Public Education Employees Health Insurance Plan

Preferred Blue Flexible Spending Plan

Effective October 1, 2014

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WELCOME

All of us at Blue Cross and Blue Shield of Alabama pledge to you we will provide the best service we can in the administration of your PEEHIP Flexible Employee Benefits Plan. The following information summarizes your PEEHIP Flexible Employee Benefits Plan. This booklet serves as the plan document and as a summary plan description.

Blue Cross and Blue Shield of Alabama is an **independent** corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Association.

The PEEHIP sponsored plan offers three programs designed to save you money.

- Health Care Flexible Spending Account (Health FSA)
- Dependent Care Account (DCA)
- Premium Reduction Program (PRP)

If you have any questions, please contact PEEHIP, or the plan administrator, Blue Cross and Blue Shield of Alabama.

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits please contact our Customer Service Department at 1-800-213-7930. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-800-213-7930. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.

PUBLIC EDUCATION FLEXIBLE EMPLOYEE BENEFITS PLAN

Eligibility

All actively employed members of PEEHIP are eligible to participate in the PEEHIP Flexible Employee Benefits Plan. PEEHIP will allow members who are participating in another school system sponsored flex plan to enroll in the PEEHIP Flexible Employee Benefits Plan for a “short plan year” upon the end of the school's flex plan year. These members must enroll in the PEEHIP Flexible Benefits Plan within 45 days following the school's flex plan's year end.

Your Enrollment Decision

Participation in the PEEHIP Health FSA and DCA is voluntary. Each year, during the PEEHIP annual open enrollment period you will have an opportunity to enroll in the PEEHIP Flexible Employee Benefits Plan that will be effective as of the first day of the next plan year.

New employees can enroll in the Health FSA and/or DCA within 30 days of employment with an effective date of their employment date.

You will receive enrollment information from PEEHIP.

Open Enrollment Period

Each year, Open Enrollment for the PEEHIP Flexible Benefits Plan begins July 1 and extends through September 30. Open enrollment forms are accepted via mail, or the preferred method of enrollment is for participants to enroll online via the Member Services link found on the main page of the PEEHIP web site at www.rsa-al.gov.

Contributions to the Account

During the annual enrollment period, you decide how much you want to contribute to your Health FSA and/or DCA for the following plan year. Contributions are made on a pretax basis and deducted from your paycheck during the plan year. The "plan year" will be October 1st through September 30th.

PEEHIP reserves the right to limit the contributions and reimbursements to highly compensated members for the plan to satisfy certain nondiscrimination tests under federal law.

Health FSA

You can direct up to a maximum of **$2,500** to your account each year to pay for eligible health care expenses. There is a $120 minimum annual contribution amount.

In the case of a new employee, you decide how much you want to contribute for the balance of the year following your date of employment.

DCA

You can direct up to a maximum of $5,000 to your account each year to pay for dependent day care expenses so you (and if married, your spouse) can work outside the home or attend school full-time. If you and your spouse file income taxes separately, the most either of you can put into a program like the DCA is **$2,500**. There is a $120 minimum annual contribution amount.

Note: Unpaid volunteer work or volunteer work for a nominal salary does not qualify as work outside the home. Please refer to the Internal Revenue Service regulations for clarification.

Use It or Lose It Rule (and $500 Carryover Provision)

Before deciding how much to contribute to either your Health FSA or DCA, it's important to carefully consider your needs and estimate your expenses for the year. You need to plan carefully because under the current IRS regulations, you forfeit any money in your Dependent Care account after all eligible expenses have been reimbursed, and will forfeit any unused amounts in excess of $500 remaining in your Health FSA at the end of the plan year. This is often referred to as the "use it or lose it" rule. Apart from submitting all of your Requests for Reimbursement by the close of each plan year, there are two plan features that help you avoid losing money as a result of the use it or lose it rule. The first feature is the $500 carryover provision; the second is the timely filing period.

$500 Carryover Provision (Applicable to Health FSA Only)

The Department of Treasury and Internal Revenue Service issued Notice 2013-7 on October 31, 2013 announcing a modification to the long standing "use-it-or-lose-it" rule applicable to health Flexible Spending Accounts (FSAs). The Public Education Flex Employees' Benefits Board on December 2, 2013, adopted the modification for inclusion in the PEEHIP **Health** FSA Plan, effective with the October 1, 2013 flex plan year. The modification allows up to $500 of unused funds remaining in a health FSA at the end of the plan year to be carried over and used in the following plan year for covered health FSA eligible expenses. The carryover limit will apply to all plan participants. Under IRS rules, the carryover provision is an **alternative** to the grace period provision and the IRS does not permit a plan to have both. Consequently, PEEHIP will cancel the grace-period provision at the same time the new carryover

provision is effective.

Even though the grace period provision will be canceled, the “use-it-or-lose-it” rule still applies to the carryover provision. **Therefore, any unused amounts in excess of $500 remaining in your health FSA at the end of the plan year will be lost.**

The new carryover provision does not affect the maximum contribution amount you can make to your health FSA. For plan year 2014, the maximum contribution amount is $2,500.

