



Flexible Spending Accounts Administrative Manual – 2012

Table of Contents

Section 1: General Information	1
I. Flexible Spending Account Options	1
II. Tax Savings.....	1
Section 2: Plan Administration	2
I. Employer definition	2
II. Plan Administrator	2
III. Claim Administrator	2
IV. Plan and Claim Administrator’s Duties	2
V. Information to be provided to the Plan Administrator	3
VI. Decision of Plan Administrator Final.....	3
VII. Review Procedures	3
Section 3: Employee Eligibility	4
I. Eligibility to Participate.....	4
II. Definition of an Employee.....	4
III. Waiting Periods and Breaks in Service	5
IV. Effective Date of Coverage	6
V. Employees / Spouses who are approaching age 65.....	7
Section 4: Pretax Premium Option	13
I. Enrollment.....	13
II. Status Changes	13
III. Waiver Option	14
IV. Annual Elections	14

Section 5: Health Care Flexible Spending Accounts	15
I. Introduction.....	15
II. Eligible Expenses	16
III. Deferred Compensation	18
IV. How much to contribute	19
V. Grace Period	20
VI. Status Changes	20
VII. FMLA and Non-FMLA Leaves of Absence.....	22
VIII. Ending the Account.....	23
IX. Participant Death	23
X. Filing a claim for Reimbursement	24
XI. Reimbursement Payments.....	26
XII. Stored Value Debit Card (Benny Card)	26
XIII. HEART Act – Qualified Reservist Distribution	28
 Section 6: Dependent Care Flexible Spending Accounts	 30
I. Introduction.....	30
II. Who can use the account	30
III. Eligible Expenses	32
IV. Dependent Care FSA vs. Health Care FSA	34
V. Documentation needed for submitting a Dependent Care Claim.....	34
VI. How much to deposit	35
VII. Status Changes	35

Section 1

General Information

Flexible Spending Account Program

The Flexible Spending Account program (also called a **Cafeteria Plan**) is offered by the State of Kansas (**Employer**) and administered by the State Employee Health Plan (**SEHP**).

First offered by the State of Kansas in 1991, the Flexible Spending Account program is subject to the federal rules and regulations of Internal Revenue Code (**IRC**) Section 125 concerning all cafeteria plans and is authorized by K.S.A. 75-6512 et al.

Flexible Spending Accounts allow participants to pay for health plan premiums, non-reimbursed health care expenses and dependent daycare expenses using pre-tax dollars.

I. Flexible Spending Account Options

There are currently three benefit plans offered:

1. **Pretax Premium Option** – allows participants to pay their State Employee Health Plan (**medical, dental and/or vision**) premiums on a pre-tax basis.
2. **Health Care Flexible Spending Account (HC FSA)** – allows participants to pay for qualified health expenses that are not otherwise reimbursable under the health plan, on a pre-tax basis. Eligible expenses are determined by IRS publication 502.
3. **Dependent Care Flexible Spending Account (DC FSA)** – allows participants to pay for qualified work related daycare expenses on a pre-tax basis. Qualified DC FSA expenses are determined by Section 129 of the IRS code.

II. Tax Savings

Salary reductions on a pre-tax basis means that the participant enters into an agreement with the State of Kansas to reduce their salary by the cost of Health Plan premiums and/or by the amounts elected for either, or both Flexible Spending Accounts. Since the participant's salary is reduced, the participant does not pay federal or state income taxes or Social Security taxes on these amounts. As a result, the participant's take home pay will increase by the amount they don't pay in taxes.

Did you know? Originating in 1991, enrollment in the Health Care and Dependent Care FSA's has grown from 1,548 participants to over 10,000 today.

Section 2

Plan Administration

I. Employer:

The State of Kansas shall be identified, hereinafter, as the Employer.

II. Plan Administrator:

SEHP is hereby designated as the Plan Administrator for the Flexible Spending Account Program for The State of Kansas.

III. Claim Administrator:

The State Employee Health Plan has contracted with Application Software, Inc. (**ASIFlex**) to act as claims administrator for the State of Kansas Flexible Spending Account Program.

IV. Plan and Claim Administrator's Duties:

In addition to any rights, duties or powers specified throughout the Plan, the Plan and Claim Administrators shall have the following rights, duties and powers:

- A. To interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;
- B. To adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;
- C. To determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;
- D. To develop appellate and review procedures for any Participant, Spouse Dependent or designated beneficiary denied benefits under the Plan;
- E. To provide the Employer with such tax or other information it may require in connection with the Plan;
- F. To employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;
- G. To report to the Employer, or any party designated by the Employer, after the end of each Plan year regarding the administration of the Plan, and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

Note: *Nothing in this section is meant to confer upon the Claims Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Plan Administrator regarding any amendments or change in administrative procedure, or Benefit Provider.*

V. Information to be provided to the Plan Administrator:

The Employer, or any of its agents or agencies, shall provide to the Plan Administrator any employment records of any employee's eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan.

VI. Decision of Plan Administrator Final:

Subject to applicable State or Federal law, and the provisions of the below mentioned Review Procedures, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties.

VII. Review Procedures:

In cases where the Plan Administrator denies a benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish in writing to said party a denial letter within 30 days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial.

