

*In 2010, You Decide What You Spend\* (AND Save)!*



## State of Indiana

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### Section 125

#### Medical Care Flexible Spending Account

#### Employee Enrollment Information Packet

\* - Restricted to Approved FSA-Eligible Expenses



Key Benefit Administrators - FlexPro

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# What is *FlexPro*?

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*FlexPro™* is a Flexible Benefits (Cafeteria) Plan that is approved under Section 125 of the Internal Revenue Code. It enables you to pay for certain expenses with pre-tax dollars.

**Optional Benefits:** (Some or all of these benefits may be offered by the State of Indiana)

**Employee Paid Insurance Premiums – Tax Saver** — This account automatically allows you to pay for your portion of some insurance premiums with tax-free dollars. **This is automatic for all State Employees.**

**Medical Care Flexible Spending Account (FSA)** — Medical Care costs include medical, dental, vision and hearing expenses that are not paid by insurance and other “out-of-pocket” expenses. These expenses must be incurred within the plan year. These expenses may include, but are not limited to: expenses for medical plan co-payments, deductibles, prescriptions, physician visits, chiropractic care, vision, dental/orthodontia care, and eligible over-the-counter items.

## Is a Medical Care Flexible Spending Account Right For You?

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	YES	NO
Do you have out-of-pocket costs associated with the State’s medical plan? (i.e. co-payments, deductibles, co-insurance)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have other out-of-pocket medical care expenses not covered by insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have out-of-pocket dental expenses? (i.e. cleanings, fillings, orthodontia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have out-of-pocket vision expenses? (i.e. exams, glasses, contact lenses, LASIK, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

If you answered **YES** to any of these questions, you can reduce the taxes that you pay by participating in your employer sponsored Flexible Benefits Plan, *FlexPro*, and therefore **increase your take home pay!**



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## State of Indiana

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### Medical Care Flexible Spending Account Plan Specifics

**PLAN YEAR:** 01/01/10 - 12/31/10  
**Plan Options:** Plan Maximums:

Medical Care FSA Plan Option \$ 5,000.00

#### Eligibility Requirements:

**Participation in the Medical Care FSA  
Plan Option by New Hires:**

Upon eligibility

**Participation After Termination In The  
Medical Care FSA Plan Option:**

Terminated employees will be allowed 0 days past termination of employment to incur expenses and an additional 30 days to submit expenses.

**Claims Submission:**

Claims may be submitted as needed because daily payouts occur for State participants.

**Orthodontia Services:**

At the time services begin, the initial down payment may be reimbursed. The remaining balance may only be reimbursed according to the monthly payment structure outlined in the Orthodontia contract. A copy of the Orthodontic contract needs to be provided to KBA at time of reimbursement

**Grace Period:**

The Grace Period will allow expenses incurred within the first 74 days of this Plan Year to be reimbursed from your previous Plan Year if a balance remains in that account. Claims may be incurred through the end of the Grace Period, March 15<sup>th</sup>, each plan year and submitted via the claim form no later than 90 days after the end of the Grace Period, June 15<sup>th</sup>, each plan year.

**Claims Submitted After the End  
Of the Plan Year:**

Claims incurred prior to the end of the plan year and subsequent grace period must be submitted no later than 90 days after the expiration of the grace period on June 15<sup>th</sup>.

**Status Change Notification  
Time Frame:**

Status changes must be submitted within 30 days of the Qualifying Event

# What Type of Expenses Are Eligible?

## Medical Care FSA Expenses

The following list, while **not intended to be complete**, illustrates expenses that **may** be reimbursed under the Medical Care FSA: Restrictions may apply.

### I. ELIGIBLE DENTAL & VISION EXPENSES

#### DENTAL EXPENSES

- Routine & Preventive Services
- X-rays
- Orthodontia (*A treatment plan may be required*) (see Plan Specifics page for your Plan's orthodontia guidelines)
- Restorative services, fillings, extractions, dentures

#### VISION CARE EXPENSES

- Eye exams
- Prescription eyeglasses & sunglasses
- Contact lenses & supplies
- Corrective surgery (*RK & LASIK*)

### II. ELIGIBLE MEDICAL CARE EXPENSES

#### MEDICALLY NECESSARY EQUIPMENT

- Wheelchair, crutches & lifts
- Oxygen equipment & supplies
- Blood pressure monitor

#### DIABETIC SUPPLIES

- Insulin
- Test strips, lancets, etc.
- Glucose monitor

#### PHYSICAL EXAMINATIONS

- Annual physical exam (*including prostate screening, pap smears & mammograms*)
- School & work physicals

