

Tax-Favored Accounts

2010

Reference Guide

State of Florida • People First



State of Florida • People First

Table of Contents

Eligibility Requirements	3
Appeal Process	3
Health Investor HSA	4
Flexible Spending Accounts	6
Medical Reimbursement Account	8
Limited Purpose Medical Reimbursement Account	10
Dependent Care Reimbursement Account	11
FSA Worksheets	13
Changing Your Coverage	14
COBRA Questions and Answers	16
How Participation May Affect Other Benefits	17
Deferred Compensation Worksheet	18

Eligibility Requirements

Who is eligible to participate in the Flexible Spending Account (FSA) program?

All full-time and part-time employees filling established positions are entitled to participate in the FSA program. Employees who do not fill established positions (e.g., OPS employees) are not eligible.

How does termination or leave affect my FSA?

If you terminate employment or go on unpaid leave, your eligibility for either or both FSAs may change. While your Dependent Care Reimbursement Account cannot be continued following termination or the start of unpaid leave, you may be able to change or continue your Medical Reimbursement Account election upon completion of the appropriate forms and requirements. To make this change or to continue coverage, contact the People First Service Center within 31 days of the event by visiting the People First Web site at <https://peoplefirst.myflorida.com>, or by calling 1-866-ONEHRFL (1-866-663-4735); TTY 1-866-221-0269.

Specific guidelines about termination and leave policies can be obtained from your Agency Personnel Office or the People First Service Center. In addition, the Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact your Agency Personnel Office or the People First Service Center for further information.

Terminations

If you participate in a Medical Reimbursement Account and terminate your State employment, you must complete a Medical Reimbursement Account Termination of Employment Form. Forms are available by accessing the People First Web site or by contacting the People First Service Center. If you terminate participation in the plan, claims for medical expenses incurred after your termination will not be eligible for reimbursement.

However, should contributions to your account stop for any reason, payment of claims will be suspended, regardless of account balance. For participants who have terminated, claim payments will be suspended until the People First Service Center receives a signed Medical Reimbursement Account Termination of Employment Form with selection and payment. Participants going on leave must contact their Personnel Office for existing options.

NOTE: One option on the form is to have your balance deducted from your annual or sick leave on a pre-tax basis. This option will allow you to be reimbursed for expenses incurred through the end of the plan year.

Appeal Process

If you have a request for a mid-plan year election change, FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request within 90 days of the denial for review to the People First Service Center.

Your appeal must state:

- the date of the services for which your request was denied
- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within the State's and the IRS' regulations governing the plan.

Health Investor HSA

What is a Health Savings Account?

Providing economical health care in the face of rising costs is a major issue facing the nation. To deal with this issue and help you plan for future health expenses, you will have the choice of enrolling in the Health Investor HMO or PPO, coupled with a Health Savings Account (HSA). These options enable individuals who are willing to take greater responsibility for their medical care the opportunity to reduce their insurance premiums and save money for future health expenses.

A Health Savings Account (HSA) is a tax-free account that can be used to pay health care expenses. Unlike money in a Medical Reimbursement Account, the funds do not have to be spent in the plan year they are deposited. Money in the account, including interest or investment earnings, accumulates tax-free, so the funds can be used to pay qualified medical expenses in the future¹. An important advantage of an HSA is that it is owned by the employee. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

Who is eligible to contribute to an HSA?

- Employees must be covered by the State's Health Investor PPO or Health Investor HMO. These are the eligible high deductible health plan options.
- Employees cannot be covered by any other health plan that is not a qualified high deductible health plan, including Medicare. However, they may be covered for specific injuries, accidents, disability, dental care, vision care and long-term care.
- Participants cannot be claimed as a dependent on another person's tax return.

How much may I contribute to my HSA?

If you enroll in an HSA and elect to make contributions, your contributions are deducted on a pre-tax basis. An individual with single coverage may contribute up to \$3,050 (including any State contribution) a year to an HSA. Those covering more than one family member may contribute up to \$6,150 (including any State contribution) a year. These limits, established by the federal government and subject to change, are tied to the rate of inflation. An individual age 55* and older may make "catch-up" contributions of up to \$1,000 above the limits shown above in 2010.

