Medical Expense Reimbursement Plan (MERP)
Flexible Spending Accounts (FSAs)

Before we get into the details, let's take a step back and describe the account. The Medical Expense Reimbursement Plan (MERP) pays for qualified medical expenses not covered or reimbursed by your medical plan. Generally, it covers the eligible out-of-pocket expenses you pay *other than* your premium share. The account allows you to pay for qualified expenses with before-tax dollars, which can save you 20% to 30%.

Keep in mind; you cannot be reimbursed for expenses under the FSAs in addition to claiming a tax credit on your annual tax return.

Annual Enrollment

Your enrollment for the MERP is a little different from your other health benefits. Just like your other health care benefits, once you sign up for an account your elected contributions and your participation cannot be changed until the next Annual Enrollment, unless you have a qualified family status change before that time. However, you must make an active election each Annual Enrollment period to take advantage of the MERP. **Your spending account election for one plan year will not roll over into the next plan year with one exception: you will be able to carry over a minimum of $50 and a maximum of up to $500 of unused MERP funds for use in the subsequent plan year.**

If you decide to participate in a flexible spending account, enroll through BenefitsOnline during Annual Enrollment. Your pre-tax payroll deductions will be divided and spread over 24 pay periods, beginning with your first paycheck in the plan year. For the MERP account, the maximum contribution for the full plan year is $2,550.

How Your Flexible Spending Accounts Can Work for You

Here are some highlights of what each spending account can offer you.

	Medical Expense Reimbursement Plan (MERP)
What expenses are eligible?	Your Medical Expense Reimbursement Plan (MERP) reimburses you for eligible medical care expenses that are not paid by your medical, dental and/or vision plans. Expenses can be for you or your eligible dependents, even if you or they are not covered under the City's plans.
What does "eligible dependent" mean to each spending account?	Under the Medical Expense Reimbursement Plan (MERP), an "eligible dependent" is either an individual whom you can claim as your dependent for federal income tax purposes or a child for whom you are required to provide health benefits under a court order. As a result, expenses for domestic partners and children of domestic partners may be considered for tax-free reimbursement *only* if they meet the spouse or dependent eligibility requirements set out in IRS Code section 152(a) and 152(a)9. You must provide proof of dependency when filing a claim for reimbursement.
How much can I contribute?	You can contribute a minimum of $120 up to a maximum of $2,550.
Is the account "use it or lose it"?	You are allowed to carry over money in your account that you have not used—from $50 up to $500—for use in the subsequent plan year (as long as you remain eligible). Any leftover funds less than $50 or in excess of $500 will be forfeited. Any amount remaining at the termination of employment will be forfeited.

Medical Expense Reimbursement Plan (MERP)

How Does It Work?

The Medical Expense Reimbursement Plan (MERP) helps you save money on medical care expenses by allowing you to use money that isn't taxed to pay your share of medically-related expenses. When you join, you choose to contribute a set amount to your account through payroll deductions on a pre-tax basis. You can contribute a maximum of $2,550 and a minimum of $120. As you incur eligible out-of-pocket health care expenses (medical, prescription, dental, and vision), you reimburse yourself throughout the plan year. As a result, you reduce your taxable income because your flexible spending account contributions come out of your paycheck before taxes are deducted. When you are reimbursed, the money remains tax-free.

When you have an expense that qualifies for reimbursement, you have two ways to be reimbursed:

1. **Use your Benefits MasterCard debit card.** When you enroll in the MERP, you will automatically receive a debit card for you and your family to use (unless you elect "AutoPay"). This card will have a MasterCard logo and can be used like a credit card at approved, in-network locations. The debit card draws from your MERP balance to automatically pay your share of the expenses.

   Please see the *MERP – Benefits MasterCard* section of this SPD for special rules that apply.

2. **Pay out of your own pocket and send in a claim.** Attach your receipt or the insurance company explanation of benefits (EOB) to an FSA claim form, send it in, and you'll receive a tax-free reimbursement. You can download a claim form at www.benefithelpsolutions.com.

