



FLEXIBLE SPENDING ACCOUNTS (FSA)

Plan Year 2012
July 1, 2011 – June 30, 2012

Summary Plan Description
and
Employee Enrollment

Public Employees' Benefits Program (PEBP)

Administered By



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THE BASICS OF FLEXIBLE SPENDING ACCOUNTS

What are Flexible Spending Accounts (FSA's)?

Flexible Spending Accounts (FSA's) are a way to pay out-of-pocket (un-reimbursed) health care expenses (Medical FSA) and dependent care expenses (Dependent Care FSA) on a BEFORE-TAX basis!

What Does "Before Tax" or "Pre-Tax" Mean?

FSA deductions from your paycheck are exempt from federal tax. These deductions **reduce your taxable income** reported on your income tax return.

Why Should I Participate?

The Medical FSA **can save you up to 15% - 35% in taxes** on each dollar that you spend for your share of insurance deductibles, co-pays, or other eligible health care expenses. Also, the Dependent Care FSA may save you more in taxes than the day-care tax credit (filed with your federal income tax return).

Whose Expenses Qualify for these Plans?

Since these plans are authorized by the Internal Revenue Code, **medical expenses of any family member who is a dependent for tax purposes** (special rules apply to children of divorced parents) qualify for the tax savings under the FSA, even if they are not covered under one of the health/dental plans offered by PEBP.

TAX SAVINGS EXAMPLE

By electing to direct a portion of your salary through an FSA, you essentially bank your money in a TAX-FREE account. The money is used to pay for expenses that would otherwise be paid out of your take-home pay. **This example shows how an FSA could save this employee \$375 in taxes!**

	Without FSA	With FSA	Savings with FSA
Annual Compensation	\$30,000	\$30,000	
Tax Free Expenses	<u>0</u>	<u>1,500</u>	
Taxable Income	\$30,000	\$28,500	
Federal Tax (after \$5,000 exemptions)	<u>6,250</u>	<u>5,875</u>	\$375
Net Paycheck	\$23,750	\$22,625	
After Tax Expenses	<u>1,500</u>	<u>0</u>	
Actual Take Home Pay	\$22,250	\$22,625	\$375

This person could reduce their taxes by \$375 by using the FSA!!

Savings will vary for each participant depending on variable information such as marital status, number of exemptions, and marginal tax bracket. Consult with your tax advisor to determine your actual potential savings.

SECTION I: PLAN HIGHLIGHTS

ELIGIBILITY and ENROLLMENT

To be eligible you must be:

- 1) An employee in one of the State of Nevada payroll centers -- excluding the Nevada System of Higher Education employees who have a separate plan;
- 2) Working at least 80 hours each month; and,
- 3) Enrolled in health benefits with active coverage through PEBP.

The FSA 2012 plan year is July 1, 2011 through June 30, 2012. FSA 2012 Open Enrollment (OE) will be held during the months of April and May, 2011. Check with your agency representative to confirm future open enrollment dates. To participate in a flexible spending account, you must enroll during open enrollment each year for the upcoming plan year. You may also be eligible to enroll mid-year if you experience a qualifying life status event. The Medical and Dependent Care FSA have slightly different rules regarding making an election change or enrolling mid-year.

- Mid-year new-hire enrollments may be effective on the first day of the month concurrent with their health coverage effective date *if* the FSA enrollment request is received by ASIFlex prior to the health insurance effective date. If the FSA enrollment request is received after the health insurance effective date, then the FSA coverage date will be the first of the month following.
- A new benefits-eligible employee must enroll with ASIFlex within 60 days of their health coverage effective date to obtain this coverage.
- You may also make future changes to your account within 60 days of any qualifying life status event.
- Employees enrolling for the first time should only include reimbursable expenses for *services received* from the FSA coverage effective date through the end of the plan year (June 30th).

PLAN ADMINISTRATOR

PEBP has contracted with ASIFlex to process all claims for the Flexible Spending Account program. Contact ASIFlex if you have questions regarding claims or eligible expenses.

ASIFlex, P.O. Box 6044, Columbia, MO 65205-6044

Phone: (800) 659-3035

Toll-free Fax: 1-877-879-9038

Email: asi@asiflex.com

Web: www.asiflex.com

Contact ASIFlex if you have questions regarding enrollment.