Section 3

Employee Eligibility

I. Eligibility to Participate

An individual is eligible to participate in an FSA through the State Employee Health Plan (SEHP) if the individual is: an employee, who regularly works 20 or more hours per week and/or 1,000 hours per year, has been employed by The State of Kansas for 30 days and eligible to participate in the (SEHP).

Note: *An employee is not required to enroll in the SEHP in order to participate in an FSA.*

II. Definition of an Employee

According to the provisions of Kansas Administrative Regulation (K.A.R.) 108-1-1, an active employee is eligible to participate in the SEHP if the employee is one of the following:

- Any elected official of the State of Kansas;
- Any other officer or employee of a State of Kansas agency who meets both of the following conditions:
 - Is working in one or more positions that together require at least 1,000 hours of work per year; and
 - Is in a position that is not temporary; an employee who works under employment customs at any regents institution requiring less than a full calendar year of service shall not be considered temporary;
- Any person engaged in a postgraduate residency training program in medicine at the University of Kansas Medical Center, or in a postgraduate residency or internship training program in veterinary medicine at Kansas State University, but not including student employees of a state institution of higher learning;
- Any person elected to a board position that requires less than 1,000 hours of work per year;
- Any person serving with the foster grandparent program;
- Persons participating under reduced service agreements outlined in K.S.A. 76-746, and amendments thereto; and
- Any other class of individuals approved by the Kansas State Employees Health Care Commission, within the limitations set out in K.S.A. 75-6501 et seq. and amendments thereto.

Note: *An employee should contact their human resource office to inquire about whether their position is benefits eligible.*

III. Waiting Periods and Breaks in Service

Each person who is an eligible employee under the definition mentioned above shall have 31 calendar days from their first day of employment with the State of Kansas to elect or waive enrollment in an FSA. For those eligible employees that choose to enroll in an FSA, coverage will be effective the first of the month following the completion of the 30-day waiting period. The waiting period begin date will be the first day of employment with the State of Kansas.

Example: *If you are hired on February 16th, your effective date will be April 1st. If you are hired on February 1st, your effective date will be March 1st.*

- Employees who are changing from a non-benefits eligible position to a benefits eligible position with no more than a three day break in State of Kansas or regent employment may apply calendar days employed in their previous position towards meeting the 30 – day waiting period.

Note: *Student employee positions are not benefits eligible. An employee previously in a student employee position will have to complete the 30-day waiting period.*

- If an employee is returning to work for the State of Kansas in a new position and was previously enrolled in an FSA through the SEHP, the employee may continue their FSA as long as their absence was less than three business days.

Note: *If a termination date was entered in the employee's FSA screen in SHaRP, it is the new agency's responsibility to notify SEHP that the termination should be voided. A new enrollment and/or change form is not required.*

- If an employee is returning to work for the State of Kansas, was enrolled in an FSA and the break in service was between four and thirty calendar days, the employee may continue their FSA as long as a catch-up contributions are made. Catch-up contributions are to be made on an after-tax basis via personal check. The participant should make the check payable to SEHP.
- If an employee is returning to work for the State of Kansas after a break in service of more than 30 days, the employee must wait until the next open enrollment period to enroll in an FSA. The State of Kansas allows only one FSA enrollment per year.
- If an employee is returning to work for the State of Kansas and was a State of Kansas retiree, the employee may not enroll in an FSA until the following plan year.
- If an employee is laid off from the State of Kansas for more than 30 days and/or their employment is terminated, their FSA will terminate and the employee may have the option of continuing their FSA through COBRA (after-tax payments must be made in this situation).
- The 30-day waiting period is never waived for enrollment in an FSA.

IV. Effective Date of Coverage:

The initial enrollment period for Flexible Spending Accounts is limited. Employees should submit a completed Enrollment Form to their Agency Human Resource Office within 31 days of their date of hire or new benefits eligibility. If forms are not submitted within 31 days, the employee will not be allowed to enroll until the next Open Enrollment period, unless they experience a mid-year qualified change in status.

Note: *Time spent in non-benefits eligible position will be applied to the 30 day waiting period if there is not a break in service of more than three days when an employee moves from a non-benefits eligible position to a benefits eligible position.*

For rehired employees with a break in service of 30 calendar days or less, the effective date of coverage is the first day of the month following the rehire date (assuming the employee had an FSA in effect prior to the break in service). If the rehire date is the first day of the month, the coverage effective date will also be that same day. If the employee is rehired within 30 days, the person is to enroll in the same coverage they had previously, unless the person experiences a qualified change in status. If the employee is enrolled in a HC FSA they are expected to make after-tax “catch-up” contribution for periods missed in order to continue without a break in service. If missed contributions are not caught up, the unfunded period of time will be considered a period of no coverage and claims incurred while the employee was on leave will not be paid.

V. Employees /Spouses who are approaching age 65

Employees who are planning to continue to work after they reach the age of 65 will remain eligible for FSA(s) as long as they remain in a benefits eligible position. For those participants considering retirement, please see **Section 5, part VIII** entitled: **“Ending the Account”**.