Did You Know?
Your claim form must be faxed or postmarked by the last day of the three-month period following the plan year or you will forfeit any remaining contributions that are not available for carryover in the MERP due to the "use it or lose it" rule.

If you want to submit a claim, send your claim form (with the appropriate information attached) to:

BenefitHelp Solutions
P.O. Box 67230
Portland, OR 97268
Fax: 1-888-249-5058

Be sure to keep a copy of the claim form and any attachments for your personal records. If you have questions, please call BenefitHelp Solutions at **503-219-3679** or **1-888-398-8057**.

MERP – Benefits MasterCard

When you sign up for the MERP, you will automatically receive a Benefits MasterCard unless you elect "AutoPay" (see below). The Benefits MasterCard is a debit card that is used to access the money you set aside in your MERP for pre-tax health-care-related purchases. **It works like a debit card** (automatically debiting your MERP account balance), **but you need to choose CREDIT when given the option at the check-out terminal.**

You can use your card to pay for prescription and health plan copays without having to submit a claim or documentation. However, not all expenses will be eligible for a "swipe" of the card. Some expenses—such as hospital, medical, dental and vision care provider services that are billed to you—will require additional documentation. Your card will work at the time you receive services, then BenefitHelp Solutions will send you a letter asking for any required documentation.

Here are the benefits card swipes that can be automatically approved per the IRS rules:

- Prescription medications purchased at a pharmacy that has Inventory Information Approval System (IIAS) software (most major retail pharmacies have the IIAS software)
- Copayment matches—like a $10 copay for a doctor's visit with your Kaiser physician will be automatically approved because the plan recognizes the Kaiser network $10 copay
- Recurring expenses of the same amount to the same provider, established with documentation
- Eligible over-the-counter products purchased at a pharmacy with IIAS

The following types of benefits card swipes ***will not be automatically approved*** and will require you to submit documentation to verify that the charges are valid (and not paid by any other health plan). The paperwork required is called "substantiation documentation."

- Deductible payments
- Coinsurance payments
- Vision expenses (except copay)
- Dental expenses (except copay)

When BenefitHelp Solutions (BHS) requires additional documentation, you'll receive a letter outlining the details they need. Send the letter back to BHS with a copy of the provider bill or the health plan's Explanation of Benefits to complete the transaction.

Using your Benefits MasterCard after the plan year
You should not use your benefits card to pay for expenses *incurred* during the prior plan year (July 1 to June 30) but *charged* during the current plan year, even if the charge is made during the run-out period (July 1 to September 30). Your Benefits MasterCard should only be used for expenses incurred within the current plan year.

What Is "Substantiated Documentation"?

All substantiation documents must include the following details: who, what, when, how and by whom.

- Who was treated?
- What services were provided (including the diagnostic codes for the services received)?
- When was the service provided?
- How was the service paid—what amount is covered by your insurance plan?
- Who provided the service?

To provide these answers, you can submit:

- An Explanation of Benefits (EOB) from your insurance carrier
- An itemized bill from the provider, if the services are not covered by your insurance carrier

More Details

What is a letter of medical necessity, and when would I need one?
A letter of medical necessity (LOMN) is required when expenses may or may not be eligible, depending on the condition being treated. Vitamins and other supplements fall into this category. Go to www.benefithelpsolutions.com for a list of eligible and ineligible expenses and documentation requirements.

Do I need to get a prescription for OTC products?
Yes. You can use the card at the pharmacy counter if you have a prescription for an OTC medication that qualifies for reimbursement.

Do I need a prescription as well as a letter of medical necessity?
You may. The letter of medical necessity includes specific information on the condition being treated and the expected benefits of the service or supply. This information is generally not included on a prescription.

