

2011-2012

Flexible Benefits Accounts



The State of Illinois
FSA Booklet



Accessing Your Benefits

Our Customer Care Center offers you a variety of resources to make inquiries about your benefits and Flexible Spending Accounts (FSAs), including information from the website, Interactive Voice Response system (IVR) and our Customer Care Representatives.

On the Web

Visit "www.myFBMC.com" to access our home page. Use the navigational tabs along the top of the Web page to get answers to many of your benefits questions.

If you previously registered an e-mail address and password, you may continue using this information. If you haven't registered, log in to the website as a first time user. Follow the link on the login page and register through Premier Login.

Benefits

You can check your benefit status, read benefit descriptions, use our tax calculator and much more.

FSA Claims

Check the status of your FSA claims, download forms, get information about mailing and faxing your claim and see transactions that need documentation.

FSA Balance(s)

View your FSA balance(s) and contributions or review monthly statements and your transaction history.

myFBMC Card® Visa® Card

Please visit www.myFBMC.com to activate your myFBMC Card®. You may also download a card fact sheet or claim form, read detailed instructions on proper card use and review our IIAS Store List to maximize card convenience.

Profile

Change your account profile, access your Member ID or select a new phone Personal Identification Number (PIN).

Resources

Browse through our extensive resource library, including: benefit materials, eligible medical and dependent care expenses, required documentation, Over-the-Counter drug listings and benefit tips.

FSA Forms

Download applicable forms for FSA reimbursement and Direct Deposit.

Over the Phone

Our automated phone system, IVR, can be reached 24-hours a day by calling 1-800-865-3262. IVR allows you to access your benefits any time, follow the voice prompts to find out information about your benefits such as:

- Current FSA balance(s)
- Current active benefits
- FSA claim status
- Mailing address verification
- Obtain FSA claim forms
- Change your PIN

Personal Identification Number (PIN)

To access the IVR system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your PIN. After your initial login, you will be asked to register and select your own confidential PIN to access this system in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero.

Record your PIN here.

Remember, this will be your PIN for IVR access.

If you forget your PIN, call Customer Care at **1-800-342-8017**.

Note: Please be sure to keep this FSA Booklet in a safe, convenient place, and refer to it for benefit information.

The State of Illinois

Important Dates to Remember

Your Period of Coverage* dates are: July 1, 2011, through June 30, 2012

FSA Run-out Period due date: September 30, 2012

MCAP Grace Period: July 1, 2012, through September 15, 2012

* May differ if you have a mid-year qualifying change in status.

Important Enrollment Information

- Your FY2012 Plan Year is July 1, 2011, through June 30, 2012.
- When submitting a reimbursement request, be sure to send all information and documentation directly to Fringe Benefits Management Company, a Division of WageWorks. Do not send this information to the State of Illinois, FSA Unit.
Please note: In addition to the State of Illinois' dedicated medical and dependent care claims submission fax number, there is a toll-free fax number for claims submission. Please see pages 8 & 12 for more information.
- Remember, if you experience a mid-year qualifying change in status, your period of coverage may change and expenses incurred are connected to that same time period. A split period of coverage may occur if you make a mid-year change due to a qualifying change in status. Please see page 14 for more information.
- The myFBMC Card® is available to enhance your Medical Care Assistance Plan (MCAP). See pages 9 & 10 for further details.
- Direct Deposit is a reimbursement option for both MCAP and DCAP.
- Orthodontic services can be paid for with the myFBMC Card® when services are rendered. The entire amount of the patient's responsibility for the orthodontic services is eligible to be reimbursed in full. See pages 7 & 8 for information.
- If enrolling during the Benefit Choice Period, return your completed Enrollment Form to your Group Insurance Representative (GIR) before the Benefit Choice deadline of May 31, 2011. Your enrollment will be effective July 1, 2011.
- If enrolling during the plan year, return your completed Enrollment Form to your Group Insurance Representative (GIR) within 60 days of your qualifying event. Your enrollment will be effective the first day of the pay period following the date the enrollment form was signed or the date of the event, whichever is later.

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Making Your Benefits Work for You — It's Easy.

