PIMA COUNTY FLEXIBLE BENEFITS PLAN

Flexible Benefits Summary Plan Description

Administered by

ASI FLEX

TAX SAVINGS EXAMPLE

By electing to direct a portion of your salary through the Plan, you essentially use this money to pay for expenses on a TAX-FREE basis that would otherwise be paid out of your take-home pay.
This example shows how the Plan could save this employee $332 in taxes!

	Without Plan	With Plan	Savings with Plan
Gross Income	$25,000	$25,000	
Medical expenses run through the Plan		1,200	
Taxable Income	$25,000	$23,800	
Federal Tax*	2,985	2,805	180
State Income Tax	790	730	60
Social Security (FICA) Tax	1,913	1821	92
Paycheck After Taxes	$19,312	$18,444	
Expenses not run through the Plan	1,500	300	
Your Spendable Income	17,812	$18,144	**$332**

This person could reduce their taxes by $332 by using the FSA!!
Notice that not all of this employee's expenses were run through the Plan.
*Estimate based on 15% Marginal Tax Bracket - single with standard deduction

INTRODUCTION

A Flexible Spending Account (FSA) is an employer-sponsored plan that lets you deduct dollars from your paycheck before they are taxed and put them into a special account.

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 save at least 25% on out-of-pocket family care expenses.

Flexible Spending Accounts offer tax savings for your out-of-pocket medical expenses. Most people save at least 25% on each dollar that is set aside.

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 the FSA, ASIFlex will send you a confirmation of your enrollment and reimbursement forms to your home address. As you incur eligible expenses throughout the plan 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. You are not taxed on these reimbursements. After each claim, you will receive an account summary.

Federal rules state that you will only be able to be reimbursed for expenses you incur during the plan year, which runs from January 1 – December 31. All claims must be submitted on or before March 31st. IRS rules state that if you do not use the money in your account, any remaining unused funds will be forfeited to your employer. However, the IRS now allows an employer to allow a maximum of $500 in the health care or limited purpose health care FSA to roll over to the following plan year. Pima County has chosen to allow this rollover feature. So if you still have funds remaining in your health care or limited purpose health care FSA on December 31, up to $500 will roll over to the following year for your use during that plan year. NOTE: This roll over feature is not available for the dependent care FSA.

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 earning figures. (You can check with your local Social Security office to explore any effect this may have on your benefits – which are usually very minor.)

The Pima County Flexible Benefits Plan has contracted with ASIFlex to perform certain administrative functions for the Plan. ASIFlex processes all claims for the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account. If you have any questions concerning claims, please contact ASIFlex, P. O. Box 6044, Columbia, MO 65205, 800-659-3035, email: asi@asiflex.com, or on-line at www.asiflex.com.

FREQUENTLY ASKED QUESTIONS

Q. WHAT IS THE PIMA COUNTY FLEXIBLE BENEFITS PLAN

The Pima County Flexible Benefits Plan is a way to pay for certain out-of-pocket (unreimbursed) Medical Care expenses (Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account) and Dependent Care Expenses (Dependent Care Flexible Spending Account) on a **BEFORE-TAX** basis!

Q. WHAT DOES "BEFORE TAX" OR "PRE-TAX" MEAN?

Deductions through the Plan from your paycheck are exempt from federal and state income tax and Social Security tax. These deductions reduce your **taxable** income reported on your W-2 and on your income tax returns.

Q. WHO CAN PARTICIPATE IN THE PIMA COUNTY FLEXIBLE BENEFITS PLAN?

Permanent full time or part time employees may participate, provided that the election procedures are followed.

An individual may participate in the Health Care Flexible Spending Account Plan or the Limited Purpose Health Care Flexible Spending Account Plan, but not both during the same Plan Year.

The following classes of employees cannot participate in the Pima County Flexible Benefits Plan:

- Leased employees (as defined by §414(n) of the Code);
- Contract workers and independent contractors;
- Temporary employees and casual employees (Employees hired short-term to meet specific needs of the Employer, as determined in the Employer's sole discretion); and
- Individuals paid by a temporary or other employment or staffing agency.

Q. WHY SHOULD I PARTICIPATE?

Paying for medical expenses through the Plan can save you as much as 25% - 40% in taxes on each dollar that you spend for your share of insurance deductibles, co-pays, or items not covered by insurance. Also, the Dependent Care Flexible Spending Account may save you more in taxes than the day-care tax credit (filed with your federal income tax return).

Q. IF I REDIRECT PART OF MY PAY, WON'T I MAKE LESS MONEY?

No. Your spendable income will increase by the amount of your tax savings.