What if I cannot substantiate a card swipe?
If a card swipe is not substantiated, it becomes an ineligible expense. You can:

- Submit manual claims that can be used to offset the ineligible expenses (to use up your balance with legitimate claims). These are considered "offset claims" and must be submitted before September 30 of the following plan year.
- Refund the plan

What is a recurring expense?
A recurring expense is one that is paid to the same service provider for the same amount on a regular basis. One example of a recurring expense is orthodontic installment payments. Here's how it works:

- The first time you use the card to pay an orthodontic installment, for example, you will get a letter from BenefitHelp Solutions requesting documentation
- Send BenefitHelp Solutions a copy of the contract between you and the provider showing the payment schedule and the amount, and request a recurring expense
- BenefitHelp Solutions will substantiate the first card swipe. The provider and the amount will be set up as a recurring expense for future installments.
- Once the recurring expense is set up, every month when the installment payment is made with the card, it will be approved automatically

Other examples of recurring expenses include ongoing chiropractic manipulation visits, naturopathic office visits, etc. Please note that if the provider or the amount changes, it is no longer a recurring expense. Recurring expenses must be re-established each plan year.

AutoPay Feature

If you are enrolled in a Moda Health plan and/or Delta Dental Plan…

If you do not want the Benefits MasterCard and you are enrolled in a CityCore medical plan and/or Delta dental plan, you can choose the AutoPay feature. AutoPay allows you to be automatically reimbursed for your eligible out-of-pocket medical, dental, and prescription expenses processed by Moda Health plans without having to submit claim forms or supporting documentation. When Moda Health receives a claim from your provider, they will process and pay the claim according to your plan benefits. Moda Health will send you an Explanation of Benefits (EOB) and at the same time, send the information to BenefitHelp Solutions for automatic reimbursement of eligible out-of-pocket expenses.

The amount shown on the EOB in the column labeled Patient Responsibility is the amount you will automatically receive—up to your annual MERP election amount. Orthodontia and IRS ineligible expenses, such as cosmetic procedures, are excluded from AutoPay. *If you have a non-tax-dependent domestic partner (per IRC 152d) enrolled on your health plan, you are not eligible to enroll in AutoPay. Per the IRS, non-tax-dependent domestic partner health expenses from a health reimbursement account are not reimbursable. In addition, because of complications with Coordination of Benefits, you cannot enroll in AutoPay if you or your eligible dependents are covered under more than one medical or dental insurance plan.*

How to Use Your MERP

Choose your contribution amount. Decide how much you may spend for health care for the coming year. This can help determine how much you should contribute to your MERP. Contributions must fall within the minimum ($120) and maximum ($2,550). Look at how much you spent last year by adding up your receipts. Then, think about whether you or your dependents have any planned surgeries or procedures, or need braces or glasses,

etc. If you have never used this type of account, contribute a conservative amount until you are more comfortable with it.

How Much Should I Contribute?

Need some help deciding how much to contribute? Use the following worksheet to help estimate your health care expenses for the upcoming plan year. This worksheet will help you calculate how much you may want to deposit in the MERP. Just follow these steps:

1. Based on your records for the past few years, fill in your anticipated eligible expenses
    - If the expense is paid by a health care plan, enter your copayment and any deductible
    - If the expense is not covered by the health care plan, enter the entire cost
    - Remember, the money in your MERP account can be used to pay your portion of out-of-pocket health-related expenses that your insurance plans do not cover
2. Add up the total annual expenses for you and your family
3. Enter this amount when you enroll

