one of the following conditions:

- You are a full-time benefit-eligible employee regularly scheduled to work at least 60 hours per pay period.

- You are a part-time benefit-eligible employee regularly scheduled to work at least 40 hours per pay period for 8-hour and 10-hour shift employees or 36 hours per pay period for 12-hour shift employees.

How to Enroll

Enrolling is easy and available to new hires, newly benefits eligible employees and during a qualified family status change by accessing the enrollment system (https://benefits.scripps.org) from work or home. Your completed enrollment authorizes Scripps to deposit a portion of your earnings into your FSA(s) before taxes are deducted.

The IRS requires that your FSA elections stay in effect throughout the full Plan year (January 1 – December 31). Once made, you cannot change your election during the year, unless you experience a "qualified family status change" (see *Making Changes*).

New Employees

If you are a new employee, you must complete your benefits enrollment prior to your benefit effective date (first of the month following 60 days of employment). New employees are eligible for benefits the first day of the month following 60 days of employment in a benefit-eligible position.

Newly appointed or hired department directors and above, fellows, and residents are eligible for benefits from their date of hire and must enroll within 31 days from their date of hire.

Open Enrollment

Open enrollment is your annual opportunity to enroll or make changes to your benefit elections. The elections you make will be in effect for the following calendar year.

According to IRS Regulations, you must enroll each plan year (January 1 – December 31) in the health care spending account and/or dependent care spending account, as contribution amounts are not carried forward from one plan year to the next.

When Participation Begins

New Employees

For a newly-hired (or newly eligible) employee, participation begins on the first day of the month following 60 days of your employment in a benefit-eligible position. For a newly appointed or hired department director and above, fellow or resident, participation begins on your date of hire. You must complete the enrollment process timely, in order to participate.

Open Enrollment

Your annual election will go into effect on January 1.

Making Changes

The IRS requires that your FSA elections stay in effect throughout the full plan year (January 1 – December 31). Once made, you cannot change your election during the year, unless you experience a "qualified family status change." As explained below, any change in your election must be "consistent"(under IRS rules) with the relevant status change.

Defining a Family Status Change

The following are examples of qualified status changes for the FSA:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Termination of your spouse's employment
- Commencement of your spouse's employment
- Transition from part-time to full-time work, or from full-time to part-time work
- An unpaid leave of absence
- Change in provider or cost for Dependent Care FSA

If You Have a Qualified Status Change

You have 31 days from the qualifying event to change your Health Care and/or Dependent Care FSA election. **The change in your FSA election must be due to, and consistent with, the change in your family status.** (For example, if you have a child and cover the baby under your employer Medical Plan, you could increase the amount you are contributing to your Health Care FSA, but you could not stop your FSA contributions.) You should contact the HR Service Center immediately after the change takes place, to make sure you allow yourself enough time to take the appropriate action. The HR Service Center will explain the procedure to you.

If you do not report the qualified status change within the 31 day period, you will not be allowed to make the change until the next annual open enrollment period.

If You Take a Leave of Absence

Paid Leave of Absence

Your participation in a FSA(s) will not be affected if you are granted a paid leave of absence. Payroll deductions will continue, and you can still use your FSA(s) to reimburse yourself for eligible expenses.

Unpaid Leave of Absence – Health Care FSA

While on an unpaid leave of absence, you can in certain circumstances continue your Health Care FSA through COBRA election by making payments on an after-tax basis (contact your Benefits Department for details). If no COBRA coverage is elected, you will be eligible only for reimbursements for claims incurred before the effective date of your unpaid leave or the date you stopped making contributions, whichever is later.

If you did not elect to continue participating in the Health Care FSA while you were on an unpaid leave of absence, you may elect to participate when you return to active status. The qualified status change must be created within 31 days of your return from the unpaid leave of absence.

Unpaid Leave of Absence – Dependent Care FSA

If you are on an unpaid leave of absence, your contributions and participation in the Dependent Care FSA will end. You can continue to be reimbursed from your Dependent Care FSA for eligible expenses you incurred while you were actively at work; you will ***not*** be reimbursed for expenses incurred while

on unpaid leave. Any balance in your account from contributions made before your leave can be used for claims incurred upon your return to work.

When you return from an unpaid leave, it is considered a qualified status change and you may elect to participate in the Dependent Care FSA so long as you complete the family status change within 31 days of your return to work.