Q. WHY SHOULD I PARTICIPATE IN THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT OR LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT IF I ALREADY HAVE MEDICAL INSURANCE?

The Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account offers a tax break on Medical Care Expenses NOT reimbursed by insurance. For example, the Health Care Flexible Spending Account will reimburse you for expenses for office visits, eye exams, glasses, drugs and medications used to treat medical conditions and hospital care that is not covered by Medical Insurance (*e.g.* co-payments). The Limited Purpose Health Care Flexible Spending Account coverage is more restrictive than the Health Care Flexible Spending Account but will cover expenses for dental or vision that are not paid for by the health plan.

Q. SHOULD I PARTICIPATE IN THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN OR THE LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN?

If you are enrolled in the high deductible health plan, you will be enrolled in the Health Savings Account. In this case, you will only be eligible to participate in the Limited Purpose Flexible Spending Account The Limited Purpose Health Care Flexible Spending Account Plan is designed to allow you to receive or make contributions to a Health Savings Account while you are a participant. The types of expenses covered under the Limited Purpose Health Care Flexible Spending Account Plan are significantly reduced compared to the

Health Care Flexible Spending Account Plan and only include dental or vision expenses not paid by your health plan. If you are not enrolled in the high deductible health plan, you may participate in the traditional Health Care Flexible Spending Account where medical expenses qualify that are not reimbursed under any other plan, as stated in Internal Revenue Code §213.

Q. HOW MUCH DOES IT COST?

There is an administrative fee which is paid by the County for enrolled employees actively at work, for participation in these accounts.

Q. WHAT IS THE CATCH?

No catch. Congress approved FSAs in 1978; the Tax Reform Act of 1986 reaffirmed their legitimacy.

Q. HOW MUCH WILL BE DEDUCTED FROM MY SALARY FOR THE BENEFITS I SELECT?

Your salary deduction amount for each pay period is an amount equal to your annual contribution for the benefits you elected, divided by the number of remaining paychecks in the Plan Year following your effective date. If you increase an election under the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account or Dependent Care Flexible Spending Account Plan, your payroll deductions per pay period will be an amount equal to your new reimbursement limit elected less the payroll deductions made prior to this election change, divided by the number of paychecks 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 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.

Q. WHEN CAN I MAKE A CHANGE IN MY ELECTION?

Generally your elections under the Plans are irrevocable for the Plan Year. However, during certain circumstances described below you may be allowed to change your election.

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 Pima County Flexible Benefits Plan, or a similar plan maintained by your spouse's employer or one of your dependents' employers and your desired election change corresponds with that gain or loss of coverage.

Events 1 - 5 apply to the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account. When these events occur, a change may be made to your election.

1. Your legal marital status changes through marriage, divorce, death, legal separation 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, that is considered a loss of a dependent under the Dependent Care Flexible Spending Account Plan, but not under any of the other plans.

3. You, your spouse, or any of your dependents have a change in employment status that affects eligibility under the Pima County Flexible Benefits Plan or a plan maintained by your spouse or any dependent's employer. If you terminate or take a leave of absence from Pima County, you must be gone at least 31 days for termination or leave of absence to qualify.

4. One of your dependents satisfies or ceases to satisfy the requirements for coverage under the Pima County's Plan for unmarried dependents due to attainment of age, student status or any similar circumstances.

5. You, your spouse, or one of your dependents changes residence.

Events 6 - 8 apply to the Health Care Flexible Spending Account and the Limited Purpose Health Care Flexible Spending Account, but not the Dependent Care Flexible Spending Account. When any of these events take place, a change may be made to your election.

6. You are served with a judgment, decree or court order, including a Qualified Medical Child Support Order ("QMCSO") 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 Flexible Spending Account Plan or the Limited Purpose Health Care Flexible Spending Account 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 Flexible Spending Account Plan or the Limited Purpose Health Care Flexible Spending Account Plan.

7. If you, your spouse, or a dependent become entitled to coverage under Medicare or Medicaid, you may drop or reduce coverage under the Health Care Flexible Spending Account Plan or the Limited Purpose Health Care Flexible Spending Account Plan.

8. If you, your spouse, or a dependent lose eligibility and coverage under Medicare or Medicaid, you may add or increase coverage under the Health Care Flexible Spending Account Plan or the Limited Purpose Health Care Flexible Spending Account Plan.

Events 9 - 11 apply only to the Dependent Care Flexible Spending Account. If any of the following events take place, a change may be made to your election.