Section 4

Pretax Premium Option

I. Enrollment

A participant enrolled in the SEHP may elect to participate in the Pretax Premium Option. The pretax election must be indicated on an on-line enrollment form during open-enrollment or when the participant first becomes eligible for benefits. Participation in the Pretax Premium Option reduces the amount of tax withheld from the participants pay.

II. Status Changes

According to IRS regulations, if the participant is enrolled in the Pretax Premium Option (applies to FSA's as well) and they request a change in their coverage that will change their premium amount, the participant must first experience a qualified change in status as listed in this manual. Requests submitted as a result of a qualified change in status must be made within 31 days from the date of the event. The effective date of the change will be the first day of the month following the date the request is received by SEHP. This is because the qualified change in status only allows a change to be made. The effective date of the change is dictated by the date the request is received and approved by SEHP.

Example: *A participant experiences a qualified change in status on February 15th and the request is received by SEHP on March 4th, the effective date of the change will be April 1st.*

III. Waiver Option

If an employee does not want to participate in the Pretax Premium Option, and wants to pay for the cost of their health plan premiums on an after-tax basis, the employee can indicate this on an enrollment form or on-line during open-enrollment.

IV. Annual Elections

The annual election amount is the amount a participant pledges to contribute each year to pay for unreimbursed Health Care and/or Dependent Care expenses. For existing participants this election is made on-line annually during open-enrollment. For new hires and those experiencing a mid-year qualified change in status, a paper enrollment form must be submitted to the participant's agency human resources office.

A new election must be made each year, even if the participant isn't making any changes.

Note: *Each employee is personally responsible for reviewing the payroll deductions to their paychecks (especially the first paycheck of each new year) to confirm the accuracy of their deductions. If the deduction amount(s) are not correct, the employee must contact their agency human resource office within 14 calendar days of their first pay date to request a correction. If no corrective action is taken, the participant waives the right to correct the error for the remainder of the plan year.*

Section 5

Health Care Flexible Spending Account

I. Introduction

A Health Care Flexible Spending Account can be used to pay for qualified medical, vision, prescription drug and dental expenses that are not reimbursed by the health plan.

Each participant will determine how much money to set aside each open-enrollment period for non-reimbursed health care expenses incurred during the plan year. Once the participant has determined an amount to pledge, they can enter this amount on the FSA portion of the on-line open-enrollment portal. For those participants who become eligible to enroll mid-year and/or experience a qualified change in status, a paper FSA enrollment/change form must be completed, signed and submitted to the agency human resource office and then forwarded to SEHP for approval and processing. The annual pledge amount (or contribution) is divided by the number of paychecks in which benefit premiums are withheld.

Example: *There are 26 pay periods per year, however, benefit premiums are only withheld from 24 paychecks. Therefore, an annual pledge amount of \$600 will be divided between 24 pay periods equaling a pre-tax pledge of \$25.00 per paycheck.*

For some regent employee's, there are 18 pay periods per year, however, benefits are only withheld from 16 paychecks. Therefore, an annual pledge amount of \$600 will be divided between 16 pay periods equaling a pre-tax pledge of \$37.50.

As the participant incurs health care expenses, they may request reimbursement from their account by filing a claim with our third party administrator ASI (Application Software, Inc.). The participant can receive reimbursement of their eligible expenses either by check, by direct deposit into their personal checking/savings account, or by using their Benny card (HC FSA debit card).

Note: *A participant may not transfer money between FSA accounts. Funds from a Health Care FSA cannot be used to pay for daycare expenses and vice versa.*

II. Eligible Expenses

Except for insurance premiums and long-term care expenses, eligible expenses are generally those that would otherwise be deductible on a Federal income tax return. IRS publication 502 entitled: "Medical and Dental Expenses" list those expenses that are reimbursable under an FSA. This publication can be found by going to www.IRS.gov or by going to ASI's website at www.ASIFlex.com.

Please be advised, Publication 502 is not written specifically for FSA's. Section 125 of the IRS tax code simply uses Publication 502 as a reference for eligible expenses.

Note: *An eligible expense is considered incurred and reimbursable based on the date the eligible service was provided, not when the service was paid for. To use IRS wording: "Medical expenses are incurred when the employee (or the employee's spouse or*

dependent) is provided with the medical care that gives rise to the medical expense, and not when the employee is formally billed, charged for, or pays for the medical care.”

Example: *If an expense is paid for in February, but the service isn't provided until June, the expense isn't reimbursable until June.*

NOTICE: 2011 FSA/HSA changes affecting Eligible Expenses due to Federal Health Reform

Effective January 1, 2011, over the counter (OTC) medicines will not be reimbursable unless you have a valid prescription or doctor's note.

Participants will be able to submit claims for eligible OTC medicines purchased without a prescription prior to January 1, 2011. Such claims can be filed through the end of the claims run out period for any plans that began prior to December 31, 2010. **Not applicable to HSA's.**

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

For those participants who have the FSA Debit Card (Benny Card), the below mentioned items can be purchased with the debit card after January 15th, 2011.

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

Services incurred outside of the United States

Services incurred outside of the United State are reimbursable as long as the receipt, list of services and other supporting documentation are submitted in English and amounts are converted to US dollars.