When Your Employment Ends

Health Care FSA

If you terminate during the year, you have two choices for your Health Care FSA:

1. You can close your account, in which case you will have until March 31st of the next year to submit claims for expenses incurred before your termination of employment date; or
2. You can continue your contributions on an after-tax basis by electing COBRA coverage. [See *Continued Participation in the Health Care FSA COBRA* for more information.] In this case, you can still claim reimbursements from your account for expenses incurred after you terminate, through the end of the year, provided you continue your FSA participation by making after-tax contributions.

Dependent Care FSA

If you terminate employment during the year, your contributions to your Dependent Care FSA will end. However, you can still be reimbursed for eligible expenses you incur through your last day worked. You have until March 31st of the following year to submit claims.

If You Are Rehired

If you terminate employment and are rehired more than 30 days after employment terminated but within twelve months, it will be considered a family status change. Upon your return to work you may re-enroll in a FSA(s) or have your prior elections reinstated, or increase your annual FSA contribution, up to the maximum limit.

Continued Participation in the Health Care FSA (COBRA)

Under some circumstances, you and/or your eligible dependent(s) can still participate in the Health Care FSA even after your coverage ends.

This continued coverage is available if your coverage ends because:

- Your employment terminates for any reason other than gross misconduct;
- Your scheduled work hours are reduced;
- You retire;
- You divorce or legally separate; or
- You die.

This extended coverage is provided through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and **applies to the Health Care FSA only, not to the Dependent Care FSA**.

You can elect to continue your participation in the Health Care Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Care Flexible Spending Account if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount to provide this benefit.

Losing Continued Coverage

Continued participation will end prior to year-end if the Health Care FSA is discontinued, or if you do not make your contributions on time.

Summary of Benefits

A Flexible Spending Account (FSA) allows you to set aside a portion of your salary on a pre-tax basis in a special account. You can then use the money in your account(s) to reimburse yourself for qualified health care and/or dependent care expenses. Your taxable salary is reduced by the amount you set aside in your account(s), so you pay lower income taxes and Social Security taxes.

Participation in a FSA(s) is voluntary. You decide whether you would like to participate and how much money you would like to set aside, based on the minimums and maximums shown below.

Contribution	Health Care Account	Dependent Care Account
Annual Maximum	$2,750	$5,000
Annual Minimum	$120	$120

How the Flexible Spending Account Works

You decide how much you want to set aside for eligible health care and/or dependent care expenses, incurred during the calendar year. You make a separate annual election for each account. Regular amounts are deducted each payday from your gross wages and deposited to your spending account(s). Reimbursements are issued to you from your spending account when you submit a documented claim to HealthComp, the third party administrator.

You can only claim reimbursement for expenses that you and your eligible dependents incur while you are a participant in the flexible spending accounts. If you are hired during the year or begin participating due to a qualified status change, only those services incurred after the date you start contributing to your flexible spending accounts, are eligible for reimbursement.

How Much You Can Contribute

You can contribute from $120 to $2,750 to your Health Care FSA each year, and you can contribute from $120 to $5,000 a year to your Dependent Care FSA ($2,500 if married and filing separately).

Carefully calculate the amount you contribute to your Flexible Spending Account(s). The IRS imposes a "use it or lose it" rule on FSA plans; you forfeit any money that remains in your account after reimbursement of your eligible expenses for the year. See *Limits and Restrictions* for more information.

Limits and Restrictions

To preserve the favorable tax treatment of your contributions, there are several important limitations that you should understand before participating in the FSA(s).

- A FSA is what is known as a "use it or lose it" arrangement, which means if you do not spend all of the money in your account on qualifying expenses, you lose the remaining balance. You must decide your annual pre-tax contribution to your FSA ***before*** each year begins. Once you decide your contribution amount, you cannot change it during the year unless you experience a qualified family status change; therefore, you should plan to contribute only as much as you expect to spend in the current (if new hire) or upcoming year.

- Having a **Health Care FSA** limits your tax deductions (on your tax return) for healthcare expenses. However, keep in mind that you can deduct unreimbursed healthcare expenses from your federal income tax only if they exceed the threshold established by the Internal Revenue Service.

- To be eligible for reimbursement from the **Health Care FSA**, the expenses must be for you, your child or a tax-qualified dependent (e.g., your child under age 26).. Some of the dependents you cover under your medical plan may not be tax-qualified dependents (for example: **a registered domestic partner is not usually considered a tax-qualified dependent. Unless your registered domestic partner is your tax-qualified dependent, his or her expenses are not eligible for reimbursement under the Health Care FSA.**).