9. 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 Pima County Flexible Benefits Plan.

10. You change dependent care providers (including school or other free provider). You may make a corresponding change to your Dependent Care Flexible Spending Account and your future salary reductions if you change dependent care providers.

11. You may make a corresponding change to your Dependent Care Flexible Spending Account 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 child, parent, stepchild, sibling, aunt, uncle, cousin, or in-law of the participant.

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.

If you have questions call ASI at (800) 659-3035.

Q. WHAT IF I'M ALREADY IN THE PIMA COUNTY FLEXIBLE BENEFITS PLAN?

Participation in the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account, and the Dependent Care Flexible Spending Account terminates at the end of each Plan Year. You **MUST** re-enroll each year to continue your participation.

Q. WHEN DOES PARTICIPATION BEGIN?

After you satisfy the eligibility requirements described above (new Employees may enroll within 30 days of their eligibility date), you become a Participant by enrolling online through the ADP Self Service Portal. Online enrollment will be available during the Annual Enrollment Period. You must enroll online through the ADP Self Service Portal within the time period specified in the enrollment materials. If you fail to enroll on-line as required, you will be deemed to have elected cash and will not be able to elect any benefits under

the Plan until the next Annual Enrollment Period (unless a "Change in Election Event" occurs). Enrollment during the Plan Year is effective the 1st of the month following enrollment.

Q. WHAT IS THE "ANNUAL ENROLLMENT PERIOD" AND THE "PLAN YEAR"?

The Annual Enrollment Period is the period prior to the beginning of the Plan Year during which you have an opportunity to elect to participate under the Plan by enrolling online through the ADP Self Service Portal. You will be notified of the timing and duration of the Annual Enrollment Period.

You may choose to enroll in one or more of the benefits offered or to receive your entire Pima County pay, without these benefits.

The Plan Year is the 12 months beginning on each January 1 and ending on December 31 of the same calendar year.

Q. WHAT IF I DON'T USE ALL OF THE MONEY I ELECT IN THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT, THE LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT OR THE DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT?

ASI can help you estimate your allowable expenses for the Plan Year. However, if you do have funds remaining in any account at the end of the Plan Year, per IRS regulations, that amount will be lost by you and retained by Pima County to help offset plan expenses. In the case of the Health Care and Limited Purpose Flexible Spending Account, any balance remaining under $500 will be carried over into the next plan year, provided you are still employed by the County.

Q. ARE THERE ANY NEGATIVES THAT I SHOULD KNOW ABOUT?

Yes, because you are not paying Social Security tax on that portion of your income that has been redirected, your Social Security benefits may be slightly reduced. However, if you invest your tax savings, in many cases you would have more money available at retirement than the benefit you would have received from the amount not paid into Social Security.

Expenses reimbursed by the Health Care Flexible Spending Account Plan or the Limited Purpose Health Care Flexible Spending Account Plan may not be deducted on your individual income tax return. Likewise, expenses deducted on your income tax return may not be filed for reimbursement through your Health Care Flexible Spending Account or your Limited Purpose Health Care Flexible Spending Account.

Additionally, participation in the Dependent Care Flexible Spending Account Plan 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 Dependent Care Flexible Spending Account Plan. The IRS will not allow you to receive two tax breaks on the same expenses.

Q. WHEN WILL MY PARTICIPATION IN THE PLAN END?

Your participation will end when you terminate employment with Pima County. This means you will no longer be able to make contributions to the Plan. If 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. If 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 you return to work after 30 days during the same Plan Year, you may make a new election for the remainder of the Plan Year. Except as specified in the section on Coverage Continuation (COBRA) in the Health Care Flexible Spending Account Plan and the Limited Purpose Health Care Flexible Spending Account 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. Your participation will also end at the end of the expiration of the Period of Coverage, if the Plan is terminated, or if you a file false or fraudulent claim for benefits.

Your coverage in the FSA program will end (except as specified in the section on Coverage Continuation) on the last day of the month in which you were last employed. E.g. if your last day of employment is March 5th, your coverage will end March 31st, unless you elect to continue your coverage.

Q. WHAT IF I GO ON FMLA?

If you go on FMLA then you can maintain your Health Care Flexible Spending Account or your Limited Purpose Health Care Flexible Spending Account but not your Dependent Care Flexible Spending Account. Please refer to the FMLA paragraph in the Health Care Flexible Spending Account Plan and the Limited Purpose Health Care Flexible Spending Account Plan Summary. If your Health Care Flexible Spending Account or Dependent Care Flexible Spending Account coverage ends while you are on FMLA leave for any reason (including for non-payment of deductions), then you may re-enter the Health Care Flexible Spending Account Plan, the Limited Purpose Health Care Flexible Spending Account Plan or the Dependent Care Flexible Spending Account Plan upon return from FMLA on the same basis as you were participating prior to the leave.