All medications purchased outside of the United States must be consumed in the country in which they were purchased before they are reimbursable.

Example: Medications related to a procedure preformed outside of the United States.

III. Deferred Compensation

Deferred Compensation is not allowed under Section 125-5 of the IRC and invalidates the cafeteria plan if it does occur. Deferred compensation occurs when a cafeteria plan allows a participant who incurs an expense in one plan year to receive reimbursement in another plan year. Since Flexible Spending Accounts have a “use it or lose it” component and funds must be spent, all expenses must be substantiated by the end of the plan year in order to receive reimbursement. The only two exceptions the IRS makes to this rule are for scheduled Orthodontia expenses and/or Durable Medical Equipment expenses that may cross over into the next plan year.

Note: The SEHP plan year runs from January 1st through December 31st but also includes a two and a half month grace period through March 15th of the following year. This allows a participant additional time to spend down their balance from the previous plan year.

Example: An expense incurred in January 2012 must be substantiated by March 15th 2013 to be eligible for reimbursement. See paragraph V for more information.

IV. How much to contribute

During open-enrollment, a participant must consider how much to contribute and/or pledge to their HC FSA. The State of Kansas has established a minimum and maximum amount a participant can contribute annually and per paycheck. The minimum and maximum amounts are as follows:

2012 HC FSA Maximum/Minimum Contributions	Minimum	Maximum
24 deduction period employees / per paycheck	\$8.00 /	\$208.33 /
24 deduction period employees / annually	\$192.00	\$5,000.00
16 deduction period (Regents) / per paycheck	\$12.00 /	\$312.50 /
16 deduction period (Regents) / annually	\$192.00	\$5,000.00

If a participant and their spouse are both State of Kansas employees and eligible to participate, each may make the maximum contribution to their HC FSA. However, an eligible claim may only be submitted **for one account**.

For new mid-year participants (new hires), their annual election will be divided by the number of remaining paychecks in the calendar year.

Nine month (16 pay periods) participants:

For participants who work nine months of the year (teachers, professor, etc.) receiving 16 paychecks versus 24, the following contribution/deduction schedule will apply:

- All nine month (16 pay) employees will make FSA contributions from January 1st through April 30th (first eight payments). Contributions will then resume from September 1st through December 31st (final eight payments).
- Claims will continue to be paid through the summer as long as the participant returns to employment in the fall. If they do not return, coverage will be terminated back to June 30th, or half way point of the year.

Note: *There are no employer (State of Kansas) contributions for the Health Care and/or Dependent Care Flexible Spending Account.*

V. Grace Period

In May 2005, the IRS updated its regulations to allow for a 75 day (2 and a half month) “Grace Period” immediately following each calendar year to allow participants to spend down their account and use the remaining funds before they are forfeited. Therefore, as previously mentioned, the plan year now includes a two and a half month extension from January 1st through March 15th following the calendar year. The deadline to file a 2012 claim is April 30th, 2013. Exceptions will not be made for claims submitted after April 30th.

Note: *If a participant incurs a claim during the Grace Period and wants the expense to be applied to the previous plan year, they must indicate which year’s funds are to be used when submitting the claim form. Otherwise, funds from the previous year will be used.*

VI. Status Changes

As previously mentioned, a participant has 14 calendar days from their first pay date to confirm that the proper amount(s) are being deducted and request any corrections. After that, mid-year changes are not allowed unless the participant experiences a qualified change in status. This is because the Uniform Coverage rules mentioned in Section 125 of the IRS Guidelines state that a participant’s full contribution amount is to be made available up-front and that reimbursement of a claim cannot be limited to the amount a participant has contributed prior to the end of the plan year. However, since a participant’s full contribution amount is available up-front, their election **cannot be stopped and is irrevocable**. This is to help prevent a participant from being reimbursed their full annual contribution amount and then terminating their account without contributing their full annual pledge.

Example: *A participant pledges to contribute \$1,200 to their HC FSA, and on March 1st they incur a claim for \$600. Even though only \$300 will have been contributed at this point, 100% of the claim is reimbursable. The difference will then be made up with future contributions.*

A qualified change in status is defined below as:

- The employee's marriage, divorce or court-approved legal separation;
- The birth or adoption of a dependent;
- The death of a spouse or dependent;
- The gain or loss of legal custody of a dependent;
- A dependent's eligibility is affected due to reaching age 23 or marriage;
- A change in the employment status of the employee, the employee's spouse or the employee's dependent such as:
 - A change from a benefits eligible position to a benefits non-benefits eligible position,
 - Termination or commencement of employment of the employee, spouse or dependent which affects FSA coverage for the employee, spouse and/or dependent.
- Gain or loss of Medicare or Medicaid.
- An unpaid leave of absence by the employee, spouse or dependent which affects the FSA coverage of the employee, spouse and/or dependent. If reactivated, the employee must step back into the same enrollment and contribution amount. This applies to an employee's leave or return under FMLA as well.

