ARIZONA

DEPARTMENT OF ADMINISTRATION

BENEFITS

State of Arizona Flexible Spending Account

Summary Plan Description

Effective January 1, 2019

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INTRODUCTION

The State of Arizona has contracted with ASIFlex (ASI) to perform certain administrative functions for the Benefit Options Plan. ASI processes all claims for the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account.

Eligible employees are provided the option to participate in an employer-sponsored Flexible Spending Account (FSA) plan. The FSA Plan allows the employee to make pre-tax payroll contributions into an FSA account that is protected from taxes.

FSA accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes. In accordance with Internal Revenue Code Section 125, allowable premiums for health and dental insurance are currently taken on a pre-tax basis. Money used from a FSA account is non-taxable when it is used to pay for qualified out-of-pocket family care expenses. Depending on their tax bracket, an employee could save 1/3 or more in taxes on out-of-pocket family care expenses.

IRS rules and regulations impose annual non-discrimination testing requirements on the plan to ensure compliance. Testing results may cause ADOA to require any participant to reduce their pre-tax contribution election if it is determined that such action is necessary.

How Does the FSA Work?

Prior to enrolling in the FSA Plan, a participant estimates the amount of qualified out-of- pocket health care and/or dependent care expenses that will be incurred during the year. These expenses can be for the participant, their spouse, and any eligible tax dependents. The annual estimated amount will be divided into an amount equal to the number of periods in the current plan year. Though the participant's actual salary remains the same, the taxable salary as reported to the government is reduced by the amount put into an FSA account.

After a participant enrolls in a FSA Plan, ASI will send a welcome packet. This packet will include a confirmation statement and reimbursement forms. Participants can register at asiflex.com to log into the ASI website and view personal account details. As eligible expenses are incurred throughout the year, a Reimbursement Form is submitted by the participant either online, by mobile app, fax or mail along with documentation of the expense. After the claim is submitted and approved by ASI, the funds are reimbursed from the participant's FSA account. An account summary will be sent to the participant via regular mail or through a generic email and/or text alert view a secure message online using the participant's user name and password.

Only the cost of purchases made or services provided during the current plan year and while an active participant are eligible for reimbursement. The IRS rule states that if a participant does not use all of the money in the FSA account by the end of

the plan year, those funds will no longer be available. Any remaining monies in the account will be forfeited by the participant.

A participant can only increase their health flexible spending election during the plan year as a result of certain eligible event changes. The State of Arizona does not permit an employee to reduce or stop deductions for health flexible spending after the plan year has started for any reason. A participant can only increase or decrease their dependent care flexible spending election during the plan year as a result of certain eligible event changes.

Social Security benefits calculations will be based on lower taxable earnings figures. (The employee can check with their local Social Security office to explore any effects this may have on benefits – which are usually very minor.)

ESTABLISHING AND USING YOUR GENERAL-PURPOSE FLEXIBLE SPENDING ACCOUNT

Annual Maximum $2,700

If an employee is enrolled in and making contributions to the Health Savings Account (HSA) Contribution Benefit, the employee cannot be enrolled in the General-Purpose Health Care Flexible Spending Account Plan. However, an employee can enroll in the Limited–Purpose Health Flexible Spending Account Plan which can be used to cover dental and vision expenses

Enroll in the Health Care Flexible Spending Account Plan

Estimate annual out-of-pocket medical expenses; include predictable expenses and expenses for anyone who is a qualified dependent for tax purposes. There are exceptions for the expenses of children of divorced parents. If you are divorced, the child must be your son or daughter for whom you have more than 50% physical custody. Please contact ASI or see IRS Publication 502 and Publication 501 for further information.

During open enrollment, divide the estimated expenses by 26 paychecks received during the year. See the separate open enrollment checklist for detailed open enrollment instructions. New employees can enroll on-line or contact their agency liaison for an enrollment form and assistance with enrollment.

Qualifying Medical Expenses

Qualifying Medical Expenses include all medical, dental and vision expenses not covered or not reimbursed by insurance which are incurred by the participant or their eligible dependent during the plan year for medical care as defined in Section 213(d) of the Internal Revenue Code. Please refer to the following list and IRS Publication 502 for further details on qualifying expenses. Expenses qualify for the health care FSA based on when incurred, not when they are paid. Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA.

Expenses can only be claimed based on the date incurred regardless of the date billed or when the expense was paid. Below is a partial listing of qualified expenses, please refer to the ASI website for a comprehensive list of qualified expenses.