When you return from FMLA leave, you may elect whether to be reinstated in the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account Plan or the Dependent Care Flexible Spending Account with the same annual total as in effect before the FMLA leave (with increased deductions for the remaining period of coverage) or at a lower annual total coverage level for the period of FMLA leave during which you did not have payroll deductions. If you elect a lower annual coverage amount, the amount withheld from your paychecks for the purpose of paying for your Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account or your Dependent Care Flexible Spending Account will be the same as the amount withheld before your FMLA leave.

***Q*. HOW CAN I GET ANSWERS TO OTHER QUESTIONS?**

Check ASI's website www.asiflex.com. You can email ASI at asi@asiflex.com or call ASI toll free at 1-800-659-3035. A representative is available from 7 a.m. to 7 p.m. Central time.

***Q*. HOW QUICKLY WILL MY PIMA COUNTY FLEXIBLE BENEFITS PLAN CLAIMS BE PAID?**

ASI will process your claim no later than the first banking day following their receipt of the claim. Valid Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account claims will be paid on the day processed up to your annual election less prior payments. Valid dependent care claims will be paid on the day processed up to the balance in your Dependent Care Flexible Spending Account. Any excess dependent care claim will be paid as contributions are received from payroll. If there is a problem with your claim, ASI will notify you on the day the claim is processed either by U.S. Mail or by email.

***Q*. WHAT HAPPENS IF MY CLAIM FOR REIMBURSEMENT IS DENIED IN WHOLE OR IN PART?**

If your claim is denied in whole or in part, the Administrator will notify you in writing within 30 days of the date the Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Administrator is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the information required. You will have 45 days from receipt of the notice in which to provide the specified information. Decision on your claim will be suspended until the specified information is provided.) Notice of a denied claim will include:

(a) The specific reason(s) for the denial;
(b) The specific Plan provision(s) on which the denial is based;
(c) A description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
(d) Appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review relevant documents and other information (upon request and at no charge).

If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the Committee (the Benefits Committee that acts on behalf of the Administrator with respect to appeals). Your **appeal must be made in writing within 30 days** of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documentation that you feel supports your claim. You will have the opportunity to ask additional questions and make written comments. You may review (upon request and at no charge) documents and other information relevant to your appeal.

Your appeal will be reviewed and decided by the Committee in a reasonable time no later than 60 days after the Committee receives your request for review. The Committee may, in its sole discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of the medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

(a) The specific reason(s) for the decision on review;
(b) The specific Plan provision(s) on which the decision is based;
(c) A statement of your right to review relevant documents and other information (upon request and at no charge); if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on. A copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

Q. IS DIRECT DEPOSIT AVAILABLE?

Yes. You may have your claims payments sent directly to your checking, money market or savings account. ASI will send a notice of each payment to you. ASI can send this notice via email, if you prefer. Email and direct deposit provide you with the fastest, safest payment method, as well as the fastest notification method.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN (INCLUDING LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN) SUMMARY

The Health Care Flexible Spending Account plan and Limited Purpose Health Care Flexible Spending Account plan are each intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Medical Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). See **"SHOULD I PARTICIPATE IN THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN OR THE LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN?"** to determine which account you may participate in. You can elect to participate in the Health Care Flexible Spending Account plan or the Limited Purpose Health Care Flexible Spending Account plan (you may not participate in both during the same Plan Year) by completing, signing and returning an Election Form/Salary Reduction Agreement:

(a) To receive benefits in the form of reimbursements for Medical Care Expenses (Health Care Flexible Spending Account); and
(b) To pay the contributions for such Health Care Flexible Spending Account on a pre-tax salary reduction basis.

STEPS TO PARTICIPATE IN THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN OR THE LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN

1. **Estimate your family's annual out-of-pocket medical expenses**. You may include expenses for anyone included on your federal tax return (legal spouse, children, etc.). Expenses for domestic partners qualify **only if** they are a qualified tax dependent. See www.asiflex.com for definitions of qualified tax dependents. Include predictable expenses only.
2. **Enroll in the Health Care Flexible Spending Account or the Limited Purpose Health Care Flexible Spending Account**. Divide your estimate by the number of paychecks you expect to receive during the Plan Year. Complete and sign an Enrollment Form during the Annual Enrollment Period.
3. **Receive medical services.** A Medical Care 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.
4. **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.
5. **Receive reimbursements.** ASI will review your claim, and if approved, will reimburse you for the Medical Care Expenses within one business day of their receipt of the claim.

