



2008

Health Care and Dependent Care Flexible Spending Accounts



Reference Guide



Ohio**DAS**

Plan Year:
Jan. 1 - Dec. 31, 2008

Have questions about Flexible Spending Accounts?

Call Fringe Benefits Management Company
Customer Service at

1-800-342-8017

or visit

www.myFBMC.com

OR

Call the Department of Administrative Services HCM
Customer Service Team at

1-800-409-1205

or visit

www.ohio.gov/employeebenefits

Welcome to Your Flexible Spending Account (FSA) Reference Guide

As you use your FSA throughout 2008, use this guide as a handy resource to find answers to any questions that you may have. Within this guide, you will find information regarding how to:

- Use your health care and/or dependent care flexible spending account funds
- Submit a reimbursement claim
- Enroll in the direct deposit option
- Determine if an expense is eligible for reimbursement
- Use your EZ REIMBURSE® MasterCard® Card

Information can also be found at www.myfbmc.com or www.ohio.gov/employeebenefits.

Table of Contents

Flexible Spending Accounts - General Information	4
Health Care Flexible Spending Account	6
EZ REIMBURSE® MasterCard® Card	8
Dependent Care Flexible Spending Account	9
Changing Your Coverage	11
COBRA	13

What is a Flexible Spending Account (FSA)?

Your employer through Fringe Benefits Management Company (FBMC), provides you with IRS tax-favored Flexible Spending Accounts (FSAs) to stretch your health care and dependent care dollars. You must re-enroll each plan year. Enrollment does not roll over into subsequent plan years.

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax-free;
- per-pay-period deposits (24 pay periods usually) from your pre-tax salary;
- savings on federal, state and local taxes and
- security of paying anticipated expenses with your FSA.

Types of FSAs available

The State of Ohio offers a Health Care FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, eligible employees can establish both types of FSAs.

Refer to the *Health Care FSA* section (pages 6 and 7) and the *Dependent Care FSA* section (pages 9 and 10) of this Reference Guide or visit www.ohio.gov/employeebenefits (updated information will be posted by January 2008), for specifics on each type of FSA.

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Receiving Reimbursement

When submitting a claim to FBMC, your reimbursement will be processed within five business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Form.

To avoid delays, follow the instructions for submitting your requests located in the FSA materials received following enrollment.

Direct Deposit

You may want to enroll in direct deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account within 48 hours of your claim approval.
- There is no fee for this service.
- You do not have to wait for postal service delivery of your reimbursement. However, you will receive notification via mail that the claim has been processed.

To apply, complete the Direct Deposit Enrollment Form available from your **agency's payroll/personnel office and at www.myFBMC.com** or call FBMC Customer Service at 1-800-342-8017. Please note that processing your direct deposit enrollment may take four to six weeks.

How do I get the forms I need?

To obtain the forms you will need after enrolling in either a Health Care or Dependent Care FSA, such as an FSA Reimbursement Request Form, Letter of Medical Need or Direct Deposit Form, visit FBMC's Web site, www.myFBMC.com, or call FBMC Customer Service at 1-800-342-8017.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact FBMC Customer Service.

- Visit www.myFBMC.com
- Call **1-800-342-8017** (Monday through Friday, 7 a.m. - 10 p.m. ET).

Note that due to the FBMC privacy policy, we will not discuss your account information with others without your verbal or written authorization.



Visit www.myFBMC.com for a list of frequently asked questions.

You must keep your documentation for a minimum of one year and submit it to FBMC upon request.



Flexible Spending Accounts, *Continued*

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Health Care FSA or vice versa.
3. You have a 90-day run-out period (until March 31, 2009) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the 2008 plan year.
4. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service which you have not yet received.
7. Be conservative when estimating your health care and/or dependent care expenses for the 2008 plan year. IRS regulations state that any unused funds which remain in your FSA after a plan year ends, and all reimbursable requests have been submitted and processed, cannot be returned to you or carried forward to the next plan year.
8. When enrolling in either or both FSAs, written notice of agreement with the following will be required:
 - I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents;
 - I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA;
 - I will not seek reimbursement through any additional source; and
 - I will collect and maintain sufficient documentation to validate the foregoing.
 - I understand and agree that my employer and FBMC, the contract administrator, will not incur any liability resulting from and I specifically release them from my participation in any FSA or my failure to sign or accurately complete the enrollment form.

