
Flexible Spending Accounts
The State of Illinois

Plan Year 2009-2010

FSA Booklet



Accessing Your Benefits

FBMC Customer Care offers you a variety of resources to make inquiries on your benefits and Flexible Spending Accounts (FSAs), including information from the FBMC Web site, Interactive Voice Response system or Customer Care.

On the Web

Type "www.myFBMC.com" into your Internet browser to access FBMC's 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 on FBMC's Web site, you may continue using this information. If you haven't registered, or if you registered prior to January 19, 2008, log in to the site as a first time user. Follow the link on the login page and register through the FBMC Premier Login.

Benefits

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

Claims

Check the status of your claim, download forms, get more information about mailing and faxing your claim to FBMC or see transactions that need documentation.

Accounts

View your account balance and contributions or review monthly statements and your transaction history.

Payment Card

Download a card fact sheet or claim form, read detailed instructions on proper use and review our IIAS Store List to maximize card convenience. Please visit www.myFBMC.com to activate your myFBMC CardSM.

Profile

Change your account profile, access your FBMC Member ID or select a new phone PIN.

Resources

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

Forms

Download applicable forms for reimbursement and Direct Deposit.

Over the Phone

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). Allowing you to access your benefits any time, follow the voice prompts to find out information about your benefits such as:

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)

To access Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first 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 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 Reference Guide 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, 2009, through June 30, 2010.

FSA Run-out Period due date:

September 30, 2010

MCAP Grace Period:

July 1, 2010, through September 15, 2010

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

Table of Contents

4	Enrollment at a Glance
5	Eligibility Requirements
6	Flexible Spending Accounts
8	Medical Care Assistance Plan (MCAP)
10	myFBMC Card SM Visa [®] Card
12	Dependent Care Assistance Plan (DCAP)
14	FSA Worksheets
15	Changing Your Coverage
16	Beyond Your Benefits
17	Enrollment Forms
back	Benefits Directory

Enrollment at a Glance

What's New

FBMC is replacing the EZ REIMBURSE® Card with the myFBMC CardSM Visa® Card. MCAP Participants who already have the EZ REIMBURSE® Card will be receiving the myFBMC CardSM to replace their current cards. If you have questions, please contact FBMC Customer Care.

Important Enrollment Information

- Your FY2010 Plan Year is July 1, 2009, through June 30, 2010.
- When submitting a reimbursement request, be sure to send all information and documentation directly to FBMC. 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 9 & 13 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.
- FBMC offers the myFBMC CardSM as a Medical Care Assistance Plan (MCAP) enhancement. There is a \$20, non-refundable annual fee when you elect to receive the card. See Page 10 for further details.
- A split period of coverage may occur if you make a mid-year change due to a qualifying change in status. Contact FBMC for further details.
- Direct Deposit is a reimbursement option for both MCAP and DCAP.
- Certain Over-the-Counter (OTC) items are eligible for reimbursement. See Page 8 for further information.
- Orthodontic services can be paid for with the myFBMC CardSM when services are rendered. The entire amount of the patient's responsibility for the orthodontic services is eligible to be reimbursed in full. See Page 10 for information about documentation needed for reimbursement.
- 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, 2009. Your enrollment will be effective July 1, 2009.
- 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.

Making Your Benefits Work for You

— It's Easy.

- Once you review the FSA guidelines and become familiar with how the program works, you'll determine how you and your family can save a significant amount of tax money — if you understand the governing IRS rules. See Page 7 for FSA guidelines.
- When necessary, remember to submit your supporting documentation, billing statements or invoices along with your myFBMC CardSM Claim Form when using your myFBMC CardSM for medical services. FBMC will send you a Monthly Statement, indicating in BLUE which medical expenses require further documentation.
- You must check the box on your MCAP Enrollment Form to request the myFBMC CardSM each year in order to activate the card. The \$20.00 fee applies to each year you select the card.
- You may visit FBMC's Web site at www.myFBMC.com or contact FBMC Customer Care at 1-800-342-8017.