IMPORTANT HEALTH CARE FLEXIBLE SPENDING ACCOUNT AND LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT INFORMATION

Annual Maximum $2,550.00 **Annual Minimum** $100.00

Please note that the annual maximum of $2,550 is required by federal health care reform, and is a per participant limit.

Qualifying Medical Expenses under the Health Care Flexible Spending Account Plan include only those expenses that are defined as medical expenses in Internal Revenue Code §213 and are not reimbursed by any other insurance or another plan. As stated in §213, qualifying Medical Care Expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They **exclude** all insurance premiums, long-term care expenses, and cosmetic expenses. Refer to IRS Publication 502 for further details on qualifying expenses. You may link to this

publication from ASI's website. The purpose of Publication 502 is to assist people with their income tax filing. It does not address Health Care Flexible Spending Account Plans. However, most of the items listed as deductible in Publication 502 can be claimed through your Health Care Flexible Spending Account. Expenses reimbursed by the Health Care Flexible Spending Account Plan or the Limited Purpose Health Care Flexible Spending Account Plan may not be deducted on your income tax return. Expenses deducted on your income tax return may not be filed for reimbursement through your Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account. **You can only claim expenses based on the date incurred or date of service (not paid as stated in Publication 502).** Please contact ASI at asi@asiflex.com, (800) 659-3035 if you have any questions regarding particular expenses. **Under the Limited Purpose Health Care Flexible Spending Account Plan, qualified expenses are further limited to expenses for dental or vision care within the meaning of medical care as defined in Section 213 of the Code.** In addition, you may not be reimbursed from the Limited Purpose Health Care Flexible Spending Account for any dental or vision care expense which is covered (including copays, deductibles, or co-insurance) under any other health plan including a high deductible health plan.

Below is a partial listing of qualified expenses under the Health Care Flexible Spending Account Plan. Remember, expenses can only be claimed based on the date **incurred** regardless of the date you are billed or pay for the expense. Most of these expenses **do not** qualify under the Limited Purpose Health Care Flexible Spending Account plan unless they are for dental or vision care.

- Deductibles
- Co-pays
- Doctor's fees
- Dental expenses
- Vision care expenses
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Drugs & Medicines (legal) used to treat a medical condition
- Insulin
- Orthodontia (braces)
- Routine physicals
- Medical equipment
- Hearing aids including batteries
- Transportation expenses related to illness
- Chiropractor's fees
- Over the counter drugs (**see page 19 for further details)**

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
- Sunglasses - non-prescription
- Toiletries
- Medicines, drugs, herbs, or vitamins for general health and not used to treat a specific medical condition
- Expenses that are merely beneficial to your general health (*e.g.*, vacations and vitamins)
- Health club dues (not prescribed for a particular condition)
- Any sort of insurance premiums or warranties
- Long-term care expenses
- Prescription Drugs imported from another country

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 Flexible Spending Account Plan or the Limited Purpose Health Care Flexible Spending Account 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:

(a) Death of the Participant;

(b) Termination (other than for gross misconduct) or a reduction in hours;

(c) Divorce or legal separation of the Participant; or

(d) 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 the Administrator of the occurrence of an event described above.

Continuation of coverage will not extend beyond the end of the current Plan Year and 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.

Participants on leave under the Family Medical Leave Act ("FMLA") are entitled to maintain coverage for the Health Care Flexible Spending Account or the Limited Purpose Health Care Flexible Spending Account. Payment for coverage during FMLA may be made as follows:

- You may make arrangements with the Human Resources Department to **pre-pay** for coverage during the leave prior to commencing the leave. If your leave lasts longer than you expected, Pima County will take any missed contributions from your first paycheck after you return from leave.
- You may pay for coverage during your leave by making payments directly to the Plan each month.

Newborns and Mothers Health Protection Act of 1996
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998:
The Health Care Flexible Spending Account Plan as required by the Women's Health and Cancer Rights Act of 1998, includes expenses for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema). Call (800) 659-3035 for more information.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN SUMMARY

The Dependent Care Flexible Spending Account Plan is intended to qualify as a "dependent care assistance program" under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

You can elect to participate in the Dependent Care Flexible Spending Account Plan by electing:

(a) To receive benefits in the form of reimbursements for Dependent Care Expenses (Dependent Care Flexible Spending Account); and
(b) To pay the contribution for the Dependent Care Flexible Spending Account on a pre-tax salary reduction basis.

