



## University of Kentucky Flexible Spending Account Plan

### Summary Plan Description



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Administered By

ASI

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<http://www.asiflex.com/>

**NOTE: USE YOUR UNIVERSITY OF KENTUCKY EMPLOYEE ID NUMBER TO ENROLL AT OPEN ENROLLMENT AND TO FILE CLAIMS.**

## INTRODUCTION

A Flexible Spending Account (FSA) is an employer-sponsored plan that lets you deduct dollars from your paycheck and put them into a special account that's protected from taxes.

FSA accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes. FSA participation will impact earnings reported to the Social Security Administration. In accordance with Internal Revenue Code Section 125, allowable premiums for health and dental insurance are currently taken on a pre-tax basis. The more money you put in, the more tax you avoid. When you use the money in your account to pay for out-of-pocket family care expenses, you avoid paying taxes on those dollars. Depending on your tax bracket, you will probably save 25% or more on out-of-pocket family care expenses.

### **How does the FSA work?**

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

After you enroll in a FSA, ASI will send you a confirmation of your enrollment and reimbursement forms to your home address. As you incur eligible expenses throughout the year, you submit a Reimbursement Form (by fax or mail) along with documentation of the expense, and you are reimbursed with funds from your FSA account, avoiding taxes. After each claim, you will receive an account summary.

Of course, only costs of purchases made or services provided during the Plan Year or Grace Period (see definition on page 12) and while you are a participant are eligible for reimbursement. And the IRS rule says that if you don't use all of the money in the account when the plan year is up, those funds will no longer be available to you.

You can only change your election during the plan year as a result of certain eligible event changes. Also, your Social Security benefits calculations will be based on your lower taxable earnings figures. (You can check with your local Social Security office to explore any effects this may have on your benefits – which are usually very minor.)

The University of Kentucky has hired ASI to perform certain administrative functions for the Plan. ASI processes all claims for the Health Care FSA and the Dependent Care FSA. If you have any questions concerning claims, please contact ASI, P. O. Box 6044, Columbia, MO 65205, 800-659-3035, email: [asi@asiflex.com](mailto:asi@asiflex.com), or on-line at [www.asiflex.com](http://www.asiflex.com).

## ESTABLISHING AND USING YOUR HEALTH CARE FSA



**Estimate your family's annual out-of-pocket medical expenses.** You may include expenses for anyone who is a qualified dependent for tax purposes. (There are exceptions for the expenses of children of divorced parents. Please visit [www.asiflex.com](http://www.asiflex.com) for further information.) When calculating your annual election, include predictable expenses only.

**Annual Maximum \$4,000.00**

**Annual Minimum \$250.00**

**Qualifying Medical Expenses include all medical, dental and vision expenses** not covered or not reimbursed by insurance which are **incurred by you or your eligible dependent (definition available at [www.asiflex.com](http://www.asiflex.com)) during the plan year** for medical care as defined in Section 213(d) of the Internal Revenue Code. Please refer to the following list and IRS Publication 502 (available at [www.asiflex.com](http://www.asiflex.com)) for further details on qualifying expenses. **Expenses qualify for the medical FSA based on when incurred, not when they are paid. Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA.** Please contact ASI at [asi@asiflex.com](mailto:asi@asiflex.com), (800) 659-3035 if you have any questions regarding particular expenses.

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

Deductibles	Over-the-Counter drugs & medicines
Co-pays	(legal) used to treat a medical
Doctor's fees	condition (For specifics, go to
Dental expenses	<a href="http://www.asiflex.com/otc.htm">http://www.asiflex.com/otc.htm</a> )
Vision care expenses	Insulin
Prescription glasses	Orthodontia/braces (See details on
Contact lenses and solutions	page 4)
Corrective eye surgery	Routine physicals
Prescription drugs	Hearing aids including batteries
Chiropractor's fees	Transportation expenses related to
Medical equipment	illness

### **Non-Qualifying Medical Expenses**

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

Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins	Medicines, drugs, herbs, or vitamins for general health and not used to treat a medical condition
Clip-on or non-prescription sunglasses	Expenses that are merely beneficial to your general health (e.g., vacations and vitamins)
Warranties	Health club dues
Toiletries	Any sort of insurance premium
Long-term care expenses	

**Orthodontic expenses** may be assumed to be incurred at the time a monthly payment is due and paid. These monthly payments must be spread out evenly over the expected period of orthodontic treatment. Therefore, claims submitted for orthodontic payments that meet the above are allowable. You may also submit a claim for a reasonable down payment of the orthodontic treatment if the down payment is made at the time the appliances are placed. Claims for payments made prior to being due or that otherwise do not meet the above requirements will not be processed. Claims for the entire fee paid at the beginning of treatment will not be processed, nor will claims for an entire year's payments made at the beginning of the year be processed. To claim orthodontic down payments, you must include a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed. If you have questions about qualifying orthodontic expenses, please contact ASI at 1-800-659-3035 prior to enrollment in the plan.

