

UNIVERSITY OF MISSOURI

Flexible Benefits SPD

Effective January 1, 2018



This summary plan description (SPD) is designed to provide an overview of the University of Missouri's Flexible Benefits Plan (Plan). While the University hopes to offer participation in this Plan indefinitely, it has the right to amend or terminate any benefit plan. In addition to this SPD, the University plans to continue to use other methods of communication such as memos, meetings, newsletter articles or electronic media to help you stay informed.

The Plan is governed by a legal document called a Plan document. The University has taken care to accurately present the information contained in the Plan document in a way that is easy to understand. However, in the event of a disagreement between this SPD and the Plan document, the Plan document will be followed.

It's important for you to have a good understanding of all this Plan has to offer. Please review this SPD carefully. If you have questions, contact your HR Generalist or HR Service Center at the appropriate address or phone number shown below.

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You enjoy two important advantages under the University of Missouri's Flexible Benefits Plan:

- Unless you specifically elect otherwise your share of the cost of certain benefits will be taken from your pay on a *before-tax* basis. This means you pay no federal, state or Social Security taxes on those benefit premiums.
- If you like, you can choose to participate in the Health Savings Account, Health Care Flex Spending Account (FSA) or Dependent Care Flex Spending Account (FSA). These special accounts allow you to pay for many typical health or dependent care expenses with *tax-free* money.

Am I eligible to participate?

You are eligible to pay premiums for Medical, Dental, Vision, Basic Group Term Life, and Long-Term Disability insurance and make contributions to a Health Savings Account on a before-tax basis under this Plan if you are eligible to participate in the component of the Plan to which you wish to make before-tax contributions. For example, in order to pay Medical Plan premiums on a before-tax basis under this Plan, you must be eligible to participate in the Medical Plan.

If you are an active employee of the University, you are eligible for coverage under a Health Care FSA or a Dependent Care FSA, provided you also meet the following conditions:

- you are classified 75% FTE or more.
- you have an appointment duration of at least nine months.
- you are regularly scheduled to work an average of 30 hours a week.

For the purpose of this section any individual who is simultaneously employed by the University and the Harry S. Truman Veterans Administration Hospital pursuant to an agreement between said organizations, and whose joint appointments, combined, otherwise meet the requirements of this section, shall be considered an Employee.

Per diem employees are excluded as an Employee under this Plan. Variable hour employees are not eligible for coverage under a Health Care or a Dependent Care FSA under this Plan.

When does my participation begin?

Unless you submit a benefit election form, you will be automatically enrolled in the Healthy Savings Plan portion of the Medical Plan and contributions towards such coverage will be withheld from your pay, on an after-tax basis, at the tobacco non-discount rate. If you do not submit a benefit election form, you will also be automatically enrolled in the plans listed below:

- Basic Group Term Life Insurance, Option A
- Long-Term Disability, Option A

If you submit a benefit election form you can elect to pay for any or all of the coverages offered under this Plan (Medical, Dental, Vision, Basic Group Term Life, and Long-Term Disability) for which you are eligible and make contributions to any account (Health Savings Account, Health Care FSA or Dependent Care FSA) for which you are eligible, on a pre-tax basis. (Premiums for any insurance coverage elected on a benefit election form will be withheld on a pre-tax basis unless after-tax withholding is elected).

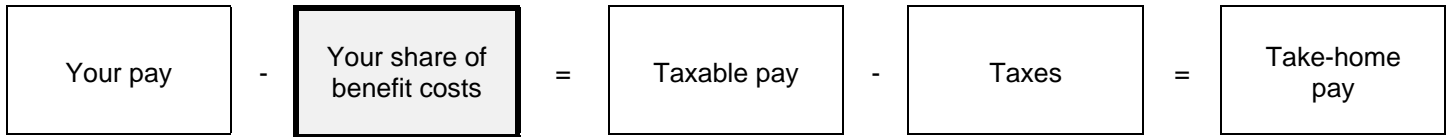
You can begin participation in the Health Care FSA or Dependent Care FSA on any January 1, provided you enrolled during the preceding enrollment period and you are in an active pay status as of January 1 of the Plan year. You may also enroll in the Health Care FSA or Dependent Care Assistance during the plan year if you experience a qualifying change in status event.