The $500 carryover provision is not cumulative. For example, an employee who carries over $500 from year one to year two does not have up to $1,000 to carry over from year two to year three, and $1,500 from year three to year four, etc. The new carryover provision allows a maximum carryover amount of only $500 per year, regardless of carryovers from prior years or account balance in the current year.

The new carryover option does not affect the ability of a health FSA to use a timely filing period. The timely filing period for the PEEHIP flex plan year is still permitted, allowing plan participants 105 days at the end of the plan year (from October 1 – January 15) to file claims for reimbursement.

Grace Period

Beginning with the October 1, 2013 flex plan year, PEEHIP will no longer offer a grace period. See the Use It or Lose It rule above for more details.

Timely Filing Period

You have 105 days after the end of the plan year (from October 1 to January 15) in which to submit a Request for Reimbursement for the Health FSA and the DCA. This period is commonly referred to as the run-out period.

If you are no longer an actively employed member, you must submit requests for reimbursement for expenses incurred prior to the date you are no longer an actively employed member of PEEHIP.

Order in Which Requests for Reimbursements are Processed (Health FSA Only)

A cafeteria plan is permitted to treat reimbursements of all claims for expenses that are included in the current plan year as reimbursed first from unused amounts credited for the current plan year and, only after exhausting these current plan year amounts, as then reimbursed from unused amounts carried over from the preceding plan year. Any unused amounts from the prior plan year that are used to reimburse a current year expense (a) reduce the amounts available to pay prior plan year expenses during the run-out period, (b) must be counted against the permitted carryover of up to $500, and (c) cannot exceed the permitted carryover.

Permitted Election Changes

Once you are enrolled in the Health FSA or DCA, you can increase or decrease your contributions for the remainder of a plan year if you have a change in status. A change in status occurs if:

- you marry, divorce, become legally separated, or have your marriage annulled;
- you or your spouse gives birth to or adopts a child (including placement for adoption);
- your spouse or a dependent dies;
- your dependent marries;
- you take leave under the Family and Medical Leave Act;
- you take an unpaid leave of absence;
- you or your spouse or your dependent begins or terminates employment, participates in a strike or lockout, or begins or returns from an unpaid leave of absence;

- you or your spouse or dependent has a change in employment status that causes you, your spouse, or dependent to become eligible (or cease to be eligible) to participate in this program or a program covering your spouse or dependent (for example, switching from full-time to part-time employment or from hourly to salaried status);
- your dependent qualifies or ceases to qualify as a dependent for purposes of Internal Revenue Code Sections 105(b) and 106(a);
- a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires coverage for your child or requires your spouse, former spouse or other individual to provide coverage for the child and that coverage is, in fact, provided; or,
- you or your spouse or dependent become enrolled in Medicare or Medicaid or lose eligibility for coverage under Medicare or Medicaid.

Short Plan Year – the PEEHIP Flexible Employee Benefits Plan will allow members who are participating in another employer sponsored plan to enroll in the PEEHIP Flexible Employee Benefits Plan for a "short plan year" upon the end of the flex plan year. These members must enroll in the PEEHIP Flexible Employee Benefits Plan within 45 days following that flex plan's year end.

Any change in the amount of your contribution must be consistent with the change in status that has occurred and meets the requirements imposed by the IRS. PEEHIP must be notified of the permitted election change within 45 days of the event. For example:

- if you enrolled in a DCA and your dependent child reaches the age of 13 and thereby ceases to be a qualified dependent for the purposes of the DCA, you could elect to decrease the amount of your contribution to your account.
- if you enrolled in a Health FSA and you or your spouse has a baby, you could elect to increase your contributions to your account to cover an increase in anticipated health care expenses.

If you have a change in status that allows you to reduce your contributions, your new election amount may not be less than the greater of (a) the amount that has been deducted from your paycheck as of the date of change, or (b), the amount of reimbursements you have received as of the date of change.

Health FSA

If you terminate employment and are rehired within 30 days and within the same plan year, then you must resume your original Health FSA election for the remainder of the plan year. If you terminate employment and are rehired more than 30 days after your termination date and within the same plan year, then PEEHIP will permit you to make a new Health FSA election for the remainder of the plan year.

DCA

If you terminate employment and are rehired within 30 days and within the same plan year, then you must resume your original DCA election for the remainder of the plan year. If you terminate employment and are rehired more than 30 days after your termination date and within the same plan year, then PEEHIP will permit you to make a new DCA election for the remainder of the plan year.

Your participation in the DCA will end when you terminate employment, go on a leave of absence, retire or die. Coverage will also end if you no longer meet the eligibility rules of the plan.

If you go on unpaid leave covered by the Family and Medical Leave Act (FMLA), you should check with PEEHIP to determine what your rights are relating to the Health FSA and DCA elections. Generally, you can continue coverage under the Health FSA or revoke your existing election under the Health FSA. If you elect to continue your coverage, you can pre-pay contributions for the period of unpaid FMLA leave. You will not be entitled to receive reimbursements for expenses incurred during the period of unpaid FMLA leave if you do not continue contributions. If you elect to be reinstated upon returning from the unpaid FMLA leave, you must choose to:

- resume coverage at the level in effect before the unpaid FMLA leave and make up the unpaid premium payments; or

- resume coverage at a level that is reduced and resume premium payments at the level in effect before the unpaid FMLA leave.

