MISSOURI STATE EMPLOYEES' CAFETERIA PLAN (MoCafe)

2018 PLAN & ENROLLMENT GUIDE
for the Employees of the
University of Central Missouri

Open Enrollment Deadline: December 1, 2017

NOTE: *If you or your spouse plan to open a Health Savings Account in 2018 and wish to receive or make contributions to that account, please note that any funds that you currently have in a Health Care Flexible Spending Account must be claimed and reimbursed by December 31, 2017 (your account balance must be $0 by December 31, 2017).* *See pages 3 and 9 for details.*

You can still enroll in the Dental & Vision Care Flexible Spending Account for reimbursement of dental and vision expenses!

Administered By: Central/ASI
800-659-3035

Download ASI's free mobile app to file claims quickly and easily!
You may also file claims online by logging into your account at
Mocafe.com
or by toll-free fax at 877-879-9038

P.O. Box 858
Columbia, MO 65205-0858

Mocafe.com

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MISSOURI STATE EMPLOYEES' CAFETERIA PLAN

Important Points!

New employees have 31 days to enroll in or to "opt out" of the Cafeteria Plan.

1. **HSA and HCFSA** – Many employers are now offering high deductible health plans (HDHP) and health savings accounts (HSA). Federal regulations do not allow contributions to an HSA if you have any non-exempt coverage. The Health Care flexible spending account (HCFSA) is non-exempt coverage. Therefore, you cannot make or receive contributions to a HSA and be enrolled in the HCFSA. **However, you may make or receive contributions to a HSA and be enrolled in the Dental & Vision Care FSA (explained in #2 below and on page 9).**

   Also please note that if you are currently enrolled in the HCFSA, your balance in the HCFSA must be $0 on or before December 31, 2017. So, please file your claims early to ensure that Central/ASI has sufficient time to process and pay your claims before December 31, 2017.

2. **Dental & Vision Care FSA** – The University offers a Dental & Vision Care FSA that can be used in conjunction with a Health Savings Account. The Dental & Vision Care FSA can only be used for dental and vision expenses. So, be sure that you plan appropriately. *NOTE: This flexible spending account (FSA) plan is not dental or vision insurance.*

3. **Maximum Limit for the Health Care FSA and the Dental & Vision Care FSA** – You may elect up to $2,600 as your annual maximum for these accounts. This maximum limit is a per employee limit. So, your spouse may also elect up to $2,600 if eligible for a health care FSA through his/her employer (even if he/she is also employed by the University).

4. "**Opt Out**" – Because the vast majority of employees benefit by paying eligible insurance premiums on a pre-tax basis, all eligible University-sponsored insurance premiums will be deducted pre-tax from your paycheck unless you actively opt-out of the program. By changing the Plan from "opt-in" to "opt-out", the University has made it much easier for employees to reduce the amount of income and Social Security taxes withheld from the employee's check each pay period.

   If you would rather pay taxes on the insurance premiums that come out of your paycheck, **you must "opt out" during open enrollment each year** by indicating "Cancel Pre-tax" on an enrollment form or by using the on-line enrollment system to "Cancel Pre-tax."

   Eligible insurance premiums include your share of the cost of University sponsored health, dental and/or vision insurance premiums.

   This change **does *not*** affect the flexible spending accounts (Health Care FSA, Dental & Vision Care FSA and the Dependent Care FSA). You *must enroll each year* during open enrollment in order to participate in these accounts!

HIGHLIGHTS

ELIGIBILITY

All employees are eligible to participate in the Dependent Care Flexible Spending Account portion of the Cafeteria Plan. Only employees who are eligible for University-sponsored health insurance are eligible for the remaining portions of the Cafeteria Plan: Premium Only Participation (POP), Health Care Flexible Spending Account, and Dental & Vision Care Flexible Spending Account.

ENROLLMENT

The Cafeteria Plan plan year is January 1 through December 31st. Open Enrollment is held from October 1 through December 1. **To participate in a Flexible Spending Account (FSA), you must enroll during open enrollment each year for the upcoming calendar year**. You may also be eligible to enroll mid-year if you experience a qualifying **Change in Status** event. The Health Care, Dental & Vision Care, and Dependent Care FSA have slightly different rules regarding making an election change or enrolling mid-year.

- You may also make future changes to your account within 60 days of any qualifying Change in Status event.
- An employee who enrolls or changes his/her election should only include reimbursable expenses for *services received* from the coverage effective date through the end of the next grace period (March 15th). If you leave employment with the University, then your coverage will likely end sooner than December 31.

During Open Enrollment (October 1 through December 1), you must enroll on-line. Sign on to mocafe.com and then click on "Enrollment" to enroll on the Internet.

An email election acknowledgement will be sent to you if you provide your email address. Participants who elect the Health Care FSA, Dental & Vision Care FSA, or Dependent Care FSA will receive an election confirmation, claim forms, and Internet access instructions prior to December 31, 2017.

NEW HIRES

New Employees:

- **You have 31 days from the date of your employment to enroll in or "opt out" of the Cafeteria Plan.**
- Coverage for mid-year new-hire elections will be effective on the first day of the month following approval of the election.
- Please see further information about enrolling on page 18.

