Missouri State Employees' Cafeteria Plan

& State of Missouri Commuter Benefit Program

2021 Enrollment Guide

Open Enrollment Deadline: December 1, 2020

Administered by

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IMPORTANT INFORMATION ABOUT HSAs & FSAs

If you and/or your spouse plan to open a Health Savings Account (HSA) in 2021 and wish to receive or make contributions to that HSA, please note that any funds that you currently have in a Health FSA must be claimed and reimbursed by December 31, 2020 (your Health FSA account balance must be $0 by December 31, 2020).

This does not apply to funds in the Dental/Vision FSA. You can make and receive contributions to an HSA while you are actively participating in a Dental/Vision FSA.

CONTACT INFORMATION FOR ASIFLEX

ASIFlex Customer Service telephone hours:
Monday through Friday from 7 am to 7 pm CT &
Saturday from 9 am to 1 pm CT

MoCAFE Website	mocafe.com
Toll-free Telephone Number	800-659-3035
Toll-free Fax Number for filing claims	877-879-9038
Mailing Address for filing claims	P.O. Box 858 Columbia, MO 65205-0858
Physical Address	201 W. Broadway, Suite 4-C Columbia, MO 65203

IMPORTANT DATES

October 1, 2020	First day of Open Enrollment for the 2021 Plan Year
December 1, 2020	Last day of Open Enrollment for the 2021 Plan Year
January 1, 2021	First day of the Plan Year
February 1, 2021	First day that claims are paid (claims can be incurred starting January 1)
December 31, 2021	Last day of the Plan Year
January 1, 2022	First day of the Grace Period (claims can still be incurred during the grace period)
March 15, 2022	Last day of the Grace Period
April 15, 2022	Claims Filing Deadline – All claims must be submitted by this date

INTRODUCTION

A Cafeteria Plan is an employer-sponsored plan that lets you deduct dollars from your paycheck before they are taxed and use them to pay for certain insurance premiums as well as put them into a Flexible Spending Account (FSA).

The only premiums that may be paid for with the Cafeteria Plan are state-sponsored health, dental and vision insurance premiums.

FSA accounts are exempt from federal income taxes, Social Security (FICA) taxes and state income taxes. Cafeteria Plan participation will impact earnings reported to the Social Security Administration. (You can check with your local Social Security office to explore any effect this may have on your benefits – which are usually very minor.) The more money you put in, the more tax you avoid. When you use the money in your FSA to pay for out-of-pocket expenses for you and your family, you avoid paying taxes on those dollars. **Depending on your tax bracket, you will save at least 20% on out-of-pocket family care expenses.**

FSAs offer tax savings for your out-of-pocket eligible expenses. Most people save at least 20% on each dollar that is set aside.

How does the FSA work? When you enroll in the FSA plan, you estimate the amount of qualifying expenses you are sure you will incur during the plan year. You have that amount deducted from your paychecks in equal amounts throughout the year. Though your actual salary remains the same, your taxable salary as reported to the government is reduced by the amount you put into your FSA.

Be conservative when estimating your expenses, as you must be able to claim the funds in order to obtain reimbursement. All non-claimed funds are forfeited to the State of Missouri as required by the IRS.

After you enroll in the FSA, ASIFlex will send you a confirmation of your enrollment. As you incur eligible expenses throughout the plan year, you submit a Claim Form (via mobile app, online, fax or mail) along with documentation of the expense and you are reimbursed with funds from your FSA account. You are not taxed on these reimbursements. After each claim, you will receive an account summary.

Federal rules state that you can only be reimbursed for expenses you incur during the plan year, which runs from January 1 – December 31. IRS rules also state that if you do not use the money in your account, unused funds will be forfeited to your employer. However, the IRS allows an employer to offer a grace period which is a 2½ month period following the plan year in which the remaining funds may still be used. The State of Missouri has chosen to offer a grace period. So if you still have funds remaining in your FSA on December 31, 2021, you still have until March 15, 2022 to incur expenses. **NOTE: You must file all claims by no later than April 15, 2022.**

You can only change your election during the plan year as a result of certain eligible event changes. You cannot use Health FSA or Dental/Vision FSA funds to pay day care expenses, and you cannot use Dependent Care FSA funds to pay health, dental or vision care expenses. The FSAs are separate accounts; monies cannot be transferred between accounts.

The State of Missouri has contracted with Central Bank and ASIFlex to perform certain administrative functions for the Plan. ASIFlex processes all claims for the FSAs. If you have any questions concerning claims, please call ASIFlex at 800-659-3035 (M – F from 7 am to 7 pm CT, and Saturday from 9 am to 1 pm CT) or visit the website at mocafe.com.

ELIGIBILITY

POP, Health FSA, & Dental/Vision FSA – You must be eligible for employer-sponsored health insurance to be eligible for these portions of the Cafeteria Plan. You do not have to be enrolled in the health insurance, but you must be eligible to enroll in the insurance in order to participate.

Dependent Care FSA – All employees are eligible to participate in the Dependent Care FSA portion of the Cafeteria Plan.

NEW HIRES

New hires have 31 days from the date of hire to enroll. All new hires (other than university employees) must enroll through the SEBES website (https://www.sebes.mo.gov). SEBES information will be provided by your Human Resources Office. If you fail to enroll within the time period described above, then you cannot elect to participate in the Plan until the next Open Enrollment Period or until an event occurs that would justify a mid-year election change.

ENROLLMENT

Open Enrollment is held from October 1 through December 1. To participate in a FSA, you must enroll during open enrollment each year (see *Enrollment Instructions*). Coverage will begin the following January 1; the plan year is January 1 through December 31.

If you are enrolled in an employer-sponsored health, dental or vision insurance plan, you are automatically enrolled in the POP (see the section on *POP* for details). If you do not wish to participate, you must "opt out" during the enrollment process each year.

You may be eligible to enroll mid-year if you experience a qualifying Change in Status (see section on *Changes in Status* for details). See section on *Enrollment Instructions* for more details.

OPEN ENROLLMENT

To participate in one of the FSAs for calendar year 2021, you must enroll during Open Enrollment (October 1 – December 1, 2020). The Plan Year is January 1 – December 31, 2021. If you wish to "opt out" of the POP portion of the Plan, you must also make that election during Open Enrollment. (or within the first 31 days of employment if you are a new hire).

COVERAGE DATES

Start of Coverage:

- January 1, 2021 – for those who enroll during open enrollment; or
- The first of the month after the election is approved by ASIFlex for all others.