Qualified Medical Expenses (Partial Listing)	
• Deductibles	• Medical equipment
• Co-pays	• Insulin
• Doctor's fees after expenses incurred	• Orthodontia/braces
• Dental expenses	• Routine physicals
• Vision care expenses	• Hearing aids including batteries
• Prescription glasses	

- Contact lenses and solutions
- Corrective eye surgery
- Prescription drugs
- Chiropractor's fees
- Transportation expenses related to illness
- Over-the-Counter medicines (legal) used to treat a medical condition. A valid prescription must be submitted for reimbursement.

Non-Qualifying Medical Expenses

Below is a partial list of medical related items that do not qualify under the Plan. There may be other items that do not qualify that are not listed here, please refer to the ASI website for a list of qualified expenses.

Non-Qualifying Medical Expenses
(Partial Listing)

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

Orthodontic Expenses

Orthodontic expenses may be assumed to be incurred at the time a monthly payment is due and paid. These monthly payments must be spread out evenly over the expected period of orthodontic treatment. Therefore, claims submitted for orthodontic payments that meet the above are allowable. A participant may also submit a claim for a reasonable down payment of the orthodontic treatment if the down payment is made at the time the appliances are placed. Claims for payments made prior to being due or that otherwise do not meet the above requirements will not be processed. To claim orthodontic payments, a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed must be included.

Receive Medical Services

A medical expense is incurred when the services are provided. A participant must receive medical services before they can file a claim for those services. Proof of payment is not required unless it is for orthodontia.

File Claims

After medical services have been received, a claim may be submitted to ASI for those expenses if the amount of the participant's responsibility for the bill is known. See Flexible Spending Account Claims on page 18 for details on claims filing. Extra claim forms are available online at asiflex.com; or you can submit claims via mobile app or online.

Receive Reimbursements
ASI will review the claim and, if approved, will reimburse the participant for the medical expenses within two business days of their receipt of the claim.

Payment from the Health Care Flexible Spending Account will be made up to the approved amount of the participant claim or the participant's remaining annual election, whichever is less. Payment is not limited to the amount in the participant's FSA account at the time of the claim. The participant's per pay contributions will continue for the remainder of the Plan year.

Participants on Unpaid Leave (Non-FMLA)
If a participant has been on unpaid leave for longer than two pay cycles and does not elect to catch up contributions when they return, the election and corresponding coverage will cease (effective on the last day of the pay cycle contributions were paid). A new election may be made upon return to work, effective for coverage the first day of the pay period following approval of the submitted form. However, no coverage will exist for the period of time in which no contributions were made if the participant had not elected to catch up contributions prior to the end of the leave period. There will be a hold put on a participant account (no claims will be paid) if contributions are not received on two consecutive payrolls and no leave form has been filed.

Other Considerations Regarding Coverage Continuation (COBRA)
To the extent required by COBRA, a participant, his/her spouse or dependent may elect to continue the coverage elected under the Health Care Flexible Spending Account Plan even though the participant's or his/her spouse's or dependent's election to receive benefits expired or was terminated, under the following circumstances:

1. Death of the participant;
2. Termination (other than for gross misconduct) or a reduction in hours;
3. Divorce of the participant; or
4. A dependent child ceases to be a dependent under the terms of this plan.

When the Plan is notified that one of the events has occurred, the right to choose continuation coverage will be provided to each eligible person(s) if, on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments. The right to elect to continue ends 60 days from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the participant or a responsible family member to inform their agency liaison of the occurrence of an event described in 3 or 4 above.

Continuation coverage will not extend beyond the end of the current Plan Year but may terminate earlier if the premiums are not paid within 30 days of their due dates. Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the Administrator.

An administrative charge of 2% is assessed for each premium paid for continuation coverage.

A participant on unpaid leave under FMLA is entitled to maintain coverage for the Health Care Flexible Spending Account Plan. A participant must make arrangements prior to going on unpaid leave with their agency liaison to pay for coverage after they return from unpaid leave. A participant may use this option only if they make arrangements to do so prior to the commencement of the unpaid leave. If the participant does not make such arrangements prior to unpaid leave, the participant account will be revoked as of the date of their unpaid leave.

ESTABLISHING AND USING YOUR LIMITED PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT

Annual Maximum $2,700

Estimate annual out-of-pocket dental and vision expenses, including predictable expenses and expenses for anyone who is a qualified dependent for tax purposes. There are exceptions for the expenses of children of divorced parents. Please contact ASI for further information.