CLAIMS PROCESSING

- ◆ Claim forms available at - <http://www.asiflex.com>
- ◆ Mail or fax claims to ASIFlex (see address or fax number above) or submit online via <https://my.asiflex.com>.
- ◆ Claims are typically processed within 1 business day of submission
- ◆ Direct deposit and email authorization form- <http://www.asiflex.com>
- ◆ On-line account information - <https://my.asiflex.com>

BEFORE YOU ENROLL

Frequently Asked Questions

Medical FSA

- ◆ Long-term health care expenses do **not** qualify for reimbursement
- ◆ Cosmetic procedures generally do **not** qualify
- ◆ Orthodontics claims may be reimbursed as payments are made

Dependent Care FSA

- ◆ Documentation Requirement
- ◆ Required tax filing (Schedule 2 or Form 2441)

All claims must be filed by October 31st following the end of the Plan Year

SECTION II: FREQUENTLY ASKED QUESTIONS

IF I REDIRECT (Pre-tax) PART OF MY PAY, WON'T I MAKE LESS MONEY?

No. By electing to direct a portion of your salary through an FSA, you essentially bank your money in a TAX-FREE account, which allows you to save money by reducing your taxes. For example, you pay an office visit co-payment to your doctor and then claim reimbursement for this expense from your TAX-FREE account. You pay no taxes on this reimbursement, and your spendable income will increase by the amount of your tax savings.

WHY SHOULD I PARTICIPATE IN THE MEDICAL REIMBURSEMENT ACCOUNT IF I ALREADY HAVE MEDICAL INSURANCE?

The Medical Reimbursement Account offers a tax break on medical care expenses NOT reimbursed by insurance. For example, deductibles, co-pays, coinsurance, expenses for office visits, eye exams, glasses, prescribed medicine, and hospital care.

HOW MUCH DOES IT COST?

You pay a small fee of **\$3.50** per month to participate in either one or both flexible spending accounts. (There is an additional annual fee of **\$18** for those selecting the convenience of a FSA debit card.)

WHAT IS THE CATCH?

No catch. Congress approved FSA's in 1978; the Tax Reform Act of 1986 reaffirmed their legitimacy. The plans have long been in many Fortune 500 companies' benefit packages. Many state governments also include the plans in their benefit packages.

WHAT IF I DON'T USE ALL OF THE MONEY IN MY FLEXIBLE SPENDING ACCOUNT?

ASIFlex can help you estimate your allowable expenses for the plan year. However, if you do have **funds remaining in your account at the end of the year**, that amount **will be forfeited** by you as required by federal regulations.

ARE THERE ANY NEGATIVES THAT I SHOULD KNOW ABOUT?

If you do not use all the money in your account, **you will forfeit it.**

WHAT IF I'M ALREADY IN THE FSA?

Participation in both accounts terminates at the end of each plan year. **You must re-enroll each year** to continue your participation.

If I enroll in the PEBP Health Savings Account, can I still enroll in the regular Medical FSA?

No. Federal rules prevent an individual who is enrolled in a High Deductible Health Plan with a Health Savings Account to enroll in the Medical FSA. However, you may sign up for the Limited Scope FSA which allows you to set aside pre-tax money for vision and dental expenses.

ARE THERE ANY RESTRICTIONS IF MY SPOUSE ALSO CONTRIBUTES THROUGH HIS/HER EMPLOYER'S FSA PLAN?

- The reimbursement limit for a Medical FSA Plan is established by *each* employer, so you may each contribute an amount up to *each respective* employer's plan limit. However, you may only claim reimbursement of each expense from one plan (not the same expense under both plans). PEBP's limit for the 2012 Plan Year is **\$6,000** for the Medical FSA.
- The Dependent Care FSA Plan calendar year limit is established by the IRS. You and your spouse may together elect a maximum of **\$5,000** for both the 2011 and 2012 Tax Years. Also, if you are married and do not file a joint tax return you can set aside up to \$2,500 in the dependent care.

WHEN CAN I MAKE CHANGES?

You can change benefits during open enrollment (prior to the start of each plan year). Generally, **you will not be able to change your election** during the plan year. However, if you plan well, that should not be a problem since you will only elect deductions equal to expenses that you know you will have.

You might be able to make a change under the following circumstances if you experience a life status event change;

- ◆ Are served with a judgment, decree or court order;
- ◆ Change your dependent care provider; or,
- ◆ Go on Family Medical Leave

To make an eligible change during the plan year, **contact ASIFlex within 60 days of a qualifying life status event**. ASIFlex may request proof of a qualifying life status event.