COVERAGE DATES

Start of coverage:

- January 1, 2018 for participants who make an election during open enrollment
- The first of the month after the election is approved by the Cafeteria Plan for all others

End of coverage:

- December 31, 2018 or the end of the month in which the last contribution from payroll was received under the Health Care FSA or Dental & Vision Care FSA.

Expenses must be incurred:

- Health Care FSA and Dental & Vision Care FSA expenses must have been incurred on or before the end of coverage.
- Dependent Care FSA expenses may be incurred through the end of the plan year.
- Grace Period Coverage: If you are still participating in the FSA at the end the plan year, then you may also continue to submit expenses incurred through the Grace Period (until March 15, 2019).

PLAN ADMINISTRATOR

The State of Missouri has contracted with Central/ASI to process all claims for the Flexible Spending Account program. Contact Central/ASI if you have questions regarding claims, eligible expenses, or elections.

Central/ASI
P. O. Box 858,
Columbia, MO 65205-0858
Phone: (800) 659-3035; Toll-Free Fax: 1-877-879-9038
Email: asi@asiflex.com
Web: mocafe.com

CLAIMS PROCESSING

- You can file claims with ASI's mobile app for your smartphone or tablet. Download the free app from any of the following: asiflex.com, the App Store for Apple devices, or the Google Play Store for Android devices.
- You can file claims online or forms are available to print at mocafe.com
- Mail or fax claims to Central/ASI
- Claims typically processed within 1 business day (**starting February 1, 2018**)
- Direct deposit authorization – via online account settings or form obtained at mocafe.com
- E-mail authorization – via online account settings or form obtained at mocafe.com
- On-line account activity – mocafe.com, click on Account Detail
- InfoLine/125: (800) 366-4827 (634-1333 from Jefferson City)
- **If a Health Care FSA or Dental & Vision FSA deduction is not taken in full on any paycheck, then no claims can be processed/paid until the missing deduction(s) are paid in full.**

All FSA claims for calendar year 2018 must be filed by April 15th, 2019.

QUICK REFERENCE - BENEFITS

a) Qualified Insurance Premiums
- Easy tax savings (basically a discount) on your cost for qualified payroll-deducted insurance plans

b) Health Care FSA
- Save taxes on known, predictable costs of medical, dental & vision care during the plan year

c) Dental & Vision Care FSA
- Save taxes on known, predictable costs of dental & vision care during the plan year
- This FSA can be used in conjunction with a health savings account (HSA)

d) Dependent Care FSA
- Save taxes on costs of care and well-being for your dependents while you work

FREQUENTLY ASKED QUESTIONS

IF I REDIRECT (Pre-tax) PART OF MY PAY, WON'T I MAKE LESS MONEY?

No. By electing to direct a portion of your salary through the Plan, you essentially bank your money in a TAX-FREE account, which allows you to save money by reducing your taxes. For example, you purchase a prescription medicine and then claim reimbursement for the co-pay from your TAX-FREE account. You pay no taxes on this reimbursement, and your spendable income will increase by the amount of your tax savings.

WHY SHOULD I PARTICIPATE IN THE HEALTH CARE FSA IF I ALREADY HAVE MEDICAL INSURANCE?

The Health Care FSA offers a tax break on medical care expenses **NOT** reimbursed by insurance. For example, deductibles, co-pays, coinsurance, expenses for office visits, eye exams, glasses, prescribed medicine, qualified over-the-counter medicine and hospital care.

HOW MUCH DOES IT COST?

Administrative costs are paid by the University of Central Missouri.

WHAT IF I DON'T USE ALL OF THE MONEY IN MY FSA ACCOUNT?

Central/ASI can help you estimate your allowable expenses for the calendar year. However, if you do have funds remaining in your account at the end of the year, you still have an additional 2 ½ months to incur expenses. If after the grace period, you still have funds remaining in your account or if you fail to claim incurred expenses on or before April 15, 2019, then you will forfeit that amount as required by the Plan. (Since you do not file claims with the cafeteria plan office for the insurance premium part of the plan (POP), there are no funds remaining at the end of the year and no forfeitures.)

ARE THERE ANY NEGATIVES THAT I SHOULD KNOW ABOUT?

If you do not use all the money in your Health Care FSA, Dental & Vision Care FSA or Dependent Care FSA, **you will forfeit it**. Since you are reducing the amount of tax that you are paying, your Social Security benefit calculations will be based on your lower taxable earnings figures – the effects are usually very minor.

WHAT IF I'M ALREADY IN THE PLAN?

Participation in the FSA accounts terminates at the end of each calendar year. **You must re-elect each year** to continue your participation. **Participation in the insurance categories of the plan (POP) is automatic - No form is required unless you want to pay taxes on your insurance premiums – see "Opt Out."**

ARE THERE ANY RESTRICTIONS IF MY SPOUSE ALSO CONTRIBUTES THROUGH HIS or HER EMPLOYER'S FSA PLAN?

- The reimbursement limit for a Health Care FSA is established by *each* employer, so you may each contribute an amount up to *each respective* employer's plan limit (not to exceed $2,600 for 2018). However, you may only claim reimbursement of each expense from one plan (not the same expense under both plans). The University's plan limit is **$2,600** for the Health Care FSA or the Dental & Vision Care FSA. If both you and your spouse are employed by the University, you may each contribute up to $2,600 per calendar year. **Federal regulations prohibit you from making contributions to an HSA if your spouse participates in a general purpose Health Care FSA.**
- The Dependent Care FSA deduction limit is a household limit established by the IRS. Therefore, you and your spouse may **together** elect not more than **$5,000** per calendar year.

