

STATE OF OREGON

Flexible Spending Account Summary Plan Description

Save more money by using pre-tax dollars to pay for out-of-pocket medical expenses and/or child care expenses for you, your spouse and any tax dependents.



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What is an FSA?

The simple answer is that a FSA (Flexible Spending Account) is a pre-tax spending account that allows you to save money on out-of-pocket medical or child care expenses for you, your spouse and any of your tax dependents.

What is an FSA and how does it work?

A Flexible Spending Account (FSA) is an employer-sponsored plan that lets you deduct dollars from your paycheck and put them into a special account that's protected from taxes. You can use these pre-tax dollars to pay for some of your out-of-pocket medical and/or child (or adult dependent) care expenses. The State of Oregon has contracted with ASIFlex to manage the Health Care FSA and Dependent Care Assistance Plan, process claims, and provide customer service for Public Employees Benefits Board (PEBB) enrollees.

FSA accounts are exempt from federal and state income taxes and Social Security (FICA) taxes. When you use the money in your account to pay for out-of-pocket health care expenses, you avoid paying taxes on those dollars. The more money you put into a Flexible Spending Account, the more tax you avoid. Depending on your tax bracket, you could save 25% or more on your out-of-pocket health care expenses.

However, the amount you put into an FSA will lower your income that your employer reports to the Social Security Administration. This means your Social Security benefits will be calculated based on your lower taxable earnings.

How does the FSA work?

When you enroll in the FSA plan, you estimate the amount of qualifying health care costs your family will have in a plan year. You have that amount deducted from your paychecks in equal amounts throughout the year.

After you enroll in an FSA, ASIFlex will send a confirmation of your enrollment and claim forms to your home address. As you incur eligible costs throughout the year, you can submit a claim form and documentation of your costs to ASIFlex (by toll-free fax or mail). ASIFlex will reimburse you with funds from your FSA account, avoiding taxes. You will receive an account summary after each claim and at the end of each quarter.

ASIFlex will only reimburse you for your costs for eligible purchases or services during the plan year (January 1 through December 31) and extended grace period (January 1 through March 15 following the end of the plan year, only if you are a participant on the last day of the plan year) while you are enrolled. Internal Revenue Service (IRS) rules state that if you don't use all of the money in the account by the end of the plan year, you will lose those funds.



Whom can I contact if I have questions?

PEBB has hired ASIFlex to administer the FSA program. Please contact ASIFlex with any questions or concerns.

Mailing Address:	ASIFlex PO Box 6044 Columbia, MO 65205
Customer Service:	1-800-659-3035 Monday - Friday 5 a.m. to 5 p.m. PST, Saturday 7 a.m. to 11 a.m. PST
Email:	asi@asiflex.com
Web site:	http://orpebb.asiflex.com

FREQUENTLY ASKED QUESTIONS

Q. WHO CAN PARTICIPATE IN THE FLEXIBLE SPENDING ACCOUNT?

An individual is eligible to participate in this Plan (the Health FSA Component and the DCAP Component) if the individual:

- is an employee of a PEBB Participating Employer, including state officials, in exempt, unclassified, classified, and management service positions who are expected to work at least 90 days; and
- works at least half-time or are in a position classified as a job share.

Once an Employee has met the Plan's eligibility requirements, an Employee may elect coverage effective the first day of the next calendar month.

The following classes of employees cannot participate in the State of Oregon PEBB Flexible Spending Account:

- Leased employees(as defined by §414(n) of the Code);
- Contract workers and independent contractors;
- Temporary employees and casual employees(Employees hired short-tem to meet specific needs of the Employer, as determined in the Employer's sole discretion); and
- Individuals paid by a temporary or other employment or staffing agency.

Q. WHY SHOULD I PARTICIPATE?

Paying for medical expenses through the Plan can save you as much as 25% - 40% in taxes on each dollar that you spend for your share of insurance deductibles, co-pays, or items not covered by insurance. In addition, the Dependent Care Assistance Program may save you more in taxes than the day-care tax credit (filed with your federal income tax return).

Q. IF I REDIRECT PART OF MY PAY, WON'T I MAKE LESS MONEY?

No. Your spendable income will increase by the amount of your tax savings.

Q. WHY SHOULD I PARTICIPATE IN THE HEALTH FSA IF I ALREADY HAVE MEDICAL INSURANCE?

The Health FSA offers a tax break on Medical Care Expenses NOT reimbursed by insurance. For example, the Health FSA covers expenses for office visits, eye exams, glasses, drugs, and medications used to treat medical conditions and hospital care not covered by Medical Insurance (e.g. co-payments).



Q. HOW MUCH DOES IT COST?

The State of Oregon pays all administrative costs.

Q. WHAT IS THE CATCH?

No catch. Congress approved FSAs in 1978; the Tax Reform Act of 1986 reaffirmed their legitimacy.

Q. HOW MUCH WILL BE DEDUCTED FROM MY SALARY FOR THE BENEFITS I SELECT?

Your per pay period deduction will be equal to your annual election amount, divided by the total number of pay periods you have in a given year. E.g. if your annual deduction amount is \$720, and you are paid once a month (12 times per year), your per pay period deduction will be \$720 divided by 12 pay periods, or \$60 per pay period. Please note that in this example, the \$60 will be deducted from your gross pay before taxes are calculated.

If you increase your election during the plan year due to a qualified status change (e.g. if you have a child and make a change in election amount), the increased amount will be available to you for expenses incurred on or after the effective date of the increase.

Q. WHEN CAN I MAKE A CHANGE IN MY ELECTION?

Generally, your elections under the Plans are irrevocable for the Plan Year. However, you may be able to change your election during certain circumstances described below.

You may change your election if you, your Spouse, or a Dependent experience an event listed below which results in a gain or loss of eligibility for coverage under the State of Oregon PEBB Flexible Spending Account, or a similar plan maintained by your Spouse's employer or one of your Dependent's employer and your desired election change corresponds with that gain or loss of coverage.