Eligibility Requirements

MCAP

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 will need to 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 MCAP after I terminate employment or retire?

You may continue participation in 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 throughout the end of the plan year. You should contact your GIR prior to termination or retirement for any available options.

DCAP

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 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 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.

Flexible Spending Accounts

What is a Flexible Spending Account?

Fringe Benefits Management Company (FBMC) provides you with IRS tax-favored Flexible Spending Accounts (FSAs) to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

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

Is an FSA right for me?

If you spend \$240 or more on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- 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) as well as a Dependent Care Assistance Plan (DCAP). If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Medical Care Assistance Plan (MCAP)

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

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-Counter items (some exclusions apply, see page 8).

Dependent Care Assistance Plan (DCAP)

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

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

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

Receiving Reimbursement

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

Direct Deposit

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 receive notification that the claim has been processed).
- Once enrolled, you do not need to enroll again for consecutive plan years.

To apply, complete the Direct Deposit Enrollment Form available at www.myFBMC.com or www.benefitschoice.il.gov, or call FBMC Customer Care at 1-800-342-8017. 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 that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

FSA Savings Example*

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

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

\$1,132!

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

Flexible Spending Accounts

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your 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, 2010; the run-out period ends September 30, 2010. Eligible DCAP expenses are those that occurred during the plan year, July 1, 2009, through June 30, 2010.
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 FY2010 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 customers to maintain complete documentation, including keeping copies of statements, invoices or bills for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To obtain forms you will need after enrolling in either a MCAP or DCAP, such as an FSA Reimbursement Request Form, Letter of Medical Need or Direct Deposit Form, you can visit FBMC's Web site, www.myFBMC.com, or call FBMC Customer Care at 1-800-342-8017. For more information, refer to the *Getting Answers* section of this Reference Guide.

Will contributions affect my income taxes?

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

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

When is my effective date if I enroll in the program mid-year?

If you elect to 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 FY2010 Plan Year (June 30, 2010) for an MCAP. This grace period ends on September 15, 2010. **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 FY2010 MCAP.

You should not confuse the new grace period with the plan's "run-out period." The run-out period extends until September 30, 2010. This is a period for filing claims incurred anytime during the FY2010 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 by FBMC, and the proper plan year account will be debited accordingly. This is true for both reimbursement requests submitted via a paper claim, as well as myFBMC CardSM 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.

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 you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on Page 9.

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 18 years old or younger (23 years, if a full-time student) 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 maximum annual amount of reimbursement for eligible health care expenses will be available throughout 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.

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 to FBMC for reimbursement.

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

Your 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, such as: allergy treatments, antacids, cold remedies, first-aid supplies and pain relievers. For a more comprehensive list of eligible OTC items, please visit www.myFBMC.com.

You may be reimbursed for OTCs through your MCAP if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your employer's 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. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at www.myFBMC.com. 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 then current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual 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.

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 (\$0.24 per mile - subject to change during the plan year)
- parking fees
- tolls and
- transportation to another city.

Medical Care Assistance Plan (MCAP)

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 Reimbursement Request 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 MCAP, the money you set aside for health care expenses is deducted from your salary before taxes. If you are enrolled in 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.

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 or fax a correctly completed FSA Reimbursement Request Form along with the following:

- a receipt, invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost or

Partial List of Medically Necessary Eligible Expenses*

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

Note: Budget conservatively. No reimbursement or refund of 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.

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

Mail to: Fringe Benefits Management Company
P.O. Box 1810
Tallahassee, FL 32302-1810

Toll-free fax: 1-866-440-7152

State of Illinois' dedicated fax: 1-850-514-5817

Visit www.myFBMC.com for a list of frequently asked questions. You must keep your documentation for a minimum of one year and submit to FBMC upon request.

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

myFBMC CardSM Visa[®] Card

The myFBMC CardSM Visa[®] Card is issued by First Horizon.