What documentation of expenses do I need to keep?

The IRS requires FSA participants to maintain complete documentation, including copies of statements, invoices or bills for reimbursed expenses, for a minimum of one year.

Will contributions affect my income taxes?

Salary reductions made under one or both FSAs will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information.

What Kind of Costs Are Involved?

If you enroll only in a Health Care Spending Account (HCSA):	If you enroll only in a Dependent Care Spending Account (DCSA):	If you enroll in both Flexible Spending Accounts:
<ul style="list-style-type: none"> ■ The state will pay the monthly administrative fee if your election amount is \$1,000 or more. ■ You will be charged a \$2.25 monthly administrative fee if your election amount is less than \$1,000. 	<ul style="list-style-type: none"> ■ The state will pay the monthly administrative fee. 	<ul style="list-style-type: none"> ■ The state will pay the monthly administrative fee if your HCSA election amount is \$1,000 or more. ■ You will be charged a \$2.25 monthly administrative fee if your HCSA election amount is less than \$1,000.

Health Care FSA

What is a Health Care FSA?

A Health Care FSA is an IRS tax-favored account you can use to pay for your eligible health care expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free.

Whose expenses are eligible?

Your Health Care FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child
- your qualifying relative

An individual is a **qualifying child** if he or she is not someone else's qualifying child and:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada;
- has a specified family-type relationship to you;
- lives in your household for more than half of the taxable year;
- is 18 years old or younger (23 years old if a full-time student) at the end of the taxable year; and
- has not provided more than one-half of their own support during the taxable year.

An individual is a **qualifying relative** if he or she is a U.S. citizen national or a resident of the U.S., Mexico or Canada and:

- has a specified family-type relationship to you, is not someone else's qualifying child and receives more than one-half of their support from you during the taxable year **or**
- if no specified family-type relationship to you exists, is a member of and lives in your household (without violating local law) for the entire taxable year and receives more than one-half of their support from you during the taxable year.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Health Care FSA.

Can travel expenses for medical care be reimbursed?

Travel expenses primarily for, and essential to, receiving health care, including health care provider and pharmacy visits, may be reimbursable through your Health Care FSA. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- transportation to another city
- parking fees
- tolls

**Minimum Annual Health Care Spending Account Deposit*:
No Minimum**
**Maximum Annual Health Care Spending Account Deposit*:
\$3,000 (for 2008 calendar year)**

* Including administrative fee, if applicable. Please see Page 5.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Health Care FSA reimbursement as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires the complete name of all medicines and drugs be documented on pharmacy invoices (including prescription number, date(s) of service and total dollar amount). This information must be included when submitting your request to FBMC for reimbursement.

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may be reimbursable through your Health Care FSA. Save valuable tax dollars on certain categories of OTC items, medicines and drugs, such as: allergy treatments, antacids, cold remedies, first-aid supplies and pain relievers. For a more comprehensive list of eligible OTC items, please visit www.myFBMC.com.

You may be reimbursed for OTCs through your Health Care FSA if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s);
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug;
- the reimbursement request is for an expense allowed by your employer's Health Care FSA plan and IRS regulations; and
- you submit your reimbursement request in a timely and complete manner already described in your benefits enrollment information.

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at www.myFBMC.com. As soon as an OTC item, medicine or drug becomes eligible under any of the categories, it will be reimbursable retroactively to the start of the then current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Health Care FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable through your Health Care FSA if the following proper documentation is provided:

- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service, the cost for the service; and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment (only required if a participant requests reimbursement for the total program cost spread over a period of time).

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under the state's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment or call FBMC Customer Service at 1-800-342-8017.

When are my funds available?

Once you sign up for a Health Care FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available at the beginning of the 2008 calendar year.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

Should I claim my expenses on IRS Form 1040?