Election changes are effective the first day of the month following the Plan Administrator's receipt and approval of written notification of the new election. (For example: Your healthcare coverage is effective on February 1st and you submit your FSA enrollment on February 2nd, your expenses starting on March 1st will be reimbursable.) Any increase in the election amount designated by a participant may include only those expenses that the participant incurs on or after the effective date of the increase.

All changes shall be consistent with the qualifying life status event.

A. Qualifying change in life status events are defined as any one of the following four (4) changes in status.

1. Your legal marital status changes through marriage, divorce, death, or annulment.

2. Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. If your child no longer qualifies for day care because he or she turned 13, then that is a loss of a dependent under the Dependent Care FSA, but not under the Medical FSA.
3. You have a change in employment status that affects eligibility under this plan, including a change from full time to part time or vice versa.

If you terminate or take a leave of absence, you must be gone at least 31 days for the termination or leave of absence to qualify as a change in status. If your spouse or any of your dependents have an employment status change that affects eligibility under a plan maintained by your spouse's or any dependent's employer, then you may increase or add coverage under *this* plan if coverage is lost under the *other* employer's plan.

If participation terminates and then you return to employment within 60 days in the same plan year, then your election will be reinstated as it was immediately prior to the termination of employment. If you return to employment after 60 days in the same plan year, then you may make a new election for the remainder of the plan year. You will not be able to be reimbursed for medical or dependent care expenses incurred during the termination period.

4. One of your dependents satisfies or ceases to satisfy the requirements for coverage under the Medical FSA for unmarried dependents due to attainment of age, student status, or any similar circumstances.

In addition, the change in status event must result in a gain or loss of eligibility for coverage under this plan or a plan maintained by your spouse's employer or one of your dependent's employers and your election modification must correspond with that gain or loss of coverage.

For example:

- You adopt a two-year-old child during the plan year.
- Since your number of dependents changes due to the adoption, you experience a life status event.
- Your child is now eligible for coverage under the Medical and Dependent Care FSA's.
- You would be allowed to increase the amount you set aside in the Medical and Dependent Care FSA's, or enroll in those plans if you are not already enrolled.
- However, you would not be able to decrease or drop either category because there was only a gain of eligibility, and not a loss of eligibility.
- A decrease does not correspond with the gain of eligibility.

- B. A judgment, decree, or court order resulting from a divorce, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for your child allows you to make an election change to your Medical FSA, to:
 - a. Provide coverage for the child, if the order requires coverage under your plan; or,
 - b. Cancel coverage for the child, if the order requires your former spouse to provide coverage.

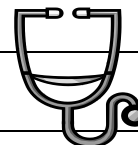
- C. If you change dependent care providers, you may make an election change to reflect the cost of the new provider. Election decreases are allowed when your child is no longer in childcare or is only in after school care due to entering kindergarten or first grade. (This is considered a provider change.)
- D. If you take an unpaid Family Medical Leave (FML) for more than 31 days, you may revoke an existing election under the Medical FSA. However, you must revoke your Dependent Care FSA since you are not working. Upon returning from FML, you may choose to be reinstated in either benefit if such coverage was terminated during the FML. Such reinstatement will be on the same terms as prior to taking FML. You have no greater right to benefits for the remainder of the plan year than an employee who has been continuously working during the plan year.

If your coverage under the Medical or Dependent Care FSA's terminates while you are on FML, you will not be entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If you elect to be reinstated in a benefit upon return from FML your coverage for the remainder of the plan year is equal to your election for the 12-month period of coverage, prorated for the period during the FML for which no premiums were paid. (See additional information on FML on page 9.)

WHAT ARE MY RIGHTS ON CLAIMS APPEALS?

You will receive written notice of any denied claims. You will have 30 days to file a written appeal of that specific claim denial with the ASIFlex claims office. The ASIFlex claims office will provide you with a written notice of the resolution of this appeal within 60 days of the appeal.

SECTION III: ESTABLISHING AND USING YOUR MEDICAL FSA



Estimate you and your family's annual out-of-pocket health care expenses. You may include expenses for anyone who qualifies as a dependent for your federal tax return (spouse, children, etc.). Include predictable expenses only. (Remember that Plan Year 2012 is July 1, 2011 – June 30, 2012)

Enroll in the Medical FSA. Enter your estimated medical care for the Plan Year. (Deductions are generally taken out of the second check of each month.) Contact your agency representative if you need assistance.

