



Flexible Spending Account Operations Summary

What are Flexible Spending Accounts?

Flexible spending accounts allow Participants use pre-tax dollars to pay for out-of-pocket medical expenses, dependent care expenses and employer-sponsored medical-related insurance premiums. The amounts deducted from Participants salary to pay for these expenses are called elections. Because these expenses are paid with pre-tax dollars, Participants' are taxed on a lower gross salary, thereby saving money that would otherwise be spent on federal, state and FICA taxes.

FlexSystem Operations

FlexSystem Participants need to determine elections for each benefit in which they wish to participate during the course of the Plan Year and to fill out a corresponding Enrollment Form at the time of their eligibility or at the start of the Plan Year. **Call FlexSystem at 1-800-422-4661, press 8 and ask a FlexSystem Client Services Representative for assistance with the enrollment forms.** Return completed enrollment forms to the Client. The elections are specific to each type of flexible spending account, meaning that dollars set aside for dependent daycare can only be used for dependent care, and not for out-of-pocket medical expenses, etc. As in the past, employer-sponsored premiums are sent directly to the insurance provider. The Client deducts the amount elected that is not an employer-sponsored premium, and deposits the withholding amounts with FlexSystem. FlexSystem maintains these funds in an account until reimbursement is requested.

FlexSystem Reimbursements

Participants can request reimbursement any time a qualified expense has been incurred. The service related to the expense needs only to have taken place; it need not be paid before requesting reimbursement. Simply complete a Request for Reimbursement Form and submit it to FlexSystem for reimbursement. See your Request for Reimbursement Form for submission options. Only claim reimbursements (a) for eligible expenses incurred during the applicable plan year, (b) for eligible plan participants, and (c) for expenses that have not been previously reimbursed under this or any other benefit plan or claimed as an income tax deduction. It is the Participant's responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply may delay payment.

FlexSystem processes requests for reimbursement daily. Once a request is reviewed and approved, a Reimbursement Check is issued. For dependent care and independent insurance premium reimbursements, there must be sufficient funds in the account for the full Request to be reimbursed. If there are insufficient funds in the account, a check for that particular account's balance amount only will be issued. The outstanding balance of the request will remain as an open item until additional deposits are received from payroll, at which time an additional check will be issued. Out-of-pocket medical expenses will be reimbursed for the full amount of the request, provided the total of the request does not exceed the total annual election.

Approved requests received by FlexSystem before noon CST will be processed that day, with checks mailed and direct deposits made the following day. Example: for a reimbursement request received by FlexSystem at 11:00 am CST Tuesday, the check will be mailed and direct deposit initiated on Wednesday. Actual receipt of the reimbursement depends on the mail and banking systems.

Account Communication

Each Reimbursement Check contains a summary of the account's activity for the type(s) of accounts being reimbursed. Participants can access their FlexSystem accounts 24-hours a day on our Interactive Voice Response (IVR) System and on the TASC web site. To access the IVR just call 1-800-422-4661 (or locally, 608-241-1900), and press 3. To access this information on the TASC website (www.accesstasc.com), click on the Clients Only link on the left side of the screen. Participants will need their Client ID, Participant ID and Pin Number assigned by TASC to access their account on both the IVR and the web site. Near the end of the Plan Year, Participants will have the opportunity to enroll/re-enroll in the upcoming new Plan Year. Clients can change plan parameters at this time as well.

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The three months following the end of the Plan Year are considered the transitional period. During this time, Participants can still submit Reimbursement Requests for expenses that were incurred in the previous Plan Year. The Plan Year will be automatically closed three months following the end of the Plan Year, or sooner if directed by the Client. Once closed, unused funds are returned to the Client. This is referred to as the Use-It-or-Lose-It Rule.

Use-It-or-Lose-It Rule

It is important to be conservative in making elections because any unused funds following the close of the Plan Year are not refundable to the Participant and are returned to the Client. This risk is the same as paying an insurance premium. If Participants do not use the health care, the premium is not returned. Precautionary steps are taken to avoid having balances in the Flexible Spending Accounts at year-end. Participants should use the IVR and web site to keep track of their account balances.

Change in Elections During the Plan Year

The following are a few examples of events that allow Participants to make a mid-year change to their annual election:

- Marriage or divorce of the Participant
- Death of the Participant's spouse or dependent
- Birth or adoption of an Participant's child
- Commencement or termination of employment by either the Participant or spouse
- A change in part-time or full-time status by either the Participant or spouse
- An unpaid leave of absence taken by the Participant or spouse
- A significant change in premiums or dependent care expenses

Each Plan Year anniversary provides an opportunity to change elections when re-enrolling for the next year.

Dependent Care Qualifications

A Section 125 Cafeteria Plan allows for the inclusion of Dependent Care (Section 129 of the Internal Revenue Code) benefits. Dependent Care expenses that may be run through a Cafeteria Plan must meet the following test: *The primary purpose of expenses for care of a qualifying individual must be to assure his or her well-being and protection.*

Eligibility for the dependent care benefit requires that certain criteria be met with respect to the expense, the provider, etc.

- A. The dependent care expenses must be work related. The care must be necessary for the Participant and the Participant's spouse to work, to look for work, to attend school full-time, or if the Participant or spouse is physically unable to care for their children.
- B. The dependent care expenses provided during a calendar year cannot exceed \$5,000. In the case of a married individual filing a separate tax return, the limit is \$2,500. This amount may be less if the Participant's earned income or spouse's earned income is less than \$5,000.

The dependent care expenses must be for the care of one or more qualifying persons. A qualifying person is one of the following:

- A. A dependent who was under age 13 when the care was provided and for whom an exemption can be claimed.
- B. A spouse who was physically or mentally unable to care for himself or herself.
- C. A dependent who was physically or mentally unable to care for himself or herself and for whom an exemption can be claimed.

Kindergarten Expenses

Expenses for food, clothing and education are not considered expenses paid for the care of a qualifying individual. In respect to the food and clothing issue, these costs may be included if they are incidental to and cannot be separated from the total cost of caring for a qualifying person. In respect to educational costs, it is clear they cannot be included. Kindergarten expenses are purely educational costs. Therefore they cannot be included. Conversely, pre-kindergarten costs may be included.

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