Events 1 - 5 apply to the Health FSA, and the Dependent Care Assistance Program. When these events occur, a change may be made to your election.

1. Your legal marital status changes through marriage, divorce, death, legal separation, or annulment.
2. Your number of Dependents changes because of birth, adoption (or placement for adoption), or death. If your child no longer qualifies for Dependent care because he or she turned 13, that is considered a loss of a Dependent under the Dependent Care Assistance Plan, but not under any of the other plans.
3. You, your Spouse or any of your Dependents have a change in employment status that affects eligibility under the State of Oregon PEBB Flexible Spending Account or a plan maintained by your Spouse or any Dependent's employer. If you terminate or take a leave of absence from State of Oregon, you must be gone at least 31 days for termination or leave of absence to qualify.
4. One of your Dependents satisfies or ceases to satisfy the requirements for coverage under the State of Oregon's Plan for unmarried Dependents due to attainment of age, student status, or any similar circumstances.
5. You, your Spouse, or one of your Dependents changes residence.

Events 6 - 8 apply to the Health FSA, but not the Dependent Care Assistance Program. When any of these events take place, you may change your election.

6. You are served with a judgment, decree or court order, including a Qualified Medical Child Support Order ("QMCSO") regarding coverage for a Dependent. If the order requires you to pay for medical expenses not paid by insurance for a Dependent child, then you may add or increase coverage under the Health Care Flexible Spending Account Plan. If the order requires that another person pay for medical expenses not paid by insurance for the Dependent child, then you may drop or reduce coverage under the Health Care Flexible Spending Account Plan.
7. If you, your Spouse, or a Dependent become entitled to and covered under Medicare or Medicaid, you may drop or reduce coverage under the Health Care Flexible Spending Account Plan.
8. If you, your Spouse, or a Dependent lose eligibility and coverage under Medicare or Medicaid, you may add or increase coverage under the Health Care Flexible Spending Account Plan.

Events 9 - 11 apply only to the Dependent Care Assistance Program. If any of the following events take place, you may change your election.

9. You may change your election to correspond with a change made under another employer-sponsored plan as long as the change made under the other plan was permitted by IRS regulations or was made for a period of coverage that is different from the State of Oregon PEBB Flexible Spending Account.
10. You change Dependent care providers (including school or other free provider). You may make a corresponding change to your Dependent Care Assistance Program and your future salary reductions if you change Dependent care providers.
11. You may make a corresponding change to your Dependent Care Assistance Program and your future salary reductions if your Dependent care provider who is not your relative changes your costs significantly. Note: A relative is any person who is a child, parent, stepchild, sibling, aunt, uncle, cousin, or in-law of the participant.

You must request and submit an employee update form to your agency within 60 days of the date of the qualifying event. If approved the election change becomes effective on the 1st of the month following the qualifying event or the submission of the appropriate forms to your agency whichever is later.

If you have questions call ASIFlex at (800) 659-3035.

Q. WHAT IF I'M ALREADY IN THE STATE OF OREGON PEBB FLEXIBLE SPENDING ACCOUNT?

Participation in the Health FSA and the Dependent Care Assistance Program terminates at the end of each Plan Year. You MUST re-enroll each year to continue your participation.

Q. WHEN DOES PARTICIPATION BEGIN?

After you satisfy the eligibility requirements described above, you become a Participant by completing an electronic enrollment or FSA Enrollment form (Election Form/Salary Reduction Agreement) and returning it to your agency within 60 days of your eligibility date. The effective date of your enrollment is the first of the month following your on line enrollment or submission of the appropriate forms.

During the Open Enrollment Period, the FSA Enrollment Form or enrollment on line is available. You must complete the electronic enrollment or the FSA Enrollment Form and return it to your agency within the period specified in the enrollment materials. Your coverage is effective the first day of the new plan year.

If you fail to complete, sign and return a FSA Enrollment Form or enroll on-line as required, you will be deemed to have elected cash and will not be able to elect any benefits under the Plan until the next Open Enrollment Period (unless a "Change in Election Event" occurs)

Q. WHAT IS THE "OPEN ENROLLMENT PERIOD" AND THE "PLAN YEAR"?

The Open Enrollment Period is a period prior to the beginning of the Plan Year that you have an opportunity to elect to participate under the Plan by filling out, signing and returning an FSA Enrollment form or enrolling on-line. You will be notified of the timing and duration of the Open Enrollment Period.

You may choose to enroll in one or more of the benefits offered or to receive your entire compensation in cash.

The Plan Year is the 12 months beginning on each January 1, and ending on December 31 of the same calendar year.

How to estimate your Flexible Spending Account contribution.

Step 1

Estimate your family's annual out-of-pocket medical expenses. You may include expenses for yourself, your opposite-sex spouse, or anyone who is a qualified tax dependent. (There are exceptions for the expenses of children of divorced parents. Please call ASIFlex at 1-800-659-3035 for more information.) When calculating your annual expenses, include predictable expenses only.

Due to the Federal Defense of Marriage Act (DOMA), expenses for same-sex domestic partners qualify only if they are a qualified tax dependent. In order for a same-sex domestic partner's out-of-pocket medical expenses to qualify for your FSA, he or she must meet the standards of the "qualifying relative" clause of IRC 152. To be considered a qualifying relative, a person must share the primary residence with the taxpayer, receive over half of his/her support from the taxpayer and be a U.S. citizen.

What expenses can be reimbursed by my FSA?

You can use your FSA to pay for medical, dental, and vision expenses not covered or reimbursed by your PEBB health plans. (See Section 213[d] of the Internal Revenue Code for qualifying medical care.) These expenses must be incurred by you or your eligible tax dependents during the plan year or grace period. The Internal Revenue Code defines incurred as when the services are provided that give rise to the expense, regardless of when they are billed or paid. (See exception for orthodontia below.) Please contact ASIFlex at asi@asiflex.com or 1-800-659-3035 if you have questions about particular expenses.

Below is a partial list of qualified expenses. Please refer to IRS Publication 502 for further details on qualifying expenses.