Since you will forfeit any unused money in your account, you should carefully estimate your anticipated Health FSA and DCA costs for the year before deciding the amount of your contribution. Remember, unless you have a change in status, your contribution amount cannot be changed until the next plan year.

How the Health FSA Works

The Health FSA allows you to set aside up to $2,500 a year, pretax, for health-related expenses not reimbursed by any other program or plan. You then use those pretax dollars to reimburse yourself for out-of-pocket health care expenses incurred on or after the date of your enrollment.

Eligible Expenses

Your Health FSA can be used to reimburse you for your own expenses, as well as those of your eligible dependents, as long as the expenses are:

- amounts paid for “medical care” as described in Internal Revenue Code Section 213(d);
- not reimbursable under any other health plan in which you participate; and
- incurred after the date of your enrollment and during the plan year; however, if your PEEHIP membership terminates during the plan year, health care expenses must be incurred before your termination date (unless you elect coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 [COBRA]).

Specifically, health care expenses eligible under the plan are those not paid in full under any health care plan in which either you or your spouse participates, including annual deductible, copayments and fees over the usual and customary limits.

Eligible expenses do not include health, dental or life insurance premiums.

Following are some examples of health care expenses that are reimbursable by the Health FSA. This is a partial list extracted from IRS publications and is subject to change.

Allowable Health Care Expenses Include:

- acupuncture
- ambulance transportation expenses
- artificial limbs
- artificial teeth
- birth control pills prescribed by a doctor
- braille books and magazines
- car controls for handicapped
- chiropractors
- Christian Science practitioners
- contact lenses, as well as the equipment and materials required for using them
- crutches
- dental fees
- doctors' fees
- drug and alcohol addiction treatment
- eyeglasses

- fertility enhancement (including in vitro fertilization and surgery)
- guide dogs
- hearing aids
- hospital services
- lab fees
- lead-based paint removal
- learning disability tuition
- nursing services
- optometrists
- oxygen
- prescription drugs (legend/prescription drugs which Federal Law prohibits dispensing without a prescription)
- prescribed over-the-counter drugs (drugs which are prescribed by a physician even though Federal Law does not require a prescription)
- psychoanalysis
- special schools for the handicapped
- sterilization
- surgery (other than cosmetic surgery)
- therapy (medical)
- transplants of organs
- transportation to/from health care provider
- weight-loss plans prescribed by a physician to treat a specific disease
- wheelchairs
- X-rays

For a more complete list of eligible expenses, consult your personal tax advisor or refer to IRS publication 502, Medical and Dental Expenses which contains a list of deductible expenses. (This publication can be obtained through your local IRS office or from www.irs.gov.)

Note: Misuse of spending account funds is a violation of Internal Revenue Service regulations.

Eligible Dependent Expenses

Your Health FSA can be used not only to cover your own expenses, but also can be used for the cost of services received by your spouse and your dependents who qualify as dependents for purposes of Internal Revenue Code Sections 105(b) and 106(a), even if they're not covered by the company's health or dental plan.

Under IRS regulations, eligible expenses incurred by your dependents, as described in Internal Revenue Code Sections 105(b) and 106(a), are eligible for reimbursement from your Health FSA. If you have a question as to whether or not a dependent is eligible, you should consult with the IRS or your personal tax advisor for more information.

What the Plan Doesn't Cover

Although the Health FSA covers a wide variety of health care expenses, there are some expenses that are not eligible for payment. For example, expenses you incur in connection with activities that are merely beneficial to your general health and not directly related to specific health care are not

reimbursable. Other types of health care that are not eligible include:

- Health, dental or life insurance premiums;
- expenses incurred for health clubs, spas and weight loss programs (unless prescribed by a physician solely for the purpose of treating an illness or accident);
- over-the-counter medicines and drugs unless prescribed by a physician and submitted with a copy of the prescription;
- expenses for which you receive benefits from any health, dental, vision or other health care plan;
- most kinds of cosmetic health services and supplies (unless medically necessary and not covered by a health plan), hair transplants, electrolysis, and teeth whitening;
- dietary and herbal supplements such as vitamins, fiber, and minerals (unless prescribed by a physician solely for the purpose of treating an illness);
- over-the-counter medications filled on or after January 1, 2011 unless you have a prescription from a doctor.

The general rule is this: Health expenses are eligible for reimbursement from the account only if they're expenses paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

Tax Effects

The Health FSA can help you reduce your taxes, which in turn can increase your annual take home pay.

Tax Savings

The Health FSA lets you set aside a certain amount of money from your paycheck before you pay taxes. You are taxed only on the part of your pay remaining. The result is lower income, which means lower federal income taxes, lower Social Security taxes, and in many cases, lower state income taxes as well.

Effect on Other Benefit Plans

Because account contributions reduce Social Security taxes, your Social Security benefits could be slightly less than if you had not contributed to the plan. Consult with your employer's Benefits Office to determine the impact, if any, that your participation in the Health FSA may have on any other benefit plans offered by your employer.