WHEN CAN I MAKE CHANGES?

You can change benefits during open enrollment**.** Generally, **you will not be able to change your election** during the calendar year. You might be able to make a change under the following circumstances if…

1. You have a special enrollment right under HIPAA;
2. You experience a Change in Status event;
3. You are served with a judgment, decree or court order;
4. You or someone in your family's entitlement to Medicare or Medicaid changes;
5. There is a change in the cost of your insurance with the University;
6. There is a change in the coverage provided by your insurance with the University or by the insurance your spouse or dependents have with their employer;
7. You go on Family Medical Leave or on military leave.

CHANGE IN STATUS EVENTS

To make an eligible change during the calendar year, **contact Central/ASI within 60 days of a qualifying Change in Status event**. Central/ASI may request proof of a qualifying Change in Status event. You will also need to complete the appropriate paperwork with the insurance plan to add/drop/change your insurance coverage.

Election changes to qualified payroll-deducted insurance premium payments are effective with the first required premium payment (first of the next month for new hires) after the event and the approval of the new election. Election changes for the Health Care FSA, Dental & Vision Care FSA, and Dependent Care FSA are effective the first day of the month following Central/ASI's receipt and approval of the new election. (For example: You submit your FSA enrollment on February 2nd, your expenses starting on March 1st will be reimbursable and pre-tax deductions will start on paychecks issued in March.) In the case of birth, adoption, or the placement of child for adoption, the election change request becomes effective retroactive to the first of the month in which the event occurs. Any increase in the election amount designated by a participant may include only those expenses that the participant incurs on or after the effective date of the increase.

All election changes must be consistent with the qualifying Change in Status event. **The only changes in status under which you can reduce your Health Care FSA or your Dental & Vision Care FSA election are legal marital status changes due to death, divorce, or annulment, or if there is a reduction in your number of dependents (as defined in section 152 of the Internal Revenue Code) due to death.** See also the information on Family Medical Leave .

1. **HIPAA.** If a special enrollment right under HIPAA entitles you to enroll a dependent, your spouse, or yourself in the University's Health, Dental or Vision insurance, you can include the new premium in the Cafeteria Plan.

2. **Qualifying Change in Status events** are defined as any one of the following four (4) changes in status:

a) Your **legal marital status** changes through marriage, divorce, death, or annulment.

b) Your **number of dependents changes** by reason of birth, adoption (or placement for adoption), or death. If your child no longer qualifies for day care because he or she turned 13, then that is a loss of a dependent under the Dependent Care FSA, but not under any of the other categories.

c) You have a **change in employment status** that affects eligibility under this plan.

If you terminate or take a leave of absence, you must be gone at least 31 days for the termination or leave of absence to qualify as a Change in Status. If your spouse or any of your dependents have an employment status change that affects eligibility under a plan maintained by your spouse's or any dependent's employer, then you may increase or add coverage under *this* plan if coverage is lost under the *other* employer's plan.

If participation terminates and then you return to employment within 31 days in the same calendar year, then your election will be reinstated as it was immediately prior to the termination of employment. If you return to employment after 31 days in the same calendar year, then you may make a new election for the remainder of the calendar year. You will not be able to be reimbursed for Health Care or Dependent Care expenses incurred during the termination period.

d) **One of your dependents satisfies or ceases to satisfy the requirements for coverage** under one of the qualified insurance plans, Health Care FSA, or Dental & Vision Care FSA (decreases in the Health Care FSA or the Dental & Vision Care FSA are not allowed) for dependents due to attainment of age, student status, or any similar circumstances.

In addition, the Change in Status event must result in a gain or loss of eligibility for coverage under this plan or a plan maintained by your spouse's employer or one of your dependent's employers and your election modification must correspond with that gain or loss of coverage.

For example:

- You adopt a two-year-old child during the calendar year. Since your number of dependents changes due to the adoption, you experience a Change in Status event. Your child is now eligible for coverage under the University's insurance and Health Care FSA, Dental & Vision Care FSA and Dependent Care FSA. You would be allowed to increase the amount you set aside in the Health Care FSA, Dental & Vision Care FSA and Dependent Care FSA, or elect to participate in those plans if you are not already participating. However, you would not be able to decrease or drop any category because there was only a gain of eligibility, and not a loss of eligibility and a decrease does not correspond with the gain of eligibility.

3. A **judgment, decree, or court order** resulting from a divorce, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for your child allows you to make an election change to your University insurance or Health Care FSA or Dental & Vision Care FSA, to:

a) Provide coverage for the child, if the order requires coverage under your plan; or,
b) Cancel insurance coverage for the child, if the order requires your former spouse to provide coverage.

4. **Medicare and Medicaid**. If you, your spouse or a dependent becomes entitled to coverage (i.e., enrolled) under Medicare or Medicaid, other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines, you may make an election change to your University Health, Dental or Vision Insurance to cancel coverage for the affected person. Likewise, if you, your spouse, or your dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, you may make an election change to commence or increase coverage under one or more of these same benefits.