- Copays, deductibles, coinsurance & non-covered medical expenses
- Doctor's fees, dental fees, vision care, hearing expenses
- Prescription drugs
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Chiropractor's fees
- Over-the-counter drugs (legal) used to treat a medical condition
- Insulin
- Orthodontia/braces*
- Hearing aids, including batteries
- Transportation expenses related to illness
- Medical equipment
- Daycare expenses
- Babysitters
- Pre-school expenses.

*Orthodontic expenses are considered incurred when a monthly payment is due and paid.

You may submit claims for orthodontia:

- If you pay monthly throughout the expected period of orthodontic treatments, you can submit claims after each orthodontic treatment.
- If you pay the entire annual fee up front, you can claim lump sum reimbursements, as these payments are made to your provider.

To claim orthodontic down payments, you must include:

- A copy of the treatment contract and payment schedule.
- Proof of payment showing the date the braces were placed.

If you have questions on orthodontia expenses, please contact ASIFlex at 1-800-659-3035 before you enroll in the FSA plan.

What expenses cannot be reimbursed by my FSA?

This is a partial list of expenses that do not qualify:

- Cosmetic procedures (such as face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins)
- Clip-on or non-prescription sunglasses
- Warranties
- Toiletries
- Long-term care expenses
- Medicines, drugs, herbs, or vitamins for general health and not used to treat a medical condition
- Expenses that are merely beneficial to your general health (such as vacations)
- Health club dues
- Insurance premiums

For a more comprehensive list, please visit <http://orpebb.asiflex.com>.

Step 2

Enroll in the Flexible Spending Account. Divide the total amount you want to contribute to your FSA by the number of paychecks you expect to receive in 2009. See the separate open enrollment checklist for detailed instructions on how to enroll online during open enrollment.

If you are new to the Health FSA, underestimate your expenses the first year. Many people do not have a good handle on how much they are paying in out-of-pocket medical expenses until these expenses are actively tracked.

DCAP expenses are easier to estimate. Talk with your provider to insure that you know what your monthly expenses are going to be, and then plan accordingly. If you experience a rate change mid year, please check with your agency within 60 days of the change to see if you are eligible to make a change to your deduction amount.

Step 3

After you receive medical services or treatments, file a claim or use your optional Flex Debit Card to pay for these services. A medical expense is incurred when you or your covered family members receive services or treatments. After you receive the medical services or treatments and know how much you must pay, you may submit a claim for those expenses to ASIFlex, or use your Flex Debit Card to pay for these expenses. See "How to File a Claim or an Appeal" for how to file a claim. Extra claim forms are online at <http://orpebb.asiflex.com> or by contacting ASIFlex.

Please see the Flex Debit Card overview on the next page for detailed information about appropriate usage of the card.

Step 4

Receive reimbursement. ASIFlex will review your claim, and if approved, will send you reimbursement for your medical expenses the business day after ASIFlex receives the claim.

ASIFlex will reimburse your qualified expenses up to the approved amount of your claim or your remaining annual election, whichever is less. You may submit claims up to the total amount of your annual contribution, even if you have not yet contributed the full amount for the plan year. Your paycheck deductions will continue for the rest of the plan year.

Q. WHAT HAPPENS IF I HAVE MONEY LEFT IN MY ACCOUNT AFTER DECEMBER 31ST EACH YEAR?

If you have funds remaining in your Health FSA at the end of the Plan Year and you were a participant in the Health FSA on the last day of the Plan Year, a maximum of \$5,000.00 dollars of such unused funds from that account can be carried over to the Grace Period and used to reimburse eligible Medical Care Expenses incurred during the Grace Period. The Grace Period will begin immediately following the Plan Year and will run through March 15th following the end of the Plan Year, and allows you to incur expenses from January 1 through March 15 of the following year to access monies remaining from the previous plan year.

For example, Tom has \$250 remaining in his Health FSA on December 31, and no expenses left to submit. However, Tom knows that once the new plan year starts, he will have deductible expenses in January. January 30th, Tom's son breaks his leg and Tom has to pay \$300 in deductible expenses. Tom submits a claim for reimbursement through his Health FSA, and the first \$250 in expenses is applied to his remaining balance from the previous plan year, while the \$50 difference is applied to available funds from the new plan year.

The grace period is available to both Health FSA and DCAP participants, and participants are able to incur expenses through March 15th following the close of the previous plan year, to access any remaining funds. All expenses must be submitted by March 31st.

If you have funds remaining in your Health FSA or Dependent Care Assistance Program at the end of the Grace Period, that amount will be retained by State of Oregon to help offset Plan administrative expenses.

Q. ARE THERE ANY NEGATIVES THAT I SHOULD KNOW ABOUT?

Yes, because you are not paying Social Security tax on the portion of your income being redirected, your Social Security benefits may be slightly reduced. However, if you invest your tax savings, in many cases you would have more money available at retirement than the benefit you would have received from the amount not paid into Social Security

Expenses reimbursed by the Health Care Flexible Spending Account Plan may not be deducted on your individual income tax return. Likewise, expenses deducted on your income tax return may not be filed for reimbursement through your Health FSA.

Additionally, participation in the Dependent Care Assistance Plan is an alternative to taking a "Tax Credit" allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the "Tax Credit" or the Dependent Care Assistance Plan. The IRS will not allow you to receive two tax breaks on the same expenses.

Q. WHEN WILL MY PARTICIPATION IN THE PLAN END?

Your participation will end should you terminate employment with State of Oregon. This means you will no longer be able to make contributions to the Plan. Should you return to work within 30 days during the same Plan Year, your participation will be reinstated at the same election amount.

Should you return to work after 30 days during the same Plan Year, you may make a new election for the remainder of the Plan Year. Except as specified in the section on Coverage Continuation (COBRA) in the Health Care Flexible Spending Account Plan Summary, expenses incurred while you are not a participant will not qualify for reimbursement. You may continue to file for Dependent Care Expenses incurred during the Plan Year after the end of your participation in order to receive reimbursement for funds already contributed.