- Having a **Dependent Care FSA** limits the tax credits you may be able to take for dependent care expenses. You can use both the Dependent Care FSA and tax credit, provided you do not claim the same expenses for both. However, federal regulations require that your dependent care tax credit be reduced dollar for dollar by whatever you put into your FSA.

- You should ask your tax advisor to help you choose the right alternative for your tax bracket.

- You cannot transfer funds between the Health Care and Dependent Care FSAs.

- You cannot carry over any unclaimed Dependent Care FSA balances from one year to the next. Any funds remaining in your Dependent Care FSA on December 31 will be forfeited unless they are used to cover expenses incurred during that calendar year and HealthComp receives your claim for reimbursement by the following March 31st.

Additional Limits on Dependent Care FSA Contributions

If Your Spouse Also Contributes to a Dependent Care FSA

The IRS sets additional limits on your contributions if you are married and your spouse has a Dependent Care FSA through his or her employer:

- You are limited to a **combined** Dependent Care FSA contribution of $5,000 in a calendar year. This limit applies whether you have one or more dependents receiving care.
- The most you can contribute is $2,500 a year, if you file **separate** federal income tax returns.

If Your Spouse Is Either Disabled or a Full-Time Student

The IRS considers your spouse's earnings to be $250 a month if you have one eligible dependent, and $500 if you have more than one eligible dependent.

How Participating in the FSA(s) Affects Taxes and Other Benefits

Establishing a FSA can also affect your tax strategy when you file your income tax return. You should consult with a tax advisor ***before*** signing up for a FSA(s) – you cannot change your election once you have made it, unless you have a qualified family status change (as explained in *Making Changes*).

The Tax Advantages

The Internal Revenue Code Section 125 allows your employer to take the money you direct to your FSA(s) out of your pay before federal income, state income, and Social Security (FICA) taxes are deducted. In turn, your taxable income is lower, and you pay less federal, state, and FICA taxes.

Any qualifying reimbursements you receive from your FSA(s) are free from federal tax as long as you have not taken (or do not intend to take) a tax deduction or credit for related expenses when you file your federal tax return.

Impact on Other Benefits

Employer-Sponsored Benefits

While you are "reducing" your pay for tax purposes, your pay-related benefits (for example, any employer-sponsored life and disability insurance, and retirement benefits) are not reduced. Your benefits from these plans will be based on your compensation before any amounts are deducted.

Social Security

Since your Social Security (FICA) taxes are based on your reduced pay, your future Social Security benefits may be lower.

Your Flexible Spending Account Statements

The Explanation of Benefits (EOB) that HealthComp issues with each reimbursement is also a good source of information. The EOB details the amount reimbursed and your current balance.

You can also access information about your FSA account status 24 hours a day, 7 days a week by registering and logging in to HCOnline.

Your Health Care FSA

The Health Care FSA lets you pay many of your otherwise unreimbursed healthcare expenses with tax-free dollars. Since not every healthcare expense you incur is eligible for reimbursement through your FSA, it is important to know which are reimbursable and which are not.

If an expense is covered under any other plan(s), you cannot submit it for reimbursement under your Health Care FSA, until the expense has been considered by the other plan(s).

Eligible Health Care Expenses

You can use your Health Care FSA to reimbursement yourself expenses that are considered "medical care" under Section 213(d) of the Internal Revenue Code, as long as the expenses are not reimbursed by any healthcare plan. Tax rules change, so you should check with your tax advisor about the eligibility of specific expenses. You can get additional information about eligible healthcare expenses from IRS Publication 502, "Medical and Dental Expenses," which is available from your local IRS office and the IRS website at http://www.irs.gov/. For a list of eligible expenses, go to MyScrippsHealthPlan.com. Note ,however, that unlike Publication 502, qualifying health care expenses under the Plan must be "incurred" during the applicable Plan year while you are a participant.

Eligible Healthcare expenses include:

- Acupuncture
- Auto equipment such as special hand controls to assist the physically disabled
- Braille books and magazines
- Crutches
- Dental treatment
- Eye exams, lenses, frames and contact lenses
- Fertility enhancement procedures such as in vitro fertilization (including temporary storage of eggs or sperm), and infertility surgery, including an operation to reverse a prior sterilization procedure
- Guide dog or other animal used by a visually-impaired or hearing-impaired person
- Healthcare and pharmacy co-payment, deductible and coinsurance amounts
- Healthcare expenses that are above the customary charge or healthcare plan maximums
- Hearing exams and hearing aids
- Laser eye surgery
- Lead-based paint removal to protect a child who has, or who has had, lead paint poisoning from continued exposure
- Legal fees directly related to committing a mentally ill person
- Lodging while you receive medical care away from home. Care must be provided by a doctor in a licensed hospital or treatment facility, and the lodging must be primarily for, and essential to, medical care
- Long term care services required by a chronically ill person, if provided in accordance with a plan of care prescribed by a licensed health care practitioner
- Medical information plan that maintains your medical information so it can be retrieved from a medical data bank for your medical care