Tax Credits

Under current tax regulations, you cannot claim a tax deduction for health care expenses that are reimbursed through the Health FSA. You can, however, take an itemized tax deduction for any expenses in excess of your Health FSA contribution, up to the allowable limits under the law. Keep this in mind when determining whether or not to participate in the program, and contact your personal tax advisor if you have any questions.

IRS Non-Discrimination Requirements

The Health FSA is required to satisfy certain non-discrimination rules under Sections 125 and 105(h) of the Internal Revenue Code. PEEHIP is responsible for testing the plan to see whether it complies with these rules. If necessary, PEEHIP may suspend or curtail your contributions to or reimbursements from the plan to the extent determined necessary by your PEEHIP to satisfy these rules.

Request for Reimbursement

As previously mentioned, the timely filing period ends 105 days after the close of the plan year. At the

end of the timely filing period, if there are unused funds in your Health FSA or DCA, those funds will be forfeited and used by the Plan to help cover the plan's administrative costs.

Also, note that the money you direct into your Health FSA can be used to pay for eligible health care expenses. You can't pay for dependent care expenses from the Health FSA, nor can you pay for health care expenses from the DCA. In addition, funds assigned to one account cannot be transferred to the other under any circumstances.

What Constitutes a Request for Reimbursement

The Health FSA is designed to reimburse you for costs not covered by your health or dental plan and for expenses you have already paid.

Blue Cross Blue Shield of Alabama in the administration of your flex plan will use the claims data from your Blue Cross medical plan, VIVA HMO, Southland Dental and Vision, and PEEHIP's prescription drug plan to automatically generate a request from your Health FSA. What does this mean for you? It means that for the claims that are processed by any of these PEEHIP vendors the out-of-pocket amounts will automatically apply to your Health FSA and you will not have to file a request for reimbursement for these expenses. Reimbursements will automatically be made to you. For all other expenses you will be required to submit a request for reimbursement form, along with proper documentation to validate the expense as an eligible reimbursable item.

In order for the Preferred Blue Customer Service Center to treat a submission by you or your authorized representative as a Request for Reimbursement, it must be submitted on a properly completed Request for Reimbursement. You should call the Preferred Blue Customer Service Center and ask for the proper Request for Reimbursement Form. Alternatively, you can obtain a Request for Reimbursement Form and submit your form from the web site www.AlabamaBlue.com, or with the **Alabama Blue** mobile app on your smart phone. Simply fill it out and attach Explanation of Benefits (EOB) forms, bills, invoices, receipts, or other supporting statements showing the amount of the health-related expenses for which you are claiming reimbursement. For over-the-counter drugs you must also attach a copy of the physician's prescription for the drug.

Mail or fax the Request for Reimbursement Form and attachments to:

Blue Cross and Blue Shield of Alabama
Attention: Preferred Blue Customer Service Center
Post Office Box 11586
Birmingham, Alabama 35202-1586

Fax number: 205 220-7991 or toll free 1 877 889-3610

Requests for Reimbursement for eligible expenses incurred in a plan year must be submitted by the close of the timely filing period set forth above. After the close of that period any money in the account is forfeited unless subject to a properly filed Request for Reimbursement or appeal.

If the Preferred Blue Customer Service Center receives a submission that does not qualify as a Request for Reimbursement, it will notify you or your authorized representative of the additional information needed. Requests for Reimbursement for eligible expenses incurred in a plan year must be submitted by the close of the timely filing period. After the timely filing period, any money in the account is forfeited and used by the Plan to help cover the Plan's administrative cost.

Processing of Requests for Reimbursement

Even if all of the information has been received that is needed in order to treat a submission as a Request for Reimbursement, from time to time additional information might be needed in order to determine whether the Request for Reimbursement is payable. If additional information of this sort is needed, you will be asked to furnish it, and further processing of your Request for Reimbursement will be suspended until the information is received. You will have 45 days to provide the information.

Ordinarily, you will be notified of a decision within 30 days of the date on which your Request for

Reimbursement is filed. If it is necessary to ask for additional information, you will be notified of that decision within 15 days after the requested information is received. If the information is not received, your Request for Reimbursement will be considered denied at the expiration of the 45-day period you were given for furnishing the information.

In some cases, you can be asked for additional time to process your Request for Reimbursement. If you do not wish to give the additional time, your Request for Reimbursement will be processed based on the information already provided. This may result in a denial of your Request for Reimbursement.

Payment of Requests for Reimbursement

Your Request for Reimbursement will be reimbursed in full, up to the total amount you agreed to contribute to the Health FSA for the year less previous reimbursements, regardless of the amount that has been deducted from your paycheck when the expense is submitted. Your payroll deductions throughout the year will be used to repay your account if your account does not have sufficient funds at the time to pay the Request for Reimbursement.

The minimum reimbursement is $10. If your Request for Reimbursement is less than $10, you will not be reimbursed until your total Requests for Reimbursement reach the $10 minimum. Only at year-end may the reimbursed amount be less than $10.

You can register at the web site www.bcbsal.com, or through the **Alabama Blue** mobile app, to have your reimbursement direct deposited to your bank account. A Statement of Account will be mailed with each direct deposit. You will also receive a quarterly statement showing the amount of reimbursements paid and the remaining balance.