Your participation will also end at the end of the expiration of the Period of Coverage, if the Plan is terminated, or if you a file false or fraudulent claim for benefits.

Q. What happens if I have money left in my account after December 31st each year?

If you have funds remaining in your Health FSA at the end of the Plan Year and you were a participant in the Health FSA on the last day of the Plan Year, a maximum of \$5,000.00 dollars of such unused funds from that account can be carried over to the Grace Period and used to reimburse eligible Medical Care Expenses incurred during the Grace Period. The Grace Period will begin immediately following the Plan Year and will run through March 15th following the end of the Plan Year, and allows you to incur expenses from January 1 through March 15 of the following year to access monies remaining from the previous plan year.

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Your participation will also end at the end of the expiration of the Period of Coverage, if the Plan is terminated, or if you a file false or fraudulent claim for benefits.

Q. WHAT IF I GO ON PROTECTED LEAVE, (FMLA, ACTIVE MILITARY DUTY LEAVE OR CBIW) DURING THE PLAN YEAR?

If you go on FMLA then you can maintain your Health FSA but not your Dependent Care Assistance Plan. Please refer to the FMLA paragraph in the Health Care Flexible Spending Account Summary. If your Health FSA or DCAP coverage ceases while you are in protected leave for any reason (including for non-payment of premiums), then you may re-enter the Health FSA or DCAP Account upon return from the leave on the same basis as you were participating prior to the leave. You will be entitled to elect whether to be reinstated in the Health FSA or DCAP Accounts at the same coverage level as in effect before the protected leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of leave during which you did not pay premiums. If you elect a coverage level that is reduced pro-rata for the period of protected leave, the amount withheld from your Compensation on a payroll-by-payroll basis for the purpose of paying for your Health FSA or Account will be equal to the amount withheld prior to the period of the protected leave.

Q. HOW CAN I GET ANSWERS TO OTHER QUESTIONS?

Check ASIFlex's website <http://orpebb.asiflex.com>. You can email ASIFlex at asi@asiflex.com or call ASIFlex toll free at 1-800-659-3035. A representative is available from 5 a.m. to 5 p.m. Pacific Standard Time Monday through Friday, and from 7 a.m. to 11 a.m. Pacific Standard Time on Saturday.

Q. HOW QUICKLY WILL MY PEBB FLEXIBLE SPENDING ACCOUNT CLAIMS BE PAID?

ASIFlex will process your claim no later than three business days following their receipt of the claim.

- Valid Health FSA claims will be paid on the day processed up to your annual election, less any prior payments.
- Valid Dependent care claims will be paid on the day processed up to the balance in your Dependent Care Assistance Program. Any excess Dependent care claim will be automatically paid as additional contributions are received from payroll.

(NOTE: Dependent care claims are paid after services are rendered.)

If there is a problem with your claim, ASIFlex will notify you on the day the claim is processed either by U.S. Mail or by email.

Q. WHAT HAPPENS IF MY CLAIM FOR REIMBURSEMENT IS DENIED IN WHOLE OR IN PART?

If your claim is denied in whole or in part, ASIFlex will notify you in writing within 30 days of the date the ASIFlex received your claim. This time period may be extended for an additional 15 days for matters beyond the control of ASIFlex, including in cases where a claim is incomplete. ASIFlex will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the ASIFlex is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the information required. You will have 45 days from receipt of the notice in which to provide the specified information. Decision on your claim will be suspended until the specified information is provided. Notice of a denied claim will include:

- (a) The specific reason(s) for the denial;
- (b) The specific FSA Plan provision(s) on which the denial is based;
- (c) 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
- (d) Appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review relevant documents and other information (upon request and at no charge).

If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the Committee (the Benefits Committee that acts on behalf of ASIFlex with respect to appeals). Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documentation that you feel supports your claim. You will have the opportunity to ask additional questions and make written comments. You may review (upon request and at no charge) documents and other information relevant to your appeal.

Your appeal will be reviewed and decided by the Committee in a reasonable time, no later than 60 days after the Committee receives your request for review. The Committee may, in its sole discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of the medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- (a) The specific reason(s) for the decision on review;
- (b) The specific Plan provision(s) on which the decision is based;
- (c) A statement of your right to review relevant documents and other information (upon request and at no charge); if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on. A copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

Q. IS DIRECT DEPOSIT AVAILABLE for Claim Payments?

Yes. You may have your claim payments sent directly to your checking, money market, or savings account. ASIFlex will send a notice of each payment to you. ASIFlex can send this notice via email, if you prefer. Email and direct deposit provide you with the fastest, safest payment method, as well as the fastest notification method.

FSA Debit Card (Benny Card)

The FSA Debit Card provides a convenient method to pay for out-of-pocket medical expenses for you, your spouse and/or any tax dependents. The IRS has stringent regulations regarding appropriate use of the FSA Debit Card, as far as **where the card can be used**, and **when follow-up documentation is required**. The card is a great benefit, but it is important that you take a moment and understand how it works. Using the card does not eliminate the need to submit follow-up paperwork!



Where can the cards be used?

Per IRS regulations, the FSA Debit Card can only be used at Health Care Providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Control System.

- 1) Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The FSA debit card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).
- 2) Inventory Control System Restriction:** The IRS also allows a card to be used at retail stores that have an FSA Inventory Control System in place that only allows FSA-eligible items to be paid for with your FSA debit card. The card will work at these stores, even if the MCC does not indicate it is a health care provider. A list of stores with this system in place now (and some expected in the future) is available online, at www.asiflex.com/debit-cards. **Purchases at these stores should never require follow-up documentation!!**

Please note that as of 1/1/2009, IRS regulations require all pharmacies to have the Inventory Control System in place, or your card will be declined.

When do I have to turn in paperwork?