- Once you review the FSA guidelines and become familiar with how the program works, you should be able to determine how you and your family can save a significant amount of tax money – if you understand the governing IRS rules. See page 5 for FSA guidelines.
- When necessary, remember to submit your supporting documentation, billing statements or invoices along with your Claim Form when using the myFBMC Card® for medical services. You will receive a Monthly Statement, indicating in BLUE which medical expenses require further documentation.
- You may visit www.myFBMC.com or contact the Customer Care Center at 1-800-342-8017.

Flexible Spending Accounts

What is a Flexible Spending Account?

Flexible Spending Accounts (FSAs) are IRS tax-favored accounts to help you save money on your medical and dependent care expenses.

Flexible Spending Accounts feature:

- reimbursement of eligible expenses tax-free
- per-pay-period deposits from your salary before taxes
- savings on income and Social Security taxes and
- piece of mind paying for your anticipated eligible expenses.

Is an FSA Right For Me?

If you spend \$240 or more on recurring eligible expenses during your plan year, you may save money with an FSA.

- You decide the total amount you want deposited.
- A portion of your salary is deposited into your FSA each pay period.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes with each pay period.
- Determine your potential savings with a Tax Savings Analysis by visiting the "Tax Calculators" link at www.myFBMC.com.

What Types of FSAs are Available?

Your employer offers you a Medical Care Assistance Plan (MCAP) and a Dependent Care Assistance Plan (DCAP). If you incur both types of expenses during a plan year, you should enroll in both FSAs.

Medical Care Assistance Plan (MCAP)

Medical expenses may be eligible for reimbursement using your MCAP, including:

- birth control pills
- eyeglasses
- orthodontia
- Over-the-Counter[†] items (some exceptions apply, see page 7).

Dependent Care Assistance Plan (DCAP)

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

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

Refer to the *Medical Care Assistance Plan* and *Dependent Care Assistance Plan* sections of this FSA Booklet for specifics on each type of FSA.

Receiving Reimbursement

Your reimbursement will be processed within two business days from the time your properly completed and signed FSA Claim Form is received. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

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

- FSA reimbursement funds are automatically deposited into your checking or savings account within 48 hours of your claim approval.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will still receive notification that the claim has been processed).
- Once direct deposit is active, you do not need to enroll again every plan year.

To apply, complete the Direct Deposit Form available at www.myFBMC.com or www.benefitschoice.il.gov, or call Customer Care at 1-800-342-8017. Mail or fax your completed form to the number or address indicated on the form. Please note that processing your Direct Deposit enrollment may take between four and six weeks.

Where Can I Get Information About FSAs?

If you have specific questions about FSAs, contact FBMC Customer Care.

- Visit www.myFBMC.com.
- Call **1-800-342-8017** (Monday - Friday, 6 a.m. - 9 p.m. CT).

Please note – we will not discuss your account information with others without your verbal or written authorization.

[†] Over-the-Counter (OTC) drugs and medicines are no longer eligible for reimbursement without a prescription from your physician.

FSA Savings Example*

(With FSA)		(Without FSA)
\$31,000.00	Annual Gross Income	\$31,000.00
<u>- 5,000.00</u>	FSA Deposit for Eligible Expenses	<u>- 0.00</u>
\$26,000.00	Taxable Gross Income	\$31,000.00
<u>- 5,369.00</u>	Federal, Social Security Taxes	<u>- 6,401.50</u>
\$20,631.00	Annual Net Income	\$24,598.50
<u>- 0.00</u>	Cost of Eligible Expenses	<u>- 5,000.00</u>
\$20,631.00	Spendable Income	\$19,598.50

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income.

That's a potential annual savings of

\$1,032.50!

* Based upon a 20.65% tax rate (15% federal and 5.65% Social Security) calculated on a calendar year.