All election changes must be requested within 31 calendar days of the event, must be consistent with the event, and must include supporting documentation of the event. The effective date of such changes will always be the first of the month following SEHP's receipt and approval of the requested change. An election change satisfies the requirements of the consistency rule only if the election change is on account of and corresponds with the change in status that affects eligibility for coverage under an employer's plan. If an employee does not enroll in the HC FSA during Open Enrollment, or when they become first eligible, they must wait to enroll during the next Open Enrollment period. A mid-year change in the employee's annual maximum election applies to expenses incurred after the effective date of the change.

VII. FMLA and Non-FMLA Leaves of Absence:

FMLA Leave

If a participant goes on a qualifying leave of absence under FMLA, SEHP will continue to maintain the participant's Health Care and/or Dependent Care FSA, to the extent required by the FMLA, on the same terms and conditions as if the participant were still an active employee. In the event of unpaid FMLA leave, a participant may elect to continue his or her Health Care and/or Dependent Care FSA while on leave. If the participant elects to continue coverage while on leave, the participant may continue to fund their FSA in one of the following three ways:

- Pre-fund future contributions prior to going on leave using after-tax funds;
- Make scheduled semi-monthly contributions using after-tax funds (or pre-tax funds if participant has sufficient sick and/or vacation time). After-tax payments should be made payable to SEHP and should be separate from any health insurance premium due.

- Make scheduled catch-up contributions upon return from leave using after-tax funds.

Note: *If none of the above options are chosen and followed through with, the period of time in which the participant was on leave will be considered an unfunded period of no coverage and claims incurred during this time will not be payable.*

Upon return from leave, the participant is expected to resume making contributions at the same semi-monthly amount in effect prior to going on leave.

The participant may also increase remaining future contributions to off-set the contributions they missed so that their original annual pledge is met.

Non-FMLA Leave

If a participant goes on an unpaid Non-FMLA leave of absence, the participant will continue to participate in the FSA and will continue to make semi-monthly contributions through pre-tax contributions using available sick and/or vacation time. Once sick and/or vacation time is exhausted after-tax contributions will need to be made, payable to SEHP. The four payment options mentioned will apply for a Non-FMLA participant as well.

VIII. Ending the Account

FSA coverage will end at the end of the month in which termination from State of Kansas employment occurs. If an employee terminates employment with the State of Kansas or stops making contributions following a qualified change in status, the employee will face restrictions.

The employee will have until April 30th following the end of the plan year to file claims that were **incurred through the end of the month** of their termination or status change. In addition, if the employee terminates employment, they may extend their period of coverage for the HC FSA on an after-tax basis by electing continuation of coverage under COBRA (but only if paid claims have not exceeded contributions). If the State of Kansas rehires the employee after a 30 day break in State employment, they may not re-enroll until the next Open Enrollment period.

IX. Participant Death

Upon the death of a participant, a beneficiary or representative of the participant's estate may submit expenses that were incurred by the participant or eligible dependent through the end of the month in which the participant ceased to be eligible due to death. Documentation in the form of a death certificate and head of estate will be required before claims can be paid.

X. Filing a claim for Reimbursement

An employee may file a claim(s) for reimbursement from either their HC or DC FSA at any time during the plan year by completing an ASI claim form and mailing, faxing or emailing it to ASI. Claims may be filed online as well (***please see Appendix B for a claim form and Appendix D for on-line filing instructions***).

Employee's may also use their FSA Debit Card (a.k.a. Benny Card), if elected, and have the expense deducted from their HC FSA balance in real time (***please see section XI regarding the debit card for more details***).

An ASI claim form can be obtained by logging onto the ASI website at www.asiflex.com. Once on the site you can print a claim form or download a PDF fillable form. All claim forms will need to be accompanied by proof of expense in order to adjudicate the claim.

Proof of expense can be any of the following:

- A written statement from an independent third party stating that the medical, dental, prescription drug or vision expense has been incurred and clearly indicates the date the service was provided and the amount of the expense, such as an EOB (Explanation of Benefits) from your health care provider: or
- If the service is not covered by insurance (such as eyeglasses or orthodontia), a written statement from the provider, such as an original invoice or contract for orthodontic expenses, indicating the patient's name, date and type of service, and amount of the expense.

For prescription drugs, the proof of expense must show the name of the drug being dispensed. In addition, the IRS will not allow advance reimbursement of future or projected expenses from the HC FSA (this includes future orthodontia expenses).

Orthodontia Reimbursement Overview and Calculator:

Orthodontic expenses are reimbursed according to the prorated monthly fee. ASI can reimburse the initial down payment amount and then must breakdown the remainder of the charges according to the monthly fee assessed. In order to receive reimbursement for orthodontic work, a copy of the original contract must be submitted to ASI showing the total dollar amount the participant is responsible for, less any down payment amount as well as the estimated length of time the treatment will last. For example, if the total participant responsibility for orthodontic work is \$4,000, the initial down payment amount is \$1,000 and the expected treatment time is 15 months, ASI can reimburse the \$1,000 initially and then \$200 per month thereafter. Per IRS regulations, ASI is required to see that the down payment and monthly payment(s) has been paid in order to issue the reimbursements. Please remember that even if you pay for the entire amount of the orthodontic work up front, the expenses will be reimbursed only on a monthly basis.