Certain situations will allow FSA debit card transactions to be electronically substantiated, meaning that no follow-up documentation will be required. If a transaction cannot be electronically substantiated, you will receive a request for follow-up documentation from ASIFlex. Transactions are considered to be electronically substantiated if they:

- Match a co-payment, or any combination of co-payments up to five times the highest, for the health insurance plan(s) that you have elected through your employer;
- Occur at a retail outlet that has implemented the Inventory Control System; or
- Are recurring expenses for the exact same amount at the same provider and have been substantiated once via a paper claim. An example of this is if you go see a chiropractor once a month and you are assessed a fee of \$23.11 for each visit. This amount does not match a co-payment, so you will be prompted for documentation the first time. When you submit your documentation, please include a note stating that this is a recurring expense. Future transactions at the same provider, for the same amount, will not require follow-up documentation.

All other transactions will prompt a request for a detailed statement of services. You are not required to submit this documentation each time you get a request. Many ASIFlex participants gather up their statements, and simply submit these items on a monthly or quarterly basis.

Health Care FSA Summary

Use the Health Care FSA to avoid paying taxes on out-of-pocket medical expenses for you, your spouse, or any of your tax dependents.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN SUMMARY

The Health Care Flexible Spending Account Plan is intended to qualify as a “self-insured medical reimbursement plan” under Code §105, and the Medical Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees’ gross income under Code §105(b). You can elect to participate in the Health Care Flexible Spending Account Plan by completing, signing and returning an FSA Enrollment Form (Election Form/Salary Reduction Agreement) or enrolling online electing to:

- (a) Receive benefits in the form of reimbursements for Medical Care Expenses (Health FSA); and
- (b) Pay the contributions each month for such Health FSA on a pre-tax salary reduction basis.

STEPS TO PARTICIPATE IN THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN

1. Estimate your family’s annual out-of-pocket medical expenses. You may include expenses for anyone included on your federal tax return (Spouse, children, etc.). Include predictable expenses only.
2. Enroll in the Health FSA. Divide your annual out-of-pocket medical expense estimate by the number of paychecks you expect to receive during the Plan Year. Complete and sign an Enrollment Form or enroll on-line during Open Enrollment Period.
3. Receive medical services. A Medical Care Expense is Incurred when the services are provided that create the expense. You must receive medical services before you file a claim for those services.
4. File claims. After you receive the medical services and know the amount of your responsibility for the bill, you may submit a claim for those expenses to ASIFlex.
5. Receive reimbursements. ASIFlex will review your claim, and if approved will reimburse you for the Medical Care Expenses within one business day of their receipt of the claim.

IMPORTANT HEALTH CARE SAVINGS ACCOUNT INFORMATION

Annual Maximum \$5,000.00

Annual Minimum None

Qualifying Medical Expenses include only those expenses that are defined as medical expenses in Internal Revenue Code §213 and are not reimbursed by any other insurance or another plan. As stated in §213, qualifying Medical Care Expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They exclude all insurance premiums, long-term care expenses, and cosmetic expenses.

Refer to IRS Publication 502 for further details on qualifying expenses. You may link to this publication from ASIFlex's website. The purpose of Publication 502 is to assist people with their income tax filing. It does not address Health Care Flexible Spending Account Plans. However, most of the items listed as deductible in Publication 502 can be claimed through your Health FSA. You can not deduct on your income tax return expenses reimbursed by the Health Care Flexible Spending Account Plan.. You can not file for Health FSA expense reimbursements for expenses you deduct on your income tax return.

You can only claim expenses based on the date Incurred or date of service (not paid as stated in Publication 502). Please contact ASIFlex at asi@asiflex.com, (800) 659-3035 if you have any questions regarding particular expenses.

Below is a partial listing of qualified expenses. Remember, expenses can only be claimed based on the date Incurred regardless of the date you are billed or pay for the expense.

- Deductibles
- Co-pays
- Doctor's fees
- Dental expenses
- Vision care expenses
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Drugs & Medicines (legal) used to treat a medical condition
- Insulin
- Orthodontia (braces)
- Routine physicals
- Medical equipment
- Hearing aids including batteries
- Transportation expenses related to illness
- Chiropractor's fees
- Over the counter drugs

For a comprehensive list of eligible expenses, please visit <http://orpebb.asiflex.com>.

Non-Qualifying Medical Expenses

This is a partial list of medical related items that do not qualify under the Plan. There may be other items that do not qualify that are not listed here.

- Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins
- Sunglasses - non-prescription
- Toiletries
- Medicines, drugs, herbs, or vitamins for general health and not used to treat a specific medical condition
- Expenses that are merely beneficial to your general health (e.g., vacations and vitamins)
- Health club dues (not prescribed for a particular condition)
- Any sort of insurance premiums
- Warranties
- Long-term care expenses
- Prescription Drugs imported from another country
- Breast pumps

Coverage Continuation ("COBRA") To the extent required by COBRA, a Participant or his/her Spouse or Dependent may elect to continue the coverage elected under the Health Flexible Spending Account Plan even though the Participant's or his/her Spouse's or Dependent's election to receive benefits expired or was terminated, under the following circumstances:

- (a) Death of the Participant;
- (b) Termination (other than for gross misconduct) or a reduction in hours;
- (c) Divorce or legal separation of the Participant; or
- (d) A Dependent child ceases to be a Dependent under the terms of this Plan.

When the Plan is notified that one of the events has occurred, the right to choose continuation coverage will be provided to each eligible person(s) if, on the date of the qualifying event, the Participant's remaining benefits for the current Plan Year are greater than the Participant's remaining contribution payments. The right to elect to continue ends 60 days from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the Participant or a responsible family member to inform the Administrator of the occurrence of an event described above.

Continuation coverage will not extend beyond the end of the current Plan Year and/or Grace Period and may terminate earlier if the premiums are not paid within 30 days of their due dates. Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the Administrator. An administrative charge of 2% is assessed for each premium paid for continuation coverage.