If you are newly benefit hired or become newly eligible for the Plan during the Plan year, you may elect to make before-tax premium contributions for the insurance benefits listed above and before-tax contributions to a Health Savings Account by submitting an enrollment form to participate in this Plan within 31 days of your date of hire or eligibility. You will also be able to make contributions to the Health Care and Dependent Care FSAs for the Plan year in which you are newly hired or newly eligible.

Before-tax payments

You and the University share in the cost of certain benefits. If you like, you can pay your share of this cost on a before-tax basis. This means your contribution for medical, dental, basic group term life and long-term disability insurance can be paid with money on which you will not have to pay Social Security, federal and state income taxes. As a result, you pay less in taxes.

This before-tax method is a major advantage of your Flexible Benefits Plan. Under the program, your premium payment sequence works like this:



Your benefit costs are deducted *before* your taxable pay is calculated. As a result, your taxable pay is reduced. Lower taxable pay means lower taxes.

If you choose to participate, you'll also be able to pay for some typical health and dependent care expenses with before-tax money through Health Care and Dependent Care FSAs.

Do before-tax contributions affect my benefits?

Although your taxable salary is reduced when you make before-tax contributions, your total base annual earnings will be used to determine the amount of your coverage under the Retirement, Group Term Life and Long-Term Disability Plans.

However, before-tax contributions can affect the tax treatment of benefits you receive from the Plans. When you pay for a benefit coverage on a before-tax basis, the IRS views the entire cost of the benefit as being paid by your employer. In other words, the amount of your before-tax contributions is considered a contribution by the University for your benefits,

For those who pay for benefit costs on a before-tax basis, here are examples of how tax laws affect your benefits:

- If you elect more than \$50,000 in group term life insurance coverage under our Plan, the value of the life insurance amount in excess of \$50,000 is taxed as additional income. In other words, if you receive \$75,000 of life insurance coverage, you would be taxed on the value of \$25,000 (\$75,000-\$50,000) of group term coverage. The "value" of this coverage is determined according to a table used by the IRS and is called "imputed income". The value then will appear on your W-2 form at the end of the year. A before-tax premium contribution may not be used to reduce this imputed income.
- If you file your federal or state income tax returns on an itemized deduction basis you cannot use the amount of your before-tax contributions for medical or dental benefits as part of your medical expense deduction (a deduction is allowed only for out-of-pocket medical expenses that exceed 10% of your adjusted gross income.)
- Under the law, monthly income benefits received from a long-term disability plan are subject to federal and state income taxes to the extent that an employer has paid the cost of the coverage. This means that if you become disabled, the full amount of the monthly benefits you receive from the Plan would be taxable. Of course, because your contributions are made on a before-tax basis, you will pay lower taxes while you are working.
- Because Social Security taxes are not paid on the portion of your salary used to make before-tax contributions, your salary base used for calculating Social Security retirement benefits is also decreased. The end result is a slight decrease in the amount of Social Security benefits to which you are entitled. However, the decrease in Social Security benefits is generally more than offset by the immediate tax savings. The impact of such a decrease is determined by your salary level and the cost of the Plans in which you participate.

When can I change my decision?

Because of the tax advantages you enjoy under this benefit Plan, the IRS has issued restrictions as to when and what changes you may make during the year. In general, the election you make is binding throughout the year. Different restrictions may apply, however, depending on the type of change and your specific enrollment.

If you are eligible to contribute to the Health Savings Account, you may elect to make contributions to the Health Savings Account at any time on a prospective basis. You may also change the amount of your Health Savings Account contributions on a prospective basis at any time.

You cannot change your enrollment election under Basic Group Term Life or Long Term Disability for which contributions are being paid before taxes, or under a Dependent Care FSA unless your needs are affected by a “change in family status” and you cannot change your enrollment election for Medical, Dental, or Vision, or under a Health Care FSA, unless your needs are affected by a “qualified family/employment status change”.

New Health Care FSA or Dependent Care FSA elections may be made during the plan year as well as an existing election can be changed during the plan year in certain circumstances. You may change the deposit amounts during the year to these accounts only if your benefit needs are affected by a “change in family status” in the case of a Dependent Care FSA or a “qualified family/employment status change” in the case of a Health Care FSA.

What is a “change in family status”?