Flexible Spending Accounts

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your MCAP or vice versa.
3. You have a 90-day run-out period at the end of the plan year to request reimbursement of eligible FSA expenses. Eligible MCAP expenses are those that occurred either during the plan year or during the 2 1/2 month "grace period"[†] following the last day of the plan year. The grace period ends September 15, 2012; the run-out period ends September 30, 2012. Eligible DCAP expenses are those that occurred during the plan year, July 1, 2011, through June 30, 2012.
4. You may not receive insurance benefits or any other compensation for expenses that are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service that you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the FY2012 Plan Year. IRS regulations state that any unused funds that remain in your FSA after a plan year and any applicable grace period ends[†], and all reimbursable requests have been submitted and processed, cannot be returned to you or carried forward to the next plan year.
8. When enrolling in either or both FSAs, written notice of agreement with the following will be required.
 - I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents
 - I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA

- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the reimbursement.

What Documentation of Expenses Do I Need to Keep?

The IRS requires FSA participants to maintain complete documentation, including keeping copies of statements, invoices or bills for reimbursed expenses, for a minimum of two years.

How Do I Get the Forms I Need?

To obtain forms you need after enrolling in your FSA(s), such as a Claim Form, Letter of Medical Need or Direct Deposit Form, you can visit www.myFBMC.com, or call Customer Care at 1-800-342-8017. For more information, refer to the *Getting Answers* section of this FSA Booklet.

Will Contributions Affect My Income Taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower taxes and taxable income. These are some of the money-saving aspects of your FSA. Your salary reductions reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

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

When Is My Effective Date If I Enroll in the Program Mid-year?

If you enroll in an FSA after the Benefit Choice enrollment period, your effective date will be the first day of the pay period following the date the enrollment form was signed, or the date of the event, whichever is later.

†MCAP Grace Period

An IRS Revenue Notice permits a "grace period" of two months and 15 days following the end of your FY2012 Plan Year (June 30, 2012) for an MCAP. This grace period ends on September 15, 2012. **During the grace period, you may incur expenses and submit claims for these expenses.** Funds will be automatically deducted from any remaining dollars in your FY2012 MCAP.

You should not confuse the grace period with the plan's "run-out period." The run-out period extends until September 30, 2012. This is a period for filing claims incurred anytime during the FY2012 Plan Year, as well as claims incurred during the grace period mentioned above.

Claims will be processed in the order in which they are received, and the proper plan year account will be debited accordingly. This is true for paper and online reimbursement requests, as well as myFBMC Card[®] transactions. If you have funds remaining in the prior plan year's account, these funds will be used first until exhausted. Subsequent claims will be debited from your new plan year account balance.

All FY11 claims should be submitted prior to using the myFBMC Card[®] for services rendered during the two and a half month grace period.

To utilize the card during the grace period you must be enrolled in the current plan year.

The "grace period" mentioned above does not apply to DCAP.

Medical Care Assistance Plan (MCAP)

What is MCAP?

The MCAP is an IRS tax-favored account to pay for your eligible medical expenses. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on page 7.

Who is Eligible to Participate in the Medical Care Assistance Plan (MCAP)?

To participate in the Medical Care Assistance Plan (MCAP), you must be:

- a State of Illinois employee working full-time or part-time 50% or greater
- receiving a paycheck from which deductions can be taken
- eligible to participate in the State Employees' Group Insurance health plan.

May I Continue to File MCAP Claims for the Period of Time I Am Off Payroll Due to a Leave of Absence?

You must complete an MCAP COBRA form in order to continue participation in the Program while off payroll. You must send direct payments to the FSA Unit until you return to payroll. It is your responsibility to submit your MCAP COBRA payment each month; no monthly bill will be sent to you. If you elect this option, you may continue to file claims for the period of time you are off payroll. If you elect not to continue participation in MCAP through the COBRA option, no services will be eligible for reimbursement following your termination.

Can I Continue to Participate in My MCAP After I Terminate Employment or Retire?

You may continue participation in your MCAP if you complete an MCAP COBRA form prior to, or at the time of, termination or retirement. **If you elect this option, you are required to continue participation through the end of the plan year.** You should contact your

GIR prior to termination or retirement for any available options.

Whose Expenses are Eligible?

Your MCAP may be used to reimburse eligible expenses incurred by:

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

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

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 26 years old or younger at the end of the taxable year and
- have not provided over one-half of their own support during the taxable year.

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

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

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care.

When are My Funds Available?

Once you sign up for the MCAP and decide how much to contribute, the annual election amount is available for eligible health care expenses beginning the first day of your period of coverage.