Enroll in the Limited Purpose Health Flexible Spending Account Plan

During open enrollment, divide the estimated expenses by 26 paychecks received during the year. See the separate open enrollment checklist for detailed open enrollment instructions. New employees may enroll online, or may contact their agency liaison for an enrollment form and assistance with enrollment.

Qualifying Expenses

Qualifying Expenses include all dental and vision related expenses not covered or not reimbursed by insurance which are incurred by a participant or their eligible dependent during the plan year as defined in Section 213(d) of the Internal Revenue Code. Please refer to the following list and IRS Publication 502 for further details on qualifying expenses. Expenses qualify for the Limited Purpose Health FSA based on when incurred, not when they are paid. Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA.

A participant can only claim expenses based on the date incurred regardless of the date billed or when the expense was paid. Below is a partial listing of qualified expenses, please refer to the ASI website for a comprehensive list of qualified expenses.

Qualified Expenses (Partial Listing)	
• Dental expenses • Vision care expenses • Prescription glasses • Contact lenses and solutions • Corrective eye surgery • Prescription drugs used to treat a dental or vision condition	• Preventive care services—dental and vision only • Orthodontia/braces • Routine eye examinations • Over-the-Counter medicines (legal) used to treat a dental or vision condition. A valid prescription must be submitted for reimbursement.

Non-Qualifying Expenses

Below is a partial list of items that do not qualify under the Plan. There may be other items that do not qualify that are not listed here, please refer to the ASI website for a list of qualified expenses.

Non-Qualifying Expenses (Partial Listing)	
• Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins • Clip-on or non-prescription sunglasses • Warranties • Toiletries • Long-term care expenses • Any insurance premiums	• Medicines, drugs, herbs, or vitamins for general health and not used to treat a dental or vision condition • Medical expenses (not dental, vision or preventive care related) • Expenses merely beneficial to your general health (e.g., vaccinations and vitamins)

Orthodontic Expenses

Orthodontic expenses may be assumed to be incurred at the time a monthly payment is due and paid. These monthly payments must be spread out evenly over the expected period of orthodontic treatment. Therefore, claims submitted for orthodontic payments that meet the above are allowable. A participant may also submit a claim for a reasonable down payment of the orthodontic treatment if the down payment is made at the time the appliances are placed. Claims for payments made prior to being due or that otherwise do not meet the above requirements will not be processed. To claim orthodontic down payments, a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed must be included.

Receive Dental or Vision Services

A dental, vision, or preventive care expense is incurred when the services are provided. A participant must receive dental or vision services before they can file a claim for those services. Proof of payment is not required unless it is for orthodontia.

File Claims

After dental, vision or preventive care services have been received, the participant may submit a claim for those expenses to ASI if the amount of the participant's responsibility for the bill is known. See Flexible Spending Account Claims on page 18 for details on claims filing. Extra claim forms are available online or by contacting ASI.

Receive Reimbursements

ASI will review the claim, and if approved will reimburse the participant for the dental or vision expense within two business days of their receipt of the claim.

Payment from the Limited Purpose Health Flexible Spending Account will be made up to the approved amount of the claim or the participant's remaining annual election, whichever is less. Payment is not limited to the amount in the participant's FSA account at the time of the claim. The participant's per pay contributions will continue for the remainder of the Plan year.

Participants on Unpaid Leave (Non-FMLA)

If a participant has been on unpaid leave for longer than two pay cycles and does not elect to catch up contributions when they return, the election and corresponding coverage will cease (effective on the last day of the pay cycle contributions were paid). A new election may be made upon return to work, effective for coverage the first day of the pay period following approval of the submitted form. However, no coverage will exist for the period of time in which no contributions were made if the participant had not elected to catch up contributions prior to the end of the leave period. There will be a hold put on a participant account (no claims will be paid) if contributions are not received on two consecutive payrolls and no leave form has been filed with the agency liaison.

Other Considerations Regarding Coverage Continuation (COBRA)

To the extent required by COBRA, a participant, his/her spouse or dependent may elect to continue the coverage elected under the Limited Purpose Health Flexible Spending Account Plan even though the participant's, his/her spouse's or dependent's election to receive benefits expired or was terminated, under the following circumstances:

1. Death of the participant;
2. Termination (other than for gross misconduct) or a reduction in hours;
3. Divorce of the participant; or
4. A dependent child ceases to be a dependent under the terms of this plan.