The following events are changes in family status, and impact your ability to make changes in Basic Group Term Life, Long Term Disability and Dependent Care FSA elections:

- Marriage or divorce.
- Birth or adoption of a child.
- Death of your spouse or your dependent.
- A change in your or your spouse's employment from full-time to part-time or vice versa.
- The termination of, or commencement of, you or your spouse's employment.
- You or your spouse taking an unpaid leave of absence.
- A significant change in your health coverage as a result of your spouse's employment.

The Internal Revenue Service allows changes in your Dependent Care FSA if you experience a change in cost due to a change in providers. Similarly you may reduce your election when your child starts school or you no longer require dependent care.

What is a “qualified family/employment status change”?

The following events are qualified family/employment status changes and may impact your ability to make new elections or changes in existing Medical, Dental, Vision benefit elections as well as your Health Care FSA elections due to specific requirements or restrictions and must be consistent with the qualified family/employment status change

- Change in marital status as a result of marriage, divorce, legal separation, annulment or death of spouse
- Change in the number of dependents as a result of death, birth, adoption or placement for adoption, or a child ceasing to be eligible or becoming eligible as a dependent
- Change in the employment status of you or your spouse that involves the commencement or termination of employment
- Change in the work schedule of you or your spouse which involves an increase or decrease in work hours, a strike, a lockout or an unpaid leave of absence
- A change in residence or worksite of you or your spouse
- A change in entitlement to Medicare or Medicaid for you, your spouse or a dependent
- A significant change in health coverage of you or your spouse attributable to your spouse's employment
- A significant change in the cost of coverage under a health plan
- A FMLA leave of absence

- For purposes of Medical coverage benefit elections only, a change in your employment status that results in the number of hours per week you are expected to work, on average, changing from more than 30 hours per week to less than 30 hours per week after the change
 - a. You only experience a "qualified family/employment status change" for purposes of the above change if: (1) you had been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will be reasonably expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you ceasing to be eligible under the Plan; AND
 - b. (2) the revocation of the election of coverage under the Plan corresponds to your, and any related individuals who cease coverage due to the revocation, intended enrollment in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- For purposes of Medical coverage benefit elections only, you become eligible for a special enrollment period to enroll in a health plan through a health insurance marketplace established by the Patient Protection and Affordable Care Act (a "Marketplace"), or you seek enrollment in a health plan through a Marketplace during the Marketplace's annual open enrollment period.
 - a. You only experience a "qualified family/employment status change" for purposes of the above change if: (1) you are eligible for a special enrollment period to enroll in an insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing, and meets other requirements (a "Qualified Health Plan") through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; AND
 - b. (2) the revocation of the election of coverage under the Plan corresponds to your, and any related individuals', intended enrollment in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

In order for you to make a change, your benefit needs must change as a result of one of those occurrences and the change you wish to make must be consistent with the status change event. For example, a change in your spouse's employment status does not allow you to change options unless there is a significant change in the coverage of yourself or your spouse as a result of the change in employment status — such as loss of coverage.

Experiencing a "qualified family/employment status change" may allow you to change your existing Health Care FSA election or to newly enroll in the Health Care FSA.

If you have a change in status and wish to make a change in your election under this Plan, you must submit your change to your HR Generalist or HR Service Center in writing within 31 days of the event. You will be notified if the change is acceptable. Your election will become effective in accordance with the rules governing the effective date of participant elections in the component plan for which you are changing coverage. For example, if you experience a "qualified family/employment status change" and wish to change your Medical Plan coverage as a result, the date your change in coverage becomes effective will be determined by the rules governing participant elections under the Medical Plan. A change in your Health Care FSA election or Dependent Care FSA election will become effective on the first day of the month coinciding with or following the date of your change in status event or the date on which you provide notice of the event, whichever is later.

Other conditions that apply to changing your benefit plan coverage are described in each Summary Plan Description (SPD).

Special Enrollment Rights

If you, your spouse, or your dependent does not enroll in the Plan when first eligible, you may have a right to a "special enrollment" during the plan year. A special enrollment right allows you to elect to make before-tax contributions to a Health Savings Account, Health Care FSA or Dependent Care FSA or elect coverage under the Medical, Vision, Dental, Basic Group Life, or Long Term Disability component of this Plan. If you wish to enroll in the Group Life or Long Term Disability component of this Plan after your initial eligibility, you will be required to provide evidence of insurability within 31 days after the event that gives rise to your special enrollment right. The special enrollment rights are as follows:

If You Lose Other Coverage

You have special enrollment rights if all of the following conditions are met:

- You were covered under a group health plan or had other health insurance at the time you declined coverage under this Plan; and
- You lost your former coverage because you stopped being eligible for that coverage (or the employer stops contributing toward your or your spouse's other coverage).