**Enroll in the Health Care FSA Plan.** During open enrollment, divide your election amount by the number of paychecks you will receive during the Plan Year. Enroll through your University of Kentucky Employee Benefits Office during open enrollment. New employees should contact their Employee Benefits Office for an enrollment form and assistance with enrollment.

**Receive medical services.** A medical expense is **incurred** when the services are provided that create the expense. You must receive medical services before you file a claim for those services.

**File claims.** After you have received the medical services and know the amount of your responsibility for the bill, you may submit a claim for those expenses to ASI. See **FSA Claims** on page 12 for details on claims filing. Extra claim forms are available over the Internet at [www.asiflex.com](http://www.asiflex.com) or from your Employee Benefits Office.

**Receive reimbursements.** ASI will review your claim, and if approved will reimburse you for the medical expenses within one day of their receipt of the claim.

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

**Participants on unpaid leave.** To maintain coverage, you must make arrangements prior to going on unpaid leave with your Employee Benefits Office to pay for coverage after you return from unpaid leave. If a participant has been on unpaid leave for longer than 30 consecutive days and did not elect to catch up contributions when they return, the election and corresponding coverage will be revoked (effective on the last day worked). A new election may be made during open enrollment for the following plan year. However, no coverage will exist for months in which no contributions were made if the participant had not elected to catch up contributions prior to the end of the 30 days. There will be a hold put on a participant's account (no claims will be paid) if contributions are not received on two consecutive payrolls and no leave form has been filed with the Employee Benefits Office.

### **Other Considerations Regarding the Health Care FSA**

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

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

When the Plan is notified that one of the events has occurred, the right to choose **continuation coverage** will be provided to each eligible person(s) if, on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments. The right to elect to continue ends 60 days from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the participant or a responsible family member to inform their Employee Benefits Office of the occurrence of an event described in 3 or 4 above.

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

## USE THE BENNY CARD TO PAY FOR YOUR MEDICAL EXPENSES

The FSA Debit Card (known as the Benny Card) provides a convenient method to pay for out-of-pocket medical expenses for you, your spouse and/or any tax dependents. The IRS has stringent regulations regarding appropriate use of the Benny Card, as far as **where the card can be used**, and **when follow-up documentation is required (use of the card DOES NOT necessarily eliminate all of the paperwork)**. The card is a great benefit, but it is important that you take a moment and understand how it works.

### Where can the cards be used?

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

- 1) Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The FSA debit card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).
- 2) Inventory Information Approval System (IIAS):** The IRS also allows the Benny Card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your FSA debit card to eligible expenses, and you will never be prompted for follow-up documentation for purchases at these stores. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The card will work at these stores, even if the MCC does not indicate it is a health care provider. A list of stores with this system in place now (and some expected in the future) is available online, at [www.asiflex.com/debitcards](http://www.asiflex.com/debitcards). **Purchases at these stores will never require follow-up documentation!!** Please note that as of 7/1/2009, IRS regulations require all pharmacies to have the IIAS in place, or your card may be declined at the point-of-sale.

### When do I have to turn in paperwork?

Debit card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of four other criteria are met. Transactions are electronically substantiated if:

- ✓ The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the **employer-sponsored** medical, vision or dental plan that participant has elected;

- ✓ The expense is substantiated through your UK health, vision or dental plan provider.
- ✓ The expense is a recurring expense that matches expenses previously approved as to amount, provider, and time period (e.g., for an employee who pays a monthly fee for orthodontia at the same provider for the same amount); or
- ✓ The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter and prescription medication (this system is allowable only if the merchant approves only qualifying items; all other purchased items must be paid for in a split tender transaction.)

Any transaction that does not meet the above criteria will prompt a request for follow-up documentation.

### **Is there a cost for the card?**

No.

### **How do I request a card?**

You can request to receive a card through the online enrollment site available during open enrollment, or by completing the debit card application form found on the UK Benefits website. Generally, it takes about 2 weeks to receive the card once it has been requested.