- Medical services and supplies not covered by your medical plan
- Osteopathic services
- Certain over-the-counter medications
- Smoking cessation programs
- Specialized equipment for the disabled, including:
    a. Cost and repair of special telephone equipment that allows a hearing-impaired person to communicate over a regular telephone, and
    b. Equipment that displays the audio part of television programs as subtitles for hearing-impaired people.

If you have any questions about what is considered an eligible expense under the Health Care FSA, you may call HealthComp Member Services at 1-xxx-xxx-xxxx. You may also visit the IRS website at http://www.irs.gov/.

Ineligible Healthcare Expenses

Just as important as understanding what is eligible for reimbursement through your Health Care FSA is knowing what is not generally eligible, including the following:

- Expenses for which you have already been reimbursed by other healthcare plans (including Medicare, Medicaid, and Scripps' or any other Medical, Dental, or Vision Plan)
- Expenses incurred by anyone other than you or your qualified dependents
- Expenses that are not deductible on your federal income tax return
- Babysitting, child care and nursing services for a normal, healthy baby. This includes the cost of a licensed practical nurse (L.P.N.) to care for a normal and healthy newborn.
- Controlled substances
- Cosmetic dental work
- Cosmetic surgery (any procedure to improve the patient's appearance that does not meaningfully promote the proper function of the body, or prevent or treat illness or disease)
- Custodial care in an institution
- Diaper service
- Electrolysis
- Funeral and burial expenses
- Healthcare plan contributions, including those for Medicare, your spouse's employer's plan, COBRA, or any other private coverage
- Health club dues
- Household help, even if such help is recommended by a physician
- Illegal medical services or supplies
- Maternity clothing
- Medical savings account (MSA) contributions
- Over-the-counter health aids or medication, not for medical care (example: vitamins, weight loss aids)
- Nutritional supplements
- Personal use items, unless the item is used primarily to prevent or alleviate a physical or mental defect or illness
- Prescription drugs for cosmetic purposes

- Weight-loss programs not prescribed by a doctor
- Special schooling for a child, even if the child may benefit from the course of study or disciplinary methods
- Transportation to and from work, even if a physical condition requires special means of transportation
- Up-front patient administration fees paid to a physician's practice
- Vitamins or minerals taken for general health purposes

Your Dependent Care FSA

You can use the Dependent Care FSA to reimburse yourself with tax-free funds for certain dependent care expenses incurred to enable you to work.

Eligibility

If you are married, you may participate in the Dependent Care FSA only if your spouse:

- Works full-time or part-time; or
- Is actively looking for work; and
- Is a full-time student for at least five months of the year; or is incapable of caring for himself or herself or for the dependent.

Who Qualifies as a Dependent?

You can use your Dependent Care FSA to cover the expenses of dependents who are defined as:

- Children who are under age 13 when the care is provided and for whom you can claim an exemption on your federal income tax return;
- Your spouse who is mentally or physically incapable of self-care; and
- Your dependent who is physically or mentally incapable of self-care, and for whom you can claim an exemption (or could claim as a dependent if he or she did not have a gross annual income of $3,000 or more).

You can use the Dependent Care FSA for a qualifying child or relative. Eligible daycare expenses may be reimbursed for:

- Your "qualifying child" (including a stepchild, foster child, child placed for adoption, or younger brother or sister) under age 13 who has the same principal residence as you for more than half the year and does not provide more than half of his or her own support during the calendar year; or

- Your qualifying child (as defined above) of any age, spouse, or other dependent who receives over half of his or her support from you (e.g., your disabled elderly parent), who is physically or mentally incapable of caring for himself or herself and has the same principal place of residence as you for more than half of the year. To reimburse daycare received outside of your home, your disabled dependent must spend at least 8 hours per day in your home. Special rules apply for divorced or separated parents with dependent children. Generally, your child must be your dependent for whom you can claim an income tax exemption. In other words, you must have legal custody of your child for over half of the year for your daycare expenses to be reimbursed through the Dependent Care FSA.