If you lose other coverage under the circumstances described above, you may request coverage under this Plan by submitting a completed benefit change form within 31 days of the other coverage ending. Your coverage under this Plan will become effective on the first of the month following the date coverage ends.

If You Lose Coverage Under Medicaid

If you declined coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program is in effect, you or your dependents are entitled to special enrollment rights when your, or your dependents', coverage under a Medicaid plan or under a state children's health insurance program is terminated as a result of a loss of eligibility for such coverage and you submit a completed benefit change form within 60 days after your or your dependents' coverage ends.

If You Acquire a Spouse or a Dependent

If you get married, have a child, adopt a child, or place a child for adoption, you may enroll yourself, together with your spouse, your newly acquired dependents, or both, in this Plan, provided you submit a completed benefit change form within 31 days of the marriage, birth, adoption, or placement for adoption. If you request coverage by submitting a completed benefit change form, your coverage will become effective on the date of the event in the case of birth, adoption, or placement for adoption, and in the case of any other event, on the first of the month following the date of the event.

If You Become Eligible for State Premium Assistance

If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you are entitled to special enrollment rights under this Plan when you or your dependents become eligible for such a premium assistance subsidy, provided that you submit a completed benefit election form within 60 days after you or your dependents are determined to be eligible for such assistance. Coverage under this Plan will become effective on the first of the month following the date of the event.

Health Care and Dependent Care FSAs

One of the key advantages of your benefits plan comes in the form of these two special accounts which offer you an opportunity for real tax savings.

The Health Care FSA provides a before-tax method of paying for certain health care expenses that aren't covered by your Medical, Dental, or Vision Plan. The Dependent Care FSA allows the payment of expenses such as day care for a child or a dependent adult in the same tax-saving manner.

In order to participate, you must re-enroll each year in the Health Care FSA and Dependent Care FSA and designate an annual amount that will be deducted from your paycheck in equal installments each pay period to be deposited to your account.

The University Health Care FSA has a 2.5 month Grace Period (through March 15 of the following year), which allows you extra time to incur expenses to use your flexible spending health care balance after the close of the plan year. The Dependent Care FSA does not have the extended period of coverage, so those expenses must be incurred during the plan year.

According to Internal Revenue Service (IRS) regulations, any money left in your accounts at the end of the Plan year or at the end of the Grace Period for the Health Care expenses account must be forfeited. This is called the “use it or lose it” rule — it’s the IRS’s way of making sure you use the accounts as they were intended. Keep this rule in mind when you’re considering how much to deposit to either account.

The Health Care FSA

The Health Care FSA allows you to pay certain health care expenses — such as deductibles, copayments, coinsurance, eyeglasses and physicals — with before-tax dollars. In the process, your taxable income is reduced and you pay less in income taxes.

If you choose to participate in this account, you’ll designate an annual dollar amount — up to \$2,600--to be deducted from your paycheck on a before-tax basis and deposited to your account. If two employees are married and each one enrolls for a Health Care FSA, each employee may enroll for the maximum amount. The annual minimum deposit is \$50. When you incur an eligible health care expense, you are reimbursed from your account with these tax-free dollars.

The Health Care FSA can be used to reimburse you for the cost of certain expenses you or your eligible dependents incur. For purposes of your Health Care FSA, your eligible dependents include (a) your son, daughter, stepchild, legally adopted child, or eligible foster child through the end of the calendar year in which such individual attains age 26; and (b) your tax dependents under the Internal Revenue Code, except that an individual's status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Internal Revenue Code's definition.

Your dependents need not be covered by the Medical Plan to have their expenses reimbursed through the Health Care FSA. However, any dependent who is not your spouse must receive more than one-half of his or her financial support from you and be claimed as an exemption on your federal tax return.