What does it cost to use the myFBMC CardSM?

There is a \$20 non-refundable, annual fee for using the card. This amount will be deducted from your MCAP account on July 1, 2009. Remember, if you elect to receive the myFBMC CardSM, the amount eligible for reimbursement will be \$20 less than the annual deduction amount you enrolled in MCAP. The maximum deduction amount is still \$4,999.92, even if you elect the card. If this is the first year that you elected the card option, two cards will be sent to you in the mail; one for you, and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date.

How do I use the myFBMC CardSM?

For eligible expenses, simply swipe the myFBMC CardSM like you would with a 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. OTC purchases at stores that are not IIAS Certified Merchants will require documentation.

When do I send in documentation for a myFBMC CardSM expense?

You must send in documentation for certain myFBMC CardSM transactions, such as those that are not a known office visit (as outlined in the State of Illinois Benefit Choice Book). When requested, you must send in documentation for these transactions. Documentation for a myFBMC CardSM 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 CardSM expense documentation for a minimum of one year, and submit it to FBMC 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 Web site or in **blue** in the *myFBMC CardSM* section of your monthly statement, you must submit the proper expense documentation to FBMC within 30 days in order to avoid having your card suspended.

If you fail to send in the requested documentation for a myFBMC CardSM expense, you will be subject to:

- withholding of payment for an eligible paper claim to offset any outstanding myFBMC CardSM transaction
- suspension of your myFBMC CardSM privileges
- the reporting of any outstanding myFBMC CardSM transaction amounts as income on your W-2 at the end of the tax year.
- Payback through involuntary withholding, even if you are no longer employed by the State.

What is the myFBMC CardSM?

The myFBMC CardSM is a stored-value card. It is a convenient MCAP reimbursement option that allows FBMC 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 CardSM to pay for eligible expenses, funds are electronically deducted from your MCAP.

What are the myFBMC CardSM advantages?

In addition to eligible medical expenses, you can also use the myFBMC CardSM for eligible Over-the-Counter (OTC) expenses at drugstores. Other advantages include:

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

Note: You cannot use the myFBMC CardSM for ineligible expenses, such as cosmetic dental expenses or eye glass warranties.

How do I get the myFBMC CardSM?

You must elect to receive the myFBMC CardSM on your Enrollment Form 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. During the plan years in which you have an MCAP, your cards will remain active until their expiration date as long as you elect the card each year. Hold on to your cards and elect the card option again on your enrollment form. You will receive the myFBMC CardSM a week before the new Plan Year begins. You can elect to receive the myFBMC CardSM at any time during the year by calling FBMC Customer Care.

To find out if a pharmacy or drugstore near you accepts the card, please refer to the **IIAS Store List** at www.myFBMC.com.

myFBMC CardSM Visa[®] Card

What agreement am I making when I use the myFBMC CardSM?

By using the myFBMC CardSM, you are agreeing to the “Written Certification” portion of the Beyond Your Benefits section on Page 16 of this Reference Guide.

Automatic Adjudication

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

For example, a doctor’s office visit may have a standard co-payment of \$15 per visit during normal office hours. When a myFBMC CardSM transaction is received at FBMC, 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, FBMC will send you a monthly statement outlining which transactions were processed and which are outstanding. Outstanding transactions that require documentation appear in **blue (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 paper claim is auto-substituted.

- The myFBMC CardSM is a payment card that electronically debits funds from your MCAP account when an eligible, uninsured medical expense is incurred. Your full annual election amount is available for use the first day of the plan year. To get the myFBMC CardSM simply check the box on the MCAP Enrollment Form. There is a \$20 non-refundable fee for the card that must be paid each year the card is elected.
- 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 the 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 to FBMC for outstanding transactions (indicated in BLUE on the monthly statement) within two monthly statement cycles, **even if you leave State employment** (providing documentation is required by the IRS).
- Even if you terminate State employment or are no longer enrolled in MCAP, you are still responsible for submitting the documentation! This is an IRS requirement!
- You can still access the funds in your MCAP account by submitting a paper claim reimbursement form, even if your card has been suspended.
- If you do not send substantiation documentation within 60 days of the swipe date, any paper claim sent in to FBMC 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 CardSM card holder must be enrolled in the State’s health, dental and vision coverage in order for your myFBMC CardSM 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 over-the-counter items purchased at an IIAS* location.
- Always save your receipts for at least one year!