When the Plan is notified that one of the events has occurred, the right to choose continuation coverage will be provided to each eligible person(s) if, on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments. The right to elect to continue ends 60 days from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the participant or a responsible family member to inform their agency liaison of the occurrence of an event described in 3 or 4 above.

Continuation coverage will not extend beyond the end of the current Plan Year but may terminate earlier if the premiums are not paid within 30 days of their due dates. Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the Administrator.

An administrative charge of 2% is assessed for each premium paid for continuation coverage.

A participant on unpaid leave under FMLA is entitled to maintain coverage for the Limited Purpose Health Flexible Spending Account Plan. A participant must make arrangements prior to going on unpaid leave with their agency liaison to pay for coverage after they return from unpaid leave. A participant may use this option only if they make arrangements to do so prior to the commencement of the unpaid leave. If the participant does not make such arrangements prior to unpaid leave, the participant account will be revoked as of the date of their unpaid leave.

ESTABLISHING AND USING YOUR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Annual Maximum $5,000

Enroll in the Dependent Care Flexible Spending Account Plan

During open enrollment, estimate annual total dependent care expenses for the Plan Year including predictable expenses only. Divide the estimate by 26 paychecks received during the year. See the separate open enrollment checklist for detailed open enrollment instructions. New employees may enroll on-line or contact their agency liaison for an enrollment form and assistance with enrollment.

A participant and their spouse together may include up to $5,000 per calendar year ($2,500 if married filing separate) or the lesser of (after subtracting all FSA deductions) the participant's or their spouse's earned income for the plan year. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for him or herself, such spouse shall be deemed to have earned income of $250 per month if the participant has one dependent and $500 per month for two or more dependents.

A Qualifying Individual is your Dependent who is under the age of 13, your Spouse or an older Dependent who is mentally or physically incapable of self-care who lives in your home at least 8 hours each day. If the participant is divorced, the Qualifying Individual must be their son or daughter for whom the participant has more than 50% custody.

A Qualified Provider can provide care in their home or outside their home. If the care is provided outside their home and the facility cares for more than 5 individuals, then it must be licensed by the State. The expenses may not be paid to the participant's spouse, their child who is under the age of 19 at the end of the year in which the expenses are incurred, or to an individual for whom the participant and their spouse is entitled to a personal tax exemption as a dependent.

The Dependent Care Flexible Spending Account is an alternative to taking a "Tax Credit" allowed with tax filing each year. A participant may receive a tax break on their expenses, but must choose whether to use the "Tax Credit" or the "FSA". The IRS will not allow a participant to receive two tax breaks on the same expenses.

- A Tax Credit is allowed for child/dependent care expenses of up to $6,000 per year for two or more dependents ($3,000 per year for one dependent). A participant files for the "tax credit" on their annual tax return at the end of the year. The credit is an amount equal to their dependent care expenses multiplied by a percentage determined by the combined adjusted gross income. The percentage decreases from a high of 35% to a low of 20% as income increases.

- The Dependent Care Flexible Spending Account Plan allows a tax break on up to $5,000 per year, $2,500 if married filing separately, for any number of dependents; one, two, or more. A participant will experience "tax savings"

throughout the year with every paycheck. Employees who pay federal taxes of 12%, state taxes of approximately 6% and Social Security taxes of 7.65% would save around 25% of expenses through the Dependent Care Flexible Spending Account Plan. As their federal tax percentage rises, they would receive an even higher tax break by using the Dependent Care Flexible Spending Account Plan.

Employees are required to file Schedule 2 with their IRS Form 1040A or Form 2441 with their IRS Form 1040 to support the amount redirected for the calendar year. This is for informational purposes. Employees will not pay taxes on the redirected amount. Payments made to the employee under this category are not taxable, but the amount redirected will appear on their W-2 form which informs the IRS that a tax break was received for that expense.

IRS rules and regulations impose annual non-discrimination testing requirements on the plan to ensure compliance of IRS Section 129. Testing results may cause ADOA to require any participant to reduce their pre-tax contribution election if it is determined that such action is necessary.