5. A **change in your cost**, with no change in coverage, for one of the qualified insurance plans will result in an automatic election adjustment to match the change in the cost. If the premium amount significantly increases you may revoke an election as long as you pick up coverage under another health plan with similar coverage.

6. **Coverage Changes**. If the coverage under any of the Insurance plans is significantly curtailed or ceases during a period of coverage, you may revoke your election under the affected plan as long as you elect coverage under another plan providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage provided to participants generally. For example, the loss of your primary

care physician would not be a significant curtailment because it does not affect participants in general.

If the plan adds a **new benefit package option** or other coverage option (or eliminates an existing benefit package option or other coverage option) during the year and you are affected by this addition or elimination, you may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

If you **change Dependent Care providers**, you may make an election change to reflect the cost of the new provider. School can be considered a new provider.

Open enrollment for spouse or dependent's employer's plan. If you make an election change to health, dental or vision insurance coverage under your spouse or dependent's employer during his or her open enrollment period (that is not for calendar year coverage) you may make a corresponding change under the Plan.

Enrollment in a Group Health Plan that offers Minimal Essential Coverage or in a Health Care Exchange or Marketplace. 1) If your employment status changes and you are expected to work less than 30 hours of service per week (even if that change does not make you ineligible for employer group health plan coverage) and you enroll in a group health plan that offers minimal essential coverage with a new coverage effective date no later than the first day of the second month following the month that includes the date the original coverage is revoked, you may also make a corresponding change to the POP category under the Plan. Such changes cannot be retroactive. **2)** If you are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or you seek to enroll in a Marketplace during the Marketplace's annual open enrollment period and you enroll in the Marketplace with a new coverage effective date no later than the day immediately following the last day the original coverage is revoked, you may also make a corresponding change to the POP category under the Plan. **Any such changes cannot be retroactive.**

7. If you take unpaid **Family Medical Leave (FMLA) or military leave** for more than 31 days, you may revoke an existing election under the qualified insurance plans or Health Care FSA or Dental & Vision Care FSA. You must revoke your Dependent Care FSA since you are not working. Upon returning from FMLA or military leave, you may choose to be reinstated in either benefit if such coverage was terminated during the FMLA or military leave. Such reinstatement will be on the same terms as prior to taking leave. You have no greater right to benefits for the remainder of the calendar year than an employee who has been continuously working during the calendar year.

If your coverage under the qualified insurance plans, the Health Care FSA, Dental & Vision Care FSA or Dependent Care FSA terminates while you are on FMLA or military leave, you will not be entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If you elect to be reinstated in a benefit upon return from FMLA or military leave your coverage for the remainder of the plan year is either equal to your election for the 12-month period of coverage, prorated for the period during the FMLA or military leave for which no contributions were made or the amount equal to your old per check deduction times the number of checks remaining in the plan year.

QUALIFIED PAYROLL-DEDUCTED INSURANCE PREMIUMS
Premium Only Participation: POP

Qualified insurance premiums include the University-sponsored health, dental, and vision insurance premiums that are payroll-deducted from your University paycheck. **No other insurance premiums qualify for pre-tax payroll deduction from your University payroll check**.

Please note that you must keep the same insurance coverage for the entire year, unless you have a Change in Status event, as explained in the previous section. You will receive exactly the same insurance benefits, but the cafeteria plan puts the extra tax savings in your pocket each month. Participating in this category of the cafeteria plan can net you 25% savings on the dollar amount of each payroll deduction. Since you will not pay income tax on your insurance premiums, your take home pay will actually increase due to the tax savings that participation in the cafeteria plan allows. Note that you are NOT buying anything extra, you are NOT changing any of the insurance coverage you sign up for, and there is NO additional paperwork on your part to realize the savings.

Opt Out Feature -- All qualified payroll-deducted University-sponsored insurance will be automatically enrolled in the Plan, to the extent you have qualified premiums, unless you opt-out of one or all of these categories by completing an on-line agreement during open enrollment each year.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HEALTH CARE FSA) AND DENTAL & VISION CARE FLEXIBLE SPENDING ACCOUNT (DENTAL & VISION CARE FSA)

There are two main differences between the Health Care FSA and the Dental & Vision Care FSA:

- **The Dental & Vision Care FSA can only be used to reimburse dental and vision expenses while the Health Care FSA can be used to reimburse the majority of health, dental and vision expenses.**
- **You cannot enroll in the Health Care FSA if you or your spouse are making or receiving contributions to a health savings account (HSA). You can, however, enroll in the Dental & Vision Care FSA.**

If you participate in the Health Care FSA, then neither you nor your spouse should allow contributions to be made to an HSA. Please note, however, that you may participate in the Dental & Vision Care FSA. Please call Central/ASI if you have any questions regarding Health Care FSAs and how they work with HSAs**.**

Please note: If you are currently enrolled in the Health Care FSA, your balance in the Health Care FSA must be $0 on or before December 31, 2017 if you choose to enroll in the HSA for 2018. So, please file your claims early to ensure that Central/ASI has sufficient time to process and pay your claims before December 31, 2017.

Estimate your annual out-of-pocket qualifying expenses for you and your family. You may include **qualifying expenses for *any* family member who is a dependent (without regard to income limitations) for federal tax purposes** (special rules apply to children of divorced parents), even if they are not covered under one of the insurance plans offered by the University. Include predictable expenses only.