However, if you pay the orthodontist the entire amount up front, you can submit a claim request for the entire plan year. ASI will reimburse you the prorated monthly amount each month. In order to get the auto payment set up, please submit a claim form requesting reimbursement for the month that the braces were put on to the end of the current plan year, along with the expected monthly reimbursement amount (total cost, less insurance, divided by expected months of treatment). You must also include a copy of the contract with your orthodontist, proof of payment (cancelled check, credit card receipt, paid receipt, etc.) and a short letter from you detailing what you are requesting and how you came up with the dollar amount. Please also include a daytime phone number so an ASI benefits counselor can contact you with any questions.

Payment will be issued on the first business day of each month. If the duration of the treatment spans more than one plan year, you must submit a new request with the same information required to initially set up the program, at the beginning of every plan year.

Note: *The IRS does not allow cancelled checks, statements of balance due and/or expense as proof of an expense.*

Note: *SEHP has the authority to terminate participation in the FSA program if it has been determined that a participant has filed a false or fraudulent claim for benefits.*

XI. Reimbursement Payments

An employee will be reimbursed daily for health care expenses. Participants enrolled in direct deposit can receive reimbursement for eligible claims as early as the next business day. A check or notice of direct deposit will be mailed to the employee's home address, or if enrolled in e-mail notification, sent via the internet.

To enroll in direct deposit or e-mail notification, the participant should contact their Agency Human Resources Office or ASI at (800) 659-3035. Claims may also be reimbursed in real time by using the stored value debit card (Benny Card) now available starting with the 2010 plan year. See section on the Debit Card below.

Note: *Participants may incur claims through March 15th of the following plan year. The deadline to submit claims for reimbursement is April 30th of the following plan year. Any funds remaining in an HC FSA will be forfeited.*

Example: *Claims may be incurred from January 1st, 2012 through March 15th, 2013 and filed by April 30th 2013.*

XII. Stored Value Debit Card (Benny Card)

Beginning with the 2010 plan year, SEHP has made a Stored Value Debit Card (a.k.a. Benny Card) available to participants on a voluntary basis. The Benny card is available for Health Care FSA participants only.

The administrative cost of having the Benny card is paid by the participant at the equivalent of \$1.00 per month. The total annual cost is deducted from the participants FSA by ASI upon the first pay period following the election of the Benny Card.

Participants interested in electing a Benny Card will receive an application in their Welcome Packet from ASI. Participants can also go to the SEHP website and print an application by going to www.kdheks.gov/hcf/sehp/FSA.htm and clicking on the **FSA Debit Card Application** link.

The Benny Card is designed to provide a more convenient method for paying out-of-pocket health expenses for the participant, their spouse and/or any tax dependent. The IRS has stringent rules and regulations regarding appropriate use of the Benny Card, as far as where the card can be used and when follow-up documentation is required. The Benny Card can be a great benefit, but it is important that participants educate themselves on how the card works.

Places to use the Benny Card:

As of June 30th, 2009 all national chain and drug stores must have an IIAS (Inventory Information Approval System) machine installed at their pharmacy checkout station. This machine discerns eligible expenses from non-eligible expenses. The Benny Card may be swiped for all eligible expenses, if any non-eligible expenses are purchased the IIAS system will separate them and require a separate form of payment. Eligible expenses will have a marker listed next to them on the receipt. The Benny Card may be used at the hospital or health care provider's office as well. However, in order for the Benny Card to be accepted the hospital or provider's credit/debit machine must have the proper Merchant Category Code (MCC) that identifies them as a health care provider.

Note: *When swiping the Benny Card participants should always select the "Credit" option. Even though the Benny Card is a Debit Card, it does not have a PIN # associated with it like a debit card does.*

Note: *Transactions made at any other merchant types will be declined at the point-of-sale, even if the expenses are eligible.*

Note: *A list of stores with the IIAS in place is available online at www.asiflex.com/debitcards.*

Follow-up documentation: There are situations that will allow Benny Card transactions to be electronically substantiated (no follow-up documentation required). Those situations are as follows:

- Expense matches a co-payment, or any combination of co-payments up to five times the highest, for the health plan(s) elected during enrollment.
- Occur at a retail outlet that has implemented the IIAS; or
- Are recurring expenses for the exact same amount at the same provider and have been substantiated once already via paper claim.

Example: *A participant visits the chiropractor once a month and is assessed a fee of \$64.35 for each visit. This amount does not match a co-payment, so the participant will receive a letter requesting documentation for this first charge. When the participant submits the documentation, the participant should mention that the expense will be recurring. Future transactions at the same provider, for the same amount, will not require follow-up documentation.*

- Expense is substantiated through a regular file feed from the health vendor (i.e. BC/BS Coventry, PHS, and UHC-UMR), Delta Dental of Kansas, or Superior Vision.
- All other transactions will prompt the user for a detailed statement of services. Participants may gather up their statements and submit them on a weekly, monthly or annual basis (annually not recommended).

Note: *ASI will send two letters requesting documentation. The second documentation request letter will include a warning that their Debit Card will be suspended as of three weeks from the date of the second letter. A third will also be sent advising the participant that their Debit Card has been suspended.*

XIII. HEART Act – Qualified Reservist Distribution

Effective January 1st, 2011, the State Employee Health Plan has adopted the HEART Act (Heroes Earnings Assistance and Relief Tax of 2008) into its Health Care FSA program for Plan Year 2011.