You may also make after-tax contributions, which apply toward the maximum annual limit(s). You will receive additional information when you enroll.

¹ Please consult your tax advisor or IRS Publication 502 with questions regarding these expenses, qualified health plans, and tax information.

* The "catch-up" contribution rule applies to employees who are or become age 55 prior to 12/31 of the election year.

Will the State make a contribution to my Health Investor HSA?

Yes! If you enroll in a high deductible HMO or PPO **and** elect an HSA, the State will make a contribution of up to \$500 (annual) for an individual with single coverage or \$1,000 (annual) for an individual with family coverage. Of course, you must be an active, full-time or part-time employee to qualify for the state's contribution.

NOTE: You do **not** have to make a contribution to your HSA (although this option is available) to receive the State's contribution. You must simply enroll in a high-deductible health plan and elect to have an HSA. The State's contribution is made each pay period over the course of a calendar year, in equal amounts. Even if you are not sure that you want to contribute to an HSA beginning in January, you may wish to enroll to ensure you receive the State's contribution.

How can I change my HSA contribution amount?

To change your benefits, you can visit the People First Service Center Web site at <https://peoplefirst.myflorida.com> or contact the People First Service Center by phone at 1-866-ONEHRFL. Specialists are available Monday through Friday, 8:30 a.m. – 5:30 p.m. EST.

How do I get funds out of my HSA?

After enrolling in the HSA and completing an HSA application, your contributions will be sent to the custodian, Tallahassee State Bank, an affiliate of Synovus[®] Financial Corp. The HSA custodian will establish an individual account for you and mail you up to two VISA[®] debit cards to your home address at no charge. You may order additional cards or a small supply of checks by contacting the HSA Customer Service Line at **1-877-367-4HSA**. You may use the debit card or checks to get funds out of your HSA. Remember, as long as you are taking funds out for qualified medical expenses incurred on or after the date the HSA was established, there are no taxable consequences to you. However, if you withdraw funds for ineligible expenses, you may have to pay taxes and penalties on those funds, unless you reimburse your HSA for the ineligible amount.

Will I be charged any banking or custodian fees?

Yes, the custodian will charge you \$3 per month for your Health Investor HSA. This fee includes the VISA[®] debit card, all transaction fees associated with the card, monthly statements and other banking services. There is a \$1 charge to process each check you write to get funds from your HSA. The custodian will deduct these fees automatically from your HSA. Other fees may apply, including fees for insufficient funds. Refer to the Tallahassee State Bank Schedule of Fees and Charges for more information.

**Tallahassee
State Bank**

Member FDIC

Health Investor HSA

When can I enroll?

Mid-year enrollees are now allowed to make the full annual contribution as long as they become eligible before December 1 of any year and if they continue to be an eligible individual for 12 months beginning with the last month in the year in which the individual became an eligible individual. Previously HSA-eligible participants were allowed to make contributions on a pro-rated, monthly basis.

If an individual does not remain HSA-eligible during the following tax year, the portion of HSA contributions attributable to months that the individual was not actually HSA-eligible will be included in their gross income, subject to a 10 percent penalty (unless the individual dies or becomes disabled).

Can I transfer funds from my IRA to my HSA?

A one-time irrevocable trustee-to-trustee transfer of IRA funds to an HSA will be allowed as long as the transferred amount does not exceed the annual HSA contribution limits⁴. Any transfer from an IRA to an HSA will reduce the maximum amount that may be contributed to an HSA during a calendar year.

Are my HSA funds invested?

Your funds will be held initially in an interest-bearing checking account at Tallahassee State Bank. The current HSA interest rate is .70% APY¹ for balances up to \$999; .80% APY¹ for balances of \$1,000 - \$4,999; .90% APY¹ for balances of \$5,000 - \$24,999; and 1.00% APY¹ on balances of \$25,000 or more, which is subject to change. To check the current rate on this account, call the HSA Customer Service Line at **1-877-367-4HSA**.