With a Health Care FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax-free, regardless of the amount. By enrolling in a Health Care FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on your health care expenses as a percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Health Care FSA include:

- insurance premiums;
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

When do I request reimbursement?

You may use your Health Care FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How do I request reimbursement?

Requesting reimbursement from your Health Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with the following:

- an invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided; or
- an Explanation of Benefits from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost; and
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the invoice or bill for the service.

Note that cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for Health Care FSA reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax Toll-Free: 1-888-800-5217

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Co-pays
Coinsurance
Deductibles
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Note: Budget conservatively. No reimbursement or refund of Health Care FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply and will be supplied to you following enrollment.

EZ REIMBURSE® MasterCard® Card

What is the EZ REIMBURSE® MasterCard® Card?

The EZ REIMBURSE® Card is a stored-value card, which means that the funds you opt to deduct for your paycheck will automatically be loaded onto this card. It is a convenient reimbursement option for the Health Care Expense Flexible Spending Account (FSA) that allows FBMC to electronically reimburse you for eligible expenses under your employer's plan and IRS guidelines. Your annual Health Care Expense FSA contribution is available to you on your card at the beginning of your plan year. When you use your EZ REIMBURSE® Card to pay for eligible expenses, funds are electronically deducted from your Health Care Expense FSA.

What are the advantages of using the EZ REIMBURSE® Card?

You can use your EZ REIMBURSE® Card for your eligible Over-the-Counter (OTC) expenses at drugstores. Other advantages include:

- instant **reimbursements** for health care expenses, including prescriptions, co-payments and mail-order prescription services;
- instant **approval of some** medical, prescription, vision and dental expenses (others require documentation);
- transactions for eligible expenses at Walgreens, Wal-Mart and Sam's Club do not require further documentation
- no out-of-pocket expense; and
- easy access to your Health Care Spending Account funds.

Note: You **cannot** use your EZ REIMBURSE® Card for cosmetic dental expenses or eyeglass warranties.

How do I get an EZ REIMBURSE® Card?

You will need to elect to receive an EZ REIMBURSE® Card on your enrollment form when you start a Health Care Expense FSA. Two cards will be sent to you in the mail; one for you, and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date.

Please note that you can elect this option to receive an EZ REIMBURSE® Card in only two situations. If you are a current employee, you may elect this option during open enrollment while new employees are able to elect when they initially enroll into a Health Care Spending FSA. Current employees are not able to sign up for a EZ REIMBURSE® Card outside of the open enrollment period.

What does it cost to use the EZ REIMBURSE® Card?

There is a \$20 non-refundable, annual fee for using the card. This amount is automatically deducted from your Health Care Spending Account.



How do I use my EZ REIMBURSE® Card?

For eligible expenses, simply swipe your EZ REIMBURSE® Card like you would with any other debit card. Whether at your health care provider or at your drugstore, the amount of your eligible expenses will be automatically deducted from your Health Care Expense

FSA. Currently, some grocery and discount store pharmacies are not programmed to accept the card. To find out if a pharmacy or drugstore near you accepts the card, please refer to the online Drugstore List at www.myFBMC.com, which is available after you log in.

When do I send in documentation for an EZ REIMBURSE® Card expense?

You must send in documentation for certain EZ REIMBURSE® Card transactions, such as those transactions that are **not from** a known office visit or prescription co-payment (as outlined in your health plan's Schedule of Benefits). When requested, you must send in documentation for these transactions. Documentation for an EZ REIMBURSE® Card expense is a statement or bill showing:

- name of the patient,
- name of the service provider,
- date of service,
- type of service (including prescription name), and
- total amount of service.

Note: This documentation must be sent with an **EZ REIMBURSE® Card Transmittal Sheet** and cannot be processed without it. Like all other FSA documentation, you must keep your card expense documentation for a minimum of one year and submit it to FBMC when requested.

As an FSA participant, you should go to www.myFBMC.com to see your account information and check for any outstanding Card transactions. If an outstanding transaction appears in red on the Web site or in blue in the *Outstanding EZ REIMBURSE® Transactions Requiring Documentation* section of your monthly statement, you must submit the proper expense documentation to FBMC prior to the end of your run-out period.