Preferred Flex Card

If you elect to participate in the Health FSA, you may be issued a stored-value card which is called the Preferred Flex Card. The Preferred Flex Card works much like a credit card, but unlike a credit card, it gives you access to your Health FSA to pay eligible health-related expenses. The Preferred Flex Card is accepted by merchants and health care providers that have been approved by Blue Cross and Blue Shield of Alabama and that accept MasterCard®. When you use the card, the amount of the eligible expense is automatically deducted from your Health FSA in the same way that check transactions are handled.

The Preferred Flex Card can be used to pay health-related expenses which are reimbursable under the Health FSA. You should retain copies of any invoices, receipts or other documentation you receive in connection with a transaction made with the card since you may have to file these with the Preferred Blue Customer Service Center in order to substantiate your charge. In many cases, this may not be necessary. If you use the card, Blue Cross and Blue Shield of Alabama can usually use its records to substantiate your charge. If a charge is not properly substantiated or if it is otherwise determined to be for an expense not eligible for reimbursement under the Health FSA, you will be required to repay the amount of the charge. A failure to do so can result in suspension or termination of your right to use the card. You are responsible for all charges on the Preferred Flex Card, including any charges on a card issued to your dependent.

When you receive your Preferred Flex Card, you will receive a Cardholder Agreement. The card must be returned to the Preferred Blue Customer Service Center if you terminate employment.

How the DCA Works

The DCA allows you to set aside up to $5,000 a year (**$2,500** a year if you and your spouse file separate tax returns), before-tax, for dependent care expenses. You then use those before-tax dollars to reimburse yourself for eligible out-of-pocket dependent care expenses.

Reimbursement Limits

There is a limit on the amount of reimbursement you can receive each calendar year that is not subject to federal income tax. If you are single on the last day of the year, you can receive reimbursement up to the amount of your earned income (generally, your compensation not including reimbursement you receive from your account) for that year.

If you are married on the last day of the year, you can receive reimbursements up to the amount of your earned income or your spouse's earned income for that year, whichever is less (but not exceeding the amount in your account). For example, if your earned income is $25,000 for the year, but your spouse's earned income is only $1,500, you can receive reimbursements of up to $1,500 during that year. If you were to receive reimbursements of more than $1,500 for the year, you may have to pay federal and state income taxes on the amount you are reimbursed in excess of $1,500.

If you are married and use the DCA, your spouse must work, be a full-time student, or be disabled. In cases where a spouse is a student or disabled, DCA calculations can be made as if that spouse earned an income of $250 per month if you have one eligible dependent, and $500 per month if you have two or more dependents.

Note: PEEHIP reserves the right to limit the contributions of and reimbursements payable to highly compensated employees, if necessary, for the plan to satisfy certain nondiscrimination tests under federal tax law.

Eligible Expenses

Your DCA can be used to reimburse you for your dependent expenses, as long as the expenses are:

- incurred so that you and your spouse can work or attend school full-time;
- incurred for services relating to the care of a dependent qualifying child under the age of 13 or your dependent or spouse who is physically or mentally incapable of caring for himself and who lives with you for more than one-half of the year; and
- incurred for services provided during the plan year. However, if your membership with PEEHIP terminates during the plan year, expenses must be incurred before your termination date.

Following are some examples of dependent care expenses that are reimbursable by the account. Eligible dependent care expenses include:

- expenses incurred for dependent day care that allow you (and if married, your spouse) to work or attend school full-time;
- licensed nursery school or day care center for children; to qualify under plan rules, the day care center must:
    - comply with all applicable state and local laws and regulations;
    - provide care for seven or more individuals; and
    - receive a fee for providing day care services;
- costs for dependent care services in or outside your home; and
- costs for household services which are in part attributable to the care of the dependent.

For expenses to be eligible for reimbursement, the person you pay to provide care for your eligible dependents cannot be your spouse, another dependent, or a child of yours under the age of 19.

For more information about eligible dependent care expenses, refer to IRS Publication 503, Child and Dependent Care Credit. This publication can be obtained through your local IRS office or from **www.irs.gov**.

What the Plan Doesn't Cover

Certain dependent care expenses are not covered under the DCA. Examples of ineligible expenses include but are not limited to:

- any amounts you pay to an immediate family member under the age of 19 or any person you claim as a dependent on your federal income tax return;
- costs for any person caring for your dependents when you or your spouse are not working, except in cases of short temporary absences or part-time employment where the dependent care expenses are required to be paid on a periodic basis that includes both days worked and days not worked;
- transportation expenses not provided by your dependent care provider;
- child support payments;
- education expenses for kindergarten and above or overnight camp expenses;
- food, clothing and entertainment; and
- cleaning and cooking services not provided by the care provider.

Eligible Dependents

As defined by the IRS, an eligible dependent may be a qualifying child (as defined in Internal Revenue Code Section 152) who is under the age 13, or a dependent who is physically or mentally incapable of self-care, who lives with you for more than one-half of the year and who qualifies as a dependent for federal income tax purposes. The dependent must live in your home at least eight hours a day.

Tax Effects

By paying dependent care expenses through the DCA, you can help reduce your taxes, which in turn can increase your annual take home pay.