Since you do not have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses the first day of your eligibility period.

Minimum Deposit:

\$20 monthly (\$240 annually)

Maximum Deposit:

\$416.66 monthly*
(\$4,999.92 annually)

* \$555.54 per month for university employees paid over a 9 month period.

Over-the-Counter Expenses[†]

Over-the-Counter (OTC) items, medicines and drugs may be reimbursable through your MCAP. Save valuable tax dollars on certain categories of OTC items, medicines and drugs. For more information please visit www.myFBMC.com.

You may be reimbursed for OTCs through your MCAP if:

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

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. It is your responsibility to remain informed of updates to this listing. As soon as an OTC item, medicine or drug becomes eligible under any of the categories, it will be reimbursable retroactively to the start of the current plan year.

[†] Over-the-Counter (OTC) drugs and medicines are no longer eligible for reimbursement without a prescription from your physician.

Medical Care Assistance Plan (MCAP)

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

Is Orthodontic Treatment Reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable if the proper documentation is attached to the initial FSA Claim Form each plan year:

- a written statement from the treating dentist/orthodontist showing the type of service, the date the service was incurred, the name of the eligible individual receiving the service and the cost for the service and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed.

Should I Claim My Expenses on IRS Form 1040?

With an MCAP, the money you set aside for health care expenses is deducted from your salary before taxes. If you are enrolled in an MCAP you cannot claim these expenses on your 1040. It is always tax-free, regardless of the amount. By enrolling in the MCAP, you guarantee your savings.

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

Are Some Expenses Ineligible?

Examples of expenses not eligible for reimbursement through your MCAP include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic services, vitamins, supplements, prescription drugs or any expenses not allowed by the Internal Revenue Code that are not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

Are Prescriptions Eligible for Reimbursement?

Yes, most filled prescriptions are eligible for MCAP reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires that either the complete name of all medicines and drugs or prescription number be obtained and documented on pharmacy invoices. This information must be included when submitting your request for reimbursement.

Can Travel Expenses for Medical Care Be Reimbursed?

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

- actual round-trip mileage (19.5 cents per mile - subject to change during the plan year)
- parking fees
- tolls and
- transportation to another city.

Partial List of Eligible Expenses*

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

Note: Budget conservatively. No reimbursement or refund of MCAP funds is available for services that do not occur within your plan year and grace period.

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

† Over-the-Counter (OTC) drugs and medicines are no longer eligible for reimbursement without a prescription from your physician.

Visit www.myFBMC.com for a list of frequently asked questions.

You must keep your documentation for a minimum of two years to submit upon request.

Medical Care Assistance Plan (MCAP)

When Do I Request Reimbursement?

You may use your MCAP to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your insurance and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date received, not the date ordered (e.g., contact lenses, dentures, etc).

How Do I Request Reimbursement?

Requesting reimbursement from your MCAP is easy. Simply mail, fax or submit through on-line submission, a correctly completed FSA Claim Form along with an Explanation of Benefits (EOB)*, a receipt, invoice or bill from you health care provider listing the date you received the service, the cost of the service, the specific type of service, the person for whom the service was provided and any uninsured portion of the cost, if applicable.

If these services could be deemed cosmetic in nature, a written statement from your health care provider indicating the service was medically necessary must be accompanied by the receipt, invoice, EOB or bill for the service.

Fax Toll-Free:

1-866-440-7152

State of Illinois' dedicated fax:

1-850-514-5817

Mail to:

Fringe Benefits Management Company,
a Division of WageWorks
PO Box 1800
Tallahassee, FL 32302-1800

You may also submit claims online at www.myFBMC.com. Simply log in to your account, click on the "Online Claims Submission" option under the Claims tab and follow the instructions.

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



myFBMC Card[®] Visa[®] Card

The myFBMC Card[®] is a convenient reimbursement option that allows quick electronic reimbursement of eligible expenses under your employer's plan and IRS guidelines. Because it is a payment card, when you use the myFBMC Card[®] to pay for eligible expenses, funds are electronically deducted from your account.

What is the myFBMC Card[®]?