STEPS TO PARTICIPATE IN THE DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN:

1. **Estimate your total Dependent Care Expenses for the Plan Year**. Include predictable expenses only.
2. **Enroll in the Dependent Care Flexible Spending Account Plan**. Divide your estimate by the number of paychecks you expect to receive during the Plan Year. You enroll online during the Annual Enrollment Period.
3. **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.
4. **File claims.** After you have received the dependent care services, you may submit a claim for those expenses to ASI.
5. **Receive reimbursements.** ASI will review your claim, and if approved will reimburse you within one 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.

IMPORTANT DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN INFORMATION

Annual Maximum $5,000.00 **Annual Minimum** There is no minimum.

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 who lives with you at least one half of the year or your spouse or an older dependent who is mentally or physically incapable of self-care who resides with the you for more than one half of the year and is a qualifying child or relative under Section 152 of the Code. The child of a divorced or separated employee is treated as a qualifying individual of the custodial parent irrespective of who claims the dependency exemption if such child is in the custody of one or both parents for more than half of the calendar year. The child is treated as having been in the custody of the parent who had custody for the greater portion of that year. If the child was not in the custody of one or both parents for more than half of the calendar year, then neither parent can be considered the custodial parent.

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

The Dependent Care Flexible Spending Account 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 Dependent Care Flexible Spending Account. 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 can 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 Flexible Spending Account Plan** allows a tax break on up to $5,000 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 Flexible Spending Account. As their federal tax percentage rises, they would receive an even higher tax break by using the Dependent Care Flexible Spending Account.

Generally those employees with a combined family income over $31,000 would have a higher percentage tax break through the Dependent Care Flexible Spending Account. Those employees with a combined income under $31,000 generally would receive a higher percentage tax break utilizing the tax credit. Please contact your tax advisor if you have questions about which is best 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. Please note that 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. This will inform the IRS that you have received a tax break on that expense through your Dependent Care Flexible Spending Account.

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 for additional information. You can access this publication from ASI's website. The purpose of Publication 503 is to assist people with their income tax filing. It does not address Dependent Care Flexible Spending Accounts. However, most of the items listed as eligible for the tax credit in Publication 503 can be claimed through your Dependent Care Flexible Spending Account. **You can only claim expenses based on the date incurred (not paid as stated in Publication 503)**. Please contact ASI at asi@asiflex.com, (800) 659-3035 if you have any questions regarding particular expenses.

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

- Day-care centers
- 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 that is not disabled.
- Child support payments.

PIMA COUNTY FLEXIBLE BENEFITS PLAN CLAIMS

ASI, (800) 659-3035 PO Box 6044 Columbia, MO 65205-6044	asi@asiflex.com Claims processed daily – within 1 day
World Wide Web www.asiflex.com for claim forms and personal account information	

Allowable expenses must be **incurred** during the portion of the Plan Year that you are a participant. Claims must be filed by March 31st following the end of the Plan Year. After March 31st, your account will be closed and any balance remaining will be retained by Pima County in accordance with federal regulations. However, if you are a currently enrolled participant in the Health Care FSA or the Limited Scope Health Care FSA on December 31 and have a balance remaining, any balance equal to $500 or less will be rolled over to an account for your use the following Plan Year while any remainder in excess of that $500 will be retained by Pima County in accordance with federal regulations. If March 31st is a holiday, Saturday, or Sunday, then claims must be filed by the first business day following March 31st.

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:**

(a) The provider's name;
(b) The date(s) of service;
(c) A description of the service(s); and
(d) 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 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. Over-the-counter medicines require a prescription from a medical doctor to be accepted. Prior to January 1, 2011, you were able to purchase over-the-counter items, such as pain relievers, cold and flu medications, etc. without a prescription. Purchase of items such as these will be denied unless a prescription is on file from a medical doctor. Purchases for general good health will

not be accepted. You will be provided with a supply of claim forms with your enrollment confirmation. You may copy the claim form or obtain extra claim forms from your Human Resources office, by contacting ASI, or over the internet at 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 the above documentation for dependent care claims.

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.

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. 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.

Payment from your Health Care Flexible Spending Account or the Limited Purpose Health Care Flexible Spending Account for expenses incurred during the Plan Year 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 monthly contributions will continue for the remainder of the Plan Year.

Payment from your Dependent Care Flexible Spending Account 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.