If you fail to send in the requested documentation for an EZ REIMBURSE® Card expense, you will be subject to one of the following payback options:

- withholding of payment for an eligible paper claim to offset any outstanding card transaction,
- suspension of your card privileges,
- payback through payroll, and
- the reporting of any outstanding card transaction amounts as income on your W-2 at the end of the tax year.

What agreement am I making when I use the EZ REIMBURSE® Card?

By using the EZ REIMBURSE® Card, you are agreeing to the "FSA Guidelines" portion of this reference guide. More information is available in the Cardholder Agreement that you receive with your card.

Dependent Care FSA

Minimum Per-Pay-Period Deposit:
\$10 if paid bi-weekly/20 if paid monthly

Maximum Annual Deposit:
The maximum contribution depends on your tax filing status as the list on this page indicates.

What is a Dependent Care FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent care expenses for qualifying individuals.

A qualifying individual includes a **qualifying child** if he or she:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada;
- has a specified family-type relationship to you;
- lives in your household for more than half of the taxable year;
- is 12 years old or younger and
- has not provided more than one-half of his/her own support during the taxable year.

A qualifying individual includes your **spouse** if he or she:

- is physically and/or mentally incapable of self-care;
- lives in your household for more than half of the taxable year and
- spends at least eight hours per day in your home.

A qualifying individual includes your **qualifying relative** if he or she:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada;
- is physically and/or mentally incapable of self-care;
- is not someone else's qualifying child;
- lives in your household for more than half of the taxable year;
- spends at least eight hours per day in your home; and
- receives more than one-half of his/her support from you during the taxable year.

Note: In case of divorce or legal separation, only the residential parent can be reimbursed using the Dependent Care FSA. Child support payments are not an eligible expense.

What is my maximum annual deposit?

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earns less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Health Care FSA, the entire maximum annual amount is not available at the beginning of the plan year, but after your payroll deductions are received.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care FSA is always tax-free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

You cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information. You also may visit www.myFBMC.com to complete a Tax Savings Analysis.

Partial List of Eligible Expenses*

After-school care
Baby-sitting fees
Daycare services
In-home care/au pair services
Nursery and preschool
Summer day camps

Note: Please budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

*IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply and will be supplied to you following enrollment.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care FSA include:

- books and supplies;
- child support payments or child care if you are a non-residential parent;
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is younger than age 19.

Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need his or her Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must provide a written statement that explains the circumstances and states that you made a serious and earnest effort to obtain the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You may request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a completed FSA Reimbursement Request Form along with documentation showing the following:

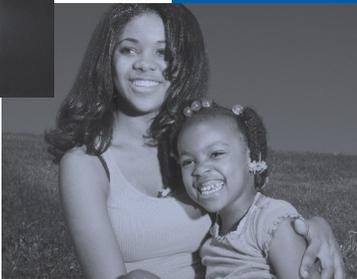
- the name, age and, if applicable, grade of the dependent receiving the service;
- the cost of the service;
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement. Cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for Dependent Care FSA reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax Toll-Free: 1-888-800-5217

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.



Changing Your Coverage

Am I permitted to make mid-plan year election changes?

Under some circumstances, the state's plan(s) and the IRS may permit you to make a mid-plan year election change to your FSA election or vary a salary reduction amount depending on the qualifying event and requested change.

How do I make a change?

You can change your Flexible Spending Account (FSA) election(s) or vary the salary reduction amounts you have selected during the plan year only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. Partial lists of permitted and not permitted qualifying events under the state's plan(s) appear on the following page. Election changes must be consistent with the event. FBMC will, in its sole discretion, review on a uniform and consistent basis the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within **60 days** of an event that is consistent with one of the events on the following page, you must complete and submit a Change in Status/Election Form to FBMC. Contact FBMC to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). Generally, mid-plan year, pre-tax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by your employer, unless otherwise provided by law. If your FSA election change request is denied, you will have **60 days**, from the date you receive the denial, to file an appeal with FBMC. For more information, refer to the "Appeal Process" section.