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

- Deductibles, copayment, and coinsurance amounts for your medical and dental plan and for your spouse’s plan (as long as you are not reimbursed for these expenses through coordination of benefits between the two plans).
- Medical, dental and orthodontia expenses not covered under any health plan.
- Eye examinations, lenses (including contact lenses), frames, and laser eye surgery.
- Hearing examinations and hearing aids.
- Birth control.
- Other expenses allowed as medical deductions by the IRS on your federal tax return that are not reimbursable under any other Plan.

Some expenses that are not eligible include the following:

- Health spa and club memberships, unless you obtain a letter of medical necessity from a medical provider and you provide a statement that you would not have joined but for the medical necessity
- Cosmetic surgery or other similar procedures, unless used to correct a deformity caused by a congenital abnormality, personal injury from accident or trauma, or to restore proper function of the body related to another medical diagnosis or condition

- Non-medical expenses such as electronic air filters and hot tubs, unless you obtain a letter of medical necessity from a medical provider. In addition, if the expense is a capital improvement to your home then only a portion will be reimbursed. Please see www.asiflex.com for further information
- Insurance premiums (individual or group)

Expenses for which you have been reimbursed from your Health Care FSA cannot be claimed as an itemized deduction on your federal income tax return. However, keep in mind that your medical and dental expenses may be deducted from your federal income tax return only if they exceed 10% of your adjusted gross income. **A detailed list of expenses can be found at www.asiflex.com.**

The Dependent Care FSA

If you're paying for care for your child or a dependent adult, you probably know what those costs will be each year— normally they're quite predictable. That predictability makes it easy to determine how much to put into your account. The Dependent Care FSA works in much the same way as the Health Care FSA, but it is a completely separate account with its own rules and procedures.

You decide how much to deposit to your Dependent Care FSA — as much as \$5,000 per year per household or \$2,500 if you are married and file a separate federal income tax return. If two employees are married and each one enrolls for a Dependent Care FSA, the maximum enrollment between both employees is \$5,000. The annual minimum deposit is \$50. When you submit an eligible expense, you will be reimbursed with the tax-free dollars you've deposited to your account, provided your balance is large enough to cover it.

The rules for determining eligible expenses under the Dependent Care FSA are the same as those that apply to the federal child care tax credit (Section 21 of the Internal Revenue Code).

In order to be eligible for reimbursement, dependent care expenses must meet the following requirements:

- The care must be necessary in order for you to work and for your spouse (if married) to work or attend school full-time (unless your spouse is disabled).
- The amount to be reimbursed must not be greater than your annual income or your spouse's annual income, whichever is lower. If your spouse is a full-time student or is mentally or physically incapacitated (and does not have a regular job), his or her financial status will be based on an assumed monthly income of \$250 if you have one eligible dependent, or \$500 if you have two or more eligible dependents.
- If the dependent is a *child*:
 - a. He or she must be younger than age 13 and dependent upon you for at least 50% of his or her financial support. (There is no age limit for handicapped children.)
 - b. You must be entitled to claim the child as an exemption on your federal tax return and you must be the child's custodial parent. The custodial parent is defined to be the parent with custody a greater length of time during the year than the other parent. If custody is split exactly 50% for one parent and 50% for the other, the custodial parent is the parent with the higher adjusted gross income. Please see IRS Publication 504 for further details (this publication may also be found at www.asiflex.com).
 - c. Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent, such as one of your older children.
 - d. If the care is provided by a facility that cares for more than six children, the facility must be licensed, if applicable, by the state in which it is located.
- If the dependent is an *adult*:
 - a. He or she must be physically or mentally incapable of caring for himself or herself.
 - b. He or she must be dependent upon you for at least 50% of his or her financial support.
 - c. Care may be provided either inside or outside your home. However, expenses outside your home (such as a nursing home) are eligible only if the dependent regularly spends at least eight hours each day in your home.

The law requires that you identify the provider of dependent care on your federal tax return. When identifying the provider, you must include the provider's name, address and Social Security number or taxpayer

identification number (TIN). These same requirements apply to the federal child care tax credit. Additionally, the University is required to report the amount of your annual account deposit on your W-2 form.

Expenses reimbursed from the Dependent Care FSA may not be used as a federal income tax credit. The maximum dollar limit under the tax credit is reduced by the amount you have been reimbursed from the Dependent Care Account.

How much can I deposit to each account?

