State of Connecticut
Medical Flexible Spending Account
Plan Summary Fact Sheet

The State of Connecticut recognizes that even with our comprehensive medical and dental benefits, many of our employees still incur medical and dental care expenses that are not covered under the State's health plan. For this reason the Office of the State Comptroller, under the provisions of C.G.S. Section 5-264(d), makes the Medical Flexible Spending Account Program (MEDFLEX) available. The MEDFLEX provides a tax-free way for you to pay for out-of-pocket medical care expenses, which allows you to save money on the cost of these products and services. The State has teamed up with Progressive Benefit Solutions (PBS) to serve as the State's administrative services provider.

HIGHLIGHTS OF THE MEDFLEX

ELIGIBILITY

The State of Connecticut MEDFLEX is available to active employees working at least half time (0.5 FTE – Full Time Equivalent). Expenses may be reimbursed for yourself, your spouse, your tax qualified dependent(s) and/or your tax qualified relative(s).

CONTRIBUTION ELECTION

For Plan Year 2013, contribution limits are between $520 and $2,500. Throughout the year, the amount chosen will be deducted evenly from your paychecks based on your pay frequency (ex. 5 pays, 26 pays, 24 pays, 12 pays).

ADVANTAGES OF THE MEDFLEX

The MEDFLEX is a valuable component of the State of Connecticut employee benefit program. Regulated by the IRS, this program allows you to set aside a portion of your income on a pre-tax basis to pay for eligible medical and dental care expenses that are not covered under the State of Connecticut health plans. In other words, the money you deposit into the MEDFLEX will never be taxed. That saves you money on every dollar you set aside. To estimate your tax savings based upon your participation see our FSA calculator at www.ctpbs.com

PROGRAM PARAMETERS

The MEDFLEX can be used to cover qualified medical care expenses defined by IRS Publication 502 as amounts paid for: (1) the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body; (2) expenses include payments for legal medical services rendered by physicians,

surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes; (3) medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness and do not include expenses that are merely beneficial to general health, such as vitamins; (4) medical expenses include transportation amounts incurred primarily for and essential to medical care.

Out-of-pocket medical expenses may be reimbursed for the employee, a spouse and IRS eligible dependents so long as: (1) expenses are qualified under IRS Code Section 105 and 213; (2) all other sources of reimbursement are exhausted (ex. health insurance plan); (3) reimbursement will not be sought from any additional source and; (4) documentation to substantiate expenses must be maintained and submitted for verification.

Below is a sample listing of eligible over-the-counter and medical products and services and ineligible expenses. Expenses may require a Letter of Medical Necessity Form in order to be considered for reimbursement. Further information regarding eligible expenses is available through IRS Publication 502 and IRS Code Section 213.

ELIGIBLE EXPENSES

Artificial Teeth	Dental Treatment (orthodontia)	Smoking Cessation Programs
Contact Lenses	Eye Glasses	Transportation
Co-pays and Deductibles	Laser Eye Surgery	Weight Loss Program

INELIGIBLE EXPENSES

Cosmetic Surgery	Health Club Dues	Massage Therapy
Electrolysis/Hair Removal	Illegal Operations/Treatments	Nutritional Supplements/Vitamins
Future Medical Care	Insurance Premiums	Teeth Whitening

OVER-THE-COUNTER EXPENSES

Aspirin/Pain Relievers	Cough Drops	Nicotine Patches/Gum/Lozenges
Cold/Flu Medicine	Decongestants	Reading Glasses
Contact Lens solutions	Nasal/Sinus Medication	Thermometers

PROGRAM LIMITATIONS

Annual Enrollment

Pursuant to IRS guidelines, you are required to re-enroll each year during the annual open enrollment period to participate in the MEDFLEX. After the annual open enrollment period you can not make any changes to your MEDFLEX unless you have a qualifying family status change. You have 31 days from the effective date of your family status change to make changes to your MEDFLEX. In addition, any changes in election must be consistent with your family status changes, which include the following:

- Marriage or divorce;
- Birth or adoption of a child;
- Death of a dependent or spouse;
- A change in dependent eligibility requirements for health benefits (ex. loss of other coverage, meeting maximum age requirements, etc.)
- A change in employment status for you, your spouse or your dependent (ex. loss, gain, full-time to part-time or vice versa);
- A change in residence for you, your spouse or dependent;
- A leave of absence taken by you or your spouse

If you are out on any leave of absence including worker's compensation, you are not required to enroll during the open enrollment period. Upon return to work, you will have 31 days in which to enroll in MEDFLEX.