Cost For:	For You:	For Your Spouse	For Your Children:
Medical/Dental Plan deductibles	$ _____	$ _____	$ _____
Medical/Dental Plan copayments/coinsurance	$ _____	$ _____	$ _____
Doctor or clinic visits, urgent care visits	$ _____	$ _____	$ _____
Prescription medication copayments	$ _____	$ _____	$ _____
Out-of-pocket physical therapy services	$ _____	$ _____	$ _____
Chiropractor visits	$ _____	$ _____	$ _____
Dental care/orthodontia	$ _____	$ _____	$ _____
Vision care, expenses for glasses and contacts	$ _____	$ _____	$ _____
Hearing care, including hearing aids	$ _____	$ _____	$ _____
Health services/supplies	$ _____	$ _____	$ _____
Other eligible expenses	$ _____	$ _____	$ _____
Total Annual Health Care Expenses:	$ _____+	$ _____+	$ _____
Your Annual Election (up to $2,500)	= $ _____ (This is the amount you may want to contribute.)		
Contribution Per Pay Period	= $ _____ (Divide your annual contribution by 24 to see what will come out of each paycheck.)		

Note: The purpose of this worksheet is to assist you, not to provide tax advice. Consult your tax advisor if you have questions about the tax consequences of using flexible spending accounts.

Tax Considerations

Flexible spending accounts are based on current tax laws and give you the advantage of those laws. Please keep in mind the following tax considerations before participating in the MERP:

- Plan participation may affect your future Social Security retirement benefits. This could happen if your taxable pay, after spending account contributions are taken out, is below the Social Security taxable wage base. However, for most employees, the immediate tax savings is of far greater benefit than the long-term impact on Social Security benefits.
- You cannot claim the same expenses through the MERP and on your tax return. Currently, a percentage of your health care expenses above your adjusted gross income are deductible for income tax purposes. With the MERP, you can save taxes immediately on the very first dollar not reimbursed by your health care plan.

$500 Carryover Allowed

The government recently updated the laws that govern Health Care Flexible Spending Accounts, like the MERP, to allow participants to carry over up to $500 of their account balance to the following year. That means if you participate in the MERP, but you don't use all of the money you've set aside for the year, you can keep up to $500 and use it in subsequent years. To account for the costs of administrative fees to maintain these carryover balances, the City has set a minimum carryover amount of $50. This means that if at the end of the plan year you have at least $50 of unused funds in your MERP account, you may carryover that amount, up to a maximum of $500.

Here's an example: The MERP plan year is from July 1 to June 30, like your other benefits. Let's say you contribute $2,000 to the MERP in 2016. Between July 1, 2016 and June 30, 2017, you only have $1,600 in claims. So you have $400 left in your account. With the new rule in place, you can carry over that $400 and use it to pay eligible health care expenses in the next plan year or until you terminate employment.

You should still plan your MERP contributions carefully; you can only carry over from $50 to $500. Any amount less than $50 or over $500 in your MERP account at the end of the plan year (June 30) will be forfeited.

MERP – What's Covered

The Medical Expense Reimbursement Plan (MERP) can be used for health care expenses that are otherwise eligible to be claimed as deductions on your federal income tax return. To be eligible under the MERP, the expenses must be incurred while you and/or your eligible dependents are participating in the MERP. Expenses incurred before you enroll, after you quit making contributions to the spending account, or after the deadline for incurred claims are not eligible.

Did You Know?

Examples of eligible expenses are listed here, but this list is not comprehensive. For the most up-to-date list, go to www.benefithelpsolutions.com/pdfs/fsa_expenses.pdf.

Eligible health care expenses include, but are not limited to, the following:

- Insurance deductibles and copayments
- Alcohol, drug or chemical dependency treatment
- Prescription medication copayments
- Chiropractic, naturopathic, osteopathic and/or acupuncture treatment
- Dental treatments (x-rays, fillings, crowns, etc.)
- Orthodontia, dental surgery, exams, cleanings
- Eyeglasses, contacts, vision exams
- Laser eye surgery, when performed to promote the correct function of the eye