Once your Health Investor HSA balance reaches \$3,500, you may invest a portion of your account balance in Fidelity Investments® Class "T" mutual funds² offered through Synovus Securities, Inc.³, the bank's brokerage provider. Your minimum initial investment in each fund must equal \$2,500; after this initial investment, you may make periodic investments in increments of \$100 or more. Additional information will be sent once your account balance reaches \$3,500. There is an annual investment fee of \$60. The mutual funds available under your Health Investor HSA are:

- Fidelity Advisor Diversified International Fund
- Fidelity Advisor Small Cap Fund
- Fidelity Advisor Mid Cap II Fund
- Fidelity Advisor Dividend Growth Fund
- Fidelity Advisor Balanced Fund
- Fidelity Investment Grade Bond Fund
- Fidelity Prime Fund – Daily Money Class

¹ The rate is effective as of July 1, 2009.

² Mutual fund investing involves risk, including loss of principal. Please carefully consider the fund's investment objective, risks, charges and expenses applicable to a continued investment in the fund before investing. For more information, please thoroughly read the prospectus prior to investing.

³ **The registered broker-dealer offering brokerage products for Synovus is Synovus Securities, Inc., member NASD/SIPC.** Investment products and services are not FDIC insured, are not deposits of or obligations of any Synovus® Financial Corp. (SFC) bank, are not guaranteed by any SFC bank and involve investment risk, including possible loss of principal amount invested. Your Synovus®-owned bank and Synovus Securities, Inc. are part of the Synovus® family of companies.

⁴ Please consult a tax advisor. Certain restrictions apply.

Are there any special tax forms or tax reporting that I must complete when filing my income taxes?

The bank will send your tax filing information, after the end of the taxable year, for your use in reporting contributions to your HSA and to report any withdrawals or distributions from your HSA. It is important that you save receipts, invoices and any explanations of benefits received from your health insurance carrier as documentation, in case you are ever asked to show proof of qualified medical expenses to the IRS.

What if I exceed the annual contribution limits established by the IRS?

The People First Service Center will monitor your HSA contributions made through payroll deduction and send an alert to your payroll administrator and advise that you are exceeding your contribution limits. The custodian will also send courtesy notices periodically reminding you to check your account balance and ensure that you are not exceeding the allowable annual contribution limits. You may decrease or stop your contributions accordingly, but the best way to ensure that you do not exceed the annual contribution limit is to elect a per-pay-period contribution that ensures you will not exceed the annual limit. Of course, you can add the "catch-up" contribution amount to these annual limits if you are age 55 or older. The catch-up contribution for 2009 is \$1000.

May I have an HSA and Medical Reimbursement Account?

Yes, individuals may enroll in a Limited Purpose Medical Reimbursement Account to pay certain eligible expenses. The Limited Purpose Medical Reimbursement Account may be used to pay expenses not covered by your Health Investor HSA or a high deductible health plan, including dental, vision and preventive care expenses. Dependent Care Spending Account eligibility is not affected by your HSA participation. Additional information will be available with your enrollment information. Information is also available by contacting the People First Service Center at 1-866-ONEHRFL or online at <https://peoplefirst.myflorida.com>.

Remember, Limited Purpose Medical Reimbursement Accounts are available to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation.

Flexible Spending Accounts

What is a Flexible Spending Account?

The State provides you with IRS tax-favored Flexible Spending Accounts (FSAs) to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax free
- per-pay-period deposits from your pre-tax salary
- savings on income and Social Security taxes and
- security of paying anticipated expenses with your FSA.

Is an FSA right for me?

If you spend money on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.

What types of FSAs are available?

The State offers you a Medical Reimbursement Account as well as a Dependent Care Reimbursement Account. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Medical Reimbursement Accounts

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Medical Reimbursement Account, including:

- co-payments
- eyeglasses
- orthodontia and
- Over-the-Counter items.

Dependent Care Reimbursement Accounts

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- daycare services
- in-home care
- nursery and preschool and
- summer day camps.

Refer to the *Medical Reimbursement Account* and *Dependent Care Reimbursement Account* sections of this Reference Guide for specifics on each type of FSA.

Receiving Reimbursement

Your reimbursement will be processed within five business days from the time People First receives your properly completed and signed FSA Reimbursement Request Form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit (when available)

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed).

Where can I get information about FSAs?

If you have specific questions about FSAs, contact People First Service Center.