There are limits on the annual amounts you may deposit to the Health Care and Dependent Care FSAs:

	Minimum	Maximum
Health Care FSA	\$50	\$2,600 (per employee)
Dependent Care FSA	\$50	\$5,000 (per household) (\$2,500 if you are married and file a separate federal tax return)

Careful planning is the key to making the most of your savings through the two accounts. Together or separately, they provide an effective way of paying certain health and dependent care expenses while reducing your taxes. However, keep in mind that you will forfeit any unused money left in your accounts at the end of the reimbursement period so plan your deposits carefully.

How do I get reimbursed?

The process of putting money into your Health Care FSA or Dependent Care FSA and getting it back out is pretty simple. It can be broken down into these steps:

- Indicate the amount you want to deposit to your accounts on the correct line on your enrollment form. This amount will be deducted from your paycheck before taxes in equal installments each pay period throughout the next year.
- Once you have incurred eligible expenses, the next step is to complete a request for reimbursement. There are numerous ways to receive reimbursement:
 - You can file a claim using your smartphone or mobile device. It is very simple. Just download the free app available in the App store or the Google play store. Search for the ASIFlex mobile app.;
 - You can file a claim online at www.asiflex.com;
 - You can file a claim using FlexMinder (see below);
 - You can use the ASIFlex Debit Card (see below); or
 - You can file a claim by completing a paper form (available at www.asiflex.com) and either:
 - Fax it to 877-879-9038;
 - Bring it to the ASI office located at 201 W. Broadway, Suite 4-C, Columbia, MO 65203; or
 - Mail it to: ASI, P.O. Box 6044, Columbia, MO 65205-6044.
- To expedite your reimbursement, the claims administrator can arrange for direct deposit to your checking or savings account. Typically, this would take no longer than two working days from the day the claim is received by the administrator.
- The administrator then uses the money in your account to reimburse your expense.

You can only be reimbursed for expenses you incur while you are participating in the accounts. The claim period for the Health Care FSA is January 1 of the Plan year until March 15 of the following year. Only qualified expenses incurred during this time period are eligible for reimbursement. The deadline for submitting requests for reimbursement for Health Care FSA claims incurred is April 15. After April 15, your prior year's Health Care FSA is closed and you will forfeit any money remaining in it.

The claim period for the Dependent Care FSA is January 1 through December 31. Reimbursement requests for Dependent Care claims must be submitted by April 15. For example, if you have eligible Dependent Care

expenses in late December, you have until the following April 15 to submit them for reimbursement. After April 15, however, your prior years' account is closed and you will forfeit any money remaining in it.

If the claims you submit for the Dependent Care FSA are more than the amount you have accumulated in it, you will be paid only as much as is in your account. The remainder of the claim will be held in a pending state until your balance is large enough to pay it and then it will be processed.

You will be reimbursed for an eligible Health Care FSA claim as long as your claims do not exceed the amount of your total annual deposit.

FlexMinder – Sign into your FSA account at www.asiflex.com and click on the FlexMinder button. Complete the request and click OK. Within a few business days, you will receive an email invitation from FlexMinder. Follow the enclosed instructions to set up your FlexMinder account. FlexMinder finds reimbursable expenses from your insurance Explanation of Benefit (EOB) statements and provides a list of EOBs to you. With just a click you can select the EOBs you wish to submit to your Health Care FSA for reimbursement. FlexMinder does all the claim paperwork for you.

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

Where can the ASIFlex Debit Card be used?

Per IRS regulations, the ASIFlex Debit 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 ASIFlex 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 ASIFlex Card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your ASIFlex 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 ASIFlex 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 ASIFlex Card will work at these stores, even if the MCC does not indicate it is a health care provider. However, you will not be able to pay for OTC drugs or medicines with the ASIFlex Card, even if you have a prescription.

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 provided the merchant has identified the product as FSA eligible!**

If you use the ASIFlex Card at merchants that have implemented the Inventory Information Approval System (IIAS), you will not be able to pay for OTC medicine with the ASIFlex 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. You can also submit this online or via the mobile app.

Do I have to turn in documentation when paying with the ASIFlex Card?

If you use the ASIFlex card, you are only required to submit backup documentation if the transaction is unable to be electronically substantiated.

Which claims can be electronically substantiated?

ASIFlex 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 three 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** health, 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 (e.g., Band-Aids, contact lens solution, etc.) and prescription medication (this system restricts purchases with the ASIFlex Card to FSA-eligible expenses).