Participants on Protected leave (FMLA, Active Military Duty leave, CBIW) leave under the Family Medical Leave Act ("FMLA") are entitled to maintain coverage for the Health FSA. Payment for coverage during FMLA may be made as follows:

If the Participant is on paid leave Health FSA coverage will continue, unless the Participant requests the termination of the Health FSA. The Participant's Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax salary reduction basis).

In the event of unpaid leave, a Participant may elect to continue his or her Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA, Active Military Duty Leave, or CBIW leave, then the Participant may pay his or her Contributions in one of the following ways:

- With after-tax dollars, by sending monthly payments to the employer by the due date established by the employer;
- With pre-tax dollars by pre-paying all or a portion of the contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the participant must make a special election to that effect prior to the date that such compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- Under another arrangement agreed upon between the participant and the employer (e.g., the employer may fund coverage during the leave and withhold "catch-up" amounts from the participant's compensation on a pre-tax or after-tax basis) upon the participant's return.

Newborns and Mothers Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health Cancer Rights Act of 1998:

The Health Care Flexible Spending Account Plan as required by the Women's Health and Cancer Rights Act of 1998, includes expenses for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call (800) 659-3035 for more information.

Dependent Care Assistance Plan Summary

Use the Dependent Care Assistance Plan (DCAP) to offset child care or elder adult dependent care expenses.

DEPENDENT CARE ASSISTANCE PLAN SUMMARY

The Dependent Care Assistance Program (DCAP) is intended to qualify as a “dependent care assistance program” under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees’ gross income under Code §129(a). You can elect to participate in the Dependent Care Assistance Plan by electing:

- (a) To receive benefits in the form of reimbursements for Dependent Care Expenses (Dependent Care Assistance Program); and
- (b) To pay the contribution for the Dependent Care Assistance Program on a pre-tax salary reduction basis.

STEPS TO PARTICIPATE IN THE DEPENDENT CARE ASSISTANCE PROGRAM ACCOUNT PLAN:

1. Estimate your total Dependent Care Expenses for the Plan Year. Include predictable expenses only.
2. Enroll in the Dependent Care Assistance Program. Divide your yearly Dependent Care expenses estimate by the number of paychecks you expect to receive during the Plan Year. Complete and sign an FSA Enrollment Form (Agreement) or enroll on-line during the Open Enrollment Period.
3. Receive Dependent care services. Dependent Care Expenses are Incurred when the day care is provided. You must receive the Dependent care services before you file a claim for those services.
4. File claims. After you have received the Dependent care services, you may submit a claim for those expenses to ASIFlex.
5. Receive reimbursements. ASIFlex will review your claim, and if approved will reimburse you within one day of their receipt of your claim up to the amount you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from payroll.

IMPORTANT Dependent Care Assistance Plan INFORMATION

Annual Maximum \$5,000.00 Annual Minimum None

You and your Spouse together may include up to \$5,000.00 per year (\$2,500 in the case of a married individual filing a separate tax return for the Plan Year) or the lesser of your earned income (after subtracting all FSA deductions) or your Spouse’s earned income for the Plan Year. Note: 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 himself or herself, 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.

A Qualifying Individual is your Dependent who is under the age of 13 who lives with you at least one half of the year, or your Spouse or an older Dependent who is mentally or physically incapable of self-care who resides with you for more than one half of the year and is a qualifying child or relative under Section 152 of the IRS Code

A Qualified Provider can provide care in your home or outside your home. If the care is provided outside your home and the facility cares for more than five individuals, then it must be licensed by the State. The expenses may not be paid to your Spouse, a child of yours who is under the age of 19 at the end of the year in which the expenses are Incurred, or to an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

The Dependent Care Assistance Program is an alternative to taking a "tax credit" allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the "Tax Credit" or the Dependent Care Assistance Program. The IRS will not allow you to receive two tax breaks on the same expenses.

- A Tax Credit is allowed for child/Dependent Care Expenses of up to \$6,000 per year for two or more Dependents (\$3,000 per year for one Dependent). You can file for the "tax credit" on your annual tax return, at the end of the year. The credit is an amount equal to your Dependent Care Expenses multiplied by a percentage determined by your combined adjusted gross income. The percentage decreases from a high of 35% to a low of 20% as your income increases.
- The Dependent Care Assistance Plan allows a tax break on up to \$5,000.00 per year, \$2,500 if married filing separately, for any number of Dependents; one, two, or more. You will experience "tax savings" throughout the year with every paycheck you receive. Employees who pay federal taxes of 15%, state taxes of approximately 6% and Social Security taxes of 7.65% would save around 28% of expenses through the Dependent Care Assistance Program. As their federal tax percentage rises, they would receive an even higher tax break by using the Dependent Care Assistance Program.

Generally, those Employees with a combined family income over \$31,000 have a higher percentage tax break through the Dependent Care Assistance Program. Those employees with a combined income under \$31,000 generally receive a higher percentage tax break utilizing the tax credit. Contact your tax advisor if you have questions about which is best for you.

You are required to file Schedule 2 with your IRS Form 1040A or Form 2441 with your IRS Form 1040 to support the amount redirected for the calendar year. Note: This is for informational purposes. You will not pay taxes on the redirected amount. Payments made to you under this category are not taxable, but the amount redirected will appear on your W-2 form. This filing will inform the IRS that you have received a tax break on that expense through your Dependent Care Assistance Program.

Qualifying Dependent Care Expenses

Qualifying child/Dependent Care Expenses are those that you incur in order for you and your Spouse (if married) to be gainfully employed that are considered to be employment-related expenses under Internal Revenue Code §21(b)(2) to the extent that you or another person (if any) incurring the expense is not reimbursed for the expense through any other Plan. Only expenses incurred for care and well-being qualify for this tax break (e.g. kindergarten, education related sports camps, summer school and private school expenses, food and transportation do not qualify). Day camp fees Incurred in order for you to work are allowable but overnight camps are not.

Refer to IRS Publication 503 for additional information. You can access this publication from ASIFlex's website. The purpose of Publication 503 is to assist people with their income tax filing. It does not address Dependent Care Assistance Programs. However, most of the items listed as eligible for the tax credit in Publication 503 can be claimed through your Dependent Care Assistance Program.