Qualifying Dependent Care Expenses

Qualifying child/dependent care expenses are those that are incurred in order for the participant and their spouse (if married) to be gainfully employed that are considered to be employment-related expenses under Internal Revenue Code §21(b)(2) to the extent that the participant or another person (if any) incurring the expense is not reimbursed for the expense through any other Plan. Only expenses incurred for care and well-being qualify for this tax break. Day camp fees incurred in order for the participant to work are allowable but overnight camps are not. IRS Publication 503 is available on the ASI website to assist with income tax filing and for additional information. IRS Publication 503 does not address Dependent Care Flexible Spending Account Plans; however, most of the items listed as eligible for the tax credit in IRS Publication 503 can be claimed through the participant's Dependent Care Flexible Spending Account. A participant can only claim expenses based on the date incurred, not paid as stated in IRS Publication 503.

Qualifying Expenses are those that enable the participant to be gainfully employed including:

Qualifying Expenses	
• Day-care centers	• Babysitters
• Day camps	• Nannies
• Adult day care center	• Au pair
• Preschool or nursery school	• Before/after school care

Non-Qualifying Dependent Care Expenses

Below is a partial list of items that do not qualify under the plan. There may be other items that do not qualify that are not listed here, please refer to the ASI website for a list of qualified dependent care expenses or IRS Publication 503.

Non-Qualifying Dependent Care Expenses (Partial Listing)	
• Care that is not incurred in order for you to work or look for work • Kindergarten or other educational expenses • Amounts paid to your spouse or dependent or to your (or your spouse's) son or daughter who is under 19 years old at the end of the year	• Food, transportation or activity fees • Care for a child for whom you have 50% or less physical custody • Overnight camps • Care for a child age 13 or older who is not disabled • Child support payments • Summer school

Receive Dependent Care Services

Dependent care expenses are incurred when the day care is provided. Dependent care services must be received before a participant can file a claim for those services.

File Claims

After a participant receives the dependent care services, they may submit a claim for those expenses to ASI. See Flexible Spending Account Claims on page 18 for details on claims filing. Extra claim forms are available online at asiflex.com.

The dependent care provider may complete the dependent care section of the claim form and sign on the line provided in lieu of providing separate documentation for dependent care claims (see page 21).

The participant must provide the tax identification number or Social Security number of the child/dependent care provider with his/her federal income tax return. Please check with the childcare provider (before enrolling in this category) to be sure the tax I.D. number or his/her Social Security number is available.

Receive Reimbursements

ASI will review the claim, and if approved will reimburse the participant within two business days of their receipt of the claim up to the amount available in the participant's account. If the claim exceeds the participant's available funds, the difference will be recorded and paid as funds become available from payroll.

Payment from the participant's Dependent Care Flexible Spending Account will be made up to the approved amount of the claim or current balance, whichever is less. Any portion of the claim which is not paid will be paid automatically as money is

contributed from payroll. Total payments for the year are restricted to the participant's annual election.

ENROLLMENT AND TERMINATION

Eligibility

All full-time employees are eligible to participate in a FSA Plan on the 1st day of the pay period after completing a benefit enrollment form. Benefits are effective the 1st day of the pay period following the receipt of a completed enrollment.

The Plan Year is the 12-month period from January 1 through December 31.

Before the start of a new plan year, members are given a certain amount of time during which they may change coverage options. Members may also elect to participate in a FSA plan at this time. This period is called open enrollment. In general, open enrollment is held in October. Action is required if you are electing a health care flexible spending and/or dependent care flexible spending account. Elections must be made before the end of open enrollment.

An employee may also enroll during the plan year if they experience a qualifying change in status and enrollment corresponds with a change in eligibility caused by that status change. See the Making a Change Section for more information. The Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan have slightly different rules regarding making an election change or enrolling mid-year.

New employees must enroll within 31 days to participate for the remainder of that plan year. If a new employee does not enroll within the 31-day time period, then they may not elect to participate in the Plan until the next Open Enrollment Period or until a change in status occurs that would justify a mid-year election change.

Enrollment during the plan year is effective the 1st day of the pay period following a completed enrollment.

Termination of Participation

Participation will end on the last day of the pay cycle contributions were paid should an employee terminate employment with the State of Arizona. This means the employee will no longer be able to make contributions to the plan or incur services for reimbursement. Should the employee return to work within 30 days during the same Plan Year, their participation will be reinstated as it was. The employee will have the option of reinstating their coverage at the same annual level they had prior to their termination or reinstating coverage at the same per pay period amount with a reduced annual amount. Should the employee choose the same annual amount, their per pay period contributions will be adjusted so that their total contributions for the year will equal their annual coverage amount. Should an employee return to work after 31 days during the same Plan Year, they may make a new election for the remainder of the Plan Year. Except as specifed in the section on Coverage Continuation (COBRA) in the Health Care Flexible Spending Account Plan Summary, expenses incurred while the employee is not a participant will not

qualify for reimbursement. An employee may continue to file for Dependent Care expenses incurred during the Plan Year after the end of their participation.