End of Coverage:
March 15, 2022, unless:

- Your employment ends and you are enrolled in the Health FSA or the Dental/Vision FSA -- your coverage will end on the last day of the month in which the last contribution from payroll is received. You may, however, be eligible for COBRA coverage (see the section on *COBRA* for details).
- You take an unpaid leave of absence for more than 31 days – your coverage will end on the last day of the month in which the last contribution from payroll was received. If you are enrolled in the Health FSA or Dental/Vision FSA, you may make plans to prepay your contributions prior to your leave; you may also pay your contributions during your leave or catch up contributions upon your return to work.
- You retire – your coverage typically ends on the last day of the month in which the last contribution from payroll is received. However, you may make arrangements to have the remaining contributions withheld on a pretax basis and thus continue coverage through the end of the current plan year. See the section on *Retirement* for details.

RETIREMENT

If you retire during 2021, you may be eligible to pay your insurance premiums and any remaining FSA contributions on a pre-tax basis. Contact your insurance provider (MCHCP, MoDOT or Conservation) for the necessary forms. If you wish to continue your FSA coverage, complete Section C of the *Change of Election Form* (forms available on mocafe.com under the *Resources* tab) and send to ASIFlex (provide a copy of the form to your HR Office as well).

Your form must be sent in at least 31 days prior to your retirement date. You can choose to have the amount divided between your last two paychecks, taken out of any lump-sum vacation payout, or a combination of these.

TERMINATION

Your participation will terminate at the end of the month in which a deduction is taken. This means you will no longer be able to make contributions to the plan or incur expenses to claim for reimbursement. Remaining funds will be forfeited.

There are two ways to continue your Health FSA or Dental/Vision FSA coverage past your termination date.

1. The first way is to choose to pay the remainder of the annual contributions from your last paycheck. Complete Section C of the *Change of Election Form* available at mocafe.com (forms available under the *Resources* tab) and send to ASIFlex (provide a copy of the form to your HR Office as well). The form must be sent in at least 31 days prior to your termination date.

2. The second way that you may be able to continue your coverage past termination is if your account qualifies for COBRA. See the section on *COBRA Coverage*.

If, during the same plan year, you return to work as an eligible employee within 31 days, your participation will be reinstated as it was prior to your termination. **This is also true for employees who transfer between agencies.**

If, during the same plan year, you return after 31 days, you will be treated as a new hire and may make new elections. You have 31 days after you return to work to make a new election for the remainder of the Plan Year (not to exceed the annual plan maximum). Funds from any prior period cannot be used for the new coverage period.

Expenses incurred while you are not a participant will not qualify for reimbursement. Participation ends on the last day of the month in which a deduction is withheld from your pay (see the section on *COBRA Coverage* for details regarding continuation of coverage participation).

You may continue to file for Dependent Care expenses incurred during the Plan Year after the end of your participation.

Your participation will also end at the end of the expiration of the Period of Coverage, if the Plan is terminated, or if you a file a false or fraudulent claim for benefits. See section on *False or Fraudulent Claims* for details.

False or Fraudulent Claims. If ASIFlex believes that false or fraudulent claims have been submitted, ASIFlex will investigate the submitted claims and forward, with all investigational findings, to the State of Missouri's Office of Administration for further investigation. In the interim, ASIFlex will deny your claim and notify you that your account has been placed on hold until the situation has been resolved. The Office of Administration will make a decision as to whether your participation will be terminated and whether to recover any funds that may have been fraudulently obtained. The Office of Administration has the authority to deny claims found to be false or fraudulent and to terminate your participation in the Plan in accordance with its discretionary duty as the Plan Administrator. The State of Missouri may take legal or disciplinary action against a member found to have committed fraud.

ACCOUNT ACCESS

You can access information on your FSA via the internet or by using ASIFlex's free mobile app. Information is continually updated to reflect the recent transactions.

You can view your current balance, find out if a claim has been processed or whether a payment has been made, or whether you need to submit backup documentation for your debit card usage.

You can also file claims and submit backup documentation online or via the free mobile app.

Information for the current Plan Year is available (previous Plan Year is also available until April 15 following the end of that Plan Year).

To access your account(s):

1. Go to mocafe.com, hover over the tab titled *Account Detail*, and click on *Participant/Account Detail*.
2. You will need to create a User Name, Password and select a security image unless you have already done so. Just follow the directions to set up your credentials the first time. Please ensure that you have a few minutes to complete this process fully. You will need to remember this information for the future.
3. Once you are signed in, you will be in the Main Menu.
4. Click the account you wish to view.
5. If you have information available for more than one Plan Year in that account, you will need to click on the Plan Year you wish to view.
6. Be sure to click "**Log out**" when you finish. This closes out your account for security purposes.

ENROLLMENT INSTRUCTIONS

DURING OPEN ENROLLMENT: You can enroll online or via paper. Please do not enroll using both methods; you only need to enroll once. If you want to use the ASIFlex debit card, you are required to enroll online in order to request the debit card.

If you wish to enroll online, you can do so in a number of different ways:

1. If you are eligible for MCHCP coverage, you can enroll through MCHCP's site during the month of October: https://my.mchcp.org
2. You can enroll through the MoCafe website at mocafe.com. Hover over the *Resources* tab, and then click on the *Enrollment* tab or sign into your account.

A paper form is available at mocafe.com. Hover over the *Resources* tab and then click on the *Enrollment* tab or the *Forms* tab. Mail your completed form to: MoCafe, P.O. Box 858, Columbia, MO 65205-0858.

MID-YEAR ENROLLMENT: You must have experienced a qualifying change in order to enroll mid-year (see section on *Changes in Status)*. Use the *Change of Election Form* available on mocafe.com (forms available under the *Resources* tab). You must submit the completed form within 60 days of the event.

NEW EMPLOYEES: Please see the section titled *New Hires*.

TAX SAVINGS EXAMPLE

	WITHOUT MOCAFE	WITH MOCAFE	SAVINGS FROM MOCAFE
Annual Compensation*	**$30,000**	**$30,000**	
Subtract Pre-tax Withholdings to pay expenses	- 0	- 1,500	
Taxable Income	$30,000	$28,500	
Subtract Federal & State Income, Social Security & Medicare Taxes	- 5,223	- 4,849	$374
Net Paycheck	$24,777	$23,651	
Subtract After Tax Expenses	- 1,500	- 0	
Actual Take Home Pay	**$23,277**	**$23,651**	**$374**

The above individual saved $374 by paying for expenses using the Cafeteria Plan!

* Employees with higher compensation will save more by reducing their taxable income. Check with your tax advisor if you have questions.

PREMIUM ONLY PLAN

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

Please note that you must keep the same insurance coverage for the entire year, unless you have a qualified Change in Status (see the section on *Changes in Status* for details). 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 will net you at least 20% 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 State-sponsored insurance will be automatically enrolled in MOCafe, to the extent you have qualified premiums, unless you opt-out of one or all of these categories by completing an on-line or paper election agreement during open enrollment each year.