- Visit the People First Web site at <https://peoplefirst.myflorida.com>
- Call 1-866-ONEHREFL (1-866-663-4735); TTY 1-866-221-0269.

Please note that due to our Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

FSA Savings Example*

(With FSA)		(Without FSA)
\$31,000	Annual Gross Income	\$31,000
<u>- 5,000</u>	FSA Deposit for Recurring Expenses	<u>- 0</u>
\$26,000	Taxable Gross Income	\$31,000
<u>- 5,889</u>	Federal, Social Security Taxes	<u>-7,021</u>
\$20,111	Annual Net Income	\$23,979
<u>- 0</u>	Cost of Recurring Expenses	<u>-5,000</u>
\$20,111	Spendable Income	\$18,979

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

\$1,132!

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Flexible Spending Accounts

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Medical Reimbursement Account or vice versa.
3. You have a run-out period (until April 15) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the plan year.
4. An IRS Revenue Notice permits a “grace period” of two months and 15 days following the end of your 2010 Plan Year (December 31, 2010) for a Medical Expense FSA. This grace period ends on March 15, 2011. Funds will be automatically deducted from any remaining dollars in your 2010 Medical Expense FSA balance. You should not confuse the grace period with the plan’s “run-out period.” The run-out period extends until April 15, 2011. This is a period for filing claims incurred anytime during the 2010 Plan Year, as well as claims incurred during the grace period mentioned above.
5. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
6. You cannot deduct reimbursed expenses for income tax purposes.
7. You may not be reimbursed for a service which you have not yet received.
8. Be conservative when estimating your medical and/or dependent care expenses for the plan year. IRS regulations state that any unused funds which remain in your FSA after a plan year ends, and all reimbursable requests have been submitted and processed, cannot be returned to you nor carried forward to the next plan year.

What documentation of expenses do I need to keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of statements, invoices or bills for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To obtain forms you will need after enrolling in either a Medical Reimbursement or Dependent Care Reimbursement Account, such as an FSA Reimbursement Request Form, and Letter of Medical Need visit the People First Web site at <https://peoplefirst.myflorida.com>, or by calling the People First Service Center at 1-866-ONEHRFL (1-866-663-4735); TTY 1-866-221-0269.

Will contributions affect my income taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Medical Reimbursement Account

Minimum Annual Deposit:	\$60
Maximum Annual Deposit:	\$5,000

What is a Medical Reimbursement Account?

A Medical Reimbursement Account is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on the next page.

Whose expenses are eligible?

Your Medical Reimbursement Account may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a **qualifying child**, if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- have not provided more than one-half of their own support during the taxable year.

An individual is a **qualifying relative** if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year **or**
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

NOTE: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Reimbursement Account.

Can travel expenses be reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Medical Reimbursement Account. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- parking fees
- tolls and
- transportation to another city.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Medical Reimbursement Account reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires the complete name of all medicines and drugs be obtained and documented on pharmacy invoices (including prescription number, date(s) of service and total dollar amount). This information must be included when submitting your request to People First for reimbursement.

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may be reimbursable through your Medical Reimbursement Account. Save valuable tax dollars on certain categories of OTC items, medicines and drugs, such as: allergy treatments, antacids, cold remedies, first-aid supplies and pain relievers.

You may be reimbursed for OTCs through your Medical Reimbursement Account if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your employer's Medical Reimbursement Account plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner already described in your benefits enrollment information.

NOTE: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis. It is your responsibility to remain informed of updates to this listing, which can be found at <https://peoplefirst.myflorida.com>. As soon as an OTC item, medicine or drug becomes eligible under any of the categories above, it will be reimbursable retroactively to the start of the then current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Medical Reimbursement Account election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Medical Reimbursement Account

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable through your Medical Reimbursement Account if the proper documentation is provided:

- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service, the cost for the service and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment (only required if a participant requests reimbursement for the total program cost spread over a period of time).

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call People First Service Center at 1-866-ONEHRFL.

When are my funds available?

Once you sign up for a Medical Reimbursement Account and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

Should I claim my expenses on IRS Form 1040?