Tax Savings

The DCA lets you set aside a certain amount of money from your paycheck before you pay taxes. You are taxed only on the part of your pay remaining. The result is lower income, which means lower federal income taxes, lower Social Security taxes, and in many cases, lower state income taxes as well.

IRS Requirements

The Dependent Care Accounts of all employees participating in the plan are required to satisfy certain nondiscrimination rules under Sections 125 and 129 of the Internal Revenue Code. PEEHIP is responsible for testing the plan to see whether it complies with these rules. If necessary, the plan administrator may suspend or curtail your contributions to or reimbursements from the plan to the extent determined necessary by the plan administrator to satisfy these rules.

Effect on Other Benefit Plans

Because account contributions reduce Social Security taxes, your Social Security benefits could be slightly less than if you had not contributed to the plan. Consult with your employer's Benefits Office to determine the impact, if any, that your participation in the DCA may have on any other benefit plans offered by your employer.

Tax Credits

Under current tax regulations, you cannot claim a tax deduction for child care expenses that are reimbursed through the DCA. You can, however, take a tax credit for any expenses in excess of your dependent care account contribution, up to the allowable limits under the law. Keep this in mind when

determining whether or not to participate in the DCA, and contact your personal tax advisor if you have questions.

Your employer is required to report the amount you contributed to the DCA on your annual W-2 form. It is your responsibility to determine if the amounts reimbursed to you for dependent care expenses are excludable from your income under Internal Revenue Service rules. Again, contact your personal tax advisor, or your local IRS office, if you have any questions.

How to File a Request for Reimbursement

The DCA is designed to reimburse you for eligible dependent care expenses you already have paid. To receive DCA reimbursements, follow the steps outlined in this section.

When you have an eligible dependent care expense, you pay it. Then, to receive reimbursement from your account, you must submit a completed Dependent Care Account Request for Reimbursement. Bills, invoices, receipts, cancelled checks, or other supporting statements from your dependent care provider must accompany the Request for Reimbursement. Mail the Request for Reimbursement and supporting statements to:

Blue Cross and Blue Shield of Alabama
Attention: Preferred Blue Customer Service Center
Post Office Box 11586
Birmingham, Alabama 35202-1586

Fax number: 205 220-7991 or toll free 1 877 889-3610

Your Dependent Care Account Request for Reimbursement will be reimbursed in full, up to the balance available in your DCA at the time you submit the Request for Reimbursement. If your account doesn't have enough money to pay the expense for which you are seeking reimbursement, the Request for Reimbursement will be held until funds are available in your account.

The minimum reimbursement is $10. If your Request for Reimbursement is less than $10, you will not be reimbursed until your total Requests for Reimbursement reach the $10 minimum. Only at year-end may the reimbursed amount be less than $10.

Reimbursement checks are processed daily. You can register at the web site www.bcbsal.com, or through the **Alabama Blue** mobile app, to have your reimbursement direct deposited to your bank account.

Requests for Reimbursement for eligible expenses incurred in a plan year must be submitted by the close of the timely filing period set forth above. After the close of that period, any unused funds in the account are forfeited.

Appeals

You or your authorized representative may appeal any adverse benefit determination. An adverse benefit determination occurs when reimbursement of your expense has been denied in whole or in part. You cannot file a claim for benefits under the plan in federal or state court (or in arbitration if provided by your plan) unless you exhaust these administrative remedies.

You have 180 days following an adverse benefit determination within which to submit an appeal.

How to Appeal Adverse Benefit Determinations

In order to file an appeal you must send the Preferred Blue Customer Service Center a letter that contains at least the following information:

- your name;
- your contract number;
- sufficient information to reasonably identify the Request for Reimbursement being appealed; and,
- a statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Preferred Blue Customer Service Center
P.O. Box 11586
Birmingham, Alabama 35202-1586

Conduct of the Appeal

Your appeal will be assigned to one or more persons within Blue Cross and Blue Shield of Alabama who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires a medical judgment (such as whether services or supplies are medically necessary), a health care professional who has appropriate expertise will be consulted. If a health care professional was consulted during the initial decision, that same person or a subordinate of that person will not be consulted during consideration of your appeal.

If more information is needed, you will be asked to provide it. If the information is not received, denial of your appeal may be necessary.

Time Limits for Consideration of Your Appeal

You will be notified of the decision on your appeal within 60 days of the date on which you filed your appeal.

In some cases, additional time may be requested to process your appeal. If you do not wish to give additional time, your appeal will be decided based on the information already received. This may result in a denial of your appeal.

Voluntary Appeals

If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). Your voluntary appeal should be in writing, and you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

Review of Final Decision of Claims Administrator

A review of a final decision by the Claims Administrator shall be by the Circuit Court of Montgomery County as provided for the review of contested cases under the Alabama Administrative Procedure Act, Section 41-22-20.

When Participation Ends With Your Health FSA and DCA

Your participation in the Health FSA usually ends if your membership with PEEHIP ends. If you terminate employment or retire before the end of the plan year, your Health FSA will terminate the first day of the following month. Membership ends when employee terminate employment, retires, goes on leave of

absence or dies. You must use or incur the money in your Health FSA by the flexible spending termination date and file for reimbursement before the 105 day filing limitation.