#### COUNSELING & PSYCHIATRIC TREATMENT

(*Prescribed by a doctor to treat a medical condition.*)

**Statement required from the doctor.** See Marriage/Family Counseling)

- Psychologists
- Psychotherapists
- Psychiatrists

#### FEES & SERVICES

- Physicians, surgeons, anesthesiologists, OB/GYN
- Ambulance
- Nursing (*including room & board*)
- Chiropractic service

- Fertility treatment
- Sterilization & reversals
- Medically necessary reconstructive services (*i.e. mastectomy or following an accident*)

- Hospital expenses

#### HEARING EXPENSES

- Testing
- Hearing aids
- Batteries & repairs

#### OTHER EXPENSES

- Prosthesis & artificial limbs
- Organ tissue donation expenses
- Tuition at special school for handicapped
- Travel necessary to seek medical treatment (*limitations apply*)
- Orthotics & orthopedic shoes (*medically necessary*)
- Laboratory fees
- Acupuncture
- Alcohol & drug rehabilitation expenses
- Special equipment for those who are deaf and/or blind (*i.e. Braille books, hearing devices, guide dogs*)
- Weight loss programs and drugs (*ONLY when prescribed by a doctor to treat obesity and/or a specific medical condition – statement required from the doctor*)
- Medical supplies
- Therapy treatments (*when prescribed by a doctor*)

### III. INELIGIBLE EXPENSES

- Cosmetic treatments or surgery (*unless necessary to alleviate a deformity related to a congenital abnormality, trauma, or disfiguring disease*)
- Expenses (*treatments and drugs*) only to improve your general health or well being
- Hair replacement treatments and drugs
- Health club dues
- Long Term Care Insurance

- Marriage & family counseling
- Nutritional supplements/vitamins
- Teeth whitening, toothbrush
- Vacations
- Vitamins to improve or to preserve general health (*even when prescribed by a doctor*)



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# Over-the-Counter Drug Reimbursements

APPROVED BY THE IRS

*The IRS has approved some over-the-counter, non-prescription, "medicines and drugs" that are taken for medical care as eligible expenses for reimbursement under your Medical Care Flexible Spending Account (FSA). "Medicines and drugs" are defined as items for your personal use (or your spouse or dependents) to alleviate or treat personal injuries or sickness. Still **not** eligible are items merely beneficial to your general health such as dietary, nutritional supplements, vitamins, toothpaste, etc.*

## Examples of Eligible Expenses

(The following list, while not intended to be complete, illustrates some over-the-counter expenses that may be reimbursed under the Medical Care FSA; some restrictions may apply and may require a letter of medical necessity from a physician.)

Allergy Medicine	Motion Sickness Pills
Antacids	Nasal Sinus Sprays or Strips
Anti-diarrhea Medicine	Nicotine Gum or patches for Stop-smoking Purposes
Bactine	Pain Reliever
Band-Aids/Bandages	Pedialyte for Ill Child's Dehydration
Bug Bite Medication	Pregnancy Test Kits
Calamine Lotion	Products for Muscle Pain or Joint Pain, i.e., Ben Gay, Tiger Balm, etc.
Carpal Tunnel Wrist Supports	Reading Glasses
Cold Medicines	Rubbing Alcohol
Cold/Hot Packs for Injuries	Sinus Medications
Condoms	Sleeping Aids used to treat occasional insomnia
Contact Lens Cleaning Solution	Special Ointment or Cream for Sunburn
Cough Drops	Spermicidal Foam
Diaper Rash Ointments	Thermometers (ear or mouth)
First Aid Cream	Throat Lozenges
First Aid Kits	Visine and other such eye products
Hemorrhoid Medication	Wart remover treatments
Incontinence Supplies	
Laxatives	
Liquid Adhesive for Small Cuts	
Menstrual Cycle Products for pain and cramp relief	



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# How Flex Works and How Much Can You Save?

This illustration demonstrates how a participating employee might save \$780 in taxes during the Plan Year by paying for his expenses with pre-tax dollars.

Please Note: This example is for illustrative purposes only.