With a Medical Reimbursement Account, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax free, regardless of the amount. By enrolling in a Medical Reimbursement Account, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on their percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Medical Reimbursement Account include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

When do I request reimbursement?

You may use your Medical Reimbursement Account to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How do I request reimbursement?

Requesting reimbursement from your Medical Reimbursement Account is easy. Simply fax or mail a correctly completed FSA Reimbursement Request Form along with the following:

- an invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided or
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost and
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the invoice or bill for the service.

Please note that cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for Medical Reimbursement Account reimbursement.

Toll-free fax: 1-888-800-5217
Mail to: People First Service Center
Flexible Spending Account
P.O. Box 1800
Tallahassee, FL 32302-1800

* EOBs are not required if your coverage is through a HMO.

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

NOTE: Budget conservatively. No reimbursement or refund of Medical Reimbursement Account funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Limited Purpose Medical Reimbursement Account

For Health Investor HSA Participants Only

Minimum Annual Deposit: \$60
Maximum Annual Deposit: \$5,000

What is a Limited Medical Reimbursement Account?

A Limited Purpose Medical Reimbursement Account is designed specifically for employees who wish to take advantage of a Health Savings Account (HSA), while continuing to enjoy the tax savings expected from an FSA. Much like a Medical Reimbursement Account, funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. **However, the funds in a Limited Purpose Medical Reimbursement Account can only be used for dental, vision and preventive care expenses not covered by your high deductible health plan.** Your HSA is designed to be used for all other medical-related expenses. A partial list of eligible Limited Purpose Medical Reimbursement Account expenses can be found on this page.

Aside from these minor differences, a Limited Purpose Medical Reimbursement Account follows the same procedures for reimbursement as a Medical Reimbursement Account.

Whose expenses are eligible?

Your Limited Purpose Medical Reimbursement Account may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a **qualifying child** if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- have not provided more than one-half of their own support during the taxable year (and receive more than one-half of their support from you during the taxable year if a full-time student age 19 through 23 at the end of the taxable year).

Partial List of Medically Necessary Eligible Expenses*

Contact lenses (corrective)
Dental fees
Eyeglasses
Guide dogs
Immunizations (child and adult)
Obesity weight-loss programs
Optometrist fees
Orthodontic treatment
Over-the-Counter Items
Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine exams
Prenatal and well-child care (routine)
Screening Services

- Cancer screening
- Heart and vascular diseases screening
- Infectious diseases screening
- Mental health conditions and substance abuse screening

Tobacco cessation programs

NOTE: Budget conservatively. No reimbursement or refund of a Limited Medical Reimbursement Account funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year.

An individual is a **qualifying relative** if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year or
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

NOTE: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Limited Purpose Medical Reimbursement Account.

When are my funds available?

Once you sign up for a Limited Purpose Medical Reimbursement Account and decide how much to contribute, the maximum annual amount of reimbursement for eligible expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible expenses at the start of your plan year, which is January 1.

Dependent Care Reimbursement Account

What is a Dependent Care Reimbursement Account?

A Dependent Care Reimbursement Account is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

You may use your Dependent Care Reimbursement Account to receive reimbursement for eligible dependent care expenses for qualifying individuals.

A qualifying individual includes a **qualifying child**, if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 12 years old or younger and
- have not provided more than one-half of their own support during the taxable year.

A qualifying individual includes your **spouse**, if they:

- are physically and/or mentally incapable of self-care
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home.

A qualifying individual includes your **qualifying relative**, if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- are physically and/or mentally incapable of self-care
- are not someone else's qualifying child
- live in your household for more than half of the taxable year
- spend at least eight hours per day in your home and
- receive more than one-half of their support from you during the taxable year.

NOTE: Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care Reimbursement Account.

What is my maximum annual deposit?

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

Minimum Annual Deposit*: \$60

Maximum Annual Deposit*: The maximum contribution depends on your tax filing status as the list on this page indicates.

* Including administrative fee

When are my funds available?

Once you sign up for a Dependent Care Reimbursement Account and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Medical Reimbursement Account, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care Reimbursement Account is always tax free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care Reimbursement Account may produce a greater tax benefit than claiming tax credits or exclusions alone.