Your participation in the DCA will end when your PEEHIP membership ends, go on a leave of absence, retire or die. Coverage will also end if you no longer meet the eligibility rules of the plan.

Any money remaining in your account at plan year end will be forfeited.

While on a Leave of Absence (Health FSA Only)

Based on enrollment selections, if you take a leave, including leave in which you receive short-term disability benefits, you may continue to have contributions deducted from your benefit pay for your participation to continue.

If you take an unpaid leave of absence, coverage continuation will be handled according to PEEHIP policy. You will be responsible for continuing your account contributions on an after-tax basis. Please contact PEEHIP for more information.

If your leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), you may revoke your existing election as described previously in the section on “Permitted Election Changes.”

Continuation of Your Health FSA Under COBRA

If you are no longer an actively employed member of PEEHIP, you can exercise your right to continue participation in the Health FSA for a certain length of time. However, before-tax funding will no longer be available, and your Health FSA contributions will be made on an after-tax basis. Refer to the next section, “Continuation of Coverage under COBRA.” PEEHIP will provide you with the appropriate information and application forms for this type of coverage.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that most employers sponsoring health plans offer employees the opportunity for a temporary extension of that coverage when it ends or changes. Since your Health FSA is considered to be a health plan, COBRA entitles you or your spouse or dependent to extend participation in the Health FSA for the remainder of the plan year in which a COBRA qualifying event occurs. However, this COBRA continuation coverage is only available if, on the date of the COBRA qualifying event, your remaining potential annual benefits under the Health FSA are greater than your remaining contributions for the year (including the additional 2% described below).

COBRA Qualifying Events

The right of you or your spouse or dependent to elect the COBRA continuation coverage described above is permitted if coverage under the Health FSA for you or your spouse or dependent is lost because of:

- a reduction in your work hours;
- the termination of your employment (for reasons other than gross misconduct);
- your death;
- your divorce or legal separation; or
- your dependent child ceases to be a dependent under the terms of the Health FSA.

Notification Responsibilities

You or your spouse or dependent, as the case may be, are responsible for notifying the PEEHIP Office, within 60 days of the occurrence of a COBRA qualifying event resulting from divorce, legal separation, or a dependent child ceasing to be a dependent under the terms of the program. If this 60-day notice is not provided, then the program is not required to provide the option of COBRA continuation coverage as a result of the qualifying event. After receiving notice of the qualifying event, or when the qualifying event is from death, reduction in work hours, or termination of employment, PEEHIP will notify you and your spouse and dependents of the right to choose COBRA coverage. Under the law, you have 60 days from

the later of the following two dates to inform PEEHIP that you want COBRA coverage:

- the date coverage would be lost; or
- the date the COBRA election form is sent to you from PEEHIP.

If You Do Not Want COBRA Coverage

If you do not want the extended COBRA coverage, no action on your part is necessary, and your participation in the Health FSA will stop on your last date of employment. However, expenses incurred after that date will not be eligible for reimbursement from the Health FSA.

If You Elect COBRA Coverage

If you elect COBRA coverage, PEEHIP is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health FSA to similarly situated actively employed members. PEEHIP - not Blue Cross and Blue Shield of Alabama - is responsible for providing COBRA coverage to you if you elect it.

If a COBRA qualifying event causes a loss of coverage under the program, the type of COBRA coverage available to a qualified beneficiary (i.e., individual or family) will generally be the same as the type of coverage in effect on the date of the loss of coverage, subject to any additional adjustments specified by us or PEEHIP or allowed for by law. If more than one qualified beneficiary is entitled to purchase COBRA coverage, all such qualified beneficiaries will be covered under one family Health FSA. If claims are received and processed by us with incurred dates preceding the loss of coverage under the Health FSA but following the date on which we have established the COBRA-FSA, we will not go back and recalculate the opening balance of the COBRA-FSA. Instead, we will process any such claims against the FSA of the member who did not have a qualifying event (usually the subscriber), or in some cases we may process the claims against the COBRA-FSA.

Payment of Contributions

If you or your spouse or dependent elect COBRA continuation coverage, the remaining contribution payments for the period of continuation coverage will be charged to you, your spouse, or dependent, as the case may be, in an amount equal to 102% of your payroll deduction amount. Payment for the additional 2% charge will be treated as an administrative charge and will not be credited to your account or the account of your spouse or dependent, as the case may be.

PEEHIP will notify you of the amount and timing of your contributions. Your contributions will be after-tax. You should send your contributions directly to PEEHIP. Failure to contribute to your account on a timely basis will result in termination of COBRA coverage.

Termination of COBRA Coverage

COBRA coverage can be terminated if:

- the company no longer provides a health care spending account to any of its employees;
- the contribution for your continuation coverage is not paid on a timely basis; or
- you become covered under another group health plan.

RESPECTING YOUR PRIVACY

PEEHIP and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, PEEHIP, for purposes related to payment or health care operations.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity and

appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

Health care operations include but are not limited to underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services and auditing functions, including fraud and abuse programs, business planning and development, business management and general administrative activities. It also includes quality assessment.