Notice about eligible dependents: You may include qualified expenses for your child(ren) who will not reach age 27 on or before December 31, 2018. Your child does not need to live with you in order for you to claim his/her qualifying expenses that you have incurred on his/her behalf. Please see IRS Notice 2010-38 for further information.

Elect participation in the Health Care or Dental & Vision FSA. Enter your estimated qualifying expenses care for the calendar year. (Deductions are generally taken out of all regular paychecks each month.) Contact your payroll/personnel representative if you need assistance.

Incur qualifying expenses. An expense is incurred on the date a service is provided or a product is purchased to create that expense. You must incur expenses *before* you file a claim for those expenses. The expense must be incurred during your period of coverage for the Plan Year.

File claims. After you have incurred the expenses and know the amount of your responsibility for the bill, you may submit a claim for those expenses to Central/ASI.

Receive reimbursements. Central/ASI will review your claim and any necessary supporting documentation. If approved, Central/ASI will reimburse you for the expenses. Claim reimbursements are issued within one business day of receipt of your claim. **Claims are accepted starting January 1 but daily reimbursements don't start until February 1, 2018.**

Some important points you should remember regarding the Health Care or Dental & Vision Care FSA are:

1. **Maximum Election:** You may include up to **$2,600** worth of qualifying expenses each year -- but not more than your earned income.

2. **Your annual election cannot be changed,** unless you experience a qualifying **Change in Status** event.

3. **You may include all qualifying expenses** not covered or not reimbursed by insurance which are **incurred** by you, your spouse, or your eligible dependents **during the start of your coverage and prior to March 15, 2019** for medical care as defined in Section 213(d) of the Internal Revenue Code. Please note that if you are enrolling in the Dental & Vision Care FSA, only dental & vision expenses qualify for reimbursement. Please refer to the Qualifying list and IRS Publication 502 (mocafe.com) for further details on qualifying expenses. Remember that expenses qualify under the Health Care FSA and the Dental & Vision Care FSA based on the **date incurred, not paid** as stated in Publication 502. **Federal regulations do not allow any insurance premiums or long-term care expenses to be included.**

4. Qualifying expenses are eligible for payment from the Plan based on when **incurred,** not when paid. An expense is **incurred** when you or one of your dependents is provided with care or purchases a qualifying product, and **not** when you are billed, are charged, or pay for the expense.

5. Allowable expenses must be incurred during the portion of the 2018 calendar year that you are a participant. **Claims for those expenses must be submitted to Central/ASI by April 15, 2019.** After that, your account will be closed and you will forfeit any balance remaining in accordance with federal regulations.

6. **You must submit a completed claim form along with copies of invoices or statements** to serve as proof that you have incurred an allowable expense in order to receive payment. Statements are required to be **from the provider/store** stating the **date of service/purchase,** a **description of services/products,** the expense **amount,** the **name of the service provider/store** and the **person for whom the service was provided.**

   For **over-the-counter items**, the receipt or documentation from the store must include the name of the drug printed **by the store** on the receipt. You must indicate the existing or imminent medical condition (items such as vitamins and nutritional supplements require a physician's statement) for which the item will be used on the receipt, on the claim form, or on a separate enclosed statement each time these items are claimed.

   You must have a prescription for all over-the-counter medicines for which you seek reimbursement through the plan. A copy of the prescription must be sent along with your completed claim form and other documentation.
   - Purchases for general good health will not be accepted.
   - For items covered by insurance, copies of insurance explanations of benefits statements may be used instead of original physician bills if the date of service and charges are shown.
   - Copies of receipts of payment, without the above, are not acceptable.
   - Copies of personal checks are not acceptable.
   - Documentation and/or copies will not be returned.
   - You will be provided with a supply of claim forms with your enrollment confirmation.
   - Extra claim forms are available on the web at mocafe.com or by calling Central/ASI at (800) 659-3035.

Orthodontic expenses may be assumed to be incurred at the time a monthly payment is due and paid. These monthly payments must be spread out evenly over the expected period of orthodontic treatment. Therefore, claims submitted for orthodontic payments that meet the above are allowable.

- You may also submit a claim for a reasonable down payment of the orthodontic treatment if the down payment is made at the time the appliances are placed.
- Claims for payments made prior to being due or that otherwise do not meet the above requirements will not be processed.
- Claims for the entire fee paid at the beginning of treatment will not be processed, nor will claims for an entire year's payments made at the beginning of the year be processed.
- To claim orthodontic down payments, you must include a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed.

7. You will be paid the full amount of your claim or the balance of your annual election, whichever is less, whenever you file a qualifying claim. Payment under the Health Care FSA and the Dental & Vision Care FSA is not limited to the amount in your account at the time of your claim. Your monthly contributions will continue for the full calendar year.

8. Claim reimbursements will be made by **direct deposit** into the bank account of your choice. A notice that a payment was made is available by **e-mail**. InfoLine/125 and mocafe.com are available 24x7 to check on reimbursements or your remaining balance.