The myFBMC Card[®] is a stored-value card. It is a convenient MCAP reimbursement option that allows us to electronically reimburse eligible expenses under your employer's plan and IRS guidelines. Your annual MCAP contribution is available to you at the beginning of your plan year. When you use your myFBMC Card[®] to pay for eligible expenses, funds are electronically deducted from your MCAP.

What are the myFBMC Card[®] Advantages?

In addition to eligible medical expenses, you can also use the myFBMC Card[®] for eligible Over-the-Counter (OTC) expenses at drugstores. For a partial list of eligible OTC items please visit www.myFBMC.com.

Other advantages include:

- instant reimbursements for health care expenses, including prescriptions, co-payments and mail-order prescription services
- transactions for eligible expenses at IAS Certified Merchants do not require further documentation
- no out-of-pocket expense and
- easy access to your MCAP funds.

Note: You should not use the myFBMC Card[®] for ineligible expenses, such as cosmetic dental expenses or eye glass warranties.

How Do I Get the myFBMC Card[®]?

You will automatically receive the card when you start an MCAP. Two cards will be sent to you in the mail; one for you, and one for your spouse or eligible dependent. Everyone will receive the Card free of charge. During the plan years in which you have an MCAP, your card will remain active until the expiration date as long as you re-enroll in the program each year.

Using the myFBMC Card[®]

There is no fee for the myFBMC Card[®].

For eligible expenses, simply swipe the myFBMC Card[®] like you would with any other credit card. Whether at your health care provider or at your drugstore, the amount of your eligible expenses will

be automatically deducted from your MCAP. Eligible OTC and prescription purchases can only be made at IAS certified merchants*. For all other qualified expenses, such as medical, vision and dental co-payments, the myFBMC Card[®] will be used normally, although additional documentation may be required. To find out if a pharmacy or drugstore near you accepts the card, please refer to the **IAS Store List** at www.myFBMC.com. Remember, you can go to www.myFBMC.com to activate your card, see your account information and check for any outstanding Card transactions.

* The Card should be used for the current plan year expenses only and should not be used for past due balances from the previous plan year.

When Do I Send in Documentation for a myFBMC Card[®] Expense?

You must send in documentation for certain myFBMC Card[®] transactions, such as those that are not a known co-pay. When indicated on your monthly statement, you must send in documentation for these transactions. Documentation for a myFBMC Card[®] expense is a statement or bill showing:

- name of the patient
- name of the service provider
- date of service
- type of service (including prescription name) and
- total amount of service.

Note: This documentation must be sent with a **Claim Form** and cannot be processed without it. Like all other FSA documentation, you must keep myFBMC Card[®] expense documentation for a

Remember, all medicinal OTC items require a prescription for FSA reimbursement and myFBMC Card[®] use.

minimum of two years, and submit it to Fringe Benefits Management Company, a Division of WageWorks, when requested.

As an MCAP participant, you should go to www.myFBMC.com to see your account information and check for any outstanding Card transactions. If an outstanding transaction appears in **red** on the website or in **blue** in the *myFBMC Card[®]* section of your monthly statement, you must submit the proper expense documentation to us within 30 days in order to avoid having your card suspended.

Note: Card transaction disputes must be filed within 60 days of the transaction date.

If you fail to send in the requested documentation for a myFBMC Card[®] expense, you will be subject to:

- withholding of payment for an eligible non-card claim to offset any outstanding myFBMC Card[®] transaction
- suspension of your myFBMC Card[®] privileges
- payback through involuntary withholding, **even if you are no longer employed by the State**
- the reporting of any outstanding myFBMC Card[®] transaction amounts as income on your W-2 at the end of the tax year.

What Agreement am I Making When I Use the myFBMC Card[®]?

By using the myFBMC Card[®], you are agreeing to the "Written Certification" portion of the Beyond Your Benefits section on page 15 of this FSA Booklet.

myFBMC Card® Visa® Card

Automatic Adjudication

Automatic adjudication is a procedure in which certain myFBMC Card® transactions are substantiated without the need of an Explanation of Benefits (EOB) or other documentation. This is done by matching known co-payments from the State's health and vision plans to the merchant from which service was received.