Incur medical care expenses. A medical care expense is incurred on the date a service is provided or a product is purchased to create that expense. You must incur medical care expenses *before* you file a claim for those expenses.

File claims. After you have incurred the medical care expenses and know the amount of your responsibility for the bill, you may submit a claim for those expenses to ASIFlex.

Receive reimbursements. ASIFlex will review your claim and any necessary supporting documentation. If approved, ASIFlex will reimburse you for the medical care expenses. Claim reimbursements are typically issued within one business day of receipt of your claim.

USE THE BENNY CARD TO PAY FOR YOUR MEDICAL EXPENSES

The FSA Debit Card (known as the Benny Card) provides a convenient method to pay for out-of-pocket medical expenses for you, your spouse and/or any tax dependents. The IRS has stringent regulations regarding appropriate use of the Benny Card, such as **where the card can be used**, and **when follow-up documentation is required (use of the card DOES NOT necessarily eliminate all of the paperwork)**. The card is a great benefit, but it is important that you take a moment and understand how it works.

Where can the cards be used?

Per IRS regulations, the Benny Card can only be used at Health Care Providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS).

- 1) **Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The FSA debit card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).
- 2) **Inventory Information Approval System (IIAS):** The IRS also allows the Benny Card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your FSA debit card to eligible expenses, and you will never be prompted for follow-up documentation for purchases at these stores. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The card will work at these stores, even if the MCC does not indicate it is a health care provider. A list of stores with this system in place now (and some expected in the future) is available online, at www.asiflex.com/debitcards. **Purchases at these stores will never require follow-up documentation!!** Please note that as of July 1, 2009, IRS regulations require all pharmacies to have the IIAS in place, or your card may be declined at the point-of-sale.

When do I have to turn in paperwork?

Debit card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of four other criteria are met. Transactions are electronically substantiated if:

- ✓ The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the **employer-sponsored** medical, vision or dental plan that participant has elected;
- ✓ The expense is a recurring expense that matches expenses previously approved as to amount, provider, and time period (e.g., for an employee who pays a monthly fee for orthodontia at the same provider for the same amount); or
- ✓ The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter supplies and prescription medication (this system is allowable only if the merchant approves only qualifying items; all other purchased items must be paid for in a split tender transaction.)

Any transaction that does not meet the above criteria will prompt a request for follow-up documentation.

What happens if I don't submit requested documentation?

Federal regulations require that the cards be deactivated if follow up documentation is not provided when requested by ASIFlex. You will receive several notifications before the cards are deactivated, and can always call ASIFlex for assistance in working through any concerns that come up.

Is there a cost for the card?

Yes. There is an \$18 annual fee that will be deducted from your available balance in July 2011. There are no refunds for the card if you terminate employment or use up your balance early in the plan year.

How do I request a card?

Current cardholders who renew for the following plan year will automatically have their card reloaded with the next year's election amount as of July 1. New enrollees will receive a welcome packet in the mail that includes an application for the debit card.

Can I request additional cards?

Yes. Everyone who requests a card will receive two Benny Cards in the mail. If you would like additional cards, they are available by emailing ASIFlex directly at asi@asiflex.com and placing your request. There is a \$5 fee for each additional card request. Please note that all cards will be in the name of the FSA participant.

Some important points you should remember regarding a Medical FSA are:

- 1. Maximum Plan Election:** You may include up to **\$6,000** worth of qualifying expenses –but not more than your earned income.
- 2. Your plan year election cannot be changed,** unless you experience a qualifying life status event.
- 3. You may include all medical, dental and vision expenses** not covered or not reimbursed by insurance which are **incurred** by the taxpayer or their eligible dependents **during the plan year** for medical care as defined in Section 213(d) of the Internal Revenue Code. Please refer to the list on page 10 and IRS Publication 502 (<http://www.asiflex.com/>) for further details on qualifying expenses.
- 4. Medical care expenses are eligible for payment from the Plan based on when **incurred**,** not when paid. An expense is **incurred** when you or one of your dependents is provided with medical care or purchases a qualifying product, and **not** when you are billed, are charged, or pay for the expense.
- 5. Allowable expenses must be incurred during the portion of the plan year or grace period that you were a participant. Claims for expenses incurred during the plan year must be submitted to ASIFlex by October 31st following the end of the plan year.** After that, your account will be closed and you will forfeit any balance remaining in accordance with federal regulations.

