

SECTION 125 PLAN

Administered by



***YOUR
GUIDE
TO YOUR
SECTION 125 PLAN***

SECTION 125 PLAN

Table of Contents

	<u>Page</u>
PART A. INTRODUCTION TO YOUR SECTION 125 PLAN.....	1
PART B. HOW THE PLAN WORKS IN GENERAL.....	3
B-1 What is a Section 125 plan?.....	3
B-2 What benefits are available?.....	3
B-3 How does the Plan save me taxes?.....	3
B-4 Since my contributions aren't subject to FICA, how does this affect my Social Security benefits?.....	4
PART C. ELIGIBILITY AND ENROLLMENT.....	5
C-1 Am I eligible to be in the Plan?.....	5
C-2 How do I become a participant?.....	5
C-3 When do I begin participating?.....	5
C-4 What is the "Plan Year"?.....	6
PART D. CHANGING YOUR ELECTIONS MID-YEAR.....	7
D-1 When can I change my coverage or payroll deduction election during the year?.....	7
D-2 What is a change in status?.....	9
D-3 What happens if I terminate employment?.....	10
D-4 What happens if I am rehired?.....	10
D-5 What happens if I go on leave of absence?.....	10
PART E. THE PREMIUM PAYMENT PROGRAM.....	12
E-1 What benefits does this Program provide?.....	12
E-2 How does this Program work?.....	12
PART F. THE HEALTHCARE REIMBURSEMENT PROGRAM.....	13
F-1 What benefits does this Program provide?.....	13
F-2 How does my "Healthcare Reimbursement Account" work?.....	13
F-3 How much can I contribute into this Program?.....	13
F-4 How much of a reimbursement can I receive at any given time?.....	13

F-5 What expenses are covered by this Program? 14

F-6 What are “covered healthcare expenses”? 14

F-7 What expenses are not covered?..... 16

F-8 Can I also claim a deduction for my reimbursed expenses?..... 17

F-9 When is a healthcare expense “incurred”?..... 17

F-10 If I don’t use up all the money in my account in a year, can I
get the balance back? 18

F-11 What happens if my employment terminates when I still
have funds in my account?..... 19

F-12 What happens if my employment terminates when my
account is overdrawn? 19

PART G. DEPENDENT CARE EXPENSE REIMBURSEMENT PROGRAM 20

G-1 What benefits does this Program provide? 20

G-2 Who can use this Program? 20

G-3 Who qualifies as a dependent under this Program? 20

G-4 How does my “Dependent Care Expense Reimbursement Account” work?..... 21

G-5 How much can I contribute into this Program?..... 21

G-6 What should I consider when deciding how much to contribute
into this Program? 22

G-7 How much of my account is available to pay benefits? 23

G-8 What expenses are covered by this Program? 23

G-9 What are examples of covered dependent care expenses? 24

G-10 What expenses are not covered?..... 24

G-11 When is a dependent care expense “incurred”? 25

G-12 If I don’t use up all the money in my account in a year,
can I get the balance back? 25

G-13 What happens if my employment terminates when I still have
funds in my account? 25

G-14 Can I also use the dependent care credit for expenses paid
under this Program? 26

G-15 Do I have to file any tax forms? 26

PART H. FILING A CLAIM FOR REIMBURSEMENT 27

H-1 How do I make a claim for reimbursement?..... 27

H-2 What proof do I need to submit with a healthcare expense claim? 27

H-3 What proof do I need to submit with a dependent care expense claim?..... 27

H-4 What is the deadline for submitting claims? 28

H-5 How and when are claims paid? 28

H-6 What if my claim is denied?..... 28

H-7 What is OEA Choice Trust’s decision making authority
in deciding claims? 29

PART I.	GENERAL INFORMATION ABOUT PLAN OPERATIONS	30
I-1	Who is responsible for operating the Plan?.....	30
I-2	How are benefit payments funded?.....	30
I-3	Can I assign or pledge my Plan benefits?	30
I-4	Does the Plan affect the terms of any other benefit plan?	30
I-5	Can the Plan be amended or terminated?	30
I-6	How can I obtain copies of Plan records?	31
PART J.	OEA CHOICE TRUST CONTACT INFORMATION.....	32

We are pleased to provide you with this Guide to your Section 125 Plan. Section 125 plans are extremely popular—and for a very good reason. These plans offer employees the most tax-effective way to pay for healthcare and dependent care benefits. Simply stated, your Section 125 Plan lets you make payroll deductions and pay for these benefits with *tax-free dollars*. As explained later, you can pay for the coverage you need and save on your taxes at the same time.

□ *The Section 125 Plan Advantage*

The Section 125 Plan gives you a whole new way to pay for the healthcare and dependent care benefits you and your family need. Normally, you would have to pay for these benefits on an *after-tax* basis. That is, you would pay for them with what's left in your paycheck after FICA and income taxes are taken out. The Section 125 Plan, however, changes all of that. With the Section 125 Plan, you pay for benefits on a *pre-tax* basis. That is, the money to pay for your benefits is deducted from your paycheck before taxes are taken out. FICA and federal and state income tax withholding are then figured on the amount of your paycheck that is left *after* the payments into the Section 125 Plan are deducted.

This pre-tax advantage is what makes Section 125 plans so popular. The Section 125 Plan stretches your dollar by converting money that would have gone to pay taxes into money you can use to pay benefits. Add it up. It's a great deal—you can lower your taxes, increase your take-home pay and pay for your benefits all at the same time.

In short, if you're not using the Section 125 Plan to pay for your benefits, you're wasting money.

□ *Your Menu of Benefits*

You can use your tax-free Section 125 Plan dollars to pay the premiums for spouse and dependent coverage under your group health plans.

In addition, if offered by your employer, you may also use the Section 125 Plan to reimburse you for:

- Healthcare expenses not covered by your group health plans (medical, dental, prescription drug or vision), such as deductibles, co-pays and even over-the-counter drugs; and/or
- Dependent care expenses, such as day care or elder care.

□ *It's Easy to Participate*

Participating in the Section 125 Plan is easy and convenient. Your payments for all of the benefits you select are made through automatic payroll deduction. There's no need for you to write separate checks every month to pay for the coverage you need.

□ About This Guide

This Guide briefly describes the key features of the Section 125 Plan for your convenience. It discusses your benefits, rights and obligations under the Plan. It also answers the questions most frequently asked about the Plan.

Please remember, this is only a summary of the Section 125 Plan—it is not the official Plan document. For practical reasons, this Guide cannot cover the Plan in detail and explain how every provision works in every situation or cover all of the technical IRS rules. Because of this, *if there are any conflicts between this Guide and the official Plan document, the terms of the official Plan document will be followed.* You can obtain a copy of the Plan document from OEA Choice Trust.