Note: Quality Care Health Plan (QCHP) claims and all dental claims will need to have documentation provided to Fringe Benefits Management Company, a Division of WageWorks.

For example, a doctor's office visit may have a standard co-payment of \$15 per visit during normal office hours. When a myFBMC Card® transaction is received, the co-payment amount is recognized as a standard amount and the transaction can be automatically adjudicated.

If you do not participate in the State's medical plan, automatic adjudication is not possible for co-payments and documentation will need to be submitted.

To assist employees in knowing when documentation is needed and when it is not, you will receive a monthly statement outlining which transactions were processed and which are outstanding.

Outstanding transactions that require documentation appear in blue on your monthly statement (on the Web, outstanding transactions appear in red). If a transaction remains in blue (i.e., documentation was not submitted) for two monthly statement cycles, your card will be suspended from further use until the documentation is provided or a non-card claim is auto-substituted.

- The myFBMC Card® is a payment card that electronically debits funds from your MCAP account when an eligible expense is incurred. Your full annual election amount is available for use the first day of the plan year. You will automatically receive the card when you enroll in an MCAP. There is no fee for the card.

- The card may be used at any health care provider for medical, dental or vision expenses. If the charges are in the amount of the State plan's co-payment, you do not need to submit substantiation documentation; however, if they are for any other amount, you must submit the documentation.
 - Note:** A warranty for eyeglasses is not an eligible expense.
- The card may be used at any dental provider; however, **you must always submit documentation for dental charges.**
 - Note:** Cosmetic dental procedures are not eligible expenses.
- The card may be used for prescriptions and over-the-counter medications at any pharmacy, grocery store or general merchandise store that has implemented the IIAS system* without needing to provide documentation. To view the **IIAS Store List**, visit **www.myFBMC.com** and click on the 'Resources' tab.
- When swiping the card at a merchant or health care provider location, use the credit card option (not debit card). There is NO PIN number for this card.
- You must provide substantiation documentation for outstanding transactions (indicated in BLUE on the monthly statement) within two monthly statement cycles, **even if you leave State employment.** This is an IRS requirement!
- You can still access the funds in your MCAP account by submitting a claim form, even if your card has been suspended by checking the "Pay Me" box on the claim form.
- If you do not send substantiation documentation within 60 days of the swipe date, any non-card claim sent in for reimbursement will be automatically substituted for the outstanding card transaction. Once all transactions have been satisfied, your card will be re-activated within 48 hours.

- The myFBMC Card® card holder must be enrolled in the State's health, dental and vision coverage in order for the myFBMC Card® transactions to be auto adjudicated. If you are not enrolled in the State's plan you need to send EOB's or other documentation for all card transactions, except prescription and eligible over-the-counter items purchased at an IIAS* location.
- Always save your receipts for at least two years!

Remember!

Documentation must be submitted when the card is used for the following services or expenses:

- all dental visits
- vision services that are not the State plan's co-payment amount or a multiple of that amount (up to 5 times)
- doctor's office visits that are not in the amount of the State plan's co-payment or a multiple of that amount (up to 5 times)
- hospital charges (such as inpatient and outpatient hospital visits) that are not State plan's co-payment amount

* The automatic adjudication system that allows eligible medical FSA expenses to be purchased with the myFBMC Card® is called the Inventory Information Approval System (IIAS). This system is only used for auto adjudication of prescription and eligible over-the-counter items. For a list of IIAS merchants, visit **www.myFBMC.com** and click on 'Payment Card,' then 'IIAS Store List.'

Dependent Care Assistance Plan (DCAP)

Minimum Deposit:

\$20 monthly (\$240 annually)

Maximum Deposit:

The maximum contribution depends on your tax filing status as the list to the right indicates, not to exceed \$416.66 per month*.

* \$555.54 per month for university employees paid over a 9-month period.

What is the DCAP?

The DCAP is used to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if applicable) are actively working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Who is Eligible to Participate in the Dependent Care Assistance Plan (DCAP)?

To participate in the Dependent Care Assistance Plan (DCAP), you must be:

- a State of Illinois employee actively working full-time or part-time 50% or greater
- receiving a paycheck from which deductions can be taken

Note: If you are married, your spouse must also be gainfully employed, a full-time student, disabled and incapable of self-care or seeking employment and have income for the fiscal year.