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care Reimbursement Account cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Partial List of Eligible Dependent Care Expenses*

After school care
Baby-sitting fees
Daycare services
In-home care/au pair services
Nursery and preschool
Summer day camps

NOTE: Budget conservatively. No reimbursement or refund of Dependent Care Reimbursement Account funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Dependent Care Reimbursement Account

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care Reimbursement Account include:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- healthcare or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You can request reimbursement from your Dependent Care Reimbursement Account as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care Reimbursement Account is easy. Simply fax or mail a correctly completed FSA Reimbursement Request Form along with documentation showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care Reimbursement Account. This information is required with each request for reimbursement. Cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for Dependent Care Reimbursement Account reimbursement.

Toll-free fax: 1-888-800-5217

Mail to: People First Service Center
Flexible Spending Account
P.O. Box 1800
Tallahassee, FL 32302-1800

NOTE: If you elect to participate in the Dependent Care Reimbursement Account, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

FSA Worksheets

Use the worksheets below to determine how much to deposit in your FSA. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

Medical Reimbursement Account Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles \$ _____

Coinsurance or co-payments \$ _____

Vision care \$ _____

Dental care \$ _____

Prescription drugs \$ _____

Travel costs for medical care \$ _____

Other eligible expenses \$ _____

TOTAL \$ _____

DIVIDE by the number of paychecks you will receive during the plan year.* ÷ _____

This is your pay period contribution. \$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Dependent Care Reimbursement Account Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Daycare services \$ _____

In-home care/au pair services \$ _____

Nursery and preschool \$ _____

After school care \$ _____

Summer day camps \$ _____

ELDER CARE SERVICES

Daycare center \$ _____

In-home care \$ _____

TOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year. \$ _____

DIVIDE by the number of paychecks you will receive during the plan year.* ÷ _____

This is your pay period contribution. \$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

For assistance in calculating expenses related to a Limited Purpose Medical Reimbursement Account, visit:
<http://www.myflorida.com/mybenefits/calculator/LHFSAE.htm>
and use the Limited Purpose Medical Reimbursement Account calculator.

Changing Your Coverage

Am I permitted to make mid-plan year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-plan year election change to your FSA election, or vary a salary reduction amount, depending on the qualifying event and requested change.

How do I make a change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. Partial lists of permitted and not permitted qualifying events under your employer's plan(s) appear on the following page. Election changes must be consistent with the event. Your employer will in its sole discretion, review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within **31 days** of an event that is consistent with one of the events on the following page, notify the People First Service Center of the qualifying event. You can make these elections via the People First Web site at <https://peoplefirst.myflorida.com>, by contacting the People First Service Center or by timely completing and submitting the appropriate forms to the People First Service Center. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). Generally, mid-plan year, pre-tax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by your employer, unless otherwise provided by law. If your FSA election change request is denied, you will have **31 days**, from the date you receive the denial, to file an appeal.

What is my Period of Coverage?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan year election change. For a Medical Reimbursement Account, a mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the Medical Reimbursement Account prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's Medical Reimbursement Account plan and the IRS regulations governing the plan.

Split periods of coverage do not apply to Dependent Care Reimbursement Accounts.

What are the IRS Special Consistency Rules governing Changes in Status?

Dependent Care Expenses – You may change or terminate your Dependent Care Reimbursement Account election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC (Internal Revenue Code) § 129.

Changing Your Coverage

Changes in Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes:

Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none"> • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical Reimbursement Account FSA plan.

† Does not apply to a Dependent Care FSA plan.

COBRA Questions and Answers

What is continuation coverage?

Federal law requires that most group health plans, including Medical Flexible Spending Accounts (Medical Reimbursement Accounts), give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. “Qualified beneficiaries” can include the employee covered under the group health plan, a covered employee’s spouse and dependent children of the covered employee.

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights.

How long will continuation coverage last?