Eligible Dependent Care Expenses

The Dependent Care FSA is strictly monitored by the IRS, and only those expenses that comply with Section 129 of the Internal Revenue Code of 1986 are covered. Keep in mind that the expenses must be work-related to qualify as eligible expenses. The IRS considers expenses "work-related" only if they meet ***both*** of the following rules:

- They allow you (and your spouse) to work or look for work; and
- They are for the care of a qualified person.

You can pay the following work-related expenses through your Dependent Care FSA:

- Wages paid to a baby sitter, unless you or your spouse claims the sitter as a dependent.
- Care can be provided in, or outside of, your home.
- Services of a Dependent Care Center (such as a daycare center or nursery school) if the facility provides care for more than six individuals (other than those who reside there), receives a fee, payment or grant for providing its services, and complies with all applicable state and local laws and regulations.
- Cost for adult care at facilities away from home, such as family daycare centers, as long as your dependent spends at least 8 hours at home.
- Wages paid to a housekeeper for providing care to an eligible dependent.
- Household services, including the cost to perform ordinary services needed to run your home which are at least partly for the care of a qualifying individual, are covered as long as the person providing the services is not your dependent under age 19 or anyone you or your spouse claim as a dependent for tax purposes.

If you have any questions about what is considered an eligible expense under the Dependent Care FSA, you may call HealthComp Member Services at 1-877-552-7247. You may also visit the IRS website at http://www.irs.gov/.

Ineligible Dependent Care Expenses

You cannot use your Dependent Care FSA to reimburse yourself for services that:

- Allow you to participate in leisure-time activities;
- Allow you to attend school part-time;
- Enable you to attend educational programs, meetings or seminars; or
- Are primarily medical in nature (such as in-house nursing care).

Claiming Reimbursement

When You Can File Claims

Expenses must have been incurred during the Plan Year (January 1 – December 31). An expense is incurred on the date the service is provided.

You may not be reimbursed for any expenses incurred before the plan becomes effective or for any expenses incurred after the close of the plan year, or after a separation from service (except for continuation coverage under COBRA).

For example, orthodontia payments, even if billed, will not be considered a healthcare expense under this plan until after the service has been provided. Orthodontia expenses will be reimbursed by this plan only if the expense has been incurred within the plan year. Lump sum payments or services paid in advance of the service being rendered are not reimbursable under this plan.

Orthodontia expenses may also be reimbursed if a reasonable payment schedule or service contract with expense detail is provided with the claim. A reasonable payment schedule or service contract must be prepared by your dentist and must illustrate what orthodontia services are to be provided, when the services are planned to be provided (identified by month and year), and the corresponding projected expenses associated with those services. An example of a reasonable payment schedule or service contract may include a down payment for initial services provided, and subsequent proportional payments in anticipation of follow-up services. Lump sum payments or services paid in advance of the services being rendered are not reimbursable under this plan in absence of a reasonable payment schedule or service contract.

Flex Payment Card

If you enroll in a health care spending account, you can request a Flex Payment Card from HealthComp. The card works similar to a debit card; however, it is limited to qualified expenses at pharmacies, physicians' offices, dental and vision care offices and some hospitals and other medical care providers. You can also use the card at pharmacies and other multi-use stores that have an IRS qualified system that allows the use of the card only for eligible items. When you use your card for qualified purchases, the money is instantly deducted from your health care spending account (all receipts *must* be submitted to HealthComp within 60 days of your transaction date). Failure to submit receipts on time could result in the deactivation of your debit card. If your provider does not accept the Flex Payment Card, you can pay your provider directly, and submit a receipt with a claim form for reimbursement.

Important note - A registered domestic partner is not usually considered a tax-qualified dependent. Unless your registered domestic partner is your tax-qualified dependent, his or her expenses are not eligible for reimbursement under the Health Care FSA.

Documenting Your Claim

Healthcare Expenses

When you submit a claim for reimbursement from your Health Care FSA, you must provide a copy of:

- The Explanation of Benefits (EOB) you received from your healthcare plan showing how much, if any, of your claim was paid; or
- Itemized bills from suppliers for expenses not covered by any healthcare plan. The itemized bill should include the following information:
    - Patient name;
    - Name of provider
    - Service or service provided;
    - Charge; and
    - Date of service

Your claim will not be adjudicated if the required information is not provided.