	Without Flex	With Flex
- Annual Income	\$ 30,000	\$ 30,000
- Out-of-Pocket *Pre-Tax Expenses	\$ 0,000	\$ 3,000
- Remaining Income To Be Taxed	\$ 30,000	\$ 27,000
- Estimated Taxes (26%) FICA, Federal & State **	\$ 7,800	\$ 7,020
- Out-of-Pocket After-Tax Expenses	\$ 3,000	\$ 0,000
- Take Home Pay	\$ 19,200	\$ 19,980
<b>YOUR ANNUAL TAX SAVINGS</b>	<b>\$ 0</b>	<b>\$ 780</b>

## In 2010, You Decide What You \$pend (and \$ave)!!!!!!!

Use the following worksheet to figure how much you can save by participating in a Flexible Benefit Plan.

### I. Medical Care Expenses

Estimated family annual medical/dental/vision expenses **not covered** by insurance:

Co-pays, deductibles, co-insurance \$ \_\_\_\_\_  
 Prescription drugs \$ \_\_\_\_\_  
 Over-the-counter drugs/medicines \$ \_\_\_\_\_  
 Doctor office visits \$ \_\_\_\_\_  
 Physical exams \$ \_\_\_\_\_  
 Well-baby care \$ \_\_\_\_\_  
 Chiropractic care \$ \_\_\_\_\_  
 Dental care \$ \_\_\_\_\_  
 Orthodontia \$ \_\_\_\_\_  
 Vision Exams \$ \_\_\_\_\_  
 Eyeglasses, Contact lenses, solution \$ \_\_\_\_\_  
 Insulin and related supplies \$ \_\_\_\_\_  
 Hearing care \$ \_\_\_\_\_  
 Other Medical Expenses \$ \_\_\_\_\_

Total Annual Medical, Dental, Vision Expenses: \$ \_\_\_\_\_

Multiply by an estimated tax savings of 26% x 26%

Your Estimated Annual Tax Savings: \$ \_\_\_\_\_

More take home money to pay for those eligible expenses.



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# Medical Care FSA Frequently Asked Questions

This packet is only a brief overview of benefits that may be eligible under your plan.

## Who can participate in the Plan?

All employees who have met the eligibility requirements established by the State of Indiana may participate in the Plan.

## How do I sign up?

Enroll using People Soft self service by Monday following pay period in which you were hired or during open enrollment.

## How do I determine how much money to allocate?

Be conservative! Only consider your known expenses. Do not allow for things that might happen. A list of eligible expenses and a worksheet are provided to help you calculate your expenses for the upcoming plan year.

## Are there limits?

The maximum annual family amount for the Medical Care FSA is \$5,000.

## I went to the doctor before the plan year began, but I did not pay the expense until after the plan year started. May I include that expense?

No. Services must be incurred within the plan year. The date of payment does not matter.

## Can I change my annual allocation anytime during the Plan Year?

You may change your annual allocation if you have one of the eligible status changes as defined in the State's Plan. Examples of qualifying changes in status are marriage or divorce, death of a spouse or dependent, birth or adoption of a child, and change in your employment or in your spouse's employment. Status changes must be consistent with the status change event. Please consult your Summary Plan Description for complete details.

## What happens if I do not use all of my annual allocation?

The IRS has established a "use it or lose it rule." If you do not use all of your annual allocation, you will forfeit any remaining amount. For example, if you allocate \$500 and only submit \$450 in expenses, you will lose the \$50 (not just the taxes.) So, please be conservative when you determine your annual allocation.

## What expenses are eligible under the Flex Plan?

A list of eligible and ineligible expenses as well as a list of over-the-counter items previously listed. Please pay special attention to the orthodontia claims submission requirements for your Plan which are listed on the Plan Specifics page.

## Does my plan include a Grace Period?

The IRS recently issued a new regulation governing Section 125 Flexible Spending Plans. It allowed the State to extend the deadline for participants to incur claims for their Flex Plan (medical and dependent daycare) after the end of the plan year, into the new plan year for **74** days. Paper claims to access the previous year money must be submitted no later than 90 days after the end of the Grace Period; your debit card will not work to access past year's money.

## What happens if I terminate my employment?

Termination from employment ends eligibility. Terminated employees will be allowed 0 days past termination of employment to incur expenses and an additional 30 days to submit expenses and no later than June 15<sup>th</sup>. Also, you may be eligible to continue coverage under the Medical Care FSA option through federal COBRA regulations.

## How do I submit a claim for reimbursement?

Copies of receipts for Medical Care FSA expenses must be submitted with a signed claim form. The receipts must be independent third party receipts showing the name of the provider, the date of service, the type of service, the amount of the service and the patient's name. If your insurance company covers the expense, please submit the receipt to the insurance company first. You may then forward a copy of the Explanation of Benefits from the insurance company along with the signed claim form to FlexPro™. Cancelled checks are not eligible as receipts for Medical Care FSA expenses. The total amount of reimbursement you selected for the Plan Year will be available at all times during the Plan Year.