This Guide is furnished to you by OEA Choice Trust. We intend to keep the information in this Guide current. However, the IRS rules change over time, so we cannot promise or guarantee that the information in this edition of the Guide will be correct, complete or up-to-date in the future. If you have any question about whether the information in this edition of the Guide is correct, please contact OEA Choice Trust.

□ Any Other Questions?

Please read this Guide carefully and save it for future reference. It's your first place to look for answers about your Section 125 Plan benefits and how the Plan works. If you have any questions about the Plan after reading this Guide, just contact OEA Choice Trust. The contact information is given at the end of this Guide. An OEA Choice Trust Benefits Representative will be happy to help you.

B-1 WHAT IS A SECTION 125 PLAN?

A Section 125 plan is an employee benefit plan that lets you use **tax-free** dollars to purchase a variety of healthcare and dependent care benefits. For example, you can use the Premium Payment Program (described later) to pay for coverage in your employer's group health plan for your spouse or dependents.

B-2 WHAT BENEFITS ARE AVAILABLE?

The following benefit programs can be offered through the Section 125 Plan:

- Premium Payment Program
- Healthcare Reimbursement Program
- Dependent Care Expense Reimbursement Program

These Programs are explained in detail in Parts E, F and G of this Guide. These reimbursement Programs are available to you only if your employer has chosen to make them available or if they are required to be provided under a collective bargaining agreement that covers you. Participation in any of the available programs is optional. You can choose one of the available programs, or all of them, or any combination that you feel best suits the needs of you and your family. You select the benefit programs you want to participate in when you fill out your enrollment form.

B-3 HOW DOES THE PLAN SAVE ME TAXES?

Tax Savings. The amount that you elect to pay into a benefit program is deducted from your pay **before** federal and state income taxes and FICA are calculated. Every dollar you elect to pay into the Section 125 Plan reduces the amount that is reported to the government on your Form W-2 as your taxable income. Lower taxable income means lower taxes and more spendable income for you. In other words, the Section 125 Plan lets you save on taxes as you pay for the benefits you and your family need.

To fully appreciate what the Section 125 Plan can do for you, consider what happens if you pay your health plan and other benefit costs without using the Section 125 Plan. Without the Section 125 Plan, you will be paying for those benefits with **after-tax** dollars (these are the dollars that are left after federal and state income tax and FICA tax are withheld from your paycheck). Paying with after-tax dollars does not reduce your taxable income—the full amount of your pay is reported to the government on your Form W-2.

Increased Buying Power. The Section 125 Plan also increases your buying power. This is easy to illustrate. Let's say you want to pay for \$1's worth of medical or dental benefits—

With the Section 125 Plan: If you're in the Section 125 Plan, \$1 comes right off the top of your pay, without any reduction for taxes, and goes to pay for benefits. So, the \$1 deduction from your pay buys you \$1's worth of benefits. And the taxes on your pay are figured after the \$1 is deducted, so your taxes are lower.

Without the Section 125 Plan: Now, let's say you're not in the Section 125 Plan and you want to pay for that same \$1's worth of benefits. If, for example, your combined federal, state and FICA taxes are 20%, you will need \$1.25 in gross pay to give you the after-tax \$1 that you need. To make matters worse, you probably won't get any tax benefit at all from making after-tax payments, since you can't take a deduction on your income tax return for the healthcare expenses you paid unless they exceed 7.5% of your adjusted gross income (which is not the case for most people). As you can see, the Section 125 Plan is simply the most tax-effective way for you to pay for your healthcare and dependent care expenses.

B-4 SINCE MY CONTRIBUTIONS AREN'T SUBJECT TO FICA, HOW DOES THIS AFFECT MY SOCIAL SECURITY BENEFITS?

As noted earlier, your payroll deduction contributions into the Section 125 Plan are not subject to FICA tax. As a result, your future Social Security benefits may be slightly reduced. However, most tax experts feel that the current tax savings from participating in a Section 125 plan will more than offset the slight reduction in future Social Security benefits. If you are concerned about this issue, we suggest you contribute your tax savings from the Section 125 Plan into a 403(b) tax-sheltered annuity. Increasing the contributions to your 403(b) account should more than make up for any reduction in your Social Security benefits.

C-1 AM I ELIGIBLE TO BE IN THE PLAN?

You are eligible for the Section 125 Plan if you meet the eligibility requirements set by your employer or, if applicable, of the terms of the collective bargaining agreement that covers your employment.

C-2 HOW DO I BECOME A PARTICIPANT?

Premium Payment Program. You automatically become a participant in this Program when you sign up for the group health plan unless you opt out. See Question E-2 for the details.

Healthcare Expense or Dependent Care Expense Reimbursement Program. You can participate in these programs only if your employer offers them. Your employer may offer one or both of these programs. To become a participant in an available program, you must complete an enrollment form. (Enrollment forms are available from OEA Choice Trust and can be downloaded at www.oeachoice.com.) On the enrollment form, you select the available program or programs you want and the amount you want deducted from your paycheck each pay period as your contribution to provide you with reimbursements under that program.

C-3 WHEN DO I BEGIN PARTICIPATING?

It depends on whether you are joining the Section 125 Plan for the first time or you are renewing your enrollment for the upcoming Plan Year—

First-Time Enrollment. If you are hired as an eligible employee, you can enroll for coverage for the current Plan Year at any time after you have met the eligibility waiting period set by your employer. If you turn in your enrollment form on time, you will actually enter the Section 125 Plan on the entry date set by your employer. Check with your employer's payroll department to see how many days in advance you have to turn in your completed enrollment form.

Annual Enrollment. Once you join the Section 125 Plan, you will need to re-enroll every year during the annual enrollment period. The benefit program selections and payroll deduction amounts you elected do not carry over from year to year. The only time outside of annual enrollment that you can change your benefit program elections or your payroll deduction amounts is if you have a change in status (see Questions D-1 and D-2).

You will be given advance notice of when the annual enrollment period will take place. During this time, you have the opportunity to elect the benefit programs you want to be in as well as the amount of payroll deduction contributions you want to make in the coming Plan Year. Each year's elections stand on their own, so your elections for the coming year can be completely different from what you elected the previous year.

C-4 WHAT IS THE “PLAN YEAR”?

The Plan’s records are kept on a 12-month fiscal year known as the Plan Year. The particular 12-month period used as the Plan Year is selected by your employer. Any money that you elect to contribute into one of the reimbursement programs can be used only for the eligible expenses you incur for services received during the Plan Year.

D-1 WHEN CAN I CHANGE MY COVERAGE OR PAYROLL DEDUCTION ELECTION DURING THE YEAR?