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
- prescriptions that are not in the amount of the State plan’s co-payment when purchased at a pharmacy that has not implemented IIAS*
- all over-the-counter expenses when purchased at a pharmacy that has not implemented IIAS*

* The automatic adjudication system that allows eligible medical FSA expenses to be purchased with the myFBMC CardSM is called the Inventory Information Approval System (IIAS). This system is only used for auto adjudication of prescription and 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 an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

You may use your 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 12 years old or younger and
- have not provided more than one-half of their own support during the taxable year.

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

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

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

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

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

When am I eligible to enroll in DCAP after I have a baby?

After having a baby, participants have 60 days from 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 of the event, 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.
- 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.

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 entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Should I claim tax credits or exclusions?

Since money set aside in your 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 you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information. You may also visit www.myFBMC.com to complete a tax savings analysis.

Partial List of Eligible Expenses*

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

Note: Budget conservatively. No reimbursement or refund of 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.

Dependent Care Assistance Plan (DCAP)

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.

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.

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.

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 or fax a correctly completed FSA Reimbursement Request 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.

Mail to: Fringe Benefits Management Company
P.O. Box 1810
Tallahassee, FL 32302-1810

Toll-free fax: 1-866-440-7152

State of Illinois' dedicated fax: 1-850-514-5817

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 Reference Guide for limits.)

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

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 \$ _____

Over-the-Counter (OTC) items \$ _____

Travel costs for medical care \$ _____

Other eligible expenses \$ _____

myFBMC CardSM annual, non-refundable fee (\$20.00) \$ _____

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

Daycare services \$ _____

In-home care/au pair services \$ _____

Nursery and preschool \$ _____

After school care \$ _____

Summer day camps \$ _____

ELDER CARE SERVICES

Daycare center \$ _____

In-home care \$ _____

TOTAL Remember, your total contribution cannot exceed IRS 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 - No one likes waiting for their money, why are you?
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(s) elections 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 or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence[†]	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes:

Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care 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 (if recognized by State law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid[†]	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 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 FBMC Customer Care at 1-800-342-8017 for an approximation.

FBMC Privacy Notice

4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.myFBMC.com. You have a right to a paper copy at any time. Contact FBMC Customer Care at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: This notice advises Flexible Spending Account participants of the identity and relationship between the State of Illinois and its Contract Administrator, Fringe Benefits Management Company (FBMC). FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the Flexible Spending Account plans offered herein. FBMC 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 FBMC 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.

**MEDICAL CARE ASSISTANCE PLAN
ENROLLMENT FORM FY2010**

Pay for eligible medical expenses not covered by your insurance or any other plan.

Section A – Type of Enrollment

Benefit Choice Enrollment

New Hire Date of Hire ____ / ____ / _____

Mid-Year Enrollment **Qualifying Change in Status Code Required** (see chart in Section D) _____

I certify that the above eligible change in status event occurred on ____/____/_____

Section B – Employee Information

Social Security Number	Last Name	First	Initial
		()	
Street Address	City	State	Zip Code
			()
Agency			Work Phone

Section C – Deduction Information, Authorization and myFBMC CardSM Request

Deduction Information and Authorization - I authorize the State of Illinois to deduct the amount indicated below from each paycheck for my MCAP account.

The number of deductions for semi-monthly or bi-weekly payrolls is 24.
The number of deductions for monthly payrolls is 12 (could be less for university employees).