HEALTH FLEXIBLE SPENDING ACCOUNT
OR DENTAL/VISION FLEXIBLE SPENDING ACCOUNT

You cannot enroll in both a Health FSA and a Dental/Vision FSA. There are two main differences between the two accounts:

- **The Dental & Vision FSA can only be used to reimburse dental and vision expenses while the Health FSA can be used to reimburse the majority of health, dental and vision expenses.**
- **You cannot enroll in the Health 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 FSA.**

These accounts can be used to pay for your and your eligible dependents' health, dental and/or vision expenses.

Annual Maximum $2,750.00

The maximum contribution limit for the Health FSA and the Dental/Vision FSA is established by each employer not to exceed the federal maximum allowed. So you may contribute an amount up to each respective employer's maximum. If both you and your spouse are employed, you may each contribute up to the maximum amount allowed by your respective employers. **However, you may only claim reimbursement of each expense from one plan or one account (not the same expense under both plans or accounts).**

You cannot participate in both the Health FSA and make contributions to or have contributions made to your **HSA.** If you enroll in a High Deductible Health Plan, you may not participate in the Health FSA as your employer will be making a contribution to your HSA. Please note, however, that you may participate in the Dental & Vision FSA. If you participate in the Health FSA, then neither you nor your spouse should allow contributions to be made to an HSA. If your spouse participates in a Health FSA through his/her employer, then you risk significant tax penalties if you select the HDHP option. Please call MoCafe if you have any questions regarding Health FSAs and how they work with HSAs**.**

Please note: If you are currently enrolled in the Health FSA, your balance in the Health FSA must be $0 on or before December 31, 2020 if you choose to enroll in the HSA for 2021. So, please file your claims early to ensure that ASIFlex has sufficient time to process and pay your claims before December 31, 2020.

Qualifying Expenses

For the Health FSA, qualifying expenses include all medical, dental and vision expenses not covered or not reimbursed by insurance which are incurred by you, your spouse and/or your eligible dependents during the Plan Year. These expenses are defined in Section 213(d) of the Internal Revenue Code and in the Glossary of this document.

For the Dental/Vision FSA, qualifying expenses include only dental and vision expenses not covered or not reimbursed by insurance which are incurred by you, your spouse and/or your eligible dependents during the Plan Year.

Please refer to the following list and IRS Publication 502 (available at mocafe.com) for further details on qualifying expenses. **You can only claim expenses based on the date incurred (not paid as stated in 502).** Please contact ASIFlex at (800) 659-3035 if you have any questions regarding particular expenses.

OVER THE COUNTER (OTC) MEDICINES & FEMININE HYGIENE PRODUCTS

GREAT NEWS! OTC medicines are now eligible for reimbursement from the Health FSA **without** obtaining a prescription from your doctor.

Here is a partial list of the OTC medications that are eligible for reimbursement:

- Pain relievers (acetaminophen, aspirin, ibuprofen, etc.)
- Allergy medication
- Cold medicine (cough syrups, decongestants, lozenges, etc.)
- Nasal Spray
- Eye drops/Artificial tears
- Antibacterial/ Antifungal medicines
- Sleep aids
- Heartburn & Acid reducing medicines
- Laxatives

OTC medicines that are used for dental and/or vision purposes are eligible for reimbursement from the Health FSA or the Dental/Vision FSA.

In addition, feminine hygiene products are now eligible under the Health FSA. Here is a partial list of these items:

- Tampons
- Pads
- Menstrual cups
- Sponges

Below is a partial listing of qualified expenses for the Health FSA. Expenses can only be claimed based on the date incurred regardless of the date you are billed or pay for the expense.

Deductibles & copayments	Dental Expenses
Office Visits	Hearing Aids
Corrective eye surgery	Orthodontia (Braces)
Prescription and OTC drugs	Medical Equipment
Transportation expenses (used to obtain treatment)	Eyeglasses, contact lenses & contact lens solution

Equipment, supplies, and diagnostic devices such as bandages, hearing aid batteries, blood sugar test kits, etc. are also eligible for reimbursement.

Orthodontic expenses can not be paid prior to services being provided. To claim orthodontic payments, you must include a copy of the treatment contract along with proof of payment or a receipt of payment. Eligible expenses include a reasonable downpayment to cover initial services and monthly amounts as additional services are provided.

Non-Qualifying Expenses

This is a **partial** list of related items that **do not** qualify under the FSAs. There are other items that do not qualify that are not listed here.

Clip-on or non-prescription sunglasses	Warranties & insurance premiums
Toiletries	Long-term care expenses
Expenses that are merely beneficial to your general health and not used to treat a specific medical condition such as vacations, vitamins, health club dues, etc.	Cosmetic procedures such as face lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins, etc.

Eligible Dependents - Expenses for you and your spouse are eligible for reimbursement. Federal rules stipulate that expenses for your children or tax dependents will qualify for reimbursement through the program if one of the following criteria are met:

1) **If the individual is your adult child** – the individual must be a "child" of the taxpayer (son, daughter, stepson, stepdaughter) or an eligible foster child and be age 26 or younger for the entire plan year in which medical expenses are claimed; or
2) **If the individual qualifies as your tax dependent**, as either a qualifying child or a qualifying relative. See IRS Publication 502 available on mocafe.com (under *Useful Links* tab).

Under the Health FSA, you may include qualified expenses for your children until the end of the year in which your children reach age 26. Your child does not need to live with you in order for you to claim their health expenses that you have incurred on their behalf (special rules apply to children of divorced parents – see mocafe.com for further information).

Payment from your Health FSA will be made up to the approved amount of your claim or your remaining annual election, whichever is less. Payment is not limited to the amount in your account at the time of your claim. The per pay period contributions will continue for the remainder of the Plan year.

Participants on a leave of absence. You should make arrangements prior to going on an unpaid leave of absence with your Human Resources Office in order to maintain coverage. You may make arrangements to pre-pay for coverage, to make payments while on leave, or to pay for coverage after you return from leave. If you have been on an unpaid leave of absence for longer than 30 consecutive days and did not make arrangements to pay for coverage, the coverage will be suspended on the last day of the month in which a deduction was taken. Once your coverage is suspended, your ASIFlex Card will be also be suspended. A new election may be made upon 60 days of return to work, effective for coverage upon the receipt and approval of the submitted form. However, no coverage will exist for months in which no contributions were made.