Generally, your benefit program elections and payroll deduction amounts must remain in effect for the entire Plan Year. (This is the IRS's rule, not your employer's or OEA Choice Trust's.) However, you can change your election if one of the following events occurs:

- **Change in Status.** These are certain changes in your family circumstances or job situation that are recognized by the IRS. These changes in status are explained in the next question.
- **Special Enrollment Rights.** In some cases, your group health plan will allow you to enroll yourself or your dependent outside of that Plan's normal annual enrollment period. Refer to your booklet for the group health plan for when these mid-year enrollments are allowed. If you or your dependent enrolls in the group health plan mid-year, you are allowed to change your election under the Section 125 Plan to correspond to the mid-year enrollment in the group health plan. If your special enrollment in the group health plan is made on a retroactive basis, you can elect to increase your payroll deduction contributions under this Plan for the rest of the Plan Year to make up the additional cost of the retroactive coverage.
- **Judgment, Decree or Order.** If a decree or order resulting from a divorce, legal separation, annulment or change in legal custody of a child of yours requires you to provide health coverage for that child, you may change your election under this Plan as necessary to provide that coverage. If, on the other hand, the order requires your former spouse to provide coverage, you may change your election to cancel coverage for that child.
- **Entitlement to Medicare or Medicaid.** If you or your spouse or dependent becomes enrolled under Part A or Part B of Medicare or Medicaid (other than coverage solely under the federal pediatric vaccine program), you may change your election and cancel coverage for the affected person under our group health plan.
- **A Significant Premium Increase.** If there is a minor mid-year increase in the cost of insurance premiums, your payroll deduction contributions will automatically be increased to meet the premium increase and keep your coverage in place. However, if OEA Choice Trust determines that the increase is significant, you will be able to change your Section 125 Plan election to cover the increase or you can revoke your election and cancel your coverage completely or change to a different benefit program (if one is available).

- **A Significant Coverage Change.** If the coverage offered under your group health plan ever significantly decreases or is terminated, you will be able to change to a different plan with similar coverage. However, you may **not** revoke your election entirely and completely opt out of the Section 125 Plan.

- **Reduction in Compensation.** If your pay is reduced to a point where your payroll deduction contributions are not enough to pay the entire premium for the coverages you have elected, your payroll deductions will be adjusted as follows:
 - (1) If you are still actively at work, your payroll deduction contributions will be suspended. The suspension will be effective as of the last day of the pay period that begins on or after the date the compensation reduction is effective. You may be eligible to elect COBRA coverage (see Question F-11).
 - (2) If the reduction in pay is due to unpaid leave (including unpaid family and medical leave), you can continue making your contributions under one of the options explained in Question D-5.
 - (3) If the reduction is because you have had an on-the-job injury and are on workers' compensation, your payroll deduction contributions will be suspended. You may elect to continue coverage during the period you are off work under one of the payment options explained in Question D-5.
 - (4) When you once again start making enough to pay the entire premium, your payroll deduction contributions will automatically resume.

When You Can't Change

You **cannot** change your benefit or payroll deduction election simply because:

- You decide you can't afford the amount you elected.
- You have an unforeseen expense and you need the money for something else (e.g., car or home repairs).
- You decide you really won't be able to use the entire amount you elected to contribute.

Again, these are IRS rules, not your employer's or OEA Choice Trust's.

D-2 WHAT IS A CHANGE IN STATUS?

A change in status includes:

- Marriage;
- Divorce, annulment or legal separation;
- Birth or adoption of a child (pregnancy is **not** a change in status);
- Death of a spouse or covered dependent;
- Your spouse starting or leaving a job;
- You or your spouse switching from full-time to part-time employment (or vice versa), but only if that change affects your eligibility to be in this Plan;
- You or your spouse taking an unpaid leave of absence;
- A dependent ceasing to satisfy the requirements for dependent coverage; or
- A significant change in the health plan coverage provided by your spouse's employer.

Special Rules for Healthcare Expense Changes. You cannot cancel your participation in the Healthcare Reimbursement Program or elect to reduce your contributions at a time when your Healthcare Reimbursement Account is overdrawn.

Special Rules for Dependent Care Changes. In addition to the change in status reasons listed above, you can also change your dependent care election if—

- You change dependent care providers;
- There is a change in the cost of your dependent care provider;
- You or your spouse has a change in work schedule which increases or decreases the amount of dependent care you need; or
- You are divorced or separated and you either become, or cease to be, the custodial parent.

If you change providers, you must provide the required information about the new provider on your Request For Reimbursement Claim Form (available from OEA Choice Trust or you can download the form at www.oechoice.com).

Changes Must Be Consistent with the Need. Your requested change will be allowed only if it is necessary and appropriate as a result of the change in status. (For example, if you have a new child, an election to drop or reduce coverage would probably not be consistent with that change in status.)

When to Request a Change. If you want to change your level of coverage because of a change in status, you will generally have to request the coverage change within a month of the date the status change occurred.

When the Change Becomes Effective. Changes will generally be made on a prospective basis only. They will be made as of the first payroll period that begins after your request is processed, or as soon afterwards as is administratively feasible. Retroactive changes will be allowed in special circumstances. Check with OEA Choice Trust if you want to see if your change can be made on a retroactive basis.

D-3 WHAT HAPPENS IF I TERMINATE EMPLOYMENT?

If you terminate employment for any reason, your payroll deduction contributions to the Section 125 Plan will, of course, stop. Your participation in the Section 125 Plan will also stop as of the date you terminate employment. However, you may be able to continue participating in the Healthcare Reimbursement Program through the end of the Plan Year (see Question F-10).

D-4 WHAT HAPPENS IF I AM REHIRED?

If you terminate employment and are later rehired, you will be treated as a new employee. You can re-enroll in the Section 125 Plan at any time during the remainder of the Plan Year in which you are rehired. If you do not re-enroll during this time, you will have to wait until the next annual enrollment period to re-enroll.

If you are rehired during the same Plan Year in which you terminated employment, IRS rules do not allow you to change from your previous benefit and payroll deduction elections until the following Plan Year (unless, of course, you have a qualifying change in status).

D-5 WHAT HAPPENS IF I GO ON LEAVE OF ABSENCE?

It depends on whether the leave is paid or unpaid and the reason for the leave.

Paid Leave. Your payroll deduction contributions will continue automatically for the remainder of the year in which your leave began. If you want to continue participating in the Section 125 Plan in the following year, you will need to re-enroll during the annual enrollment period.

Unpaid Leave. Your payroll deduction contributions will, of course, stop. However, you must continue to pay your cost for the coverage during the leave period to keep your coverage in place. You can continue payments on either an after-tax basis or a pre-tax basis under these options—

- ***Pay-As-You-Go Option (After-Tax Payments):*** If you want to keep your benefits in force, you may continue paying the required contributions on an *after-tax* basis. That is, you will need to send in a personal check for the payments required. Please contact your employer to make the necessary arrangements. If you fail to make a payment, your coverage will be cancelled 30 days after the payment was due.

- **Pre-Payment Option (Pre-Tax Payments):** You can elect to “pre-fund” the payments that will become due during the balance of the Plan Year in which your leave period begins. You do this by increasing your payroll deduction contributions in the pay periods before the leave.