NOTE: You can only claim expenses based on the date Incurred (not paid as stated in Publication 503).

Please contact ASIFlex at asi@asiflex.com, (800) 659-3035 if you have any questions regarding particular expenses.

Partial List of Qualifying Expenses are those that enable you to be gainfully employed including:

- Day care centers
- Babysitters
- Day camps
- Nannies

For a complete list please visit <http://orpebb.asiflex.com>.

Non-Qualifying Dependent Care Expenses

This is a partial list of items that do not qualify under the Plan. There may be other items that do not qualify that are not listed here.

- Care that is not Incurred in order for you to work or look for work.
- Care for a child for whom you have fifty percent or less physical custody.
- Kindergarten or other educational expenses.
- Overnight camps, summer school.
- Care for a child age thirteen or older who is not disabled.
- Food, transportation or activity fees.
- Child support payments.
- Amounts paid to your Spouse or Dependent or to your (or your Spouse's) son or daughter who is under nineteen years old at the end of the year.

STATE OF OREGON
PEBB FLEXIBLE SPENDING ACCOUNT CLAIMS
HEALTH FSA
AND
DEPENDENT CARE ASSISTANCE PROGRAM

Administered by ASIFlex

Phone: (800) 659-3035

Email: asi@asiflex.com

Mailing Address: PO Box 6044
Columbia, MO 65205-6044

Internet: <http://orpebb.asiflex.com> for claim forms and personal account information

Allowable expenses must be Incurred during the portion of the Plan Year that you are a Participant.

Grace Period:

If you were a participant in the Health FSA on the last day of the Plan Year, qualified Medical Care Expenses, up to \$5,000.00, incurred during the Grace Period will be paid or reimbursed from your unused Health FSA balance. The Grace Period will begin immediately following the end of the Plan Year and will run through March 15th following the end of the Plan Year.

If you were a participant in the Dependent Care Assistance Program on the last day of the Plan Year, qualified Dependent Care Expenses, up to \$5,000.00, incurred during the Grace Period will be paid or reimbursed from your unused DCAP balance. The Grace Period will begin immediately following the end of the Plan Year and will run through March 15th following the end of the Plan Year.

“Use it or Lose It” Rule:

All Claims must be filed by March 31st following the end of the Plan Year. After March 31st, your account will be closed and any balance remaining will be retained by State of Oregon in accordance with federal regulations. If March 31st is a holiday, Saturday, or Sunday, then claims must be filed by the first business day following March 31st.

Claims (DCAP and Health FSA)

You must submit a completed claim form along with copies of invoices or statements from the provider to serve as proof that you Incurred an allowable expense in order to receive payment. Statements must include all of the following:

- (a) The provider’s name;
- (b) The date(s) of service;
- (c) A description of the service(s); and
- (d) The expense amount.

- Not acceptable: Copies of personal checks and paid receipts, without the above information, (a) through (d).
- Documentation or copies will not be returned.
- For over-the-counter items, the receipt or documentation from the store must include the name of the drug printed on the receipt.
- You must indicate the existing or imminent medical condition (items such as vitamins and nutritional supplements may require a physician's statement) for which the item will be used on the receipt, claim form, or on a separate enclosed statement each time these items are claimed.
- Items purchased for general good health or preventative measures are not qualified.

ASIFlex will send you a supply of claim forms with your enrollment confirmation. You may copy the claim form or obtain extra claim forms from your Human Resources office, by contacting ASIFlex, or over the Internet at <http://orpebb.asiflex.com>.

You may have the Dependent care provider complete the Dependent Care section of the claim form and sign on the line provided in lieu of providing the above documentation for Dependent care claims.

NOTE: The tax identification number or Social Security number of the child/Dependent care provider should be listed on each of your claim forms. You must also provide this number with your federal income tax return. Please check with your childcare provider (before enrolling in this plan) to be sure that you are able to obtain their tax I.D. number or his/her Social Security number.

Orthodontic expenses may be reimbursed as they are paid. Please submit your treatment plan, along with proof of payment with each claim that you submit.

Payment from your Health FSA for expenses incurred during the Plan Year will be made up to the approved amount of your claim or your remaining annual election, which ever is less. Payment for expenses incurred during the Grace Period will be made up to the lesser of the approved amount of your claim, your remaining annual election, or \$5,000.00 (less prior expenses incurred during the Grace Period). Payment is not limited to the amount in your account at the time of your claim. Your monthly contributions will continue for the remainder of the Plan Year.

Claims during the Grace Period will be processed against the prior Plan Year to the extent you have available funds. Any remaining claims will be processed against the current Plan Year.

Payment from your Dependent Care Assistance Program will be made up to the approved amount of your claim or your current balance, which ever is less. Payment for expenses incurred during the Grace Period will be made up to the lesser of the approved amount of your claim, your current balance, or \$5,000.00 (less prior expenses incurred during the Grace Period). Any portion of your claim which is not paid will be paid automatically as money is contributed from payroll. Total payments for the year are restricted to your annual election.

Direct deposit into the bank account of your choice is available for your claim payments. By using direct deposit you will not need to wait for a check to arrive or deposit your self. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by email. If you prefer, a check can be mailed to you instead of payment by direct deposit.

Email notice If you choose direct deposit, ASIFlex can send your notices of payment directly to your email account.

INTERNET ACCESS

You can access your Health Care FSA and your DCAP Account on the Internet 24 hours a day, 7 days a week. Information is updated every morning to reflect the previous day's transactions. You can find out if a claim has been processed, a payment has been made, or your current balance using the internet access. Information for the current Plan Year is available (the previous Plan Year until March 31st following the end of that Plan Year is available as well). There is no personally identifying information on the internet, which means this information will be meaningful to you, but not to anyone else.