9. Participants on Family Medical Leave or military leave are entitled to maintain coverage. Coverage and claims reimbursement will not be disrupted as long as monthly contributions are received (either by payroll deduction or by direct payment to the Plan) by the end of each month. The participant must make arrangements, **before** going on leave, with their payroll/personnel representative for prepayment of contributions. Reimbursements will be discontinued if the contribution is not received by the end of any month. A participant who terminates coverage prior to going on Family Medical Leave or military leave may immediately reinstate coverage for qualifying expenses upon return to work. Such reinstatement of coverage and continuation of the original per check or annual election must be made within 60 days of returning to work.

HEALTH CARE FSA EXPENSES

Only the portion of the expenses you owe after insurance payments can be claimed. **Qualifying expenses** are those expenses that are incurred by you, your spouse, or your eligible dependents **during the calendar year** for medical care as defined in Section 213(d) of the Internal Revenue Code, excluding all insurance premiums and long term care expenses.

Qualifying medical care expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. Refer to IRS Publication 502 for additional information (mocafe.com). However, **expenses qualify** for the Health Care FSA **based on when incurred, not when paid,** and federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA. Please contact ASI if you have a question on specific qualifying items.

QUALIFYING EXPENSES – only a partial list

- Deductibles
- Co-pays & Coinsurance
- Doctor fees
- Chiropractor fees
- Dental expenses
- Vision care expenses
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Drugs and medicines treating an existing medical condition
- Orthodontics (braces)
- Routine physicals
- Medical equipment (necessary for an existing medical condition)
- Hearing aids, including batteries
- Transportation expenses related to illness

NON-QUALIFYING EXPENSES – only a partial list

- Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins. A cosmetic procedure to correct a birth defect or performed as a result of a disfiguring injury may qualify. Please enclose a note from your physician with the claim stating the existing medical condition and why the treatment is required.
- Non-prescription sunglasses or clip-on sunglasses.
- Expenses merely beneficial to your general health (e.g., vacations and vitamins).
- Herbs, vitamins and nutritional supplements not used to treat an existing physician-diagnosed condition.
- Special food even if purchased due to a medical condition unless the food treats the medical condition.
- The cost of a weight-loss program if the purpose of the weight control is to maintain your general good health.

NOTICE

Women's Health Cancer Rights Act of 1998

The Health Care FSA as required by the Women's Health and Cancer Rights Act of 1998, includes expenses for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call ASI at (800) 659-3035 for more information.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's nor newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

DENTAL & VISION CARE FSA EXPENSES

Only the portion of the expenses you owe after insurance payments can be claimed. **Qualifying expenses** are those expenses that are incurred by you, your spouse, or your eligible dependents **during the calendar year** for medical care as defined in Section 213(d) of the Internal Revenue Code and limited to those expenses related to vision and dental care, excluding all insurance premiums and long term care expenses.

Qualifying dental and vision care expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any dental or vision health. Refer to IRS Publication 502 for additional information (mocafe.com). However, **expenses qualify** for the Dental & Vision Care FSA **based on when incurred, not when paid,** and federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA. Please contact ASI if you have a question on specific qualifying items.

QUALIFYING EXPENSES – only a partial list

- Deductibles
- Coinsurance
- Dental expenses
- Vision care expenses
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Medicines treating a dental or vision condition
- Orthodontics (braces)
- Routine dental or eye exams

NON-QUALIFYING EXPENSES – only a partial list

- Cosmetic procedures; e.g. teeth whitening and veneers. A cosmetic procedure to correct a birth defect or performed as a result of a disfiguring injury may qualify. Please enclose a note from your physician with the claim stating the existing medical condition and why the treatment is required.
- Non-prescription sunglasses or clip-on sunglasses

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Estimate your total dependent care expenses for the year. Include predictable expenses only.

Elect participation in the Dependent Care FSA. Enter your estimated dependent care expenses. Divide your estimate by the number of deductions you will have taken during the calendar year. (Deductions are generally taken out of all regular paychecks of each month.) Contact your payroll/personnel representative if you need assistance.

Receive dependent care services. Dependent care expenses are incurred when the day care is provided **not** when you are billed or pay for the expense. You must receive the dependent care services before you file a claim for those services.

File claims. After you have received the dependent care services, you may submit a claim for those expenses to Central/ASI. Even if you have to pre-pay for dependent care, you must wait to file the claim until the end of the service period you are claiming.

Receive reimbursements. Central/ASI will review your claim, and if approved will reimburse you. Claim reimbursements are issued within one business day of the receipt of your claim up to the amount that you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from your payroll contributions.

Some important points you should remember regarding the Dependent Care FSA are:

1. This category is an alternative to taking a "Tax Credit" allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the "Tax Credit" or the "FSA". The IRS will not allow you to receive two tax breaks on the same expenses.

Child Care Credit: The Dependent Care FSA is an alternative to taking a Tax Credit on your tax return. You may claim a tax credit equal to your dependent care expenses (up to $6,000 per year for two or more dependents or $3,000 per year for one dependent) multiplied by a percentage. The percentage decreases from a high of 35% to a low of 20% as your household adjusted gross income increases.

The Dependent Care FSA is limited to $5,000 per year (for you and your spouse together), $2,500 if married filing separately, for any number of dependents. You will experience "tax savings" throughout the year with every paycheck you receive. If you are subject to the 15% federal tax rate you will save approximately 25% of expenses through the Dependent Care FSA. If you pay a higher federal rate, you will receive an even higher tax break through the Dependent Care FSA.