You can also elect to have the required payments taken out of any sick pay, vacation pay or severance pay you may be entitled to receive during the leave period.

- **Catch-Up Option:** This option is available only if agreed to by your employer. Under this option, you and your employer agree, before your leave begins, that your employer will advance the premium payments you would be required to make during your leave. You agree that you will repay these advances when your leave ends.

Your employer has the discretion as to whether it will enter into a Catch-Up Option Agreement with you. In making its decision, your employer will take into account factors such as the length of your leave, how long you have been employed and whether you can afford to make the premium payments required during your leave under one of the other options.

When you return to work, your repayments to your employer will be made by pre-tax payroll deductions spread out over the remainder of the year in which you return.

If you do not return from your leave, you must repay the advanced premiums on an after-tax basis with a personal check or make other payment arrangements with your employer. Your employer can choose to recover the premiums it advanced for you from any amounts it owes you (such as unpaid wages or vacation pay). Your employer also has the right to bring a collection action against you if you do not repay these advances. However, your employer cannot pursue a collection if you do not return to work because of a serious medical condition or unforeseen circumstance. If this is the case, you may be required to provide a medical certification or other documentation acceptable to your employer as proof of your medical condition.

Family or Medical Leave. If you are on paid leave, your regular payroll deduction contributions will continue (unless you adjust them for a change in status). If the leave is unpaid, you have the same payment options discussed above for unpaid leaves.

E-1 WHAT BENEFITS DOES THIS PROGRAM PROVIDE?

The Premium Payment Program lets you use tax-free dollars to pay your portion of the premiums for the medical, dental, prescription drug, vision and life insurance coverages you have selected.

E-2 HOW DOES THIS PROGRAM WORK?

It's simple—you are automatically enrolled in the Premium Payment Program when you enroll in your group health plan. There is nothing more for you to do. The premiums you are required to pay for health plan coverage you elect for yourself, your spouse or your dependents will be automatically deducted from your paycheck on a pre-tax basis each pay period.

If for some reason you do not want the premiums deducted from your paycheck on a pre-tax basis, you can sign a waiver and opt out of the Premium Payment Program. The waiver form is available from OEA Choice Trust. If you sign a waiver, you will need to make arrangements with your employer to have your required premiums deducted from your paycheck on an after-tax basis.

PART F THE HEALTHCARE REIMBURSEMENT PROGRAM

F-1 WHAT BENEFITS DOES THIS PROGRAM PROVIDE?

The Healthcare Reimbursement Program allows you to make pre-tax payroll deduction contributions into a “Healthcare Reimbursement Account.” This account will be used as a spending account to reimburse you for the uninsured medical, dental, drug and vision expenses you pay for yourself, your spouse and your dependents.

As explained earlier, the payroll deduction contributions you make into this Program are not subject to income tax or FICA. And the reimbursements you receive are not taxable income to you. Depending on your tax bracket, this means that you are effectively getting a discount of 20% to 40% or more on the price of the healthcare expenses that are reimbursed under this Program.

F-2 HOW DOES MY “HEALTHCARE REIMBURSEMENT ACCOUNT” WORK?

When you sign up for this Program, a Healthcare Reimbursement Account is set up in your name. This is a bookkeeping account that is used to keep track of the payroll deduction contributions you make into this Program and the reimbursements you receive.

F-3 HOW MUCH CAN I CONTRIBUTE INTO THIS PROGRAM?

The minimum and maximum amounts you can contribute into your Healthcare Reimbursement Account for any Plan Year will be announced during the annual enrollment period.

Not a Combined Family Limit

If your spouse is participating in a healthcare reimbursement program at his or her job, the amount your spouse is contributing into that program does not affect what you can contribute into this one and vice versa. You each have your own separate minimum and maximum limits according to the terms of the program each one of you is in.

F-4 HOW MUCH OF A REIMBURSEMENT CAN I RECEIVE AT ANY GIVEN TIME?

At any given time, the amount that is available in your Healthcare Reimbursement Account to pay reimbursements is the full amount you elected to contribute into your account for the Plan Year minus the amount of any previously reimbursements you already received that year. This account balance is available even if it is more than the amount of payroll deduction contributions that have been credited to your Healthcare Reimbursement Account at that time.

For example, if you elect to contribute \$100 per month, that's \$1,200 worth of reimbursements you can claim for the Plan Year. The entire \$1,200 will be available right from the first day of the Plan Year. And if you were to receive, say, \$200 in reimbursements in the first month, that would leave you with \$1,000 you could claim for the rest of that year.

F-5 WHAT EXPENSES ARE COVERED BY THIS PROGRAM?

Your expenses will be reimbursed as long as—

- They would qualify as a covered healthcare expense (see Questions F-6 and F-7).
- They are incurred during the Plan Year (see Question F-9).
- They are supported by receipts, billing statements, etc. (see Question H-2).

F-6 WHAT ARE “COVERED HEALTHCARE EXPENSES”?

Generally, these are the types of healthcare expenses that are deductible for federal income tax purposes. The following are examples of the healthcare expenses covered under this Program—

- Acupuncture and naturopathy
- Benefits in excess of your group health plan's payment limits
- Co-payments and deductibles under your group health plan
- Contact lenses
- Contact lens cleaning solutions
- Dental and orthodontia costs (exams, braces, etc.)
- Dentures
- Dietary supplements (*see the special rules in the box below*)
- Doctors outside your group health plan
- Drug and alcohol treatment
- Eye examinations
- Eyeglasses (including prescription sunglasses)
- Hearing aids and examinations
- Herbal supplements (*see the special rules in the box below*)
- Home improvements needed because of medical conditions
- Medical supplies
- Orthopedic shoes
- Over-the-counter drugs (such as antacids, allergy medicines, pain relievers, cold medicines, etc. used to treat injuries or sickness)
- Oxygen equipment and oxygen

- Prescription drugs not covered by your group health plan
- Prosthetic limbs
- Psychiatric and psychological care
- Seeing eye dogs (and their care and feeding)
- Special education for the disabled
- Supportive or corrective devices (including special mattresses, elastic stockings, etc.)
- Transportation to receive medical care (including ambulances)
- Treatments and procedures not covered by your group health plan (e.g., excluded conditions, experimental treatments, etc.)
- Vitamins (*see the special rules in the box below*)
- Wheelchairs and crutches

Special Rules for Dietary and Herbal Supplements and Vitamin

You can be reimbursed for dietary and herbal supplements and vitamins only if they are prescribed by your medical practitioner for the treatment or prevention of a specific disease or condition (e.g., calcium to treat osteoporosis or vitamins with folic acid to prevent birth defects).

You cannot be reimbursed if you are taking dietary or herbal supplements or vitamins just to improve your appearance or your general overall health or your sense of well-being, even if your medical practitioner prescribes them for any of these reasons.