MAKING A CHANGE

Except as specified in this section, a participant's election under the FSA Plan is irrevocable for the Plan Year.

A participant may change their election if the participant, their spouse, or their dependent experience an event listed below which results in a gain or loss of eligibility for coverage under the State of Arizona Flexible Spending Account Plan, Health Care Flexible Spending Account Plan, or Dependent Care Flexible Spending Account Plan or a similar plan maintained by their spouse's employer or one of their dependent's employer and their desired election change corresponds with that gain or loss of coverage.

The State of Arizona does not permit an employee to reduce or stop deductions for health care flexible spending after the plan year has started for any reason.

Qualified Life Event	Applicable Plan		
	General Purpose Health Care FSA Plan	Limited – Purpose Health FSA Plan	Dependent Care FSA Plan
Legal marital status changes through marriage, divorce, death or annulment.	✓	✓	✓
Number of dependents changes by reason of birth, adoption (or placement for adoption), or death. If a child no longer qualifies for dependent care because he or she turned 13, then that is a loss of a dependent under the Dependent Care Flexible Spending Account Plan, but not under any of the other plans.	✓	✓	✓
The participant, their spouse or any of their dependents have a change in employment status that affects eligibility under the State of Arizona Flexible Benefit Plan or a plan maintained by their spouses or any dependent's employer. A participant returns to work after	✓	✓	✓

31 days of termination or leave of absence from State of Arizona.			
A judgment, decree or court order, including a qualified medical child support order regarding coverage for a dependent. If the order requires the participant to pay for medical, dental and/or vision expenses not paid by insurance for a Dependent child, then they may add or increase coverage under the General-Purpose Health Care Flexible Spending Account Plan or the Limited-Purpose Health Flexible Spending Account Plan as applicable.	✓	✓	
If a participant, their spouse or dependent loses eligibility and coverage under Medicare or Medicaid, they may add or increase coverage under the General-Purpose Health Care Flexible Spending Account Plan or Limited-Purpose Health Flexible Spending Account Plan as applicable.	✓	✓	
A participant may change their election to correspond with a change made under another employer-sponsored plan as long as the change made under the other plan was permitted by IRS regulations or was made for a period of coverage that is different from the State of Arizona Flexible Benefit Plan.			✓
A change in dependent care providers (including school or other free provider). A corresponding change may be made to the Dependent Care			✓

Flexible Spending Account and future salary reductions.			
Account and future salary reductions			
A corresponding change to Dependent Care Flexible Spending Account and future salary reductions if the dependent care provider who is not a relative changes costs significantly. A relative is any person who is a relative according to Code §152(a)(1) through (8), incorporating the rules of Code §152(b)(1) and (2).			✓

The election change request must be submitted to ADOA within 31 days of the date of the qualifying event and becomes effective on the 1st day of the pay period following the event and the approval of the completed application for enrollment.

A Salary Reduction amount for a pay period is, an amount equal to the annual contribution for the participant's FSA election, divided by the number of pay periods in the Plan Year following the effective date. If there is an election increase under the Health Care Flexible Spending Account Plan, Limited-Purpose Health Flexible Spending Account Plan or Dependent Care Flexible Spending Account Plan, the Salary Reductions per pay period will be an amount equal to the new reimbursement limit elected less the Salary Reductions made prior to such election change, divided by the number of pay periods remaining in the Plan Year beginning with the election change effective date.

Any increase in election may include only those expenses that are incurred during the period of coverage on or after the effective date of the increase. Coverage for the remaining period of the year shall be calculated by adding the amount of contributions made prior to the change to the expected contributions after the effective date of the change and subtracting prior reimbursements.

FLEXIBLE SPENDING ACCOUNT CLAIMS

Please contact ASI for questions concerning qualified expenses, personal account information or filing claims. You may also obtain information at asiflex.com and sign into your account detail to view your account statement, submit claims, read secure messages, and manage your personal account settings.