If you fund your Medical Reimbursement Account entirely, you may continue your Medical Reimbursement Account (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the Medical Reimbursement Account for the year. For example, if you elected a Medical Reimbursement Account benefit of \$1,000 for the plan year and have received only \$200 in reimbursement, you may continue your Medical Reimbursement Account for the remainder of the plan year or until such time that you receive the maximum Medical Reimbursement Account benefit of \$1,000. The participant must elect to continue coverage no later than 60 calendar days from (a) the employment termination date; or (b) the date the participant is notified by the Department of his or her eligibility to continue participation.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee’s spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

You should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a **63-day gap** in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) **within 31 days** after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Keep Your Address Updated

In order to protect your family’s rights, you should keep your employer and People First informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. For Medical Reimbursement Accounts, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage **within 45 days** after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage **within that 45 days**, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the People First Service Center to confirm the correct amount of your first payment.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the **first day of each month**. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 31 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

How Participation May Affect Other Benefits

For More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer.

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

When you participate in the Pretax Premium component and/or the Reimbursement Account component of the Flexible Spending Accounts Program, you save both federal income and social security taxes. However, participation may affect the benefits you receive from other tax-deferred or employee benefit plans:

Social Security

Over the long run, paying less Social Security taxes could slightly reduce your Social Security retirement or disability benefits. However, the taxes you save over the years should more than offset the slight reduction you might see at retirement.

Florida Retirement System (FRS)

Your benefits from the FRS are not affected in any way by your participation in the Flexible Spending Accounts Program. FRS benefits are calculated on your gross salary before pre-tax premiums or reimbursement account contributions are deducted.

Life Insurance and Pay Raise Calculations

Your pay raises and the value of your State Group Life Insurance will continue to be based on your base annual earnings, before pre-tax premiums or reimbursement account contributions deducted. FSA participation will have no impact.

State University System Optional Retirement Program

If you participate in the State University System Optional Retirement Program (ORP), the amount contributed by the State to your ORP account will not be affected by your participation in either part of the Flexible Spending Accounts Program. However, the maximum that you may contribute to the ORP will be based on your adjusted gross income, after pre-tax premium and/or reimbursement account contributions. Please contact the Division of Retirement for further information.

State Deferred Compensation Plan

The State Deferred Compensation Plan allows you to tax-defer 25 percent or a maximum \$10,000 per year of your income (after FSA deductions are taken), whichever is less. If you contribute the maximum or near maximum allowed under the State Deferred Compensation Plan, you should be aware that the Flexible Spending Accounts Program may affect your maximum allowed deferral. The examples and worksheets on Page 18 will help you determine if you might be affected. Contact the State of Florida Deferred Compensation Office or your deferred compensation provider if you have any questions.

Deferred Compensation Worksheet

The following example shows how a deferred compensation contribution could be affected by participation in pre-tax premiums and/or reimbursement accounts.

In this example, the participant could contribute a maximum of \$7,401.50 (\$29,606 X 25%) to his Deferred Compensation Plan. If he were contributing his maximum of 25 percent before participating in the pre-tax premium plan, his deferral amount would have been \$7,750 (\$31,000 X 25%). He would need to contact his deferred compensation provider to make an adjustment. If your current annual deferred compensation contribution is more than the amount shown on your maximum deferral line, you will need to contact your deferred compensation provider to make an adjustment in your deferral.

Example:

Annual Salary.....	\$ 31,000
Annual Pretax Health Insurance Premium	\$ 1,394
Reimbursement Account Contribution	\$ - 0
Annual Pretax Supplemental Insurance Premium	\$ - 0
Adjusted Gross Income	\$ 29,606
Maximum Deferred Compensation Contribution.....	x .25
	\$ 7,401.50
	(or \$13,000, whichever is less)

Your Deferred Compensation Worksheet:

Annual Salary.....	\$ _____
Annual Pretax Health & Life Insurance Premium	\$ _____
Annual Reimbursement Account Contribution.....	\$ _____
Annual Pretax Supplemental Insurance Premium	\$ _____
Adjusted Gross Income	\$ _____
Maximum Percent Contribution.....	x .25
Maximum Deferral	\$ _____
	(or \$13,000, whichever is less)



People First Service Center
Flexible Spending Accounts
P.O. Box 1878 • Tallahassee, Florida 32302-1878
1-866-ONEHRFL (1-866-663-4735); TTY 1-866-221-0269
<https://peoplefirst.myflorida.com>

Information contained herein does not constitute an insurance certificate or policy.