Generally those employees with a combined taxable income over $31,000 or paying over $3,000 for care for only one child will save more through the Dependent Care FSA.

Please contact your tax advisor if you have questions about which is best for you. You must choose whether to use the Tax Credit or the Dependent Care FSA.

2. You and your spouse together may include **up to $5,000** per year **($2,500** in the case of a married individual filing a separate tax return for the calendar year) or the lesser of your (after subtracting all FSA deductions) or your spouse's earned income for the calendar year. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of $250 per month if you have one eligible dependent in dependent care and $500 per month if you have two or more eligible dependents in dependent care.

3. You may include only those child/dependent care expenses that you incur in order for you and your spouse to be gainfully employed. Only expenses incurred for the care and well-being qualify for this tax break (education related sports camps, summer school and private school expenses, food and transportation do not qualify). **Child support payments are not allowable.** Day camp fees incurred in order for you to work are allowable but overnight camps are not. Please refer to The section on Dependent Care FSA Expenses and IRS Publication 503 for further details on qualifying expenses. You may link to this publication from the website at mocafe.com.

Remember that expenses qualify under the Dependent Care FSA based on the **date incurred, not paid** as stated in Publication 503.

4. Expenses are eligible for payment from the plan based on when **incurred** not when paid. Expenses are **incurred** when your dependent is provided with the care that gives rise to the expense, and **not** when you are billed, charged for, or pay for the care.

5. **YOUR ANNUAL ELECTION CANNOT BE CHANGED,** unless you experience a qualifying **Change in Status**.

6. Day care expenses are limited to care for children **under age 13**, for whom you have more than 50% custody, or for a relative, who is a dependent for tax purposes, who is physically or mentally incapable of caring for himself or herself and who lives in your home at least 8 hours each day.

7. The expenses may not be paid to your spouse, a child of yours (or your spouse's) who is under the age of 19 at the end of the year in which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

8. Reimbursable **expenses** must be **incurred** during the portion of the plan year (including the grace period) **after you become a participant. You must file claims** for expenses that you incurred during the plan year and/or grace period **by April 15** following the end of the calendar year. After that, your account will be closed and **you will forfeit any remaining balance** in accordance with federal regulations.

9. If you **terminate employment**, you may continue to file claims for qualifying expenses incurred during the same calendar year until you have been reimbursed the balance in your account. **You must file claims** for expenses that you incurred during the 2018 plan year **by April 15, 2019**.

10. **You must submit a completed claim form** along with **copies** of invoices or statements **from the provider** to serve as proof that you have incurred an allowable expense in order to receive payment. Statements are **required** to **include,** the **provider's name**, the **date(s) of service,** a **description of the services,** and the expense **amount.** Copies of personal checks and paid receipts, without the above information, are not acceptable. Documentation and/or copies will not be returned. You will be provided with a supply of claim forms with your election confirmation. Extra claim forms are available from the web site at mocafe.com or by calling Central/ASI at (800) 659-3035. Instead of providing the above documentation, you may have the provider complete the dependent care section of the claim form and sign on the line provided. **The dependent care service period must be completed before you file a claim for those services.**

11. Claim reimbursements will be made by **direct deposit** into the bank account of your choice. A notice that a payment was made is available by **e-mail**. InfoLine/125 and mocafe.com are available 24x7 to check on reimbursements or your remaining balance.

12. The tax identification (ID) number or Social Security Number of the child/dependent care provider should be listed on each of your claim forms and must be provided with your federal income tax return. Please check with your childcare provider (**before** enrolling in this category) to be sure that you are able to obtain their tax ID number or his/her Social Security Number.

13. You are required to file Schedule 2 with your IRS Form 1040A or **Form 2441** with your IRS Form 1040 to support the amount redirected (pre-taxed) for the calendar year. Please note that this is for informational purposes. You will not pay taxes on the redirected amount. Claim reimbursements made to you under this category are not taxable, but the amount redirected will appear on your W-2 form. This will inform the IRS that you have received a tax break on that expense through the FSA.

14. Participants on leave (paid or unpaid) under **Family Medical Leave** are entitled to terminate coverage during the leave and reinstate coverage immediately on return to work. Such **reinstatement must be made within 60 days of returning to work**.

DEPENDENT CARE FSA EXPENSES

QUALIFYING EXPENSES – partial list only

Expenses must be necessary for you (and your spouse if you are married) to work

- Expenses for a dependent care center
- Expenses for a "babysitter"
- Expenses for care of a dependent under age 13
- Expenses for care of a dependent who is physically or mentally incapable of caring for herself or himself

NON-QUALIFYING EXPENSES – partial list only

- Care while you are not working or looking for work
- Care for a child for whom you have 50% or less physical custody
- Care for a child age 13 or older who is not disabled
- Kindergarten
- Summer school
- Overnight camps
- Separately billed fees for food, transportation, activities, etc.
- Summer school education or enrichment
- Elder daycare for a dependent with gross income over the Federal exemption limit
- Nursing homes

FLEXIBLE SPENDING ACCOUNT - CLAIM FILING REQUIREMENTS

A statement from the independent provider of service showing all of the following must support each item claimed:

- Name of the service provider/store,
- Person for whom the service was provided,
- Date(s) of service (not payment or billing date),
- Cost of service (not just the amount paid),
- General description of service/products.