Coverage Period. You can only be reimbursed for expenses you incur during the plan year and any additional grace period. So if you remain active, your coverage may extend from January 1, 2021 – March 15, 2022. IRS rules also state that if you do not use the money in your account, unused funds will be forfeited to your employer. **NOTE: You must file all claims by no later than April 15, 2022.**

COBRA COVERAGE

Coverage Continuation (COBRA). To the extent required by COBRA, a participant or their spouse or dependent may elect to continue the coverage elected under the Health FSA or the Dental/Vision FSA even though the participant's or their spouse's or dependent's election to receive benefits expired or was terminated, under the following circumstances:

1) Death of the participant;
2) Termination (other than for gross misconduct) or a reduction in hours*;
3) After retirement*;
4) Divorce of the participant;
5) A dependent child ceases to be a dependent under the terms of this plan.

* Please see the section on *Termination* for additional details related to coverage and reimbursement.

When the Plan is notified that one of the events has occurred, the right to choose **continuation coverage** will be provided to each eligible person(s) if, on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments. The right to elect to continue ends 60 days from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the participant or a responsible family member to inform ASIFlex of the occurrence of an event described in bullet points 4 or 5 above.

Continuation coverage will not extend beyond the end of the current Plan Year but may terminate earlier if the premiums are not paid within 30 days of their due dates. **Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the Administrator.** An administrative charge of 2% is assessed for each premium paid for continuation coverage.

ASIFLEX CARD (FSA DEBIT CARD)

Don't throw away your card. Keep it from year to year!

You may elect to receive an ASIFlex Card for use in paying for health, dental and vision care received during the Plan Year. The ASIFlex Card provides a convenient method to pay for out-of-pocket health care expenses for you, your spouse and/or any qualified dependents. The IRS has stringent regulations regarding appropriate use of the ASIFlex Card, such as **where the card can be used**, and **when follow-up documentation is required (use of the ASIFlex Card DOES NOT necessarily eliminate all of the paperwork)**. The ASIFlex Card is a great benefit, but it is important that you take a moment and understand how it works.

How do you request an ASIFlex Card?

- *If you already have an ASIFlex Card,* you do not need to request a new one. Keep that card and your new 2021 balance will be loaded onto the card effective 2/1/2021.
- *If you don't already have an ASIFlex Card,* you will have the opportunity to request a debit card be sent to you during the open enrollment process. Once you receive your card, you will need to follow the instructions contained in the packet in order to activate the card.
    - If you were enrolled in the plan in 2020 but did not have the *ASIFlex Card* and are now requesting the *ASIFlex Card* for the 2021 plan year, please understand that the card can only be used on or after 2/1/2021 and only for the 2021 plan year account. So, if you have 2020 funds left over that you wish to use during the grace period, you will need to submit claims in the normal manner (see the section titled *Claims Filing Instructions - FSAs* for instructions).
- *If you are a late enrollee or want to request a debit card after open enrollment*, you will need to complete a debit card application form (available on mocafe.com under the *Resources* tab) and mail it to ASIFlex.

No 2021 funds will be available on the card until February 1, 2021.

JUST REMEMBER: While the debit card makes it easier to pay for your health care services, the IRS still requires ASIFlex to ensure that the services are for eligible expenses. So, it is important to remember to always ask for an itemized statement from your provider as there are times when ASIFlex will ask you for follow-up documentation to prove that the card transaction was for an eligible expense.

When is documentation required to be submitted? IRS regulations require you to submit documentation for certain card transactions. The only items that do not require follow-up documentation are:

- Flat dollar copayments under your employer's insurance Plans
- Identified recurring expenses (such as a regular monthly payment to the same provider for the exact same dollar amount)
- Prescriptions or over-the-counter health care medicines and products purchased at pharmacies/merchants that identify which products are qualified health care items

All other expenses require documentation. ASIFlex will notify you if documentation is required. If you receive a request, provide the itemized statement or the insurance plan's explanation of benefits (EOB) statement. Three requests for documentation are sent by mail or email/text alert as follows:

1. Initial Notice – Sent approximately five days after ASIFlex receives notice of the card transaction
2. Reminder Notice – Sent 21 days after the first request
3. De-activation Notice – Sent 21 days after the reminder notice and card is inactivated. Additionally, future claim submissions may be offset by the outstanding amount

How can you submit the requested documentation? You can submit the documentation online through your account, via the mobile app, or by mail or fax. To submit online, just follow the online instructions and click on the highlighted claim. If you do not submit the requested documentation, IRS rules require that your card be temporarily de-activated and future claim submissions will be offset by the outstanding amount.

For additional details regarding IRS regulations governing use of the card, visit mocafe.com (hover over the *Programs* tab and then click on the *Debit Card* tab).

REMINDER: Each time that you use the card, you must ask the provider for an itemized statement. An itemized statement must include:

1. Provider name/address
2. Patient name
3. Date the service was provided (regardless when paid or billed)
4. Description of the service or health care supply
5. Dollar amount owed

Note: A credit card receipt, cancelled check, paid-on-account statement, or balance-forward statement is not sufficient. You can also use an Explanation of Benefits (EOB) to document expenses.

Where can the card be used? Per IRS regulations, the ASIFlex Card can only be used at Health Care Providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS).

1) **Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The FSA debit card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).

2) **Inventory Information Approval System (IIAS):** The IRS also allows the ASIFlex Card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your ASIFlex Card to eligible expenses, and you will never be prompted for follow-up documentation for purchases at

these stores. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the ASIFlex Card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The ASIFlex Card will work at these stores, even if the MCC does not indicate it is a health care provider.

A list of stores with this system in place now (and some expected in the future) is available online, at mocafe.com (hover over the *Programs* tab and then click on the *Debit Card* tab; then click on *List of IIAS Approved Merchants*). **Purchases at these stores will never require follow-up documentation!** IRS regulations require all pharmacies to have the IIAS in place or your card may be declined at the point-of-sale.

What happens if I don't submit requested documentation? As detailed above, there are times when you may use the ASIFlex Card to purchase FSA eligible items or services and additional documentation will be required to substantiate the transaction, in accordance with IRS Regulations. When follow up documentation or a statement of services is required, ASIFlex will send you an e-mail or letter requesting this documentation. The requested information should include the following information: name of provider, name of member (or member's spouse or dependent), date the service was provided, brief description of the service(s) provided, and the amount that was your responsibility.

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

When you use the ASIFlex Card for a transaction requiring documentation, those dollars are identified as "overpaid" within your FSA account until the transaction is substantiated. If you submit a manual claim before the ASIFlex Card transaction is substantiated, the dollars associated with the manual claim will be used to offset the overpaid dollars from the ASIFlex Card transaction. This will prevent the manual claim from being reimbursed in part, or in full, depending upon the dollar amount of the manual claim. Once the ASIFlex Card transaction is substantiated, the manual claim used to offset the ASIFlex Card transaction will be reimbursed in full. See the following examples for further explanation:

Example 1: Lisa pays her eye doctor $250 for contacts using her ASIFlex Card. ASIFlex sends Lisa a notice asking for follow-up documentation for the $250 purchase. Prior to submitting the detailed statement from her eye doctor, Lisa submits a manual claim to ASIFlex for a $100 prescription which she paid for out-of-pocket. ASIFlex will process the $100 claim but no payment will be issued that day. Instead, the amount of the manual claim will be used to offset the ASIFlex Card transaction. This will result in ASIFlex showing Lisa's' overpaid amount reduced from $250 to $150. Two weeks later Lisa submits the follow up documentation for the ASIFlex Card transaction used to purchase the contacts to ASIFlex. ASIFlex will then process the supporting documentation for $250 and Lisa will be issued a payment of $100 for her manual prescription claim.