### **Can I request additional cards?**

Yes. Everyone who requests a card will receive two Benny Cards in the mail. If you would like additional cards, they are available by emailing ASIFlex directly at [asi@asiflex.com](mailto:asi@asiflex.com) and placing your request. Please note that all cards will be in the name of the FSA participant.

## ESTABLISHING AND USING YOUR DEPENDENT CARE FSA



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

**Annual (household) Maximum \$5,000.00    Annual Minimum \$500.00**

You and your spouse together may include up to \$5,000.00 per year (\$2,500 in the case of a married individual filing a separate tax return for the plan year) or the lesser of your (after subtracting all FSA deductions) or your spouse's earned income for the plan year. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of \$250 per month if you have one dependent and \$500 per month if you have two or more dependents.

**A Qualifying Individual** is your Dependent who is under the age of 13 (when services are incurred) or your Spouse or an older Dependent who is mentally or physically incapable of self-care who lives in your home at least 8 hours each day. If you are divorced, the Qualifying Individual must be your son or daughter for whom you have more than 50% physical custody. Please call ASI before enrolling in this account if you have unique day care or joint custody arrangements. Be sure to notify your Employee Benefits Office within 30 days of a change in eligibility of a qualifying individual if you need to change your election.

**A Qualified Provider** can provide care in your home or outside your home. If the care is provided outside your home and the facility cares for more than 5 individuals, then it must be licensed by the State of Kentucky. The expenses **may not** be paid to your spouse, a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred, or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

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

- A **Tax Credit** is allowed for child/dependent care expenses of up to \$6,000 per year for two or more dependents (\$3,000 per year for one dependent). You file for the "tax credit" on your annual tax return, at the end of the year. The credit is an amount equal to your dependent care expenses multiplied by a percentage determined by your combined adjusted gross income. The percentage decreases from a high of 35% to a low of 20% as your income increases.
- The **Dependent Care FSA** Plan allows a tax break on up to \$5,000.00 per year, \$2,500 if married filing separately, for any number of dependents; one, two, or more. You will experience "tax savings" throughout the year with every paycheck you receive. Employees who pay federal taxes of 15%, state taxes of approximately 6% and Social Security taxes of 7.65% would save around 28% of expenses through the Dependent Care FSA Plan. As their federal tax percentage rises, they would receive an even higher tax break by using the Dependent Care FSA Plan.

Generally those employees with a combined family income over \$31,000 will have a higher percentage tax break through the Dependent Care FSA Plan. Those employees with a combined income under \$31,000 generally will have a higher percentage tax break using the Tax Credit. **Please contact your tax advisor if you have questions about which is better for you.**

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

### **Qualifying Dependent Care Expenses**

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

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

- Day-care centers
- Day camps
- Babysitters
- Nannies

### **Non-Qualifying Dependent Care Expenses**

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

- Care that is not incurred in order for you to work or look for work
- Kindergarten or other educational expenses
- Instructional or sport specific camps; e.g. Ballet camp, soccer camp, summer school
- Food, transportation or activity fees
- Amounts paid to your spouse or dependent or to your (or your spouse's) son or daughter who is under 19 years old at the end of the year
- Care for a child for whom you have 50% or less physical custody
- Overnight camps
- Care for a child age 13 or older who is not disabled
- Child support payments

**Enroll in the Dependent Care FSA Plan.** During open enrollment, divide your election amount by the number of paychecks you will receive during the Plan Year. Enroll through your University of Kentucky Employee Benefits Office during open enrollment. New employees should contact their Employee Benefits Office for an enrollment form and assistance with enrollment.

**Receive dependent care services.** Dependent care expenses are **incurred** when the day care is provided. You must receive the dependent care services before you file a claim for those services.

**File claims.** After you have received the dependent care services, you may submit a claim for those expenses to ASI. See **FSA Claims** on page 12 for details on claims filing. Extra claim forms are available by contacting ASI or over the Internet at [www.asiflex.com](http://www.asiflex.com).

You may have the dependent care provider complete the dependent care section of the claim form and sign on the line provided in lieu of providing separate documentation for dependent care claims (see page 12).

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

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

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

## ENROLLMENT AND TERMINATION

**Eligibility:** Any employee who is employed by the University or a participating Affiliate as a regular half-time or more employee may participate in the Health Care FSA. Any employee who is employed by the University or a participating Affiliate who has sufficient earnings to have the necessary deductions made may participate in the Dependent Care FSA.