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?

As detailed above, there are times when you may use the ASIFlex Debit Card to purchase FSA eligible items or services and additional documentation will be required to substantiate the transaction, in accordance with IRS Regulations. When follow up documentation, or a statement of services is required, ASIFlex will send you an e-mail or letter requesting this documentation. The requested information should include the following information: name of provider, name of member (or member's spouse or dependent), date the service was provided, brief description of the service(s) provided, and the amount that was your responsibility.

ASIFlex will send the initial request for follow up documentation within a few days of the ASIFlex Card transaction. Should you not comply with the request, ASIFlex will make a second request in approximately three weeks. Should you not comply with the second request, a third notice will be sent to you stating that the ASIFlex Card has been "suspended" because the requested documentation was not received by ASIFlex.

When you use the ASIFlex Card for a transaction requiring documentation, those dollars are identified as "overpaid" within your FSA account until the transaction is substantiated.

If you submit a manual claim before the ASIFlex Card transaction is substantiated, the dollars associated with the manual claim will be used to offset the overpaid dollars from the ASIFlex Card transaction. This will prevent the manual claim from being reimbursed in part, or in full, depending upon the dollar amount of the manual claim. Once the ASIFlex Card transaction is substantiated, the manual claim used to offset the ASIFlex Card transaction will be reimbursed in full. See the following examples for further explanation:

Example 1: John goes to the dentist and pays \$200 for a root canal with his ASIFlex Card. He then receives a notice from ASIFlex requesting follow up documentation. John submits the statement of services from his dentist along with the notice received from ASIFlex. ASIFlex reviews and processes the follow up documentation to substantiate the claim. John's FSA account will no longer be showing as "overpaid" since all follow up documentation was submitted.

Example 2: Lisa pays her eye doctor \$250 for contacts using her ASIFlex Card. ASIFlex sends Lisa a notice asking for follow-up documentation for the \$250 purchase. Prior to submitting the detailed statement from her eye doctor, Lisa submits a manual claim to ASIFlex for a \$100 prescription which she paid for out-of-pocket. ASIFlex will process the \$100 claim but no payment will be issued that day. Instead, the amount of the manual claim will be used to offset the ASIFlex Card transaction. This will result in ASIFlex showing Lisa's overpaid amount reduced from \$250 to \$150. Two weeks later Lisa submits the follow up documentation for the ASIFlex

Card transaction used to purchase the contacts to ASIFlex. ASIFlex will then process the supporting documentation for \$250 and Lisa will be issued a payment of \$100 for her manual prescription claim.

If you are unable to provide documentation for an ASIFlex Card transaction in question, you may submit expenses incurred out-of-pocket to offset the ASIFlex Card transaction. The expenses that are incurred out-of-pocket must not also be paid for using the ASIFlex Card.

Should you neglect to submit the requested documentation and the plan year comes to an end (following the Plan's provision for documentation to be submitted by April 15), ASIFlex will provide notice to the University that the claim was not substantiated within the plan year as required by IRS Regulations. **If you are actively employed by the University and do not repay your claims, a wage attachment will be processed to deduct the amount of the unsubstantiated claim/s from your pay.**

If you do not provide requested documentation and leave University employment or retire, a W-2 will be provided to you for the year in which the funds were not repaid and these funds will be reported to the IRS as earnings for which taxes must be paid. See the following example for further explanation:

Example: Lori's daughter Carrie goes to the dentist to receive a crown in 2017. Lori uses her ASIFlex Card for the \$750 expense. Lori terminates employment the following week. ASIFlex sends Lori three notices requesting follow up documentation, and receives no response or repayment from Lori. At the end of the plan year (following the grace period provision to April 15, 2018) ASIFlex will notify the University of the overpayment. The University will then issue a W-2 for 2018 in January, 2019, to the member and to the IRS, which will report the \$750 overpayment as taxable income.



While the ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses, the ASIFlex Debit Card is **NOT** a paperless option and **DOES NOT** eliminate paperwork. There are times when you may use the ASIFlex Debit Card to purchase FSA eligible items or services and additional documentation **will still be required** to substantiate the transaction in accordance with IRS Regulations.

Concerns and questions regarding this process should be directed to ASIFlex at asi@asiflex.com or 1-800-659-3035.