Grace Period: If you are a participant as of June 30th of a Plan Year, you may continue to incur expenses through September 15th to use any remaining funds in the Plan Year that just ended. Claims for expenses incurred during this Grace Period are paid from the oldest year's funds first unless you request otherwise.

6. You must submit a completed claim form along with copies of invoices or statements to serve as proof that you have incurred an allowable expense in order to receive payment. Statements are required to be from the provider/store stating the date of service/purchase, a description of services/products, the expense amount, the name of the service provider/store and the person for whom the service was provided.

For over-the-counter items, the receipt or documentation from the store must include the name of the item printed (by the store) on the receipt. You must indicate the existing or imminent medical condition for which the item will be used on the receipt, on the claim form, or on a separate enclosed statement each time these items are claimed.

- Purchases for general good health will not be accepted.
- For items covered by insurance, copies of insurance explanations of benefits statements may be used instead of original physician bills if the date of service and charges are shown.
- Copies of receipts of payment, without the above, are not acceptable.
- Copies of personal checks or credit card receipts are not sufficient documentation.
- Documentation and/or copies will not be returned.
- You will be provided with a supply of claim forms with your enrollment confirmation.
- Extra claim forms are available, from the ASIFlex web site at www.asiflex.com or by calling ASIFlex at (800) 659-3035.

7. Orthodontic expenses may be assumed to be incurred at the time a payment made. To claim orthodontic down payments, you must include 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.

8. You may be paid the full amount of your claim or the balance of your annual election, whichever is less, whenever you file a qualifying claim. Payment under the Medical FSA is not limited to the amount in your account at the time of your claim. Your monthly contributions will continue for the remainder of the plan year.

9. Claim reimbursements may be made by **direct deposit** into the bank account of your choice. By using direct deposit you will not need to wait for a check to arrive or get it deposited. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by **e-mail**. If you prefer, a check can be mailed to you instead of payment by direct deposit.

10. Participants on Family Medical Leave are entitled to maintain coverage for the Medical FSA. Coverage and claims reimbursement will not be disrupted as long as monthly contributions are received (either by payroll deduction or by direct payment to the Plan) by the end of each month. The participant must make arrangements, **before** going on leave, with their agency representative for prepayment of contributions. Reimbursements will be discontinued if the contribution is not received by the end of any month. A participant who terminates coverage prior to going on Family Medical Leave may immediately reinstate coverage for qualifying

expenses upon return to work. Such reinstatement of coverage and continuation of the original election must be made within 60 days of returning to work.

11. Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA.
12. **If you are enrolled in the Health Savings Account**, you may sign up for the Limited Scope FSA, and use pre-tax money to pay for vision or dental expenses. The advantage to signing up for this program is that you can allow your HSA funds to stay in an interest bearing account, and still use pre-tax money for eligible expenses.

MEDICAL FSA – QUALIFYING EXPENSES

Only the portion of the expenses you owe after insurance payments can be claimed. **Qualifying expenses** are those expenses which are **incurred** by the taxpayer or their eligible dependents (visit www.asiflex.com for definition of qualified dependents) **during the plan year** for medical care as defined in Section 213(d) of the Internal Revenue Code, excluding all insurance premiums and long term care expenses.

Qualifying medical care expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. Refer to IRS Publication 502 for additional information (www.asiflex.com). However, **expenses qualify** for the Medical FSA **based on when incurred, not when paid**, and federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA. Please contact ASIFlex if you have a question on specific qualifying items.

Below is a partial listing of qualified expenses

- ◆ Deductibles
- ◆ Co-pays
- ◆ Coinsurance
- ◆ Doctor's fees
- ◆ Dental expenses
- ◆ Vision care expenses
- ◆ Prescription glasses
- ◆ Contact lenses and solutions
- ◆ Corrective eye surgery
- ◆ Drugs and medicines
- ◆ Insulin
- ◆ Orthodontics (braces)
- ◆ Routine physicals
- ◆ Medical equipment (necessary for an existing medical condition)
- ◆ Hearing aids, including batteries
- ◆ Transportation expenses related to illness
- ◆ Chiropractor's fees

NOTICE - Changes due to the Patient Protection and Affordable Care Act (PPACA)

The federal health care reform bill passed in March, 2010 states that as of January 1, 2011, over the counter (OTC) drugs and medicines will only be reimbursable through your Health Care FSA if you have a valid prescription. See the list below for examples of OTC medicines. Insulin still qualifies for reimbursement without a prescription.