Termination

If you terminate employment or cease to be an eligible participant under the plan, your program participation will end. Any amounts taken after termination will be reimbursed on an after-tax basis. Expenses for services rendered after the termination date are ineligible for reimbursement.

Upon termination or a qualified participant or beneficiary event, you or your beneficiary may be entitled to COBRA continuation coverage under the MEDFLEX. You or your beneficiary may receive reimbursement for qualified medical expenses incurred after termination or qualified event provided contributions and a 2% administrative fee are made on an after-tax basis. The participant must have a positive balance in the MEDFLEX account, continuation coverage for the remainder of the plan year must equal or exceed the remaining account balance and COBRA must be elected within 60 days of the COBRA notice. Refer to the Summary Plan Description or contact PBS at 1-866-906-8023 for additional eligibility and enrollment information.

Use It or Lose It

The IRS "Use It or Lose It" rule stipulates that monies remaining in your MEDFLEX account at the end of the Plan Year (December 31) be forfeited unless claimed by March 31 after the end of the Plan Year.

ENROLLMENT

To enroll or make a change in the MEDFLEX you must complete a MEDFLEX Enrollment/Change Form during the annual open enrollment period or within 31 days of a qualifying family status change. You may download the form directly from the OSC web site http://www.osc.state.ct.us/empret/indxhlth.htm or the PBS web site www.ctpbs.com or contact PBS at 1-866-906-8023.

CLAIM REIMBURSEMENT

To facilitate reimbursement of qualified MEDFLEX expenses, participants have the option of electing a Prepaid Benefits Card issued by PBS through the Benny™ Prepaid Benefits Card Program. If you choose to use the Prepaid Benefits Card, you must complete the Pre-paid Benefits Card Election section on the MEDFLEX Enrollment/Change Form. At the beginning of the plan year, your election amount will be automatically loaded to your card and is available for reimbursement. As you incur qualified medical and dental care expenses, your funds will be automatically withdrawn from your account with a swipe of the Pre-paid Benefits Card.

Only the cost of medical products and services allowed under the IRS Code Section 213 and the State of Connecticut MEDFLEX Plan Document are eligible for reimbursement. If these medical products and services include expenses that can be provided for both a medical and cosmetic, capital expenditure, personal, living and/or family purpose, a Medical Necessity Form Letter must be submitted along with your MEDFLEX Claim Reimbursement Form.

Note that health care services must be "incurred" before you file a claim for reimbursement. IRS guidelines stipulate that "expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expense and not when the patient is formally billed, charged for or pays for the medical care." The date of medical service must be within the plan year of participation. If expenses are for orthodontia, an orthodontia contract must be submitted with your first plan year claim. If your payment plan is monthly, you may submit a reimbursement request after each monthly payment is due. If your entire treatment is pre-paid, the amount will be pro-rated and reimbursed over the course of the orthodontia treatment.

You may use the Benny™ Prepaid MasterCard® Card at qualifying medical merchant locations where a MASTERCARD™ credit card is accepted. The Benny Prepaid Benefits Card may only be used at those locations which have a health-care related merchant category code. Examples of qualified locations include those who use an Inventory Information Approval System (IIAS), such as: physician offices, pharmacies, dental offices, grocery and discount stores, hospitals and vision centers. Qualified locations who use an IIAS only allow the Card to purchase items identified as eligible expenses. If

your purchase has both eligible and ineligible expenses, the location will only accept the Benny Card for the eligible expenses. Ineligible expenses must be paid via another method. You can not use your Prepaid Benny Card at locations that do not use an IIAS.

Regardless of the form of reimbursement (Prepaid Benefits Card or other form of payment) IRS provisions stipulate that all expenses be substantiated; however, many transactions are automatically substantiated by the card system using one of the below IRS-approved substantiation methods:

- ✓ Recurring Expense – Recurring transactions will be processed and approved without recurring documentation after the initial transaction's substantiating receipts or other documentation have been reviewed and approved. Documentation requests will not be required so long as the subsequent recurring expense equals the same amount, duration and provider as the initial transaction.
- ✓ Co-pay Matching – The expense specifically matches your health plan's co-pay. For example, if the healthcare provider office visit co-pay is $10 and your payment for the office visit was $10, a substantiating receipt may not be required.
- ✓ IIAS Approved – Your FSA-eligible products are purchased at a location that uses the IIAS. In the unlikely event that your card payment is denied at a location that uses the IIAS, you will be required to submit substantiating documentation in order to received reimbursement.