The HEART Act is designed to help military personnel called to active duty who may otherwise forfeit dollars set aside in a health care FSA. According to the Act, an employer and/or Plan Sponsor may make a cash distribution of unused FSA contributions to eligible reservists without disqualifying its cafeteria plan. The withdrawal is known as a Qualified Reservist Distribution or (QRD). However, there are qualifications that must be met before a QRD can be made:

1. The individual must be a “reservist”, as defined in 37 U.S.C. Section 101, which means the reservist must be a member of one of the following;
 - a. Army National Guard of US;
 - b. Army Reserve;
 - c. Navy Reserve;
 - d. Marine Corps Reserve;
 - e. Air National Guard of US;
 - f. Air Force Reserve
 - g. Coast Guard Reserve; or
 - h. Reserve Corps of the Public Health Service
2. An amendment has been made to the Employer’s Plan Document to allow for QRD’s **(this has been done effective 01/01/2011)**.
3. The participant is called to active duty for a period of 180 days or more or for an indefinite period.
4. The request for distribution must be made after the order for active duty is issued, but before the last day of the plan year (or grace period, if applicable).

Finally, QRD’s are taxable, and should be included in the gross income and wages of the employee, and are subject to employment taxes. A QRD must be reported as wages on the employee’s W-2 for the year in which the QRD is paid to the employee.

Section 6

Dependent Care Flexible Spending Account

I. Introduction

A Dependent Care Flexible Spending Account can be used to pay for an employee's eligible **work-related dependent daycare expenses**.

The employee determines how much they will spend on dependent care during the year. These expenses must be employment-related, and are amounts the employee will spend in order for the employee and/or their spouse to be employed. The employee can enroll in the Dependent Care FSA on-line during Open Enrollment or via FSA Enrollment Form for eligible mid-year new hires. Contribution amounts are deducted from each paycheck on a pre-tax basis. As the employee incurs dependent care expenses, they can receive reimbursement for their eligible expenses by filing claims each month. The employee will receive reimbursement for their eligible expenses by check or direct deposit.

Note: *IRS regulations prohibit the transfer of funds from a Dependent Care FSA to a Health Care FSA and vice versa. It is extremely important for employees to understand what a Dependent Care FSA does and does not cover. A Dependent Care FSA does not cover health expenses for dependents, but is for daycare related expenses only.*

II. Who can use the account

An eligible employee may elect to participate in the Dependent Care Account if they are:

- Single;
- Married, and the dependent care expenses are necessary for both parents to work; **or**
- Married and the employee's spouse is either incapable of self-care, actively seeking employment, or is a full-time student at least five months during the year.

Eligible Dependents

According to IRS Publication 503, entitled: **Child and Dependent Care Expenses**, your child and dependent care expenses must be for the care of one or more qualifying persons:

- Your qualifying child who is your dependent and who was under age 13 when the care was provided and who lives with you more than half of the calendar year. A child over age 13 can also be eligible if they are considered physically and/or mentally incapable of caring for themselves.
- Your spouse and / or relative who was physically or mentally not able to care for themselves and lived with you for more than half of the year.

Child(ren) of divorced or separated parents or parents living apart

Even if you cannot claim your child as a dependent, he or she is treated as your qualifying person if:

- The child was under age 13 or was physically or mentally not able to care for themselves,

- The child received over half of their support during the calendar year from one or both parents who are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or lived apart at all times during the last six months of the calendar year,
- The child was in the custody of one or both parents for more than half the year, **and**
- You were the child’s custodial parent (the parent with whom the child lived for the greater part of the year).

Note: *The custodial parent is the parent with custody for the greater portion of the calendar year. IRS regulations further provide that this is the parent with whom the child resides for the greater number of nights during the calendar year.*

Note: *The noncustodial parent cannot treat the child as a qualifying person even if that parent is entitled to claim the child as a dependent under the special rules for a child of divorced or separated parents.*

Note: *A participant is not entitled to a refund of contributions if they enroll in a Dependent Care FSA on the assumption that their child will be living with them for at least 50% of the calendar year, but then doesn’t.*

III. Eligible Expenses

An expense is considered eligible if it enables the employee (and spouse, if married) to be gainfully employed or to look for gainful employment.

Note: *Volunteer work is not considered employment.*

Schools

As noted above, the purpose of qualified dependent care is to pay for care for a qualifying dependent so a parent or guardian can be gainfully employed or look for gainful employment. Only “custodial” expenses – those related to the child’s protection and well-being – may be reimbursed under a Dependent Care FSA; expenses that are simply educational or instructional in nature do not qualify.

In addressing the definition of educational expenses, IRS regulations specify two standards:

1. The full amount paid to a nursery school is considered a qualified expense (even if the nursery school provides educational services); and
2. Educational expenses for a child in kindergarten or a higher grade are not qualified expenses.

Camps

Summer day camp expenses qualify as eligible expenses, but overnight camp expenses do not. The cost of a day camp or similar program may qualify even if the camp specializes in a particular activity.