Equipment, supplies, and diagnostic devices such as bandages, hearing aid batteries, blood sugar test kits, etc. will remain eligible for reimbursement without a prescription.

Following is a list of examples of OTC medicine categories no longer eligible for reimbursement without a prescription after January 1, 2011:

Acid Controllers	Allergy & Sinus
Anti-Diarrhea Products	Anti-Gas Products
Anti-Itch & Insect Bite Products	Baby Rash Ointments
Cold Sore Remedies	Cough, Cold & Flu Products
Digestive Aids	Hemorrhoid Remedies
Laxatives	Motion Sickness
Pain Relievers	Respiratory Treatments
Sleep Aids & Sedatives	Stomach Ailment Remedies

If you use the Benny Card at merchants that have implemented the Inventory Information Approval System (IIAS), you will not be able to pay for OTC medicine with the Benny Card, even if you have a prescription on file with ASIFlex. You will be required to submit a reimbursement request, along with a copy of the prescription and the cash register receipt in order to be reimbursed for these expenses.

NON-QUALIFYING EXPENSES

- ◆ Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins
*These services do **not** generally qualify. For a medically necessary cosmetic procedure, enclose a note with the claim stating the existing medical condition and why the treatment is required.*
- ◆ Sun glasses, non-prescription or clip-on sunglasses
- ◆ Toiletries
- ◆ Expenses that are merely beneficial to your general health (e.g., vacations and vitamins)
- ◆ Herbs, vitamins and nutritional supplements not used to treat an existing diagnosed medical condition
- ◆ The cost of a weight-loss program if the purpose of the weight control is to maintain your general good health
- ◆ Health club dues

SECTION IV: ESTABLISHING AND USING YOUR

DEPENDENT CARE FSA



Estimate your total dependent care expenses for the plan year. Include predictable expenses only. Remember that Plan Year 2012 is July 1, 2011 – June 30, 2012.

Enroll in the Dependent Care FSA. Enter your estimated dependent care expenses. Divide your estimate by the number of deductions you will have taken during the plan year. **Remember to not exceed \$5,000 in any calendar year.** (Deductions are generally taken out of the second check of the month.) Contact your agency representative if you need assistance.

Receive dependent care services. Dependent care expenses are incurred when the day care is provided. You must receive the dependent care services before you file a claim for those services.

File claims. After you have received the dependent care services, you may submit a claim for those expenses to ASIFlex.

Receive reimbursements. ASIFlex will review your claim, and if approved will reimburse you. Claim reimbursements are issued within one business day of the receipt of your claim up to the amount that you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from your payroll contributions.

Some important points you should remember regarding a Dependent Care FSA are:

This category is an alternative to taking a “Tax Credit” allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the “Tax Credit” or the “FSA”. The IRS will not allow you to receive two tax breaks on the same expenses.

The Dependent Care FSA is limited to \$5,000 for Plan Year 2012 for any number of dependents. [In no event shall a married individual filing a separate tax return for the calendar year exceed \$2,500.] You will experience “tax savings” throughout the year with every paycheck you receive. If you are subject to the 25% federal tax rate you will save approximately 25% of expenses through the Dependent Care FSA. If you pay a higher federal rate, you will receive an even higher tax break through the Dependent Care FSA.

Generally those employees with a combined taxable income over \$69,000 or single parents with taxable income over \$37,000 will save more through the Dependent Care FSA.

Please contact your tax advisor if you have questions about which is best for you. You must choose whether to use the Tax Credit or the Dependent Care FSA.

- 1.** You and your spouse together may include **up to \$5,000 per calendar year (\$2,500** in the case of a married individual filing a separate tax return for the calendar year) or the lesser of your (after subtracting all FSA deductions) or your spouse’s earned income for the calendar year. [In no event shall a married individual filing a separate tax return for the calendar year exceed \$2,500.] 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 himself or herself, such spouse shall be deemed to have earned income of \$250 per month if you have one dependent and \$500 per month if you have two or more dependents.
- 2.** You may include only those child/dependent care expenses that you incur in order for you and your spouse to be gainfully employed. Only expenses incurred for care and well-being qualify for this tax break (education related sports camps, summer school and private school expenses, food and transportation do not qualify). **Child support payments are not allowable.** Day camp fees incurred in order for you to work are allowable but overnight camps are not. Please refer to page 13 and IRS Publication 503 for further details on qualifying expenses. You may link to this publication from ASIFlex's website at www.asiflex.com.
- 3.** Expenses are eligible for payment from the plan based on when **incurred** not when paid. Expenses are **incurred** when your dependent is provided with the care that gives rise to the expenses, and **not** when you are billed, charged for, or pay for the care.
- 4. YOUR PLAN YEAR ELECTION CANNOT BE CHANGED,** unless you experience a qualifying life status event.