You will need to include your medical practitioner's written prescription, including a statement of the medical condition for which the dietary or herbal supplement or vitamin is being prescribed, every time you submit a claim for reimbursement.

To give you an idea of the types of healthcare expenses that can be reimbursed, see IRS Publication 502, *Healthcare Expenses*, the sections called "What Medical Expenses Are Includible" and "What Expenses Are Not Deductible." This publication is available from the IRS by calling 1-800-TAXFORM or going to www.irs.gov/pub/irs-pdf/p502.pdf. Be careful relying on this IRS publication, however. It is intended to be a guide for determining what expenses are deductible on your federal tax return, not what expenses are reimbursable from a healthcare reimbursement program. Not all expenses that are deductible are reimbursable (e.g., health insurance premiums) and not all expenses that can be reimbursed are deductible (e.g., over-the-counter drugs).

Orthodontia Treatment

- To be reimbursed for orthodontic services, you must submit a Section 125 Orthodontia Expense Worksheet completed by the orthodontist, along with the treatment contract and receipt of payment stating the date the braces were placed.
- Regardless of whether full payment is made when treatment begins, only those expenses related to the services received at the initial treatment will be eligible for reimbursement. If a down payment is made, only an amount up to or equal to the initial services received will be reimbursed.

OEA Choice Trust will determine whether a down payment can be reimbursed. If you need to make a down payment, please check with us before you decide how much to contribute to your Healthcare Reimbursement Account for the Plan Year.

- **Monthly Payments:** Orthodontic services are assumed to be incurred at the time a monthly payment is due and paid. The orthodontist will need to allocate the total charges over each year in relation to services performed. You can only be reimbursed for services received in each Plan Year. Claims for payments made before they are due will not be processed.

F-7 WHAT EXPENSES ARE NOT COVERED?

The following are examples of the types of expenses that *cannot* be reimbursed under this Program—

- Health insurance premiums
- Any expense reimbursed under any insurance policy or other medical/dental program
- Cosmetic treatments, including cosmetic surgery, cosmetic dental treatments such as teeth bleaching, treatments for baldness such as Rogaine or hair transplants, skin treatments such as Retin-A and electrolysis (unless the cosmetic treatment or surgery is necessary to treat a congenital problem, an injury or a disfiguring disease)
- Dietary or herbal supplements or vitamins are not covered—even if they are prescribed by your medical practitioner—if you are taking them just to improve your appearance or for your general overall health or sense of well-being. (They can be covered, however if you are taking them to treat or prevent a specific disease or condition diagnosed by your medical practitioner. See Q&A F-6 for the details.)

- Expenses that are merely beneficial to your general health, such as exercise, nutrition and recreation (such as spas, hot tubs or tanning beds)—unless they are prescribed by your doctor
- Toiletries (toothpaste, shaving cream, lotions, etc.)
- Cosmetics (face creams, deodorants, hand lotions, etc.)
- Illegal operations or treatments (e.g., medical marijuana or other controlled substances not allowed under federal law, even if prescribed by a physician)

F-8 CAN I ALSO CLAIM A DEDUCTION FOR MY REIMBURSED EXPENSES?

No. You cannot claim a deduction on your income tax return for any healthcare expense reimbursed under this Program. However, paying those expenses with pre-tax dollars through this Program gives you more of a tax savings than paying them yourself and then taking a deduction. In fact, if you're like most people, you probably couldn't claim a deduction in any case, since healthcare expenses must exceed 7.5% of your adjusted gross income before they're deductible. And you can't even claim a deduction for some of the expenses that can be reimbursed under this Program—most notably, over-the-counter drugs.

If you do claim a deduction for a reimbursed expense, the amount of the reimbursement becomes taxable to you. For example, if you pay a \$100 doctor bill this year, claim it as a deduction on your tax return and also submit it for reimbursement under this Program, you will need to report the amount of the reimbursement as taxable income in the year you receive the reimbursement payment.

F-9 WHEN IS A HEALTHCARE EXPENSE “INCURRED”?

Knowing when a healthcare expense is incurred is very important for two reasons—

First, the Healthcare Reimbursement Program can only reimburse claims that are incurred after you enter the Program.

Second, the money you contribute into this Program during a Plan Year can only be used to reimburse claims incurred during that Plan Year.

A claim is incurred when you (or your spouse or dependent) actually receive the medical or dental services or supplies, not when you are billed for them or when you pay for them. A few examples should make this rule clear—

Example 1. You went to the doctor before you entered the Section 125 Plan but you received the bill after you joined the Plan.

Answer: You can't be reimbursed.

Example 2. You prepay your doctor this year for services to be given next year.

Answer: You can't be reimbursed from any of the money you contributed to this Program for this year, but you can be reimbursed next year from the amounts you contribute that year, provided you actually receive the services you paid for.

Example 3. You see the doctor this year, but she doesn't bill you until next year.

Answer: You can be reimbursed, but only from the money you contributed to this Program for this year.

F-10 IF I DON'T USE UP ALL THE MONEY IN MY ACCOUNT IN A YEAR, CAN I GET THE BALANCE BACK?

IRS's "Use-It-Or-Lose-It" Rule. Your Healthcare Reimbursement Account is subject to the IRS's infamous "Use-It-Or-Lose-It" rule. This rule states that any money contributed into your account for a Plan Year can be used only to pay healthcare expenses incurred during that Plan Year. Any money left in your Healthcare Reimbursement Account after paying for all qualified expenses for that year must be forfeited. The excess cannot be distributed to you in cash, it cannot be carried over to the next Plan Year and it cannot be used to pay for benefits under any other program in the Section 125 Plan. For example, the surplus cannot be used for dependent care expenses.

Planning Is Important!

Studies of Section 125 plans across the country have shown that, with some planning, employees can minimize the risk of forfeiting benefits.

You can start your own planning by reviewing your uninsured healthcare expenses for the past few years. Add on to this the additional uninsured expenses you can predict you will have during the upcoming year. This will give you a good idea of what your uninsured healthcare expenses will be. Then elect to contribute a percentage of that amount into your Healthcare Reimbursement Account—say somewhere between 75% and 90%.

While this is a conservative approach and may not cover all of your uninsured expenses for the year, it will give you a cushion to help avoid forfeiting any money at the end of the year.

F-11 WHAT HAPPENS IF MY EMPLOYMENT TERMINATES WHEN I STILL HAVE FUNDS IN MY ACCOUNT?

Generally, your coverage ends on the date your employment terminates, and you can be reimbursed only for claims incurred up through the date of your termination. However, you have the option to continue coverage past your termination date by electing COBRA coverage.