Example 2: John goes to the dentist and pays $200 for a root canal with his ASIFlex Card. He then receives a notice from ASIFlex requesting follow up documentation. John submits the statement of services from his dentist along with the notice received from ASIFlex. ASIFlex reviews and processes the follow up documentation to substantiate the claim. John's FSA account will no longer be showing as "overpaid "since all follow up documentation was submitted.

If you are unable to provide documentation for an ASIFlex Card transaction in question, you may either: 1) submit expenses incurred out-of-pocket to offset the ASIFlex Card transaction (the expenses incurred out-of-pocket must not be paid for using the ASIFlex Card); or 2) repay the unsubstantiated claims by submitting payment to ASIFlex by check or by requesting ASIFlex to debit your bank account.

Should you neglect to submit the requested documentation and the plan year comes to an end (following the Plan's provision for documentation to be submitted by April 15), ASIFlex will provide notice to your employer that the claim was not substantiated within the plan year as required by IRS Regulations. You will be asked to repay the unsubstantiated claims by submitting payment by check to the State of Missouri

– Office of Administration. If you are actively employed by a State agency or participating university and do not repay your claims, a wage attachment will be processed to deduct the amount of the unsubstantiated claim(s) from your pay.

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

> **Example:** Lori's daughter Carrie goes to the dentist to receive a crown. Lori uses her ASIFlex Card for the $750 expense. Lori terminates employment the following week. ASIFlex sends Lori three notices requesting follow up documentation, and receives no response. At the end of the plan year, ASIFlex will notify Lori's employer of the overpayment. Lori's employer will then issue a W-2 in January of the following year, to the member and to the IRS, that will report the $750 overpayment as taxable income.

Concerns and questions regarding this process should be directed to ASIFlex at 1-800-659-3035.

Is there a cost for the ASIFlex Card? No, the first set of two (2) cards are provided for free.

Can I request additional ASIFlex Cards? Yes. Everyone who requests a card will receive two ASIFlex Cards in the mail. If you would like additional cards, sign into your online account at mocafe.com. From the *Main Menu*, click on the *Debit Card Information* button under the *Resources* section. Then click on the *FSA Debit Card Order Form* button. Please note that all ASIFlex Cards will be in the name of the FSA participant.

Can I use the ASIFlex Card to pay for OTC medicine at stores that have implemented IIAS?

Health FSA: Yes; If you are enrolled in the Health FSA, you can now purchase OTC medicine with the ASIFlex Card at merchants with IIAS.

Dental/Vision FSA: No; If you are enrolled in the Dental/Vision FSA, the debit card will not work in this manner. You will need to submit claims to be reimbursed for OTC medicines that are vision or dental related.

The ASIFlex Debit Card can only be used to pay for qualified expenses under the Health FSA or the Dental/Vision FSA – not the Dependent Care FSA.

DEPENDENT CARE (DAY CARE) FLEXIBLE SPENDING ACCOUNT

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

Annual (Household) Maximum $5,000.00

This account can only be used to reimburse day care expenses!

You and your spouse together may include up to $5,000.00 per calendar year ($2,500 in the case of a married individual filing a separate tax return for the plan year) or the lesser of your or your spouse's earned income for the plan 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 $200 per month if you have one dependent and $400 per month if you have two or more dependents.

A Qualifying Individual is your Dependent who is under the age of 13 (when services are incurred) or your Spouse or an older Dependent who is mentally or physically incapable of self-care who lives in your home at least 8 hours each day. If you are divorced, the Qualifying Individual must be your son or daughter for whom you have more than 50% physical custody. Please call ASIFlex before enrolling in this account if you have unique day care or joint custody arrangements.

A Qualified Provider can provide care in your home or outside your home. If the care is provided outside your home and the facility cares for more than 5 individuals, then it must be licensed by the State. The expenses **may not** be paid to your spouse, a child of yours 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.

The Dependent Care FSA 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. You can, however, use the tax credit for any expenses in excess of the amount you used through the FSA up to the maximum allowable under the tax credit.

- A **Tax Credit** is allowed for child/dependent care expenses of up to $6,000 per year for two or more dependents ($3,000 per year for one dependent). You file for the "tax credit" on your annual tax return, at the end of the year. The credit is an amount equal to your dependent care expenses multiplied by a percentage determined by your combined adjusted gross income. The percentage decreases from a high of 35% (for those with household income less than $15,000) to a low of 20% (for those with household income equal to or greater than $43,000). See IRS Publication 503, Child and Dependent Care Expenses, for a list of credits at each income level.

- The **Dependent Care FSA** allows a tax break on up to $5,000.00 per year, $2,500 if married filing separately, for any number of dependents; one, two, or more. You will experience "tax savings" throughout the year with every paycheck you receive. Employees who pay federal taxes of 12%, state taxes of approximately 6% and Social Security taxes of 7.65% would save around 25% of expenses through the Dependent Care FSA. As their federal tax percentage rises, they would receive an even higher tax break by using the Dependent Care FSA. The higher your tax bracket, the bigger the benefit.

Please contact your tax advisor if you have questions about whether the tax credit or the FSA is better for your situation.

You are required to file Form 2441 with your IRS Form 1040 to support the amount redirected for the calendar year. This is for informational purposes. You will not pay taxes on the redirected amount. Payments made to you under this category are not taxable, but the amount redirected will appear on your W-2 form which informs the IRS that you have received a tax break on that expense.

Qualifying Dependent Care Expenses are those that you incur in order for you and your spouse (if married) to be gainfully employed that are considered to be employment-related expenses under Internal Revenue Code §21(b)(2) to the extent that you or another person (if any) incurring the expense is not reimbursed for the expense through any other Plan. Only expenses incurred for care and well-being qualify for this tax break (Kindergarten, summer school and private school expenses, food and transportation do not apply). Day camp fees incurred in order for you to work are allowable but overnight camps are not. Refer to IRS Publication 503 (available at www.asiflex.com) for additional information. The purpose of Publication 503 is to assist people with their income tax filing. It does not address Dependent Care FSAs. However, most of the items listed as eligible for the tax credit in 503 can be claimed through your Dependent Care FSA. **You can only claim expenses based on the date incurred (not paid as stated in 503)**. Please contact ASIFlex at asi@asiflex.com, (800) 659-3035 if you have any questions regarding particular expenses.