Other Uses and Disclosures that do not Require your Written Authorization

The Plan may disclose your health information to persons and entities that provide services to the Plan and assure the Plan they will protect the information or if it:

- Constitutes summary health information and is used only for modifying, amending or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan
- Constitutes de-identified information
- Relates to worker's compensation programs
- Is for judicial and administrative proceedings
- Is about decedents
- Is for law enforcement purposes
- Is for public health activities
- Is for health oversight activities
- Is about victims of abuse, neglect or domestic violence
- Is for cadaveric organ, eye or tissue donation purposes
- Is for certain limited research purposes
- Is to avert a serious threat to health or safety
- Is for specialized government functions
- Is for limited marketing activities

Additional Disclosures to Others without your Written Authorization

The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Official.

Uses and Disclosures Requiring your Written Authorization

In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan an authorization, you can revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Official.

Our Use and Disclosure of Your Personal Health Information

As a business associate of the plan, we (Blue Cross and Blue Shield of Alabama) have an agreement with the plan that allows us to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.

YOUR PRIVACY RIGHTS

This section of the notice describes your rights with respect to your health information and a brief description of how you can exercise these rights. To exercise your rights, you must contact the Plan's Privacy Official at 877-517-0020.

Restrict Uses and Disclosures

You have the right to request that the Plan restricts uses and disclosure of your health information for activities related to payment, health care operations and treatment. The Plan will consider, but may not agree to, such requests.

Alternative Communication

The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plan to send health information to a different address than that for the Member.

Copy of Health Information

You have a right to obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudications, and other decisions. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You can also be asked to pay a fee of $1.00 per page based on the Plan's copying, mailing, and other preparation costs.

Amend Health Information

You have the right to request an amendment to health information that is in a "designated record set." The Plan may deny your request to amend your health information if the Plan did not create the health information, if the information is not part of the Plan's records, if the information was not available for inspection, or the information is not accurate and complete.

List of Certain Disclosures

You have the right to receive a list of certain disclosures of your health information. The Plan or its business associates will provide you with one free accounting each year. For subsequent requests, you can be charged a reasonable fee.

Right to a Copy of Privacy Notice

You have the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

Complaints

You can complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

The Plan's Responsibilities

The Plan is required by federal law to keep your health information private, to give you notice of the Plan's

legal duties and privacy practices, and to follow the terms of the notice currently in effect.

This Notice is Subject to Change

The terms of this notice and the Plan's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plan. If any material changes are made, the Plan will distribute a new notice to participants and beneficiaries.

Your Questions and Comments

If you have questions regarding this notice, please contact the Plan's Privacy Official at 877-517-0020.

PREMIUM REDUCTION PROGRAM

Participation in the Premium Reduction Program

PEEHIP offers the benefits under the Premium Reduction Program to provide eligible members with certain tax-free benefits allowed by the Internal Revenue Service ("IRS") in lieu of taxable compensation. Tax-free benefits are provided under the Premium Reduction Program for all PEEHIP sponsored benefit plans. Premiums are excludible from income under Sections 105 (b) or 106 of the Internal Revenue Code.

Under the Premium Reduction Program, PEEHIP medical, dental, vision, cancer and hospital indemnity product premiums will be paid with pre-tax dollars. Additionally, other products qualifying for pre-tax deductions pursuant to Internal Revenue Code Section 125 offered to PEEHIP members by third-party vendors with authorized payroll slots shall be included in the Premium Reduction Program with the exception relating to long term disability products and life insurance explained below.

The Premium Reduction Program **excludes** short term and long term disability plans and life insurance from inclusion as pre-tax benefits regardless of whether they qualify under Internal Revenue Code Section 125.

Under the Premium Reduction Program, your paycheck is reduced by the amount needed to pay your premium under a qualified PEEHIP sponsored benefit plan. You do not need to make a separate election to participate in the Premium Reduction Program. By electing to participate in a qualified PEEHIP sponsored plan, you are automatically enrolled in the Premium Reduction Program. You will be permitted to change your election as and when you are permitted to make enrollment or disenrollment decisions related to the underlying PEEHIP sponsored plans.

Premium Reduction Program Administrator

PEEHIP Board has general responsibility for the operation and administration of the Premium Reduction Program. PEEHIP Board has the discretion and authority to interpret the Premium Reduction Program and determine eligibility for participation. Such interpretations and determinations by PEEHIP Board are final and conclusive unless they are arbitrary or capricious.

Definitions

Dependent: An individual who is properly covered for the purposes of Internal Revenue Code Sections 105 (b) and 106 (a).

Employer: The school or other educational institution for whom you work and through whom you are eligible to participate in any qualified PEEHIP sponsored program.

Participant: An eligible PEEHIP member who has elected to participate in one or more features of the Public Education Flexible Employee Benefits Plan.

Public Education Flexible Employee Benefits Plan Administrator: The PEEHIP Flexible Employee Benefits Board.

Public Education Flexible Employee Benefits Plan Year: October 1st through September 30th.

PEEHIP: Public Education Employees Health Insurance Plan.

450 Riverchase Parkway East
P.O. Box 11586
Birmingham, Alabama 35202-1586

Customer Service Department:

1-800-213-7930 toll-free

Website:

www.AlabamaBlue.com

14000/FLX
Preferred Blue Flexible Spending Plan

04/2015