If you elect COBRA coverage under the Healthcare Reimbursement Program, you must continue contributing into your Healthcare Reimbursement Account and you will continue to be reimbursed for claims incurred up through the end of the year in which your employment terminated. (Note: This is a separate COBRA election from the COBRA election you may want to make to continue your coverage under your group health plan.) You can elect Healthcare Reimbursement Program COBRA coverage only if you have not overspent your Healthcare Reimbursement Account as of the date your employment terminated (taking into account all claims incurred up through that date).

If you elect Healthcare Reimbursement Program COBRA coverage, you will have to continue contributing on an after-tax basis the same amount that was being deducted from your paycheck on a pre-tax basis. In addition, there will be a small administrative fee added on. You will need to send in a check to your employer for each payment or make other payment arrangements with your employer.

F-12 WHAT HAPPENS IF MY EMPLOYMENT TERMINATES WHEN MY ACCOUNT IS OVERDRAWN?

If, when you terminate employment, you have been reimbursed more than you contributed into your Healthcare Reimbursement Account, you are not required to repay the amount of the excess reimbursements you received. However, you cannot continue coverage past your termination date.

PART G DEPENDENT CARE EXPENSE REIMBURSEMENT PROGRAM

G-1 WHAT BENEFITS DOES THIS PROGRAM PROVIDE?

The Dependent Care Expense Reimbursement Program allows you to be reimbursed on a pre-tax basis for the childcare or adult dependent care expenses that are necessary to allow you or your spouse to work, look for work or attend school full-time. You do this by making pre-tax payroll deduction contributions into a “Dependent Care Expense Reimbursement Account.” Your account will be used as a spending account to reimburse you for your day care and other dependent care expenses.

As explained earlier, the payroll deduction contributions you make into this Program are not subject to income tax or FICA. And the reimbursements you receive are not taxable income to you. Depending on your tax bracket, this means that you are effectively getting a discount of 20% to 40% or more on the price of the healthcare expenses that are reimbursed under this Program.

G-2 WHO CAN USE THIS PROGRAM?

Dependent care expenses are covered under this Program only if they are necessary to allow you or your spouse to go to work, look for work or attend school full-time. This means that, generally, you can use this Program only if you are single or if your spouse is working. If your spouse is not working, you can use this Program only if your spouse qualifies as a disabled dependent or is a full-time student for at least five months during the year.

G-3 WHO QUALIFIES AS A DEPENDENT UNDER THIS PROGRAM?

A dependent is someone you could claim as a dependent on your federal income tax return (or could claim as a dependent except that his or her income is too high) and is either—

- A child of yours under the age of 13; or
- Your spouse or your dependent (including a child 13 or older or a parent or grandparent), provided he or she—
 - Is physically or mentally incapable of caring for himself or herself; and
 - Spends at least eight hours a day in your home.

Special Rule for Divorced or Separated Parents

Generally, if you are divorced or separated and you are the custodial parent, your child may qualify as a dependent under this Program even if you are not claiming him or her as a dependent on your federal income tax return. See “Child of Divorced or Separated Parents,” in IRS Publication 503, “Child and Dependent Care Expenses” for the details.

G-4 HOW DOES MY “DEPENDENT CARE EXPENSE REIMBURSEMENT ACCOUNT” WORK?

When you sign up for this Program, a Dependent Care Expense Reimbursement Account is set up in your name. This is a bookkeeping account that is used to keep track of the payroll deduction contributions you make into this Program and the reimbursements you receive.

G-5 HOW MUCH CAN I CONTRIBUTE INTO THIS PROGRAM?

Minimum/Maximum. The minimum amount you can contribute to this Program will be announced during the annual enrollment period. The maximum amount depends on your federal income tax return filing status and, if your spouse is not working, it is also limited under the nonworking spouse rule discussed below—

- If you are single, the maximum contribution is \$5,000
- If you are married and file a joint tax return, the maximum is \$5,000
- If you are married, but your spouse maintains a separate residence for the last six months of the calendar year and you provide more than one-half of the cost of maintaining your dependent and you file a separate tax return, the maximum is \$5,000
- If you are married, live with your spouse and file a separate tax return, the maximum is \$2,500

Nonworking Spouse Rule. If you're married, the amount you can contribute to this Program cannot be more than your spouse's earned income. That is, your limit is either the \$5,000/\$2,500 maximum discussed above or your spouse's income for the year, **whichever is lower**. This generally means that **this Program is not available to you if your spouse is not working**. However, if your spouse is not working because he or she is physically or mentally incapable of taking care of himself or herself, or if your spouse is a full-time student for at least five months of the year, your spouse is deemed to have earned income of \$200 (\$400 if you have more than one dependent) for each month he or she is incapacitated or is attending school.

This is a Combined Family Limit

The dollar limits discussed above apply on a family basis. So, if your spouse is participating in a dependent care expense reimbursement program provided by his or her employer, the \$5,000 limit (or \$2,500 limit, if applicable) applies to the both of you on a combined basis. You each don't get your own separate dollar limit.

Examples. To see how the maximum contribution limits and this special rule work, let's look at how they work in a typical case. Jack is a married employee with two dependent children. He earns \$30,000 and files a joint tax return with his spouse. The following examples show how the maximum limits and the special rule affect the amount he can contribute to this Program.

Example 1. If Jack's spouse has no earned income and is not incapacitated or a full-time student, Jack can't contribute anything to this Program.

Example 2. If Jack's spouse is a full-time student for nine months out of the year, Jack may contribute up to \$3,600. This is because Jack's spouse is deemed to have earned income of \$3,600 (\$400/month (since Jack has more than one dependent) x 9 months = \$3,600).

Example 3. If Jack's spouse earns \$4,000 a year at a part-time job, Jack could contribute up to \$4,000.

Example 4. If Jack's spouse makes \$6,000 a year at her part-time job instead of \$4,000, Jack could contribute up to the \$5,000 maximum for married filing jointly.

OEA Choice Trust Not Responsible For Calculating Your Contribution Limit

OEA Choice Trust will not be verifying your or your spouse's income or tax filing status and has no liability if you incorrectly calculate the maximum amount you can contribute into this Program.

G-6 WHAT SHOULD I CONSIDER WHEN DECIDING HOW MUCH TO CONTRIBUTE INTO THIS PROGRAM?

Estimate Your Upcoming Expenses. When you enroll in this Program, your first step should be to come up with a realistic estimate of your dependent care expenses for the coming Plan Year. Look at your expenses last year and try to anticipate the expenses you might have in the coming year. And talk to your dependent care provider about the charges you can expect to pay during the next year, including any rate increases.

If you are a newly eligible employee who is joining this Program after the current Plan Year has begun, you need to be careful to estimate only the amount of dependent care expenses you will incur from the date your participation begins through the end of the Plan Year. This is because the expenses you incurred before your participation started are not eligible for reimbursement.

Remember to exclude from your total expenses any upcoming vacations and other special events during which your dependent will not be receiving dependent care that enables you and your spouse to work or attend school full-time.