Qualifying Expenses are those that enable you to be gainfully employed including:

Day care centers	Babysitters
Day camps	Nannies

Non-Qualifying Dependent Care Expenses – This is a **partial** list of items that **do not** qualify under the plan. There may be other items that do not qualify that are not listed here.

Care that is not incurred in order for you to work or look for work	Care for a child for whom you have 50% or less physical custody
Kindergarten or other educational expenses	Care for a child age 13 or older who is not disabled
Virtual or online classes	Child support payments
Amounts paid to your spouse or dependent or to your (or your spouse's) son or daughter who is under 19 years old at the end of the year	Elder daycare for a dependent with gross income over the Federal exemption limit
Food, transportation or activity fees	Overnight camps (even if the cost of the overnight portion can be separated)

Enroll in the Dependent Care FSA. See the separate open enrollment checklist for detailed open enrollment instructions. Enroll on-line during open enrollment. Print and maintain the confirmation statement as you will be required to provide it if there is a discrepancy in your election. Your annual election will be divided by the number of paychecks from which a deduction will be taken during the plan year. New employees should see the section on *New Hires* for additional information.

Participants on Paid or Unpaid Leave. Dependent Care expenses are not eligible for reimbursement during a period of leave. Because of this, you may choose to have your deductions stopped prior to going on leave. When you return to work, you will have 60 days to reinstate your coverage with the same or a new annual election.

Receive dependent care services. Dependent care expenses are **incurred** when the day care is provided. 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 ASIFlex. For information on filing claims, please see the section titled *Claims Filing Instructions - FSAs*.

You may have the dependent care provider complete the dependent care section of the claim form and sign on the line provided in lieu of providing separate documentation for dependent care claims.

You will need the tax identification number or Social Security number of the child/dependent care provider. You must provide this number 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 I.D. number or their Social Security number.

Payment from your Dependent Care FSA will be made up to the approved amount of your claim or your current balance, whichever is less. Any portion of your claim which is not paid will be paid automatically as money is contributed from payroll. Total payments for the year are restricted to your annual election.

CHANGES IN STATUS

Except as specified in this section, your election under the Plan is irrevocable for the Plan Year. It is the employee's responsibility to request a change by sending a *Change of Election Form* to ASIFlex. The *Change of Election Form* is available on mocafe.com (forms available under the *Resources* tab). **The election change request must be filed within 60 days of the date of the qualifying event.** If the election change request is approved, the change will become effective on the 1st of the month following the event and the approval of the request. If the event is a birth, adoption or placement for adoption, coverage can be retroactive to the date of the event. Requests received after 60 days will not be approved.

Change in Status events can be quite complex; contact ASIFlex with any specific questions by calling 800-659-3035.

You may change your election if you, your spouse, or a dependent experience an event listed below and your desired election change corresponds with that event. Changes are only allowed if one of the specific events listed below has occurred that caused the needed change in your account. Otherwise, your election is effective through the end of the plan year.

In addition, the only changes in status that allow for a reduction or cancellation of your Health FSA or Dental/Vision FSA elections are: 1) legal marital status changes due to death, divorce or annulment; or 2) a reduction in your number of dependents due to death.

Qualifying Changes in Status: (the type of change that is allowed is listed below each type of status change)

- **Gaining a Newly Eligible Dependent via:**
  - Marriage;
  - Birth, adoption or placement for adoption; or
  - A dependent becomes your eligible tax exemption (e.g., appointed guardianship or relative moves into your home that you are able to claim on your federal income tax return).

  You may add the newly eligible dependent to your insurance. In addition, you may enroll in or increase your Health Care FSA or your Dental/Vision FSA. If the newly eligible dependent is under the age of 13 or incapable of caring for his or herself, then you may enroll in or increase your Dependent Care FSA.

- **Death of a Spouse or Dependent:**
  You may cancel or decrease coverage levels of insurance. You may also decrease or cancel your Health FSA or Dental/Vision FSA. If the deceased dependent was under age 13 and or incapable of self-care, then you may decrease or cancel your Dependent Care FSA.

- **Divorce, Legal Separation or Legal Annulment:**
  You may drop your ex-spouse from your insurance only in the case of divorce or legal annulment. You may decrease or cancel your Health FSA or Dental/Vision FSA.

- **Loss of an Eligible Dependent** (e.g., child reaches age where no longer eligible for the benefit) – You may drop the dependent from your insurance if the dependent is no longer eligible for the insurance. If the dependent was under the age of 13 or incapable of caring for his or herself, then you may also decrease or cancel your Dependent Care FSA. ***Please note:*** *You cannot decrease or cancel your Health FSA or Dental/Vision FSA for this reason. Your child's expenses are no longer eligible under the Health FSA or Dental/Vision FSA for the entire year in which the child will reach age 27.*

- **Change in Employment Status:**
  - Termination of Employment;
  - Start Unpaid Leave of Absence;
  - Return from an Unpaid Leave of Absence;
  - Spouse Starts New Job or Becomes Newly Eligible for Benefit; or
  - Spouse Terminates Employment or Loses Eligibility for Benefit.

  If the change in employment status affects eligibility for coverage under a State of Missouri benefit or under a plan maintained by your Spouse or any Dependent's employer, then you may: 1) make a corresponding change to your insurance; 2) enroll in or increase your Health FSA or Dental/Vision FSA; or 3) make a corresponding change to your Dependent Care FSA.

  If your employment status changes from an expectation to work 30 hours or more per week to an expectation to work less than 30 hours per week (even if that change fails to make you ineligible for Employer-sponsored group health plan coverage); AND you enroll in a group health plan that offers minimal essential coverage (as defined by the Affordable Care Act) 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, then you may cancel your insurance coverage on a prospective basis only.

  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, then you may cancel your insurance coverage on a prospective basis only.

- **Dependent Day Care Changes:**
  - Change Providers;
  - Change in Day Care Costs; or
  - Work Schedule Changes.

  If you change day care providers, if your day care costs change or if your work schedule changes, you may make corresponding changes to your Dependent Care FSA. Here are a few examples: Example 1) If your child starts school in the fall and you change from a full-time day care provider to after-school care, you could decrease the amount you were contributing to the Dependent Care FSA. Example 2) Your child is attending daycare, but then the child's grandparent offers to watch the child for free. You may decrease or cancel your election for the Dependent Care FSA because the costs have changed. Example 3) Your day care provider increases the cost of caring for your child. You may increase your election amount unless the provider is a relative. *A relative is any person who is a child, parent, stepchild, sibling, aunt, uncle, cousin, or in-law of the participant.* Example 4) If you or your spouse change work schedules which change the hours that you need outside care, you may increase or decrease your election consistent with that change.