Is there a cost for the ASIFlex Card?

The first set of two (2) cards is provided at no cost. There is, however, a \$5.00 replacement card or additional card fee.

Can I request additional ASIFlex Cards?

Yes. Everyone who requests a card will receive two ASIFlex Cards in the mail. If you would like additional cards, complete the ASIFlex Card application form and submit to ASIFlex. There is a \$5 fee for each additional ASIFlex Card request. Please note that all ASIFlex Cards will be in the name of the FSA participant.

Can I use the ASIFlex Card to pay for OTC medicine at stores that have implemented IAS if I have a prescription on file with ASIFlex?

No, you will not be able to pay for OTC medicine with the ASIFlex 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. However, you may use the card to purchase health care products that are not considered a drug or medicine.

Special rules to remember

While the accounts are a good way for you to reduce your taxes, you should be aware of several important rules:

- The IRS requires that any money not used for eligible expenses incurred during the year be **forfeited**. This means you should put aside money only for those expenses you feel certain you will incur during the Plan year. (An expense is “incurred” on the date the service is provided — not when you pay for it.)
- Dependent Care FSA elections may be made during the plan year as well as an existing election can be changed during the plan year if your benefit needs are affected by a “change in family status”.
- Health Care FSA elections may be made during the plan year as well as an existing election can be changed during the plan year if your benefit needs are affected by a “qualified family/employment status change”.
- The accounts are completely separate, so you may not use deposits to your Health Care FSA to fund dependent care expenses, or Dependent Care FSA funds to pay health care expenses.

What if I elect the wrong plan on accident?

If the Plan Administrator determines that there has been an error, such as a clerical or administrative error or an election in which the participant is clearly unable to benefit, then the Plan Administrator may make an adjustment to correct such error. Such error must be based on clear and convincing evidence that a mistake was made. An example of a participant clearly being unable to benefit would be an election for dependent care when the participant has no dependents.

Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator, and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he/she considers equitable and practicable.”

When does my participation end?

Your participation in the Health Care or Dependent Care expense accounts will end as of December 31 of each year. The University Health Care FSA has a 2.5 month Grace Period (through March 15 of the following year), which allows you extra time to incur expenses to use your flexible spending health care balance after the close of the plan year. The FSA Dependent Care account does not have the extended period of coverage, so those expenses must be incurred during the plan year.

Additionally, if you leave employment with the University, you are no longer eligible to participate, or if you no longer receive pay from which the necessary contributions can be taken, your before-tax deposits to the accounts will stop as of the last day of the month in which your employment pay or eligibility ends.

Can I continue my Health Care and/or Dependent Care expense accounts after termination?

You will be notified by mail if you are eligible for Health Care FSA COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will come from the University’s COBRA Administrator and will give you instructions for electing COBRA coverage.

You will have until April 15 of the year following your termination of participation to submit expenses for the Health Care FSA. You may include any expenses incurred up to the end of the month in which your flexible spending account deduction/(s) terminates. You may not be reimbursed for expenses incurred after this date unless you continue your health care deposits by making direct payments to the University’s COBRA Administrator on a post-tax basis.

The Dependent Care FSA is not eligible for continued coverage through COBRA. You will have until April 15 of the year following your termination of participation to submit expenses for the Dependent Care expense account.

Claim questions

If any portion of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things that you can do to appeal the decision. Most of your questions can be answered quickly by either calling or writing the University (Plan Administrator).

If the University determines that all or part of your claim is not eligible for reimbursement, you will receive a notice that gives the following information:

- the specific reason for the denial
- a specific reference to the provision of the Plan on which the denial is based
- a description of any additional information that may be needed and the reason for it
- an explanation of the Plan's claim review procedure

If you believe that your claim has been processed incorrectly, you have 60 days following the receipt of the claim denial to file a petition for review with the University. You need to state in writing the specific reasons for which you believe you are entitled to different or greater benefits.

Within 60 days after the University receives your petition for review, the University will give you the opportunity to present your position orally or in writing. You will also have the opportunity to review pertinent documents. The University will notify you of the final decision within 60 days following the receipt of your specific request for review. If, because of special circumstances the 60 day period is not sufficient, the final decision may be extended for another 60 days at the election of the University. You will be informed at the onset of the extension if this becomes necessary.