It's also important to consider your child's age. Keep in mind that generally you cannot be reimbursed for expenses you incur after your child turns age 13. So, if your child will be turning age 13 before the end of the Plan Year, you should estimate your dependent care expenses only for the time up to your child's 13th birthday. Also, if your child will start attending school in the fall, you should take that into account when estimating your expenses.

Don't Forget the "Use-It-Or-Lose-It Rule." When determining the amount you want to contribute, make sure you take into account the risk of forfeiting any unused contributions (see Question G-12).

Keep Records. We strongly encourage you to keep copies of all the claims, bills and receipts you submit for reimbursement. This will help you estimate your expenses for the following year as well as providing you with the necessary tax records in case the IRS questions the dependent care expenses you claimed.

G-7 HOW MUCH OF MY ACCOUNT IS AVAILABLE TO PAY BENEFITS?

The amount that is available at any given time to pay reimbursements from your Dependent Care Expense Reimbursement Account is the current balance of your account. This would be the total amount of contributions paid into your account up until that time minus the total amount of reimbursements paid out of your account up to that time.

If you submit more in claims than you have available in your account, the overage will be reimbursed as new payroll deduction contributions are received.

G-8 WHAT EXPENSES ARE COVERED BY THIS PROGRAM?

Your dependent care expenses can be reimbursed under this Program only if—

- They were for someone who qualifies as your dependent under the IRS rules (see Question G-3).
- They qualify as eligible dependent care expenses under the IRS rules (see Question G-9).
- They are incurred during the Plan Year (see Question G-11).
- They are supported by receipts, billing statements, etc. (see Question H-2).

G-9 WHAT ARE EXAMPLES OF COVERED DEPENDENT CARE EXPENSES?

Dependent care expenses that can be reimbursed under this Program include—

- Dependent care provided either in or outside your home by someone who is not your spouse, your child under age 19 or your dependent.
- Day care or elder care centers.
- Before and after-school care (other than tuition expenses).
- Day camp or nursery school.
- Summer or holiday camp.
- Late pick-up fees.
- Expenses for a housekeeper whose duties include caring for your dependent.

G-10 WHAT EXPENSES ARE NOT COVERED?

You **cannot** use this Program to pay for—

- Dependent care provided by your spouse, by a child of yours under the age of 19 or by someone you or your spouse could claim as a dependent on your federal tax return.
- Tuition or education fees (including kindergarten).
- Sports lessons, field trips or equipment.
- Food, clothing or diapers.
- Overnight camping.
- Transportation to and from your dependent care provider (including picking up your baby-sitter).
- Baby-sitting for an evening out.
- Expenses paid in advance.
- Late payment fees.
- Placement fees for finding a dependent care provider (such as an *au pair*).
- Residential nursing home expenses.

G-11 WHEN IS A DEPENDENT CARE EXPENSE “INCURRED”?

Knowing when a dependent care expense is incurred is very important for two reasons—

First, the Dependent Care Expense Reimbursement Program can only reimburse claims that are incurred after you enter the Program.

Second, the money you contribute into this Program during a Plan Year can only be used to reimburse claims incurred during that Plan Year.

A claim is incurred when you actually receive the dependent care services, not when you are billed for them or when you pay for them. A few examples should make this rule clear—

Example 1. You used a day care center before you entered the Section 125 Plan, but you received the bill after you joined the Plan.

Answer: You can't be reimbursed.

Example 2. You prepay the day care center this year for services to be given next year.

Answer: You can't be reimbursed from any of the money you contributed to this Program for this year. You can be reimbursed from the money you contribute to this Program in the next year provided you actually receive the services you paid for.

Example 3. You use the day care center this year, but it doesn't bill you until next year.

Answer: You can be reimbursed, but only from the money you contributed to this Program for this year.

G-12 IF I DON'T USE UP ALL THE MONEY IN MY ACCOUNT IN A YEAR, CAN I GET THE BALANCE BACK?

Any unused balance will be forfeited since the IRS's "Use-It-Or-Lose-It" rule also applies to your Dependent Care Expense Reimbursement Account (see Question F-10). However, this rule is less of a problem with dependent care expenses than it is with healthcare expenses, since dependent care expenses are typically more predictable. You may still want to err on the conservative side when you're deciding how much to contribute into this Program as discussed in Question F-10.

G-13 WHAT HAPPENS IF MY EMPLOYMENT TERMINATES WHEN I STILL HAVE FUNDS IN MY ACCOUNT?

You can be reimbursed only for the claims you incurred up through the date of your termination. Any balance remaining after those claims are paid will be forfeited.

G-14 CAN I ALSO USE THE DEPENDENT CARE CREDIT FOR EXPENSES PAID UNDER THIS PROGRAM?

No. You cannot claim the dependent care income tax credit for any expenses that are paid under this Program. Before you decide to sign up for the Dependent Care Expense Reimbursement Program, you will need to determine whether you would save more by taking the tax credit instead.

For example, your dollar limit may be higher under the Dependent Care Expense Reimbursement Program than under the dependent care income tax credit. The maximum limit under the Dependent Care Expense Reimbursement Program is \$5,000. The maximum amount of expenses that can be taken into account in determining the tax credit is \$3,000 if you have one dependent and \$6,000 if you have two or more dependents.

Generally, the tax credit is more favorable for employees in the 15% tax bracket. For them, the tax credit can provide a benefit of up to 35% of their dependent care expenses, while the Dependent Care Expense Reimbursement Program would only provide a 15% benefit.

What's the Best Choice for You?

As you can see, you will need to consider a number of factors to determine which option will give you the largest tax savings. These factors include the number of your dependents, your marital status, adjusted gross income, itemized deductions, personal exemptions and the amount you spend on dependent care.

For more information about the dependent care income tax credit, see IRS Publication 503, "Child and Dependent Care Expenses." You may also use IRS Form 2441, "Child and Dependent Care Expenses," to help you determine whether the Dependent Care Expense Reimbursement Program or the tax credit is a better choice for you. You may want to talk to your tax advisor before you make your decision.

G-15 DO I HAVE TO FILE ANY TAX FORMS?

Yes. In order for the reimbursements you receive under this Program to be tax-free, you must file IRS Form 2441, "Child and Dependent Care Expenses" with your federal tax return. You will have to list on this form the name and taxpayer identification number of any person who provided you with dependent care services that were reimbursed under this Program.

H-1 HOW DO I MAKE A CLAIM FOR REIMBURSEMENT?

To be reimbursed, you must complete and submit a claim form to OEA Choice Trust along with acceptable proof of the expense. Claim forms are available from OEA Choice Trust (or you can download them at www.oeachoice.com).

H-2 WHAT PROOF DO I NEED TO SUBMIT WITH A HEALTHCARE EXPENSE CLAIM?