In addition to the above, certain expenses have special documentation requirements:

- **Cosmetic procedures or medicines:** Generally do not qualify. However, an expense could qualify if purchased/incurred to correct a birth defect or a condition that is a result of an injury. See "note" below.
- **General good health items:** Exercise programs or equipment, weight loss drugs or programs, vitamins, etc. that are for better health do not qualify for reimbursement. See "note" below.
- **Massage therapy:** Only qualifies if treating an existing medical condition. See "note" below.
- **Medical equipment:** Only qualifies if treating an existing medical condition. See "note" below.
- **Orthodontics:** See specifics.
- **Over-the-counter medicines & drugs:** See specifics. Due to recent federal legislation, you must also submit a copy of a prescription from your doctor for over-the-counter medicines. The medical condition that is being treated must be stated for **each** item claimed. Vitamins, herbs and nutritional supplements require a diagnosed medical condition by a physician in a statement from that physician along with the list of items **necessary** for treating that condition. Go to www.asiflex.com for more details.
- **Sperm or egg storage fees:** Generally do not qualify. However, if "temporary" and scheduled for use in the near future, they may qualify. Storage fees associated with undefined use in the future do not qualify.

"Note": Requires a letter from a physician written within the previous 12 months, stating the nature of the medical condition, the specific equipment, service(s) or item(s) claimed and that it/they is/are essential to (or necessary for) treating that stated medical condition. Merely recommending an item is not sufficient.

Caution: Not all statements you receive from your provider are acceptable to use for supporting documentation for a claim. Please be sure that the statements (receipts) you receive for a co-pay state that they are for a "co-pay" on the statement.

Claim Delivery Methods: 1) Mobile App – You may download ASI's mobile app to your smartphone or tablet and use your device's camera to capture and submit your documentation. You can download the free app from asiflex.com, the App Store for Apple devices, or the Google Play Store for Android devices. **2) Online –** You may also file your claim electronically by completing an online claim form. Just scan and attach your documentation. **3) Fax –** You may also fax claims to ASI toll-free at (877) 879-9038. Please fax a claim only one time. Notification that a fax was received should be available on the web under Account Detail by the end of the next business day. **4) Mail or Drop off –** Mail claims to PO Box 858, Columbia, MO 65205-0858 or drop claims off at 201 W. Broadway (Broadway Professional Park), Building 4, Columbia.

Claims appeals: You will receive written notice of any denied claims. You will have 30 days to file a written appeal of that specific claim denial with the claims office. The ASI claims office will provide you with a written notice of the resolution of this appeal within 60 days of the appeal.

Top 5 reasons claims cannot be paid:

1. The date of service is not on the documentation from the provider. "Balance forward" and "received on account" are not sufficient.
2. The employee does not submit documentation from the provider.
3. Faxed information is not legible or the fax machine cuts off part of a page.
4. The employee forgets to sign the claim form.
5. An expense is claimed twice or the employee faxes the same claim more than once.

CAFETERIA PLAN TAX SAVINGS EXAMPLE

By electing to direct a portion of your salary through the Cafeteria Plan, you essentially bank your money in a TAX-FREE account. The money is used to pay for expenses that would otherwise be paid out of your take-home pay. **This example shows how the Plan could save this employee $420 in taxes!**

	Without the Cafeteria Plan	With the Cafeteria Plan	Savings with the Cafeteria Plan
Annual Compensation	$30,000	$30,000	
Tax Free Expenses	0	1,500	
Taxable Income	$30,000	$28,500	
Federal Tax (after $5,000 exemptions)	6,250	5,830	$420
Net Paycheck	$23,750	$22,670	
After Tax Expenses	1,500	0	
Actual Take Home Pay	$22,250	$22,670	**$420**

This person could reduce their taxes by $420 by using the Cafeteria Plan!!

Savings will vary for each participant depending on variable information such as marital status, number of exemptions, and marginal tax bracket. Consult with your tax advisor to determine your actual potential savings.

CAFETERIA PLAN ELECTION INSTRUCTIONS

During Open Enrollment, you can enroll on-line.

The Missouri State Employees' Cafeteria Plan open enrollment period is from October 1 through December 1.

You can enroll by using the Plan's website: mocafe.com and clicking on "**Enrollment**"

OR by signing into your account at mocafe.com and clicking on **"Open Enrollment"**

Opt-out of the Cafeteria Plan for 2018

If you do not want to participate in the Cafeteria Plan for the insurance premium portion for 2018, (you want to pay the premiums with your "after tax" amount), you also do this through the website listed above. This does not cancel your insurance coverage it just tells the University to deduct your premiums after they tax you on that amount.

If you need to make a change before open enrollment closes but after exiting this web site, you simply enroll again using this procedure. The last enrollment submitted is used for your 2018 plan year election.

Changes of Election or New Hire Enrollment Mid-Year

All election changes and employee new hire enrollments during the plan year are processed on paper forms available through Human Resources. Please review the election change events on pages 6 – 8 prior to completing a change form. You will need to know the event that allows the change and the event date to complete this form. New hires must enroll within 31 days of their hire date. All new hire elections are effective the first of the month following the plan's receipt of this enrollment agreement.