- Hearing aids, aids and assistance for the handicapped
- Doctor and hospitalization expenses and services
- Lab fees, physical exams, x-rays and vaccinations
- Infertility treatment such as shots, treatments, surgery, GIFT—as long as the procedure or treatment is done to overcome an inability to have children
- Nursing homes and nursing services
- Psychiatric, psychology and/or psychotherapy treatment
- Surgery, sterilization, gynecology, obstetrics, anesthesia
- Over-the-counter medication or medications used to alleviate or cure a sickness (any **over-the-counter medications must be prescribed by a doctor** to be reimbursable)*
- Over-the-counter supplies such as band-aids, gauze and first-aid kits, provided the amount purchased can be reasonably used within a plan year
- Mileage to and from health provider visits
- Weight loss services for morbid obesity (not including the cost of food and/or over the counter medications)
- Speech or physical therapy, transplants, and other medically necessary treatment

* Some over-the-counter medications may be reimbursable with a Letter of Medical Necessity from your doctor. Over-the-counter herbs, supplements and vitamins are eligible only with a prescription and Letter of Medical Necessity from your doctor.

MERP – What's Not Covered

While certain expenses are eligible, others are not. Ineligible health care expenses include, but are not limited to:

- Insurance premiums
- Fitness programs
- Health club dues
- Expenses reimbursed by other sources of insurance
- Nutritional supplements which are merely beneficial to general health and are not used in a course of treatment for a medical condition (or that you do not have a doctor-provided prescription *and* Letter of Medical Necessity for)
- Massage therapy is generally not covered, but may be an eligible expense when for treatment related to an acute or chronic medical condition. You are required to provide a letter of medical necessity with the diagnosis from your physician **or** the claim received from the massage therapist must include information indicating the condition being treated and that you were referred by your physician. You need to provide this information only once, per condition. Massage therapy is not covered for treatment for a non-medical reason or for depression.

Did You Know?

You can use the money in your MERP account to pay for eligible health-related expenses for your dependents—even if they are not enrolled in a plan offered by City of Portland.

For example: your child is covered by your spouse's dental plan, and needs braces. You can use your MERP funds to pay eligible out-of-pocket orthodontia expenses for your child (as long as the charges are not covered by your spouse's dental plan and as long as the child is your qualified tax dependent).

Frequently Asked Questions About the Flexible Spending Accounts

1. **Who is eligible to participate in the Medical Expense Reimbursement Plan (MERP)?** Your eligible dependents must be *eligible* to participate in the City's medical/vision and dental plans to be eligible to have expenses reimbursed under a MERP, with one exception. Domestic partners and their children are not eligible to have expenses reimbursed through a MERP unless they are considered to be a tax dependent under Code 152 of the Internal Revenue Code.
2. **How much can I claim from the MERP?** You can submit a claim for reimbursement from the MERP at any time during the plan year for an amount equal to your annual salary reduction election, minus amounts of your prior claim reimbursements.
3. **Can my MERP claim reimbursements go directly into my checking or savings account?** Absolutely. To make the reimbursement process even easier, you can set up direct deposit for your claims reimbursements. To do so, go to www.benefithelpsolutions.com/ to print out a form. Complete the form, attach a copy of a voided check for automatic checking account deposit ***or*** savings account deposit slip for automatic savings account deposit and submit the form to BenefitHelp Solutions at the address listed in the *How Does It Work?* section.
4. **I've recently gotten married. Can I change my MERP contribution amount mid-year?** You may change your MERP contribution amount but the eligible expenses must be consistent with the specific family member. Only expenses incurred while your spouse is eligible for City benefits are allowed.
5. **If I leave the City, when will my MERP expire?** If you terminate employment or cease to be an eligible employee for any reason, your contributions end on your last day of work. You will only be able to seek reimbursement for expenses you incurred from July 1 of the plan year through your termination date, unless you elect to continue your coverage under COBRA on an after-tax basis. If you are subsequently re-employed during the same plan year (and after 30 days following your termination) and have not elected to continue your medical reimbursement plan under COBRA on a post-tax contribution, no new election may be made until the next plan year. If you are on an approved family leave, contact the Benefit Information Line at **503-823-6031** for information concerning your options for continuing or terminating your MERP participation.