**The Plan Year** is the twelve-month period from July 1st through June 30th.

**Open enrollment** is normally held shortly before the beginning of the Plan Year. Check with your Employee Benefits Office for the exact dates. You may enroll during open enrollment each year for the upcoming Plan Year by completing an enrollment form during open enrollment. You may also enroll during the plan year if you experience a qualifying change in status and enrollment corresponds with a change in eligibility caused by that status change. See the **Making a Change Section** for more information. The Health Care FSA Plan and the Dependent Care FSA Plan have slightly different rules regarding making an election change or enrolling mid-year. Forms are available from your Employee Benefits Office.

**New employees** must enroll by the 1<sup>st</sup> of the month coincident with or next following your hire date to participate for the remainder of that plan year. You enroll by completing an enrollment form available from your Employee Benefits Office. Enrollment forms should be sent by the first of the month preceding the date of eligibility to ensure timely enrollment. If you fail to enroll within the time period described above, then you may not elect to participate in the Plan until the next Open Enrollment Period or until an event occurs that would justify a mid-year election change.

**Enrollment during the plan year** is effective the 1st of the pay cycle following the Employee Benefits Office receipt of your enrollment form.

**Termination of participation:** Your participation will end on your last day of work should you terminate employment with the University of Kentucky. This means you will no longer be able to make contributions to the plan. Should you return to work within 30 days during the same Plan Year, your participation will be reinstated as it was. You will have the option of reinstating your coverage at the same annual level you had prior to your termination or reinstating your coverage at the same per pay period amount with a reduced annual amount. Should you choose the same annual amount, your per pay period contributions will be adjusted so that your total contributions for the year will equal your annual coverage amount. If your coverage ends during the plan year you must wait until the next Open Enrollment period to re-enroll in the Plan. Except as specified in the section on Coverage Continuation (COBRA) in the Health Care FSA Plan Summary, expenses incurred while you are not a participant will not qualify for reimbursement. You may continue to file for Dependent Care expenses incurred during the Plan Year after the end of your participation.

## MAKING A CHANGE

**Except as specified in this section, your election under the Plan is irrevocable for the Plan Year. It is the employee's responsibility to file a change with their agency's Employee Benefits Office. The election change request must be filed within 30 days of the date of the qualifying event and becomes effective on the 1st of the month following the event and the approval of the request. Requests received after 30 days will not be approved.**

You may change your election if you, your spouse, or a dependent experience an event listed below which results in a gain or loss of eligibility for coverage under the University of Kentucky FSA Plan, Health Care FSA Plan, or Dependent Care FSA Plan or a similar plan maintained by your spouse's employer or one of your dependent's employer and your desired election change corresponds with that gain or loss of coverage. Changes are only allowed if one of the specific events listed below has occurred that caused the needed change in your account. Otherwise, your election is effective through the end of the plan year.

Events 1 - 3 apply to the Health Care FSA Plan and the Dependent Care FSA Plan.

1. Your legal marital status changes through marriage, divorce, death or annulment.
2. Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. If your child no longer qualifies for dependent care because he or she turned 13, then that is a loss of a dependent under the Dependent Care FSA Plan, but not under any of the other plans.
3. You, your spouse or any of your dependents have a change in employment status (termination, retirement, new employment, change from part time to full time or vice versa) that affects eligibility for health insurance, the Health Care FSA or the Dependent Care FSA with the University of Kentucky or a plan maintained by your spouse's or any dependent's employer. Please see page 9 for specifics related to termination of employment from the University of Kentucky.

Events 4 - 6 apply to Health Care FSA Plan, but not the Dependent Care FSA Plan.

4. You are served with a judgment, decree or court order, including a qualified medical child support order regarding coverage for a dependent. If the order requires you to pay for medical expenses not paid by insurance for a Dependent child, then you may add or increase coverage under the Health Care FSA Plan. If the order requires that another person pay for medical expenses not paid by insurance for the Dependent child, then you may drop or reduce coverage under the Health Care FSA Plan.
5. If you, your spouse or a dependent becomes entitled to and covered under Medicare or Medicaid, you may drop or reduce coverage under the Health Care FSA Plan.

6. If you, your spouse or a dependent loses eligibility and coverage under Medicare or Medicaid, you may add or increase coverage under the Health Care FSA Plan.

Events 7 - 9 apply only to the Dependent Care FSA Plan.