Note: *Camp must be for the care and well-being of the child and not for instructional purposes only (i.e. basketball or other sports related camp).*

Transportation, entertainment and food

Qualified expenses only include the cost of services for the dependent's well-being and safety; they do not include the cost of transportation, entertainment, food or clothing unless such items are incidental and cannot be separated from the cost of the care provided.

Ineligible care providers:

A relative living in the same household is not considered an eligible provider.

A relative is defined as:

- Child under age 19
- Parent
- Stepchild
- Sibling
- Aunt
- Uncle
- Cousin
- In-law of the participant

***Example:** A payment made by a participant to his or her 15- year-old daughter for babysitting a sibling would not be qualified, nor would payments for child care made to an employee's parent if that parent is claimed as a dependent by the employee.*

IV. Dependent Care FSA vs. Health Care FSA

The rules for dependent care FSA's are similar to those for health FSA's, with one important exception – dependent care FSA's are not subject to the uniform coverage rule (meaning 100% of the pledge amount is not available up front). This is because dependent care expenses usually are incurred on a periodic, level basis. Unlike health care FSA's, it would be customary for a participant to incur significant dependent care expenses in advance of dependent care contributions. Expenses should track contributions fairly closely, except perhaps during holidays or summer vacations.

V. Documentation needed for submitting a Dependent Care Claim

Dependent care expenses will only be reimbursed from a dependent care FSA if the participant provides a written statement from an independent third party stating that the expense has been incurred and the total amount of the expense has been provided. Participants will be required to provide itemized bills, receipts or contracts for the amount claimed, including:

- The dependent's name;
- The period during which the services were rendered;
- The name, address, and taxpayer identification number(TIN) or Social Security number of the individual or organization providing services; and

- A description of the service provided.

Participants will be reimbursed only for daycare services provided between January 1st and December 31st of the plan year for which they are enrolled.

Note: *Dependent Care participant may also simply have the daycare provider sign the claim form in order for the claim to be paid.*

Note: *The Dependent Care FSA does not have a Grace Period.*

VI. How much to deposit

During open-enrollment, a participant must consider how much to contribute and/or pledge to their DC FSA. The State of Kansas has established a minimum and maximum amount a participant can contribute annually and per paycheck. The minimum and maximum amounts are as follows:

2012 DC FSA Maximum / Minimum Contributions	Minimum	Maximum
24 deduction period employees/per paycheck	\$16.00/	\$208.33/
24 deduction period employees/annually	\$384.00	\$5,000.00
16 deduction period (Regents)/per paycheck	\$24.00/	\$312.50/
16 deduction period (Regents)/annually	\$384.00	\$5,000.00

Note: *If a participant and their spouse are both enrolled in a Dependent Care FSA, whether both are State Employee's or not, the contribution maximum cannot exceed \$5,000 per household.*

VII. Status Changes

As previously mentioned, a participant has 14 calendar days from their first pay date to confirm that the proper amount(s) are being deducted and request any corrections. After that, mid-year changes are not allowed unless the participant experiences a qualified change in status.

A qualified change in status is defined below as:

- The employee's marriage, divorce or court-approved legal separation;
- The birth or adoption of a dependent;
- The death of a spouse or dependent;
- The gain or loss of legal custody of a dependent;
- A dependent's eligibility is affected due to reaching age 13;
- A change in the employment status of the employee, the employee's spouse or the employee's dependent such as:
 - A change from a benefits eligible position to a benefits non-benefits eligible position,
 - Termination or commencement of employment of the employee, spouse or dependent which affects FSA coverage for the employee, spouse and/or dependent.

- An unpaid leave of absence by the employee, spouse or dependent which affects the FSA coverage of the employee, spouse and/or dependent. If reactivated, the employee must step back into the same enrollment and contribution amount. This applies to an employee's leave or return under FMLA as well.
- Change in daycare provider (including kindergarten);
- A significant increase or decrease in the current dependent care provider's rate (excludes relatives).

Note: *If a participant goes on a Leave of Absence, their Dependent Care FSA will be terminated effective the first of the month following the date that the participant went on leave. **The participant will not be responsible for making Dependent Care contributions during this time, even if the participant is on leave due to an illness, injury or disability and are still utilizing daycare services.** This is because Dependent Care FSA expenses are only reimbursable while the participant is actively at work.*

Note: *Please see part VII for more information regarding a Leave of Absence.*

All election changes must be requested within 31 calendar days of the event, must be consistent with the event, and must include supporting documentation of the event. The effective date of such changes will always be the first of the month following SEHP's receipt and approval of the requested change. An election change satisfies the requirements of the consistency rule only if the election change is on account of and corresponds with the change in status that affects eligibility for coverage under an employer's plan. If an employee does not enroll in the DC FSA during Open Enrollment, or when they become first eligible, they must wait to enroll during the next Open Enrollment period.

Note: *A mid-year increase in a participant's contribution amount will only apply to expenses incurred after the effective date of the change.*

Break in daycare services

If an employee experiences a situation where there will be a break in daycare services due to a summer break and/or situation where a spouse will be at home for a period of time, the participant may stop their Dependent Care contributions as of the first of the month following the end of daycare services and resume making contributions as of the first of the following month in which the spouse returns to work.