Dependent Care Expenses

To file a claim for reimbursement, complete the "FSA / Limited Purpose FSA" claim form. Copies of the form are available on HCOnline or from the HR Service Center. You must provide the following information in your claim submission:

- Dependent's name;
- Provider's name, address and tax ID (or Social Security) number;
- The cost, nature and place of the service(s) performed;
- Proof of payment; and
- An indication of whether the provider is related to you and, if so, how (if the provider is your child, you must also include the child's age)

You may ask your dependent care provider to sign the claim form as verification of payment. Detailed bills or receipts are also considered acceptable documentation for dependent care expenses.

You are also required to report your provider's taxpayer identification number or Social Security number when you file your tax return.

Reimbursement

HealthComp processes FSA claims as they are received, and issues FSA claim payments.

You can be reimbursed through your Healthcare FSA for qualifying healthcare expenses up to the annual amount you elected at enrollment even if all of it has not been deducted from your paychecks.
You can be reimbursed for dependent care expenses only up to the amount in your Dependent Care FSA when you file a claim. Any unpaid amounts still due you will be processed in the next claim cycle when (and if) you have sufficient funds in your Dependent Care FSA to cover them.

You will receive an Explanation of Benefits (EOB), which reflects the status of your account, each time you submit a request for reimbursement (for example, the amount of the claim, how much of it is eligible for reimbursement, what has been paid to date from your FSA, any amounts still payable, and any balance remaining in your Account).

Contact information for claim submission and customer service for HealthComp is as follows:

HealthComp Administrators
PO Box 45018
Fresno, CA 93718-5018
Fax: 1-559-499-2464
Customer Service: 1-877-552-7247

How to Appeal a Denied Claim

If your claim is entirely or partially denied the reason(s) for the denial will appear on the Explanation of Payment (EOP) you receive from HealthComp. Your written appeal should be submitted to:

HealthComp Administrators
PO Box 45018
Fresno, CA 93718-5018

Health Care FSA Claims

If you think your claim has been wrongfully denied, you have 180 days after receiving the written denial to request a review. Your request for a review, called an appeal, must be submitted to HealthComp in writing. Be sure to explain why you think you are entitled to reimbursement, and attach any documentation that will support your claim. HealthComp must respond to your written request for a review within 30 days of receiving it, explaining the reasons for their decision in clear, understandable language. HealthComp's appeal determination decision is final and binding. You can also follow this procedure if you do not receive any response to your claim within 30 days after you have initially filed it with HealthComp.

Dependent Care FSA Claims

If you think your claim has been wrongfully denied, you have 60 days after receiving the written denial to request a review. Your request for a review, called an appeal, must be submitted to HealthComp in writing. Be sure to explain why you think you are entitled to reimbursement, and attach any documentation that will support your claim. HealthComp must respond to your written request for a review within 60 days of receiving it. If a longer response time is required, HealthComp will notify you. HealthComp's decision is final and binding. You can also follow this procedure if you do not receive any response to your claim within 90 days after you have initially filed it with HealthComp.

Plan Information

Your ERISA Rights: Health Care FSA

The Employee Retirement Income Security Act of 1974, known as ERISA, guarantees your rights as a Plan participant in the Health Care FSA. ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue healthcare coverage for yourself, spouse and/or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance with obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory; or

Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration U.S.
Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

General Information about the Plan

Plan Administrator:
Scripps Health, Inc.
4275 Campus Point Court
San Diego, CA 92131

Agent for Service of Legal Process:
Scripps Health, Inc.
Office of the General Counsel
10140 Campus Point Drive, CPA 415
San Diego, CA 92131
Employer Identification Number: 95-1684089

Plan Number: 505
Plan Year: Calendar Year

Type of Plan and Source of Payment of Benefits: Welfare. Benefits are paid solely from Scripps Health general assets.

Type of Administration

Administrative Services Contract with HealthComp

The Plan Administrator (and its delegatee, HealthComp) has full discretionary authority to interpret the Plan and determine all issues and matters related to the Plan (including, but not limited to whether, or to what extent, a claim is payable under the Plan). Any determination by Scripps or HealthComp relating to the Plan (including, but not limited to, the denial of any claim) shall be final and binding in the absence of clear and convincing evidence that such determination was arbitrary and capricious.

Amendment or Termination of the Plan

Scripps has the right to amend or terminate the Plan, in whole or in part, at any time by a written instrument signed or approved by a duly-authorized officer of Scripps. The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any non-forfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description covers the major features of the Flexible Spending Account program administered by HealthComp, effective January 1, 2021. The plan description has been designed to provide a clear and understandable summary of the Plan, and serves as the Summary Plan Description (SPD) required for plans subject to ERISA.