5. Day care expenses are limited to care for children **under age 13**, for whom you have more than 50% custody, or for a spouse or dependent who is physically or mentally incapable of caring for himself or herself and who lives in your home at least 8 hours each day.

6. The expenses may not be paid to a child of yours 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 you or your spouse is entitled to a personal tax exemption as a dependent.

7. Reimbursable **expenses** must be **incurred** during the portion of the plan year **after you become a participant**. You must **file claims** for expenses that you incurred during the plan year or grace period **by October 31st** following the end of the plan year. After that, your account will be closed and **any remaining balance will be forfeited** by you in accordance with federal regulations.

Grace Period: If you are a participant as of June 30th of a Plan Year you may continue to incur expenses through September 15th to use any remaining funds in the Plan Year that just ended. Claims for expenses incurred during this Grace Period are paid from the oldest year's funds first unless you request otherwise. The FSA debit card will not be loaded with funds from the previous plan year. It is only loaded with funds from the current plan year, so it will be necessary for you to submit reimbursement requests to access funds during the FSA Grace Period.

8. If you **terminate employment**, you may continue to file claims for qualifying expenses incurred **prior** to termination during the same plan year until you have been reimbursed the balance in your account. **You must file claims** for expenses that you incurred during the plan year **by October 31st** following the end of the plan year. In addition, please refer to the continuation of coverage section of the document titled COBRA.

9. **You must submit a completed claim form** along with **copies** of invoices or statements **from the provider** to serve as proof that you have incurred an allowable expense in order to receive payment. Statements are **required to include**, the **provider's name**, the **date(s) of service**, a **description of the services**, and the expense **amount**. Copies of personal checks and paid receipts, without the above information, are not acceptable. Documentation and/or copies will not be returned. You will be provided with a supply of claim forms with your enrollment confirmation. Extra claim forms are available from the ASIFlex web site at www.asiflex.com or by calling ASIFlex at (800) 659-3035. In lieu of providing the above documentation, you may have the provider complete the dependent care section of the claim form and sign on the line provided. **The dependent care services must have been provided before you file a claim for those services.**

10. **Claim reimbursements** may be made by **direct deposit** into the bank account of your choice. By using direct deposit you will not need to wait for a check to arrive or get it deposited. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by **e-mail**. If you prefer, a check can be mailed to you instead of payment by direct deposit.

11. The tax identification (ID) number or Social Security number of the child/dependent care provider must be listed on each of your claim forms and your federal income tax return. Please check with your childcare provider (**before** enrolling in this category) to be sure that you are able to obtain their tax ID number or their Social Security number.

13. **You are required to file Schedule 2** with your IRS Form 1040A or **Form 2441** with your IRS Form 1040 to support the amount redirected (pre-taxed) for the calendar year. Please note that

this is for informational purposes. You will not pay taxes on the redirected amount. Claim reimbursements made to you under this category are not taxable, but the amount redirected will appear on your W-2 form. This will inform the IRS that you have received a tax break on that expense through the FSA.

14. Participants on leave (paid or unpaid) under **Family Medical Leave** are entitled to terminate coverage during the leave and reinstate coverage immediately on return to work. Such **reinstatement must be made within 60 days of returning to work.**

DEPENDENT CARE FSA – QUALIFYING EXPENSES

Expenses necessary for you to be gainfully employed:

- ◆ Expenses paid to a dependent care center
- ◆ Expenses paid to a "babysitter"
- ◆ Expenses paid for care of a dependent under age 13
- ◆ Expenses paid for care of a dependent who is physically or mentally incapable of caring for herself or himself

NON-QUALIFYING EXPENSES

- ◆ Care while you are not working or looking for work
- ◆ Care for child for whom you have 50% or less physical custody
- ◆ Care for child age 13 or older who is not disabled
- ◆ Overnight care or camps
- ◆ Instructional or sport specific camps; e.g. Ballet camp, soccer camp, summer school

SECTION V: NOTICE'S

Women's Health Cancer Rights Act of 1998

The Medical FSA 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 ASIFlex at (800) 659-3035 for more information or visit the following website <http://www.dol.gov/index.htm>.