You will need to provide with your claim form a copy of the provider's bill or the Explanation of Benefits form that shows:

- The type of the service or the name of the product provided
- The date the expense was incurred
- The name of the person for whom the service/product was provided (you or your spouse or dependent), unless it is an over-the-counter medication
- The person or organization that provided the service/product

H-3 WHAT PROOF DO I NEED TO SUBMIT WITH A DEPENDENT CARE EXPENSE CLAIM?

You will need to provide with your claim form:

- The name, address and taxpayer identification number (or Social Security Number, if applicable) of your dependent care provider
- The date the care was provided
- The name of the person who received the care and that person's relationship to you
- A copy of the dependent care provider's bill
- A copy of your cancelled check, receipt or proof of payment

In short, you can't be paying your dependent care provider "off-the-books."

***Can't Get Your Dependent Care
Provider's TIN or SSN?***

If your dependent care provider does not have a Taxpayer Identification Number or a Social Security Number (or won't give it to you), you need to attach a letter to your dependent care reimbursement claim form telling us you asked your dependent care provider for this information but your provider would not give it to you.

H-4 WHAT IS THE DEADLINE FOR SUBMITTING CLAIMS?

You will have three months after the close of the Plan Year to submit your claims for the expenses you incurred during that Plan Year.

H-5 HOW AND WHEN ARE CLAIMS PAID?

Reviewing Your Claim. When you turn in your claim form, OEA Choice Trust will review the claim to check that the expenses were incurred during the Plan Year and that they are supported by the correct documents. OEA Choice Trust will also determine whether the expenses can be reimbursed under the IRS rules.

Processing Time. Claims will be paid as soon as administratively feasible. Additional processing time may be required from time to time, depending, for example, on the total number of claims submitted during a particular period.

Payment Checks. A check for your approved claim will be sent to your mailing address that is on file with OEA Choice Trust. Please notify OEA Choice Trust promptly if your address changes.

H-6 WHAT IF MY CLAIM IS DENIED?

Most problems regarding claims are handled informally by simply contacting an OEA Choice Trust Benefit Representative (see Part J for the contact information). A lot of problems can be avoided by asking a OEA Choice Trust Benefit Representative in advance whether a particular healthcare or dependent care expense qualifies for reimbursement. If the matter cannot be resolved informally and you want to file a formal claim to have the denied claim reconsidered, you may submit it in writing to OEA Choice Trust.

OEA Choice Trust will reconsider your claim as soon as is administratively feasible, usually within 90 days of receiving your claim. Up to an additional 90 days may be required if the OEA Choice Trust needs more information or feels that a hearing is necessary.

If your claim is denied again, you will be notified of the reasons for the denial in plain, nontechnical language. You will also be advised of any additional information that may be useful to support your claim. Again, an OEA Choice Trust Benefit Representative will attempt to resolve the matter with you informally, but you will also have a reasonable opportunity to make a formal appeal to OEA Choice Trust's Board of Trustees. You will also be given an explanation of the appeals procedures, including the timeline for deciding your appeal.

The decision of the Board of Trustees is the final determination of your claim under the Section 125 Plan. **You cannot bring a lawsuit regarding your claim until you complete the Section 125 Plan's claims review and appeals procedures.**

H-7 WHAT IS OEA CHOICE TRUST'S DECISION MAKING AUTHORITY IN DECIDING CLAIMS?

OEA Choice Trust and its Board of Trustees have broad discretion to interpret the Plan's provisions, determine all questions concerning eligibility and benefits and make findings of fact, including deciding the sufficiency of any evidence submitted. This means that a court of law or an arbitrator can reverse a decision of the Trust's staff or the Board of Trustees only if the decision was arbitrary and capricious. That is, the decision cannot be overturned unless it was made in bad faith, was not supported by substantial evidence or was erroneous as to a question of law. In reviewing the decision, the court of law or the arbitrator will be limited to considering only the testimony and other materials that were presented to the Trust's staff or the Board of Trustees at the time the decision was made.

PART I GENERAL INFORMATION ABOUT PLAN OPERATIONS

I-1 WHO IS RESPONSIBLE FOR OPERATING THE PLAN?

Your employer has adopted the Plan and is responsible for maintaining it, including handling the payroll deductions required.

OEA Choice Trust provides administrative services only. It handles the claims processing and all other aspects of plan administration for your employer's Section 125 Plan. OEA Choice Trust may adopt any rules or procedures it believes are needed to administer the Plan.

I-2 HOW ARE BENEFIT PAYMENTS FUNDED?

Benefit payments are funded by your employer, not OEA Choice Trust. Funding is through payroll deduction contributions and, if applicable, additional contributions made by your employer. Your employer has set up an account from which OEA Choice Trust pays claims and Plan expenses.

I-3 CAN I ASSIGN OR PLEDGE MY PLAN BENEFITS?

Generally, you may not transfer your benefits under the Section 125 Plan or the balances in your Healthcare or Dependent Care Expense Reimbursement Account. That is, you may not sell them, use them as collateral, pledge them or give them away. Your creditors may not attach or garnish your Section 125 Plan benefits before they are payable to you.

However, your reimbursement accounts can be reached if there is a court order requiring you to provide medical benefits to a child or a former spouse or if you are subject to a tax levy.

I-4 DOES THE PLAN AFFECT THE TERMS OF ANY OTHER BENEFIT PLAN?

The Section 125 Plan is solely a vehicle for you to pay for benefit costs with pre-tax dollars. It does not modify or change the terms and conditions of your group health or other benefit plans. If there is any conflict between the Section 125 Plan and any other benefit plan's terms, the benefit plan's terms will control.

I-5 CAN THE PLAN BE AMENDED OR TERMINATED?

Subject to the terms of any applicable collective bargaining agreement, your employer has the authority to amend or terminate the Section 125 Plan, but generally only as of the end of a Plan Year.

OEA Choice Trust may also amend the Plan to comply with IRS rules, clarify or correct the Plan or facilitate plan administration. OEA Choice Trust may terminate its administrative services upon the terms and conditions stated in the Plan document.

I-6 HOW CAN I OBTAIN COPIES OF PLAN RECORDS?

You may examine, without charge, at OEA Choice Trust's office, all Plan documents, including the Adoption Agreement signed by your employer to adopt this Plan. However, you may not inspect materials containing confidential information about other participants.

You may obtain copies of all non-confidential Plan documents and information upon written request to OEA Choice Trust. There may be a reasonable charge for the copies.

PART J

OEA CHOICE TRUST CONTACT INFORMATION

Address

OEA Choice Trust
PO Box 23600
Tigard, OR 97281-3600

Telephone

Monday through Friday (except holidays)
8:00 AM – 5:00 PM Pacific Time

(800) 452-0914
(503) 620-3822

**Hours Benefit
Representatives
Are Available**

Monday through Friday (except holidays)
8:00 AM – 5:00 PM Pacific Time

Email

accounting@oeachoice.com

Website

www.oeachoice.com