7. You may change your election to correspond with a change made under another employer-sponsored plan as long as the change made under the other plan was permitted by IRS regulations or was made for a period of coverage that is different from the University of Kentucky Flexible Benefit Plan.
8. You change dependent care providers (including school or other free provider). You may make a corresponding change to your Dependent Care FSA and your future salary reductions if you change dependent care providers.
9. You may make a corresponding change to your Dependent Care FSA and your future salary reductions if your dependent care provider who is not your relative changes your costs significantly. A relative is any person who is a relative according to Code §152(a)(1) through (8), incorporating the rules of Code §152(b)(1) and (2).

**Your Salary Reduction** amount for a pay period is, an amount equal to the annual contribution for your FSA election, divided by the number of pay periods in the Plan Year following your effective date. If you increase an election under the Health Care FSA Plan or Dependent Care FSA Plan, your salary reductions per pay period will be an amount equal to your new reimbursement limit elected less the salary reductions made prior to such election change, divided by the number of pay periods remaining in the Plan Year beginning with the election change effective date.

Any increase in your election may include only those expenses that are incurred during the period of coverage on or after the effective date of the increase. Your coverage for the remaining period of the year shall be calculated by adding the amount of contributions made prior to the change to the expected contributions after the effective date of the change and subtracting prior reimbursements.

## FLEXIBLE SPENDING ACCOUNT CLAIMS

- Claims processed daily – within 1 day of receipt of qualified claim
- Fax or mail to ASI:  
1-573-874-0425  
P O Box 6044  
Columbia, MO 65205-6044
- World Wide Web [www.asiflex.com](http://www.asiflex.com) for claim forms and personal account information
- Direct deposit is available for claims payment
- Direct deposit notices sent via E-mail or US Mail the same day payment is generated

**Allowable expenses** must be incurred during the portion of the Plan Year or Grace Period (see definition below) that you are a participant. Claims must be filed by December 15th following the end of the Plan Year. (Employees who have terminated employment during the year must file claims for expenses incurred while covered under the plan.) After that, your account will be closed and any balance remaining will be forfeited to the University of Kentucky in accordance with federal regulations. If December 15th is a holiday, Saturday, or Sunday, then claims must be filed by the first business day following December 15th.

**Grace period:** If you are a participant as of the last day of the Plan Year (June 30<sup>th</sup>) you may continue to incur expenses through September 15<sup>th</sup> immediately following the end of the Plan Year to access funds remaining in the previous Plan Year. For expenses incurred during the Grace Period, funds are drawn from the oldest Plan Year to the extent there are funds available until these funds are depleted. Funds will be paid out of the oldest Plan Year for claims filed by December 15<sup>th</sup> following the end of the Plan Year. For example: If you have \$50 remaining in your 2009 flexible spending account as of June 30, 2009 and incur an expense for \$100 on July 10, 2009, this claim will be paid \$50 from your 2009 FSA and the remaining \$50 will be paid from your 2010 FSA. If you do not want a claim for services provided July 1<sup>st</sup> through September 15<sup>th</sup> paid out of the old plan year, please indicate this on your claim form.

**You must submit a completed claim** form along with **copies** of invoices or statements **from the provider** to serve as proof that you have incurred an allowable expense in order to receive payment. Statements are **required to include**, the **provider's name**, the **date(s) of service**, a **description of the service(s)**, and the expense **amount**. Copies of personal checks and paid receipts, without the above information, are not acceptable. Documentation or copies will not be returned. For over-the-counter items, the receipt or documentation from the store must include the name of the drug pre-printed on the receipt. You must indicate the existing or imminent medical condition (items such as vitamins and nutritional supplements may require a physician's statement) for which the item will be used on the receipt, on the claim form, or on a separate enclosed statement each time these items are claimed. You will be provided with a supply of claim forms with your enrollment confirmation. Extra claim forms are available by contacting ASI or over the Internet at [www.asiflex.com](http://www.asiflex.com).

Purchases for general good health will not be accepted. Claims for items that are purchased for an existing medical condition must be accompanied by a letter from your doctor stating the medical condition and the items that are required as treatment for that specific medical condition (if they would otherwise not qualify as a general good health item). A sample letter is available at [www.asiflex.com](http://www.asiflex.com). This letter can be used as support for 12 months from the date of the letter.

**All payments/reimbursements are made by direct deposit** into the bank account of your choice. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by **email** over the Internet.