- **Certain Legal Judgments, Decrees or Court Orders (including a Qualified Medical Child Support Order (QMCSO)) –** You may change your insurance as well as increase your Health Care FSA or Dental/Vision FSA to provide a dependent child with the corresponding coverage that you are ordered to provide. You may decrease your insurance coverage for a child if the other individual actually provides the court ordered coverage. ***Please note:*** *A court order for another individual to provide insurance coverage for a dependent is not a qualifying change in status that would allow you to decrease or cancel your Health Care FSA or Dental/Vision FSA.*

- **Eligibility Changes for Medicare and Medicaid:**
  - Gain Eligibility; or
  - Lose Eligibility.

  If you or one of your dependents become entitled to and enroll in Medicare or Medicaid, then you may terminate or decrease coverage under your insurance. ***Please note:*** *If you or one of your dependents become entitled to and enroll in Medicare or Medicaid, you cannot decrease or cancel your Health FSA or Dental/Vision FSA for this reason.*

  If you or one of your dependents lose eligibility for Medicare or Medicaid, then you may enroll in or increase your coverage under your insurance. If you or one of your dependents lose eligibility for Medicare or Medicaid, you may enroll in or increase your coverage under the Health FSA or Dental/Vision FSA.

COST TO PARTICIPATE IN MoCAFE

24 cents per month	Total cost to participate in the POP category only
$2.80 per month	Total cost to participate in any combination of POP, Health FSA, Dental/Vision FSA, and/or Dependent Care FSA if you receive claim reimbursements by direct deposit
$4.00 per month	Total cost to participate in any combination of POP, Health FSA, Dental/Vision FSA, and/or Dependent Care FSA if you receive claim reimbursements by check

REIMBURSEMENT CHOICES

You choose how to be reimbursed. **Save money by choosing to be reimbursed by direct deposit.**

Direct deposit into the bank account of your choice means there is no need to wait for a check to arrive and be deposited (and your fee is reduced for using direct deposit). A notice that a payment was made will be sent to you. This direct deposit notice is available by email or by text message.

If you receive a check for reimbursement and forget to cash it, the check is valid for six months from the issuance date. If you have received a check and have not cashed it within six months, ASIFlex will attempt to contact you via email or postal mail, and will offer to reissue the reimbursement to you.

APPEALS

(All appeals must be in writing, signed & mailed to ASIFlex)

If a claim for reimbursement is denied or if your request to enroll or change your contribution amounts is denied, you have the right to appeal that decision within 90 days. Your appeal will be reviewed, and you will be notified of the status of your appeal within 60 days of receipt of your appeal.

If the decision on your appeal is still not favorable to you, you may send a second and final appeal within 30 days of the notice that your first appeal was denied. The Office of Administration as the Plan Administrator will review all second level appeals and issue a decision within 60 days of receipt of such second appeal.

CLAIMS FILING INSTRUCTIONS - FSAs (NO CLAIMS WILL BE PAID PRIOR TO 2/1/2021)

Claim Submission Options: There are four different methods by which you may submit your claim. If you file claims using the mobile app or online, you will immediately receive a confirmation/claim number.

- **Mobile:**
  Download ASIFlex's free mobile app available at mocafe.com, Google Play or the App Store. Simply use your smartphone or tablet to take a picture of your documentation with your device's camera. Complete the requested information and file your claim! You can also use the mobile app to view information about your account(s).
- **Online:**
  Submitting your claim online is easy and convenient!
  Sign into your account at mocafe.com, hover over the *Account Detail* tab, and then click on *Participant/Account Detail*. In order to submit your claim via ASIFlex's secure online portal, you will need the following:
  - Your account user credentials (User Name, Password and Security Image).
  - Access to a scanner so that you may scan your documentation. You will be requested to upload the documentation after you complete the online claim.
- **Toll-free fax:**
  (877) 879-9038
  This option provides fast and easy claims submission. You may submit your claim via ASIFlex's toll-free fax number 24 hours a day, 7 days a week.
- **US Mail:**
  MoCafe, P.O. Box 858, Columbia, MO 65205-0858

Claim Filing Guidelines:

- Clearly print your name, address, social security number and your employer's name.
- List expenses and arrange the supporting documentation in the same order.
- Enclose required documentation.
- Claims must be filed by April 15, 2022. Any funds that are not claimed will be forfeited to the State of Missouri in accordance with federal regulations.

IRS Documentation Requirements:
Each item claimed must be supported with proper documentation, including each of the following five (5) essential pieces of information. Your claim will not be processed without the following information:

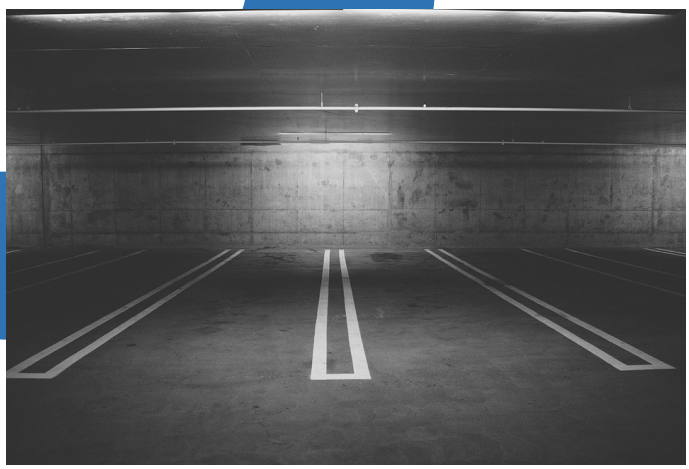
1. Name of the provider or merchant (medical or dependent care)
2. Name of the person, or persons receiving the service or care
3. Date or range of dates of service or care
4. Cost of the service, not just the amount paid
5. Description of the service or care

Without a description of the service or care provided, your claim will be denied. **Credit card receipts, cancelled checks and billing statements without detailed service information are not substantial documentation and will not be accepted.** The description of the service or care can be as generic as "copay" or "office visit". If the description of the service is not listed on the receipt provided from your service or care provider, the provider may write the description on the receipt. Please note if a receipt is not available for dependent/elder care expenses, you may have the care provider sign and date the claim form in the appropriate area instead of providing a receipt.

- **Sign the claim form**. Claim forms that are not signed will not be accepted.
- Keep copies of each receipt and claim form for tax purposes (Dependent/Elder FSA participants must file IRS Form 2441 each year with tax return). Keep in mind that you will need the provider's tax ID or Social Security Number when you file your taxes.
- Submit completed claim form and supporting documentation to ASIFlex.