My Spouse Recently Became Unemployed. May I Continue to Participate in DCAP?

No. Expenses incurred while you and/or your spouse are not actively at work, or are not actively looking for work, are ineligible for DCAP reimbursement.

May I Continue to Participate in DCAP if I or My Spouse Go Off Payroll Due to a Leave of Absence, Termination of Employment or Retirement?

No. The purpose of the DCAP is to enable participants to be reimbursed for daycare expenses while they are actively working.

Whose Expenses are Eligible?

You may use your DCAP to receive reimbursement for eligible dependent care expenses for qualifying individuals.

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

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are under 13 years old and
- have not provided more than one-half of their own support during the taxable year.

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

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

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

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

Note: Only the custodial parent of divorced or legally-separated parents can be reimbursed using DCAP.

Partial List of Eligible Expenses*

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

Note: Budget conservatively. No reimbursement or refund of DCAP funds is available for services that do not occur within your plan year.

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

When Am I Eligible to Enroll in DCAP After I Have A Baby?

After having a baby, participants have 60 days from the later of the time they or their spouse **return to work** to enroll in DCAP. The effective date of enrollment is the first day of the pay period following the date the DCAP Enrollment Form is signed or the date they return to work, whichever is later.

What is My Maximum Annual Deposit?

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

Dependent Care Assistance Plan (DCAP)

When are My Funds Available?

Once you sign up for DCAP and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike MCAP, the full annual election amount is not available at the beginning of your plan year, but as your payroll deductions are applied to your account.

Should I Claim Tax Credits or Exclusions?

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

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

To help choose between the available taxable and tax-free benefits, or a combination, consult your tax advisor and/or the IRS for additional information. You may also visit www.myFBMC.com to complete a tax savings analysis.

Are Some Expenses Ineligible?

Examples of expenses not eligible for reimbursement through the DCAP include:

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

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

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

Will I Need to Keep Any Additional Documentation?

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

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

When Do I Request Reimbursement?

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

How Do I Request Reimbursement?

Requesting reimbursement from your DCAP is easy. Simply mail, fax or submit through on-line submission, a correctly completed FSA Claim Form along with receipts showing the following:

- the name, age and grade of the dependent receiving the service

- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

If you do not get a receipt, your provider must sign the claim form in lieu of the receipt. Be certain you obtain and submit the above information when requesting reimbursement from your DCAP. This information is required with each request for reimbursement.

Fax Toll-Free:

1-866-440-7152

State of Illinois' dedicated fax:

1-850-514-5817

Mail to:

Fringe Benefits Management Company,
a Division of WageWorks
PO Box 1800
Tallahassee, FL 32302-1800

You may also submit claims online at

www.myFBMC.com. Simply log in to your account, click on the "Online Claims Submission" option under the Claims tab and follow the instructions.

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

FSA Worksheets

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

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

MCAP Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year. All services must be medically necessary.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	\$ _____
Coinsurance or co-payments	\$ _____
Vision care	\$ _____
Dental care	\$ _____
Prescription drugs	\$ _____
Eligible Over-the-Counter (OTC) items	\$ _____
Travel costs for medical care	\$ _____
Other eligible expenses	\$ _____

TOTAL Remember, your total contribution cannot exceed IRS and FSA limits for the plan year, calendar year and/or per pay period basis \$ _____

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

This is your pay period contribution \$ _____

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

DCAP Worksheet

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

CHILD CARE EXPENSES

Day care services	\$ _____
In-home care/au pair services	\$ _____
Nursery and preschool	\$ _____
After school care	\$ _____
Summer day camps	\$ _____

ELDER CARE SERVICES

Day care center	\$ _____
In-home care	\$ _____

TOTAL Remember, your total contribution cannot exceed IRS and FSA limits for the plan year, calendar year and/or per pay period basis \$ _____

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

This is your pay period contribution \$ _____

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

DIRECT DEPOSIT - With Direct Deposit there are no fees for the service and your FSA reimbursement checks are deposited into the checking or savings account of your choice within 48 hours of claim approval.