## INTERNET ACCESS

You can access your Health Care FSA and your Dependent Care FSA on the Internet 24 hours/day, 7 days/week. Information is updated every morning to reflect the previous day's transactions. Find out if a claim has been processed, a payment has been made or your current balance. Information for the current Plan Year is available (previous Plan Year as well until December 15th following the end of that Plan Year). There is no personally identifying information on the Internet. Which means this information will be meaningful to you, but not to anyone else.

1. Go to <http://www.asiflex.com>
2. Click on "**Account Detail**"
3. Click in the box to the right of "**Your FlexPin**"
4. Type your Personal Identification Number (P.I.N). Your PIN is provided on your enrollment confirmation. You can also call ASI at (800) 659-3035 to get your PIN.
5. Click "**Submit**"
6. Select the Plan Year from the drop down box if available. This box will not be displayed if only one Plan Year is available.
7. Select the category you wish to view if you are enrolled in more than one category. All transactions for the Plan Year are shown through the previous day. Information is updated early each morning.
8. Click "**Lookup**"
9. Be sure to click "**Sign out (or enter another FlexPin)**" when you finish. This closes out your account for security purposes.



# Sample Claim and Provider Documentation

This day care receipt contains the items the Internal Revenue Code requires:

1. It is signed by the provider of service - "*Ima Sitter*"
2. It contains a description of the services - "*day care services*"
3. It explicitly lists "*1-2-04 to 1-08-04*" as the range of the dates that the day care was provided.
4. It includes the amount charged for the day care "*\$300.00*"; not necessarily the amount paid.
5. It identifies the person for whom the day care was provided - "*Mike Riddick*"

Day care documentation must contain all of these items in order to be processed.

We must be able to identify the participant

I provided day care services for *Mike Riddick*

From *1/02/04* to *1/08/04*. The total sum for services provided was *\$300.00*.

Signed *Ima Sitter*  
 Ima Sitter  
 123 Main Street  
 Columbia, MO 65203  
 SSN 123-45-6789

**ASI CLAIM FORM**  
 Please read requirements on reverse side

*Riddick, John M.*      *ASI*      *111 - 22 - 4444*  
 Last Name, First Name      Employer      Social Security Number  
*110 E. Ash St.*      *Columbia MO 65203*  
 Street Address      City, State, Zip

**Dependent Care Assistance (day care, babysitting, etc.)**

Name of Dependent	Age	Service Period From To	Name, Address and Tax Payer ID number of Provider of service	Charge for Services	ASI use only
<i>Mike</i>	<i>10</i>	<i>1/02 1/08</i>	<i>Ima Sitter, 123 Main St. Columbia MO 65203 123-45-6789</i>	<i>300.00</i>	
<b>Total Dependent Day Care Claim</b>				<i>300.00</i>	

I provided the dependent care as stated above

Care Provider's original signature \_\_\_\_\_ Date \_\_\_\_\_ SSAN/Tax ID# \_\_\_\_\_

**Medical Benefits**

Date Care Provided*	Name of Service Provider	Expense Description	Name and relationship of Person for whom expense incurred	Amount that is your responsibility	ASI use only
<i>01/05/04</i>	<i>I. William See, M.D.</i>	<i>Eye Exam</i>	<i>Mary - daughter</i>	<i>10.00</i>	
<b>Total Medical Amount Requested</b>				<i>10.00</i>	

Please arrange documentation in order listed above.

\*Claims for future services will not be accepted.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self-care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

*John M. Riddick*      *01/08/04*  
 Employee Signature      Date

Separate dependent care documentation is not required if the provider signs the form after the dependent care section is completed.

*I. William See, MD*  
 Ophthalmology  
 2020 Seymour  
 Crystalview, MO 65201

Service Date	Description	Charge for Services
<i>01/05/04</i>	<i>Eye Exam</i>	<i>\$10.00</i>

Patient's Name *Mary Riddick*

This health care service payment statement contains the items the Internal Revenue Code requires:

1. It identifies the provider of service - "*I. William See, MD*"
2. It contains a description of the services - "*Eye Exam*"
3. It explicitly states the date of the eye exam - "*1/05/04*"
4. It includes the amount charged for the exam "*\$10.00*"; not necessarily the amount paid at the time of service.
5. It identifies the person receiving the eye exam - "*Mary Riddick*"

Medical documentation must contain all of these items in order to be processed.

The participant must sign the claim form.

Every request and all documentation must contain all the items shown in **blue**