\$ _____ X _____ = \$ _____
Deduction Amt Per Pay Number of Deductions Total Annual MCAP Expenses *

(Minimum = \$240.00; Maximum = \$5,000.00)

* If you elect to receive the myFBMC CardSM Visa[®] Card (below), you must include the non-refundable \$20.00 card fee in your annual deduction calculation. To figure the amount that will be deducted each pay period, divide the annual deduction amount by the number of deductions remaining in the plan year. The total annual MCAP deduction amount cannot be greater than \$5,000.00. The amount eligible for reimbursement is the total annual deduction amount less the \$20.00 fee.

myFBMC CardSM Visa[®] Card

Yes! I want the myFBMC CardSM for the upcoming FY2010 plan year (July 1, 2009 – June 30, 2010). I understand that even if I currently have the card, I must REQUEST the card for this coming plan year and pay the annual non-refundable \$20.00 fee which will be automatically deducted from my MCAP account in July. If elected, I agree to submit proper documentation as required by the IRS (see the enclosed myFBMC CardSM sheet for specific requirements).

Section D - Change in Status Code Chart

01	Birth or adoption of dependent	11	Employee returns to payroll (from being on a leave of absence)
02	Marriage	13	Employee changes employment status from Part-time less than 50% to Full-time
03	Divorce, legal separation or annulment *	15	Spouse or dependent terminates employment
07	Change of county of residence/worksites for employee or spouse *	17	Spouse or dependent changes employment status from Full-time to Part-time
08	Judgment, decree or court order *	20	Spouse enters leave of absence and loses MCAP enrollment
10	Employee commences employment	24	Coordination of spouse's annual benefit election period

Only the events listed above are eligible changes in status events for MCAP mid-year changes.

* Reviewed case-by-case

Section E – Certification Statement (Please read carefully before signing)

I understand and certify that:

- I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.
- I will forfeit any unclaimed amount remaining in my account at the end of the run-out period (September 30, 2010).
- I understand that deductions must continue during any paid leave of absence.
- I intend to participate in MCAP for the entire plan year. I do not anticipate terminating State service, retiring or going on an unpaid leave of absence.
- I will refund any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.
- I understand that services incurred after my payroll deductions or direct monthly payments (as a result of COBRA) cease, are ineligible for reimbursement.
- I understand that due to the new IRS Grace Period, I can submit claims for eligible services incurred through September 15th, 2010, and that those services will be deducted from my plan year 2010 account balance, if any. Expenses incurred after September 15th, 2010, will be reimbursed out of the 2011 plan year account, if applicable.
- To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.

Employee Signature: _____ **Date** ____/____/____

Please return the signed, completed form to your agency Group Insurance Representative.

Section F – Agency Approval (To be completed by Group Insurance Representative)

Effective Date: ____/____/____ Deduction Start Date: ____/____/____
 If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected deduction: ____/____/____

Organizational Processing Code: _____ Pay Code: _____

GIR Signature: _____ Date: ____/____/____

Telephone () _____ - _____

GIR Instructions:

- Use the FSA Inquiry Screen option 1, Deduction What If Screen – Benefit Choice Enrollment; or option 2, Deduction What If Screen – Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start Date. If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected deduction.
- Forward the original to the FSA Unit at CMS, forward a copy to payroll and retain one copy in the member's file.

**DEPENDENT CARE ASSISTANCE PLAN
ENROLLMENT FORM FY2010**

Pay for eligible dependent care expenses, such as daycare and after-school care.

Section A – Type of Enrollment

Benefit Choice Enrollment

New Hire Date of Hire ____ / ____ / ____

Mid-Year Enrollment **Qualifying Change in Status Code Required** (see chart in Section D) _____

I certify that the above eligible change in status event occurred on ____/____/____

Section B – Employee Information

<hr/> <i>Social Security Number</i>	<hr/> <i>Last Name</i>	<hr/> <i>First</i>	<hr/> <i>Initial</i>
		()	
<hr/> <i>Street Address</i>	<hr/> <i>City</i>	<hr/> <i>State</i>	<hr/> <i>Zip Code</i>
			()
<hr/> <i>Agency</i>			<i>Work Phone</i>

Section C – Deduction Information

Deduction Information and Authorization - I authorize the State of Illinois to deduct the amount indicated below from each paycheck for my DCAP account.