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 nor 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). For more information please visit the following website <http://www.dol.gov/index.htm>.

HIPAA Privacy

The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. For more information please visit the following website <http://www.hhs.gov/ocr/office/index.html>

**SECTION IV: CONTINUATION OF COVERAGE UNDER COBRA
(health reimbursement only)**

In the event that your health benefits and FSA coverage terminates because of a qualified event i.e. termination of employment (does not include retirement), you may continue your FSA coverage if you elect COBRA. Information regarding continuation of your FSA is included in the COBRA notification form that you receive from PEBP. Please note that continuation of FSA coverage only applies if you have a positive Health FSA Account balance (including the remaining monthly administrative fee and the 2% COBRA administrative fee). COBRA FSA benefits will end on the earlier of:

- You cease paying the monthly administration fee;
- your remaining FSA balance is depleted, or;
- at the end of the applicable plan year.

If COBRA is elected, it will be available only for the remainder of the applicable plan year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Employees who have incurred a COBRA qualifying event as a result of no longer being actively employed, will be responsible for the monthly administration fee. The monthly administration fee will be paid on an after tax basis.

Sample Claim and Provider Documentation

This day care receipt contains the items the Internal Revenue Code requires:

1. It is signed by the provider of service - "*Ima Sitter*"
2. It contains a description of the services - "*day care services*"
3. It explicitly lists "*1-2-04 to 1-08-04*" as the range of the dates that the day care was provided.
4. It includes the amount charged for the day care "*\$300.00*"; not necessarily the amount paid.
5. It identifies the person for whom the day care was provided - "*Mike Riddick*"

Day care documentation must contain all of these items in order to be processed.

We must be able to identify the participant

I provided day care services for *Mike Riddick*

From *1/02/04* to *1/08/04*. The total sum for services provided was *\$300.00*.

Signed *Ima Sitter*
 Ima Sitter
 123 Main Street
 Columbia, MO 65203
 SSN 123-45-6789

CLAIM FORM

Please read requirements on reverse side

Riddick, John M.

Last Name, First Name
110 E. Ash St.

Street Address

111 - 22 - 4444

Social Security Number
Columbia MO 65203

City, State, Zip

Dependent Care Assistance (day care, babysitting, etc.)

Name of Dependent	Age	Service Period		Name, Address and Taxpayer ID number of Provider of service	Charge for Services	MSCEP use	
		From	To				
<i>Mike</i>	10	<i>1/02</i>	<i>1/08</i>	<i>Ima Sitter, 123 Main St. Columbia MO 65203 123-45-6789</i>	<i>300.00</i>		
Total Dependent Day Care Claim					<i>300.00</i>		

I provided the dependent care as stated above

Care Provider's original signature

Date

SSAN/Tax ID#

Flexible Medical Benefits

Date Care Provided*	Name of Service Provider	Expense Description	Name and relationship of Person for whom expense incurred	Amount that is your responsibility	MSCEP use
<i>01/05/04</i>	<i>I. William See, M.D.</i>	<i>Eye Exam</i>	<i>Mary - daughter</i>	<i>10.00</i>	
Total Medical Amount Requested				<i>10.00</i>	

Please arrange documentation in order listed above.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

John M. Riddick
Employee Signature

01/08/04
Date

The participant must sign the claim form.

Every request and all documentation must contain all the items shown in **blue**

Separate dependent care documentation is not required if the provider signs the form after the dependent care section is completed.

I. William See, MD

Ophthalmology
2020 Seymour
Crystalview, MO 65201

Service Date	Description	Charge for Services
<i>01/05/04</i>	<i>Eye Exam</i>	<i>\$10.00</i>

Patient's Name *Mary Riddick*

This health care service statement contains the items the Internal Revenue Code requires:

1. It identifies the provider of service - "*I. William See, MD*"
2. It contains a description of the services - "*Eye Exam*"
3. It explicitly states the date of the eye exam - "*1/05/04*"
4. It includes the amount charged for the exam "*\$10.00*"; not necessarily the amount paid at the time of service.
5. It identifies the person receiving the eye exam - "*Mary Riddick*"

Medical documentation must contain all of these items in order to be processed.