- Claims processed daily – within 2 business days of receipt of qualified claim
- Direct deposit is available for claims payment
- Direct deposit notices sent via E-mail and/or text alerts; or US Mail the same day payment is generated

ASIFlex	
Mailing Address:	P. O. Box 6044 Columbia, MO 65205-6044
Customer Service:	800-659-3035
Toll-free Fax:	877-879-9038
Email:	asi@asiflex.com
On-line:	www.asiflex.com

Allowable expenses must be incurred during the portion of the Plan Year of which an employee is a participant. Claims must be filed by March 31st following the end of the Plan Year. After that, the participant's account will be closed and any balance remaining will be forfeited to the State of Arizona in accordance with federal regulations.

To receive payment, a completed claim form along with either the insurance plan Explanation of Benefits statement or copies of itemized invoices/statements from the provider must be submitted as proof that an allowable expense has been incurred. Itemized statements are required to include, the provider's name, the date(s) of service, a description of the service(s), patient name and the expense amount. Copies of personal checks, paid-on-account statements, balance-forward statements, and paid receipts that are not itemized and do not contain the above information are not acceptable. Documentation or copies will not be returned. For over-the-counter health care products the receipt or documentation from the store must include the name of the health care product printed on the receipt. Please note: In order to receive reimbursement, a valid prescription must be submitted for all over-the-counter drugs or medicines (except for insulin). A letter of medical necessity is required for vitamins and nutritional supplements. Purchases for general good health will not be accepted. Claim forms are available online at asiflex.com.

Direct deposit into the bank account of the participant's choice is available for claim payments. By using direct deposit, a participant will not need to wait for a check to arrive or be deposited. A notice that a direct deposit was made will be sent by mail or by email and/or text alert. A check can be mailed instead of payment by direct

deposit. You may sign up for email, text alerts and direct deposit through your online account detail at asiflex.com.

There are several ways to file claims:

- ASIFlex Mobile App – Using your smart phone or tablet, just snap a picture of the documentation and submit over the app! The app is free from asiflex.com, Google play or the App Store.
- ASIFlex Online – Just scan your documentation and submit through your online account detail at asiflex.com!
- USPS Mail - Complete a claim form, attach documentation, and mail to ASIFlex;
- Toll-Free Fax - Complete a claim form, attach documentation, and fax to ASIFlex.

ASIFLEX MOBILE APP

Using their phone/tablet, the ASIFlex mobile app allows participants to file claims and view their FSA account. The claim filing feature allows a participant to capture documentation using the mobile device's camera feature and submit that documentation with the claim. The mobile app also allows participants to use the microphone feature on smart devices to enter claims. This means participants can choose to speak, rather than type, some of the claim information. In addition to filing claims, participants can view the annual election amount, account balance, payments, contributions and previously submitted claims. The app is free and available online at asiflex.com or through Google play or the App Store.

ACCESSING ASIFLEX ACCOUNT

A participant may access their Health Care Flexible Spending Account, Limited-Purpose Health Flexible Spending Account and their Dependent Care Flexible Spending Account at asiflex.com 24/7! Information is updated every evening to reflect that day's transactions. Sign into your account to:

- View your account statement(s)
- View a year-to-date dashboard of your account(s)
- See if a claim was processed and paid
- Read secure messages
- Manage your personal account settings for login credentials, email, cell phone number for texts and banking information for direct deposits

Information for the current Plan Year is available until 30 days following the end of the claims run out period (the following March 31st).

To access your account:

1. Go to asiflex.com
2. Select the Online Access/Account Detail Tab; then Participant/Account Detail.
3. New Users: Click "Create an account" and follow the prompts.
4. Returning users: Enter your username and password and click "Sign In."
5. Forgot your username or password? Just click on the links.

NOTICES

Newborns' and Mothers' Health Protection Act of 1996

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

Women's Health Cancer Rights Act of 1998: Notice

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

HIPAA Privacy Regulation Requirements

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor and other parties as necessary to determine appropriate processing of claims. Please refer to the Benefit Options Guide for details on the use of PHI.

Notice of Special Enrollment Rights for Health Plan Coverage

If you decline enrollment in the State of Arizona's health plan for you or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you or your Dependents maybe able to enroll in the State of Arizona Employee's health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.

- Gain a new Dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage birth, adoption, or placement for adoption.

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the State of Arizona's health plan if you become eligible for a state premium assistance program under Medicaid of CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your Dependent becomes eligible for special enrollment rights, you may add the Dependent to your current coverage or change to another health plan.