Direct deposit into the bank account of your choice is available for your claim payments. By using direct deposit you will not need to wait for a check to arrive and to deposit it yourself. 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. If you prefer, a check can be mailed to you instead of payment by direct deposit.

Email notice If you choose direct deposit, ASI can send your notices of payment directly to your email account.

INTERNET ACCESS

You can access your Health Care Flexible Spending Account and your Dependent Care Flexible Spending Account on the Internet 24 hours/day, 7 days/week. Information is updated every evening to reflect the previous day's transactions. You can see your current balance, if a claim has been processed, and/or whether a payment has been made. You can also file claims. Information for the current Plan Year is available (previous Plan Year as well for a limited period of time).

1. Go to http://www.asiflex.com and click on "**Account Detail**"

2. You will need to create a User Name, Password and select a security image unless you have already done so. To set up your credentials the first time, you will need your Personal Identification Number (PIN). Your PIN is provided on your enrollment confirmation. You can also email ASI at asi@asiflex.com or call ASI at (800) 659-3035 to get your PIN. Please ensure that you have a few minutes to complete this process fully. You will need to remember this information for the future.

3. Once you are signed in, you will be in the Self Service Menu.

4. Click the account you wish to view.

5. If you have information available for more than one Plan Year in that account, you will need to click on the Plan Year you wish to view. All transactions for the Plan Year are shown through the previous processing day.

6. Be sure to click "**Log out**" when you finish. This closes out your account for security purposes.

GENERAL PLAN INFORMATION

The administrator	Pima County 150 W Congress, 4th Floor Tucson, AZ 85701 (520) 724-8464
The employer	Pima County 150 W Congress, 4th Floor Tucson, AZ 85701 (520) 724-8464
Named Fiduciary	Pima County

The name of the Plan is The Pima County Flexible Benefits Plan. The Plan Number is 501. The provisions of the Plan became effective on July 1, 2007. The Plan is intended to last indefinitely. However, the employer retains the right to amend or terminate the Plan at any time for any reason. Pima County's federal employee tax identification number (EIN) is 86-6000543.

The agent for Service of Legal Process is the Plan Administrator.

The benefit Plan Year is the twelve-month period from January 1 through December 31 of the same calendar year.

Although reprinted within this document, the Health Care Flexible Spending Account Plan, the Limited Purpose Health Care Flexible Spending Account Plan, and the Dependent Care Flexible Spending Account Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §105 and 129. The Health Care Flexible Spending Account Plan and the Limited Purpose Health Care Flexible Spending Account Plan are also separate plans for purposes of applicable provisions of COBRA.

The Health Care Flexible Spending Account Plan, the Limited Purpose Health Care Flexible Spending Account Plan, and the Dependent Care Flexible Spending Account Plan are entirely funded by Employee salary reductions. However, for the purposes of the Plans and the Internal Revenue Code they are considered employer contributions. All of the amounts payable under this Plan shall be paid from the general assets of the employer. Neither Pima County nor the Administrator (if other than Pima County) will maintain any fund or segregate any amount from general assets for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of Pima County from which any payment under this Plan may be made. There is no trust or other fund from which benefits are paid. While Pima County has complete responsibility for the payment of benefits out of its general assets, it may hire an unrelated third party firm to make benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected as employer and Participant contributions for benefits, and as described in the Health Care Flexible Spending Account Plan (including the Limited Purpose Health Care Flexible Spending Account Plan) Summary and Dependent Care Flexible Spending Account Plan Summary sections.

Pima County has hired ASI to perform certain administrative functions for the Plan. ASI processes all claims for the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account, and the Dependent Care Flexible Spending Account. If you have any questions concerning claims, please contact ASI, P. O. Box 6044, Columbia, MO 65205, 800-659-3035, email: asi@asiflex.com, on-line at www.asiflex.com.

It is intended that this Plan meet all applicable requirements of the Code and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine an appropriate course of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to

interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole decision and further constitutes agreement to the limited standard and scope of review described by this section.

To the extent permitted by law, the Plan Administrator and other parties assuming a fiduciary or decision making role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan. The standard shall be one of ordinary care.

Benefits Offered:

- Health Care Flexible Spending Account Plan and Limited Purpose Health Care Flexible Spending Account Plan
- Dependent Care Flexible Spending Account Plan

GLOSSARY

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code: The Internal Revenue Code of 1986, as amended.

Dependent: With regard to any health plan a dependent is a person who is a qualifying child or qualifying relative as defined in Code §152, without regard to the gross income limitations. See www.asiflex.com for definitions of a qualified tax dependent for purposes of the Health Care Flexible Spending Account Plan, including details relating to domestic partners.