What is my Period of Coverage?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan year election change. For a Health Care FSA, a mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with

amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the Health Care FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's Health Care FSA plan and the IRS regulations governing the plan.

Split periods of coverage do not apply to Dependent Care FSAs.

What are the IRS Special Consistency Rules governing Changes in Status?

- 1. Loss of Dependent Eligibility** – If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce or annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
- 2. Gain of Coverage Eligibility Under Another Employer's Plan** – If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage or has coverage increased under the other employer's plan.
- 3. Dependent Care Expenses** – You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

Changing Your Coverage

Changes in Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment. Legal separation is recognized in Ohio.
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid Change in Status (CIS) event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes:

Coverage and Cost Changes*	The state's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none"> • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Healthcare FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your agency's payroll/personnel office for additional information.

* Does not apply to a Health Care FSA plan.

† Does not apply to a Dependent Care FSA plan.

COBRA Q&A

Important Continuation Coverage Information

What is continuation coverage?

Federal law requires that most group health plans, including Health Care Flexible Spending Accounts (Health Care FSAs), give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. “Qualified beneficiaries” can include the employee covered under the group health plan, a covered employee’s spouse and dependent children of the covered employee.

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be obtained from FBMC or viewed at www.ohio.gov/employeebenefits.com.

How long will continuation coverage last?

For Health Care FSAs:

If you fund your Health Care FSA entirely, you may continue your Health Care FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, **if** you have not already received, as reimbursement, the maximum benefit available under the Health Care FSA for the year. For example, if you elected a Health Care FSA benefit of \$1,000 for the plan year and have received only \$200 in reimbursement, you may continue your Health Care FSA for the remainder of the plan year or until such time that you receive the maximum Health Care FSA benefit of \$1,000.

How can you extend the length of continuation coverage?

Second Qualifying Event*

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage, resulting in a maximum amount of continuation coverage of 36 months. Such second qualifying events include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. You must notify FBMC within 60 days after a second qualifying event occurs.

*Does not apply to State of Ohio employees.

How can you elect continuation coverage?*

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee’s spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

You should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

*Does not apply to State of Ohio employees.

How much does continuation coverage cost?

The cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event plus a two percent administrative fee.

When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage **within 45 days after the date of your election**. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact FBMC to confirm the correct amount of your first payment. Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the **first day of each month**. Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?*

If you are retiring, you may have the right to elect alternative retiree group health coverage instead of the COBRA continuation coverage described in this Notice. If you elect this alternative coverage, you will lose all rights to the COBRA continuation coverage described in the COBRA Notice. You should also note that if you enroll in the alternative group health coverage, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your alternative group health coverage ends. You must contact FBMC if you wish to elect alternative coverage.

If your group health plan offers conversion privileges, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing COBRA continuation coverage, or you may exercise this right after you have received the maximum COBRA continuation coverage available to you. You should note that if you enroll in an individual conversion policy, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

**Does not apply to State of Ohio employees.*

For More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer. You can get a copy of your summary plan description from the State of Ohio's Web site at <http://www.ohio.gov/employeebenefits>.

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

Keep Your Address Updated

In order to protect your family's rights, you should keep FBMC informed of any changes in the addresses of family members. You also should keep a copy, for your records, of any notices you send to your employer and FBMC.

Beyond Your Benefits

Notice of Administrator's Capacity

PLEASE READ: This notice advises Flexible Spending Account participants of the identity and relationship between your employer and its Contract Administrator, Fringe Benefits Management Company (FBMC). FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the Flexible Spending Account plans offered herein. FBMC will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against FBMC than would otherwise be afforded to you by law.

FBMC Privacy Notice 4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get

access to this information is provided electronically on our Web site: www.myFBMC.com. You have a right to a paper copy at any time. Contact FBMC Customer Service at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents;
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA;
- I will not seek reimbursement through any additional source; and
- I will collect and maintain sufficient documentation to validate the foregoing.

The state of Ohio, as the employer, and Fringe Benefit Management Company incur no liability resulting from an employee's participation in any FSA or a participant's actions.