Changing Your Coverage

Changing Your FSA During the Plan Year

Within **60 days** of a qualifying event, you must submit a Change in Status (CIS)/Election Form and supporting documentation to your Group Insurance Representative. Upon the approval of your election change request, your existing FSA election(s) will be stopped or modified (as appropriate). Visit www.myFBMC.com for information on rules governing periods of coverage and IRS Special Consistency Rules.

Changes in Status:	
Marital Status	A change in marital status includes marriage, death of a spouse, divorce, legal separation or annulment.
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan, including commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence[†]	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan, including moving out of an HMO service area.
Some Other Permitted Changes:	
Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care Assistance Plan benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none"> • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order[†]	If a judgment, decree or order from a divorce, legal separation, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid[†]	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 60 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical Care Assistance Plan.

† Does not apply to a Dependent Care Assistance Plan.

Beyond Your Benefits

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call Customer Care at 1-800-342-8017 for an approximation.

Notice of Administrator's Capacity

This notice advises Flexible Spending Account participants of the identity and relationship between your employer and its Contract Administrator, Fringe Benefits Management Company, a Division of WageWorks. We are not an insurance company. We have been authorized by your employer to provide administrative services for the Flexible Spending Account plans offered herein. We will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against us than would otherwise be afforded to you by law.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing even if I am no longer an employee of the State.

Glossary of Terms

Auto-Adjudication

Auto-Adjudication is an automatic process which allows medical, pharmacy, over-the-counter and vision services with known co-payments to be paid directly out of the employees MCAP account upon the employee presenting their FSA card. When the employee uses the card to pay for an item or service that has a known co-payment, documentation is not required.

Auto-Substitution

Unsubstantiated transactions appear on monthly FSA statements in blue. Employees have 60 days to substantiate these transactions. Once the 60-day time period passes, any paper claims received by the plan administrator for a different medical expense will be automatically substituted to offset the outstanding FSA card transaction.

Explanation of Benefits (EOB)

A statement from a plan administrator explaining benefit determinations.

Follow-up Documentation

Acceptable documentation includes itemized bills and Explanation of Benefits (EOB)

Inventory Information Approval System (IIAS)

The IIAS automatically processes eligible over-the-counter and prescription items by reading the item's barcode. Documentation is never required for eligible expense when the card is used at a location that has this system. Most major discount and pharmacy stores have implemented the system.

Substantiation

Transactions with known co-payments, such as physician office visits, are determined by a specific schedule of benefits and therefore do not typically require follow-up documentation (i.e. they are auto-adjudicated). However, in situations where a medical, dental, pharmacy or vision service or item does not have a specific co-payment amount, follow-up documentation must be submitted to Fringe Benefits Management Company.

Notes

Benefits Directory

State of Illinois

*Enrollment, Qualifying Change in Status,
Payroll Discrepancies*

Mon - Fri, 8:30 a.m. - 5 p.m. CT
1-800-442-1300
www.benefitschoice.il.gov

Fringe Benefits Management Company, a Division of WageWorks Customer Care Center

*Claims Eligibility and Status,
Reimbursement Checks, myFBMC Card®,
Monthly Statements, Account Balance*

Mon - Fri, 6 a.m. - 9 p.m. CT
1-800-342-8017

Flexible Spending Accounts

Automated Services

24 hours a day
1-800-865-3262
www.myFBMC.com

Services provided:

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Claim Forms
- myFBMC Card® Status
- Change IVR Access Pin

Reimbursement

P.O. Box 1810
Tallahassee, FL 32302-1810
Fax to: 1-850-514-5817
Toll-free Fax: 1-866-440-7152

myFBMC Card®

Lost or Stolen Card

24 hours a day
1-888-462-1909

Dispute Line

Customer Care
Mon - Fri, 6 a.m. - 9 p.m. CT
1-800-342-8017

Activation

24 hours a day
www.myFBMC.com

Sponsored by your employer and brought to you by

Fringe Benefits   
Management Company

A Division of WageWorks

P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Care 1-800-342-8017 • 1-800-955-8771 (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.



*Printed on Domtar Husky® Offset Opaque paper.
The paper used to create this book is made
from renewable forests using a sustainable
management process and technologies.*