The number of deductions for semi-monthly or bi-weekly payrolls is 24.
The number of deductions for monthly payrolls is 12 (could be less for university employees).

\$ _____ X _____ = \$ _____

Deduction Amt Per Pay Number of Deductions Total Annual DCAP Expenses

(Minimum = \$240.00; Maximum = \$5,000.00)

Section D - Change in Status Code Chart

01	Adoption of dependent *	13	Employee changes employment status from Part-time less than 50% to Full-time
02	Marriage	14	Spouse commences employment
03	Divorce, legal separation or annulment *	16	Spouse returns from leave of absence
08	Judgment, decree or court order *	18	Spouse changes employment status from Part-time to Full-time
10	Employee commences employment	21	Change in the cost of care
11	Employee returns to payroll (from being on a leave of absence)	24	Coordination of spouse's annual benefit election period

Only the events listed above are eligible changes in status events for DCAP mid-year changes.

* Reviewed case-by-case.

Section E – Certification Statement (Please read carefully before signing)

I understand and certify that:

- I may not change or stop my deposits to this account during the plan year unless I experience a qualifying change in status.
- I will forfeit any unclaimed amount remaining in my account at the end of the run-out period, September 30, 2010.
- I understand that I cannot submit claims for expenses incurred during periods when my spouse or I are not actively working or actively looking for employment.
- I intend to participate in DCAP for the entire plan year. I do not anticipate terminating State service, retiring or going on an unpaid leave of absence.
- I will refund any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.
- If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period in which a deduction was taken, or the last day I was actively at work, whichever is sooner.
- I understand that if either my spouse or I earn less than \$5,000.00, my DCAP contribution cannot exceed the lowest income.
- I understand that if my spouse is a full-time student or incapable of self-care, my DCAP contribution cannot exceed \$250.00/month for one dependent or \$416.66/month for two or more dependents.
- I understand that if my spouse and I file separate federal income tax returns, my DCAP contribution cannot exceed \$2,500.00.
- To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service and I will comply with the IRS requirement to file an IRS Form 2441.

Employee Signature: _____ **Date** ____/____/____

Please return the signed, completed form to your agency Group Insurance Representative.

Section F – Agency Approval (To be completed by Group Insurance Representative)

Effective Date: ____/____/____

Deduction Start Date: ____/____/____

If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected deduction:
____/____/____

Organizational Processing Code: _____

Pay Code: _____

GIR Signature: _____

Date: ____/____/____

Telephone () _____ - _____

GIR Instructions:

- Use the FSA Inquiry Screen option 1, Deduction What If Screen – Benefit Choice Enrollment; or option 2, Deduction What If Screen – Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start Date. If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected deduction.
- Forward the original to the FSA Unit at CMS, forward a copy to payroll and retain one copy in the member's file.

Notes

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

FBMC Customer Care Center

*Claims Eligibility and Status,
Reimbursement Checks, myFBMC CardSM,
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-FBMC (3262)
www.myFBMC.com

Services provided:

- *Current Account Balance(s)*
- *Claim Status*
- *Mailing Address Verification*
- *Obtain FSA Reimbursement Request
Claim Forms*
- *myFBMC CardSM Status*
- *Change IVR Access Pin*

FBMC Reimbursement

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

myFBMC CardSM

Lost or Stolen Card
24 hours a day
1-888-462-1909

Dispute Line

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

Activation

24 hours a day
www.myFBMC.com
1-888-514-6845

FBMC

Premier Benefits Solutions

Contract Administrator

Fringe Benefits Management Company
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.