STATE OF MISSOURI

COMMUTER GUIDE



COMMUTER BENEFIT PROGRAM

State and Federal tax laws allow employees to save taxes on parking at work and mass transit or vanpooling expenses incurred to get to work. Employees save by setting up a pre-tax payroll deduction that reduces taxable income. Your tax savings will vary, depending upon your tax bracket. Most employees will save at least 20% on qualified expenses.

These programs work very similarly to the Cafeteria Plan but are separate from the plan. There are two distinct differences between the Cafeteria Plan and the Commuter Benefit Program. These differences are:

- **Enrollment is ongoing**. Unlike the MOCafe plan, you are not required to re-enroll in the pre-tax spending programs every year during open enrollment. Once you enroll in the Commuter Benefit Program, your enrollment will be ongoing for as long as you are employed by the State, unless you modify your election or terminate participation.

- **You can make a change or stop your election at any point in time.** You are not restricted to making changes after experiencing a life status event. However, changes cannot be made retroactively. To make a change in election or to stop your election, please fill out the Commuter Benefit Program Election form found online at mocafe.com (hover over the *Resources* tab and then click on the *Forms* tab).

There are two separate Commuter Benefits Accounts in which State of Missouri employees are eligible to participate:

- Pre-Tax Parking – Current monthly maximum is $270*
- Mass Transit/Van Pooling – Current monthly maximum is $270*

Pre-Tax Parking: Enrolling in the Pre-Tax Parking program allows you to get a tax break for expenses incurred for parking at or near your main place of employment **or** at or near a location from which you commute to work by car pool, commuter highway vehicle or mass transit. Out-of-pocket parking fees for parking meters, garages and lots qualify for reimbursement, but parking at or near your home is not an eligible expense.

Coverage in the program commences the month after receipt of the enrollment form, and coverage is ongoing until you cancel your election.

Mass Transit/Van Pooling: Enrolling in the Mass Transit/Van Pooling program allows you to get a tax break on expenses such as transit passes, tokens, fare cards, vouchers, or similar items entitling you to ride a mass transit vehicle to or from work. The mass transit service may be publicly or privately operated and includes bus, rail, or ferry. For most Mass Transit participants, ASIFlex will issue you a voucher. However, ASIFlex may also issue a transit pass or terminal-restricted debit card directly.

Van Pooling is defined as a commuter highway vehicle with a seating capacity of at least 7 adults (including the driver). At least 80% of the vehicle mileage must be for transporting employees between their homes and workplace, with employees occupying at least one-half of the vehicle's seats (not including the driver's seat). Not all employees riding in the van must work for the State of Missouri for these expenses to be eligible. For example, you ride in a 7-passenger van with 3 other passengers and the driver. The van is only used for commuting and all five people always ride together. Since at least one-half of the seats other than the driver's seat are occupied by commuters and more than 80% of the van's use is for commuting to and from work, you can include your cost of riding the van in the Commuter Benefits Program.

Deductions for your Mass Transit/Van Pooling program commence the month following receipt of your enrollment, and coverage begins the month after that.

Enrollment: You can enroll in the Commuter Benefits Program at any time by completing an enrollment form or enrolling online (both are available at mocafe.com). Remember that you can enroll, change or terminate your pre-tax deduction at any time. However, all changes are effective on checks issued after the first of the month following the change or enrollment.

* Federal Maximums are subject to change. Please call ASIFlex at 800-659-3035 with any questions.

CLAIMS FILING INSTRUCTIONS - COMMUTER

ASIFlex will send you a welcome packet shortly after you enroll in the Commuter Benefits Program. To receive reimbursement for your expenses, you just submit a claim form and documentation to ASIFlex for processing. Forms are available on mocafe.com (hover over the *Resources* tab and click on *Forms*).

Claims and receipts may be filed via several different methods:

- online at mocafe.com (hover over the *Account Detail* tab and then click on *Participant/Account Detail*);
- faxed to (877-879-9038); or
- mailed to ASIFlex via U.S. Mail.

Mass Transit Participants: As stated above, most Mass Transit Participants will not receive cash reimbursement for expenses. Instead, ASIFlex will purchase vouchers and transit passes, and mail these to you on a regular basis. For most participants, it is anticipated these vouchers will be valid for one month at a time. If you are a Mass Transit participant (i.e. you are riding a train, bus or ferry), please contact ASIFlex via email (asi@asiflex.com) or phone (800-659-3035) to discuss how you will receive reimbursements for your Mass Transit expenses.

Reimbursement requests are generally processed within 1-3 business days of receipt. Payments are released **up to the amount you currently have available**. Payments will be released, up to your available funds, each business day. Be sure to sign up for direct deposit to have quicker access to your funds. Payments will be made by check for anyone not signing up for direct deposit.

Please note that you can claim more than you are having deducted for a given month, and the requests in excess of your available funds will roll forward to the next month and will automatically be reimbursed when your next payroll deduction occurs. However, requests that exceed the monthly Federal maximums* will only be processed up to these maximums. Please review the following example to clarify this:

> **Example:** Steve normally incurs $200 per month in van pooling expenses, so he enrolls in the Commuter Benefit Program and has $200 per month deducted pre-tax for these expenses. In January, Steve is assessed $200 by his van pool coordinator, submits a claim for that amount and is reimbursed. In February, two of the riders in the van pool take new jobs closer to home and stop riding in the van pool, so Steve is charged $275 per month for his share of the ride in February. Steve submits his claim to ASIFlex for $275, which exceeds the statutory limit* of $270 per month. ASIFlex reimburses him the $200 he has available and $70 is reimbursed the next time he has a payroll deduction. Since the statutory maximum is $270 per month for van pool expenses, the only amount that rolls forward is the $70 difference.

Documentation: Federal Regulations require you to provide a written statement from the provider of the service that supports your claim if the provider provides receipts or other documentation in the ordinary course of its business. If the provider does not provide receipts or other documentation, explain the situation in the column labeled "Attach proof of expense or explain why it is not available in the ordinary course of business." If the provider normally provides documentation such as receipts you must provide a copy with your claim.

The documentation must show:

- ✓ The name of the provider;
- ✓ The date or range of dates of parking, travel, or payment. You may not claim expenses for more than one month on one line;
- ✓ A description of the service provided (for example, "April 2021 parking" or "May 2021 bus fare"); and
- ✓ The cost of the service or the amount paid.

Cost to Participate: If you enroll in the mass transit program and are receiving vouchers in the mail or do not sign up for direct deposit, you will be assessed a fee of $4.00 per month. If you are not receiving vouchers in the mail and are signed up to receive reimbursements via direct deposit, you will be assessed a per month fee of $2.80.

* Federal Maximums are subject to change. Please call ASIFlex at 800-659-3035 with any questions.