With regard to the Dependent Care Flexible Spending Account Plan, a dependent shall be a qualifying person as defined in Code §21(b)(1), as amended (See also "Qualifying Individual" under the Dependent Care Flexible Spending Account Plan Summary.) In the case of divorced parents, the child shall be treated as a dependent of the custodial parent as described in Code §21(e)(5).

Dependent Care Expenses: Employment-related expenses as defined in Internal Revenue Code §21(b)(2).

Educational Organization: An organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

Election Form/Salary Reduction Agreement: Means the form provided by the Administrator for the purpose of allowing an eligible Employee to participate in this Plan by electing salary reductions to pay for the Health Care Flexible Spending Account Plan, Limited Purpose Health Care Flexible Spending Account Plan, and/or Dependent Care Flexible Spending Account Plan benefits. It includes an agreement pursuant to which an eligible Employee or Participant authorizes the employer to make salary reductions.

Employee: Means an individual that Pima County classifies as a common-law employee and who is on Pima County W-2 payroll. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the employer.

FMLA: The Family and Medical Leave Act of 1993, as amended.

FSA: An account established under the Health Care Flexible Spending Account Plan, Limited Purpose Health Care Flexible Spending Account Plan, or the Dependent Care Flexible Spending Account Plan.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Incurred: The date or dates that services or products are provided that give rise to an expense regardless of when the expenses are paid or billed.

Medical Care Expense: An expense incurred by you, your spouse, or a dependent for "medical care" as defined in Internal Revenue Code Section 213(d). It does not include any insurance premiums or long term care expenses. Medical Care Expenses under the Limited Purpose Health Care Flexible Spending Account Plan are further restricted to those expenses for dental or vision care that are not covered or paid by any other health plan**.**

QMCSO: A qualified medical child support order, as defined in ERISA § 609(a).

Participant: A person who is an eligible Employee and who is participating in this Plan. Participants include: (a) those who elect Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account, and salary reductions to pay for such benefits; and (b) those who elect instead to receive their full salary in cash. The following Employees are excluded from participation:

- Leased employees;
- Contract workers and independent contractors;
- Temporary employees and casual employees;
- Individuals paid by a temporary or other employment or staffing agency; and
- Employees covered under a collective bargaining agreement.

Plan: The Pima County Flexible Benefits Plan

Plan Year: The Plan Year is from January 1 through December 31 of the same calendar year.

Spouse: A person who is legally married to a participant as defined under applicable state law.

Student: Student means an individual who during 5 calendar months during the taxable year is a full-time student at an educational organization.

Claim Submission and Filing Instructions

Claim Submission Options: There are four different methods by which you may submit your claim.

- **Mobile:**
  Download ASIFlex's free mobile app available at www.asiflex.com, Google Play or the App Store. Simply use your smartphone or tablet to take a picture of your documentation with your device's camera. Complete the requested information and file your claim! You can also use the mobile app to view information about your account(s).
- **Online:**
  Submitting your claim online is easy and convenient!
  Go to https://my.asiflex.com. In order to submit your claim via ASIFlex's secure online portal, you will need the following:
  - Your account user credentials (User Name, Password and Security Image). If you have not yet set up your credentials, you will need your PIN (provided to you in your welcome packet and in each account summary statement). If you do not have your PIN, you may call Customer Service at (800) 659-3035 or contact ASI via email at asi@asiflex.com.
  - Access to a scanner so that you may scan your documentation. You will be requested to upload the documentation after you complete the online claim.
- **Toll-free fax:**
  (877) 879-9038
  This option provides fast and easy claims submission. You may submit your claim via ASIFlex's toll-free fax number 24 hours a day, 7 days a week.
- **US Mail:**
  ASIFlex, P.O. Box 6044, Columbia, MO 65205

Claim Filing Guidelines:

- Clearly print your name, address, social security number (or EID as appropriate) and your employer's name.
- List expenses and arrange the supporting documentation in the same order.
- Enclose required documentation.

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

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

Without a description of the service or care provided, your claim will be denied. **Credit card receipts, cancelled checks and billing statements without detailed service information are not substantial documentation and will not be accepted.** The description of the service or care can be as generic as "copay" or "office visit". If the description of the service is not listed on the receipt* provided from your service or care provider, the provider may write the description on the receipt.

*Please note if a receipt is not available for dependent/elder care expenses, you may have the care provider sign and date the claim form in the appropriate area instead of providing a receipt.

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