Claim forms, including detailed receipts/invoices, may be sent for processing via:

Fax to: (317) 284-7269 or (866) 241-1488

Email to: [FlexPro@keybenefit.com](mailto:FlexPro@keybenefit.com)

Mail to: Key Benefit Administrators – FlexPro  
PO Box 55210  
Indianapolis, IN 46205

## Will I receive information throughout the year telling me where I stand on my account?

Yes, you will receive periodic reports showing what has been credited to your account. You will also receive a reminder letter before your plan year ends, if you have a balance in your account.

## Will my participation in the Flex Plan affect my Social Security?

You will not pay Social Security taxes on the money you contribute to the Flex Plan. Therefore, your future Social Security benefits may be slightly reduced. However, the tax savings you receive from this plan should be more than any reduction in your Social Security benefits.

## How do I submit expenses, if I have money left from the previous year?

State employees will utilize a signed claim form and corresponding third-party substantiation, if necessary, to access the previous year's money. Debit Cards will be re-loaded with the new year plan dollars on January 1st, and previous year plan dollars will not be available except through the paper claims process.

See the **Plan Specifics** provided to the State for employee's additional answers to questions and further clarification.



THIS SIGNED FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Employee Name: \_\_\_\_\_ ID or SSN Number: \_\_\_\_\_

Email address: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Number & Street City State Zip Code☐ Please check if new address

Daytime Phone Number: \_\_\_\_\_ Number of pages: \_\_\_\_\_

*To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses with the date of service incurred by me, my spouse, or my qualified dependent(s) during the applicable plan year. I certify that these expenses have not been reimbursed by any other source, nor will any reimbursement be sought from any other source. By signing and submitting a Dependent Care Reimbursement Request, I am certifying that expenses for which I request reimbursement satisfy all dependent care guidelines. I and my spouse, where applicable, are gainfully employed or a full-time student and not on leave. In accordance with the Flex Benefit Plan, I authorize my Flexible Spending Account(s) to be reduced by the amount requested.*

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature Required**Medical Care Expenses:**

Expenses that may be covered by your (or your spouse's) medical, dental or vision plan must first be submitted to the appropriate insurance carrier. The Explanation of Benefits (EOB) you receive from your insurance carrier may then be submitted to Key Benefit Administrators - FlexPro as a qualifying receipt towards your FSA Plan. Medical care receipts must be from an independent third party and must include the Name of the Patient, Name of the Provider, Type and date of Service or Supply provided (Names of Prescriptions are required), and the Amount of the Service or Supply. Receipts for eligible over-the-counter (OTC) drugs or medicines must include the same information but the type of Supply and the Patient's Name may be hand written on the receipt by the participant if necessary. If necessary please add additional pages.

Name of Patient or Dependent	Date(s) of Service	Name of Provider or Merchant	Type of Service or Supply	Medical Care Charge for each service/supply	Flex Card Purchase Substantiation
Total					

☐ As requested, a letter of medical necessity is included. ☐ A letter of medical necessity is on file.

**Dependent Care:** Dependent Care receipts must include the Name of the Provider, Dates of Service, Name of the Dependent(s), Fee for Service or you may have your Dependent Care Provider complete and sign below (Original Signature required).

Date(s) of Service: (to &amp; from) \_\_\_\_\_ Amount to be reimbursed: \_\_\_\_\_

Dependent(s) Name: \_\_\_\_\_ Dependent(s) Date of Birth: \_\_\_\_\_

Dependent Care Provider Name and Tax ID #: \_\_\_\_\_

Dependent Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dependent Care expenses for the care of a qualifying individual that are for the purpose of enabling the employee and the spouse, when applicable, to be gainfully employed or a full-time student are eligible. Dependent Care may not be reimbursed while on Leave of Absence (LOA). *Exception for short, temporary absences.* An absence of no more than 2 consecutive calendar weeks is considered a short, temporary absence. A taxpayer who is gainfully employed is not required to allocate expenses during a short, temporary absence from work, such as for vacation or minor illness, provided that the caregiving arrangement requires the taxpayer to pay for care during the absence.

**The following reimbursement request rules apply:** Medical Care and Dependent Care expenses must be incurred within the appropriate Plan Year. See Plan Specific page for eligibility requirements. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. *Cancelled checks are not acceptable receipts.* This form must be signed and submitted with applicable receipts.



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