If your expense is not automatically substantiated, PBS will request additional supporting documentation via an email or letter request. Acceptable Supporting documentation includes:

- An Explanation of Benefits (EOB) from the insurance carrier indicating the patient name, date of service, and out-of-pocket expenses associated with claim.

- An itemized statement from the service provider for expenses not covered by insurance. The statement must include: (1) the patient's name; (2) date of service; (3) description of procedure; (4) physician name and (5) the service charge.

- Prescription Drugs – A statement from the pharmacy indicating: (1) pharmacy name; (2) patient name; (3) date of prescription fill; (4) patient cost (ex. co-pay); (5) Rx number and; (5) name of drug.

- Eligible Over-the-Counter (OTC) Medications – Health FSA Pre-Paid Benefit Cards can be used to purchase over-the-counter medicines or drugs at drug stores and pharmacies, at non-health care merchants that have pharmacies and at mail order and

web-based vendors that sell prescription drugs, if: (1) prior to purchase, (i) the prescription (as defined in Notice 2010-59) for the over-the-counter medicine or drug is presented (in any format) to the pharmacist; (ii) the over-the-counter medicine or drug is dispensed by the pharmacist in accordance with applicable law and regulations pertaining to the practice of pharmacy; and (iii) an Rx number is assigned; (2) the pharmacy or other vendor retains a record of the Rx number, the name of the purchaser (or the name of the person for whom the prescription applies), and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements1; (3) all of these records are available to the employer or its agent upon request; (4) the Pre-Paid Benefit Card system will not accept a charge for an over-the-counter medicine or drug unless an Rx number has been assigned; and (5) the requirements of the guidance defined by IRS are satisfied. If these requirements are met, the Pre-Paid Benefit Card transaction will be considered fully substantiated at the time and point-of-sale.

Over-the-Counter drugs and medicines not meeting the above requirements will require a Medical Necessity Form Letter to determine reimbursement eligibility. You may download a Medical Necessity Form Letter from the OSC web site at http://www.osc.state.ct.us/empret/indxhlth.htm, the PBS web site at www.ctpbs.com, or by contacting PBS at 1-866-906-8023.

In order for your claim to be reimbursed you must retain copies of all itemized receipts for eligible expenses. It is recommended that all receipts be retained for at least 3 years after the close of the plan year in which the expense has been incurred. Keep in mind that IRS regulations stipulate that cancelled checks, balance forward statements, and credit card and/or cash receipts cannot be used to substantiate expenses (itemized cash register receipts are acceptable substantiation for eligible over-the-counter expenses not requiring a Letter of Medical Necessity Form).

Note that missing or lost receipts will result in a claim denial. If you are unable to secure a replacement receipt or use your Prepaid Benefits Card for expenses that are deemed ineligible, your claim will be denied and you will be required to reimburse the plan with post-tax dollars. If you fail to do so, your Benny Prepaid Card will be de-activated and/or the Administrator will offset the amount of the ineligible expense from your later substantiated claims until the full amount is repaid.

In those cases where you are unable to use your Prepaid Benefits Card or if you prefer the manual reimbursement method, you must first pay for your MEDFLEX expenses, then submit a Claim Reimbursement Form to PBS for processing. Claim Reimbursement Forms may be downloaded through the PBS web site and must be submitted directly to PBS for reimbursement by mail or through the use of the on-line facility at www.ctpbs.com. If you choose the manual reimbursement method, you may request

your MEDFLEX reimbursements be paid via direct deposit. Simply access the PBS web site: www.ctpbs.com to enroll in this option.

ADDITIONAL ASSISTANCE

To learn more of the specific requirements of the Medical Flexible Spending Account Program please access the OSC web site: www.osc.state.ct.us or the PBS web site: www.ctpbs.com and click on the Education Center Box. You may also contact PBS toll free at 1-866-906-8023 or by mail at 23 Maiden Lane, North Haven, CT 06473.