To access your account:

1. Go to <http://orpebb.asiflex.com>
2. Click on "Account Detail"
3. Click in the box to the right of "Your FlexPin"
4. Type your Personal Identification Number (PIN). Your PIN is provided on your enrollment confirmation. You can also call ASIFlex at (800) 659-3035 (442-3035 from Columbia, Missouri) to get your PIN.
5. Click "Submit"
6. Select the Plan Year from the drop down box if available. This box will not be displayed if only one Plan Year is available.
7. Select the category you wish to view if you are enrolled in more than one category. All transactions for the Plan Year are shown through the previous day. Information is updated early each morning.
8. Click "Lookup"
9. Be sure to click "Sign out (or enter another FlexPin)" when you finish. This closes out your account for security purposes.

GENERAL PLAN INFORMATION

The Plan Administrator State of Oregon
1225 Ferry St SE
Salem, OR 97301
(503)373-1102

The Employer State of Oregon
1225 Ferry St SE
Salem, OR 97301
(503) 373-1102

Named Fiduciary State of Oregon

The name of the Plan is The State of Oregon PEBB Flexible Spending Account. The Plan Number is 503. The provisions of the Plan became effective on January 1, 2008. The Plan is intended to last indefinitely. However, the employer retains the right to amend or terminate the Plan at any time for any reason. State of Oregon's federal employee tax identification number (EIN) is.

The agent for Service of Legal Process is the Plan Administrator.

The benefit Plan Year is the twelve-month period from January 1 through December 31 of the same calendar year.

Although reprinted within this document, the Health Flexible Spending Account Plan and the Dependent Care Assistance Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §105 and 129. The Health Care Flexible Spending Account Plan is also a separate plan for purposes of applicable provisions of COBRA.

Funding:

The Health Care Flexible Spending Account Plan and the Dependent Care Assistance Plan are entirely funded by Employee salary reductions. However, for the purposes of the Plans and the Internal Revenue Code they are considered employer contributions. All of the amounts payable under this Plan shall be paid from the general assets of the employer. Neither State of Oregon nor the Administrator (if other than State of Oregon) will maintain any fund or segregate any amount from general assets for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of State of Oregon from which any payment under this Plan may be made. There is no trust or other fund from which benefits are paid. While State of Oregon has complete responsibility for the payment of benefits out of its general assets, it may hire an unrelated third party firm to make benefit payments on its behalf. The maximum contributions that may be made under this Plan for a Participant is the total of the maximums that may be elected as employer and Participant contributions for benefits, and as described in the Health Care Flexible Spending Account Plan Summary and Dependent Care Assistance Plan Summary sections.

Plan Administration:

It is intended that this Plan meet all applicable requirements of the Code and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine an appropriate course of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any interpretation of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review.

Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole decision and further constitutes agreement to the limited standard and scope of review described by this section.

To the extent permitted by law, the Plan Administrator, and other parties assuming a fiduciary or decision making role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan. The standard shall be one of ordinary care.

The State of Oregon has contracted ASIFlex to perform certain administrative functions for the Plan. ASIFlex processes all claims for the Health Care FSA and the Dependent Care Assistance Program. If you have any questions concerning claims, contact ASIFlex, P. O. Box 6044, Columbia, MO 65205, 800-659-3035, email: asi@asiflex.com, on on-line at <http://orpebb.asiflex.com>

Benefits Offered:

Health Care Flexible Spending Account Plan

Dependent Care Assistance Plan

GLOSSARY

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code: The Internal Revenue Code of 1986, as amended.

Dependent: With regard to any Health Care plan a Dependent is a person who is a qualifying child or qualifying relative as defined in Code §152, without regard to the gross income limitations. With regard to the Dependent Care Assistance Plan, a Dependent shall be a qualifying person as defined in Code §21(b)(1), as amended (See also "Qualifying Individual" under the Dependent Care Assistance Plan Summary.) In the case of divorced parents, the child shall be treated as a dependent of the custodial parent as described in Code §21(e)(5).

Dependent Care Expenses: Employment-related expenses as defined in Internal Revenue Code §21(b)(2).

Educational Organization: An organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

FSA Enrollment Form: Means the form or Internet web page and online process provided by the Administrator for the purpose of allowing an eligible Employee to participate in this Plan by electing salary reductions to pay for any of the Health Care Flexible Spending Account Plan, and/or Dependent Care Assistance Plan benefits. It includes an agreement pursuant to which an eligible Employee or Participant authorizes the employer to make salary reductions.

Employee: Means an individual that State of Oregon classified as a common-law employee and who is on State of Oregon W-2 payroll. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the employer.

FMLA: The Family and Medical Leave Act of 1993, as amended.

FSA: An account established under the Health Care Flexible Spending Account Plan or the Dependent Care Assistance Program.

Grace Period means a period of time as specified by the Employer during which qualified Medical Care Expenses and/or qualified Dependent Care Expenses incurred qualify for payment or reimbursement from benefits or contributions remaining unused at the end of the immediately preceding Plan year from the Health Care FSA and/or Dependent Care Assistance Program as applicable. Such Grace Period shall extend through March 15th for the Health Care FSA and March 15th for the Dependent Care Assistance Program following the Plan Year to which the Grace Period relates.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Incurred: The date or dates that services or products are provided that give rise to an expense regardless of when the expenses are paid or billed.

Medical Care Expense: An expense incurred by you, your Spouse or a Dependent for "medical care" as defined in Internal Revenue Code Section 213(d). It does not include any insurance premiums or long term care expenses.

QMCSO: A Qualified Medical Child Support Order, as defined in ERISA § 609(a).

Participant: A person who is an eligible Employee and who is participating in this Plan.

Plan: The State of Oregon PEBB Flexible Spending Account

Plan Year: The Plan Year is from January 1 through December 31 of the same calendar year.

Spouse means a person of the opposite sex who is an individual legally married to a Participant as determined under applicable state law and who is treated as a spouse under the Code. The definition of spouse does not include a former spouse. Notwithstanding the above, for purposes of the DCAP Component the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant files a separate federal income tax return, maintains a principal residence separated from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Oregon Flex Program
Administered by ASIFlex