State of Connecticut
Medical Flexible Spending Account
Plan Summary Fact Sheet

The State of Connecticut Medical Flexible Spending Account Program (MEDFLEX) provides a tax-free way for employees to pay for out-of-pocket medical care expenses, which reduces the cost of eligible products and services. The State has teamed up with Progressive Benefit Solutions (PBS) to serve as the State's administrative services provider.

ELIGIBILITY

The MEDFLEX is available to permanent, active employees (excluding per diem employees, adjunct faculty, and temporary or seasonal employees) working at least half time (0.5 FTE – Full Time Equivalent). Former employees and rehired retirees are not eligible to participate in these programs.

In order to participate in this plan, you must fill out an open enrollment form that sets forth the amount you wish to contribute for the upcoming plan year. Employees must re-enroll in the plan for each new year.

CONTRIBUTION ELECTION

The MEDFLEX is regulated by the Internal Revenue Service, which sets a maximum contribution level that an employee can contribute each calendar year. For plan year 2020 the limits are as follows:

Maximum	$2750 per year
Minimum	$520 per year

Throughout the year, the amount chosen will be deducted from your paychecks based on your pay frequency and expected duration of your payments.

PROGRAM DESCRIPTION

The MEDFLEX can be used to cover qualified medical care expenses, defined in IRS Publication 502, as amounts paid for: (1) the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body; (2) payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners, including costs of equipment, supplies, and diagnostic devices needed for these purposes; (3) medical care expenses incurred primarily to alleviate or prevent a physical or mental defect or illness and do not include expenses that are merely beneficial to general health, such as vitamins; and (4) certain expenses, such as transportation, that are incurred primarily for and essential to medical care.

MEDFLEX funds may be used to pay for medical expenses incurred for the employee, a spouse and IRS-eligible dependents so long as: (1) expenses are qualified under IRS Code Section 105 and 213; (2) all other sources of reimbursement are exhausted (ex. health insurance plan); (3) reimbursement will not be sought from any additional source; and (4) documentation to substantiate expenses must be maintained and submitted for verification upon request.

Qualified Expenses: The chart below illustrates some of the eligible over-the-counter and medical products and services. Certain expenses may require a Letter of Medical Necessity Form in order to be eligible for reimbursement. Further information regarding eligible expenses is available through IRS Publication 502 and IRS Code Section 213.

Dentures	Dental Treatment (orthodontia)	Smoking Cessation Programs
Contact Lenses	Eye Glasses	Transportation
Co-pays and Deductibles	Laser Eye Surgery	Weight Loss Program
Sunscreen	Bandages	Thermometers

Ineligible Expenses: (Partial List)

Cosmetic Surgery	Health Club Dues	Massage Therapy
Electrolysis/Hair Removal	Teeth Whitening	Nutritional Supplements/Vitamins
Aspirin/Pain Relievers	Cough Drops	Nicotine Patches/Gum/Lozenges
Cold/Flu Medicine	Decongestants	Nasal/Sinus Medication

PROGRAM REQUIREMENTS

Open Enrollment October 1 to October 31

IRS guidelines require that employees re-enroll each year during the annual open enrollment period if they want to participate in the MEDFLEX for the upcoming plan year, which begins January 1st. Prior to open enrollment current participants in the MEDFLEX will receive an enrollment form by mail; online enrollment will also be available. Forms to enroll in the plan for the upcoming calendar year will be posted on the OSC web site or the PBS web site only during the open enrollment period.

After the annual open enrollment period ends employees cannot make any changes to their MEDFLEX election unless there is a qualifying family status change. You have 31 days from the date of your family status change to make changes to your MEDFLEX election amount, and any changes must be consistent with the nature of the status changes, which include:

- Marriage or divorce;
- Birth or adoption of a child;
- Death of a dependent or spouse;
- A change in dependent eligibility requirements for health benefits (ex. loss of other coverage, meeting maximum age requirements, etc.)
- A change in employment status that affects health benefit eligibility for you, your spouse or your dependent
- A change in residence that affects health benefit coverage for you, your spouse or dependent.

If you experience a family status change, use the Mid-Year Enrollment/Change Form, CO-1306a to record a change in your deduction amount. The form is available at https://www.osc.ct.gov/agencies/forms/pdf/CO-1306Rev10-2017MedfxMidYrForm.pdf or the PBS web site www.ctpbs.com or contact PBS at 1-866-906-8023.

Leave of Absence:

If you are out on a leave of absence, including worker's compensation leave, do not enroll in this program during open enrollment period. When you return to work, you will have 31 days to enroll in MEDFLEX for the current plan year.

New Employees: New employees have up to 31 days to enroll in the MEDFLEX. (You will use the Mid-Year Enrollment/Change Form CO-1306a to do so.) Newly eligible employees will have up to 31 days to enroll after the change in status.

CLAIM REIMBURSEMENT

To obtain reimbursement of qualified MEDFLEX expenses, you can elect to use a Prepaid Benefits Card issued by PBS through the Benny™ Prepaid Benefits Card Program. If you choose to use the Prepaid Benefits Card, you must complete the Pre-paid Benefits Card Election section on the MEDFLEX Enrollment/Change Form. At the beginning of the plan year, your election amount will be automatically loaded to your card and is available for reimbursement. As you incur qualified medical and dental care expenses, your funds will be automatically withdrawn from your account with a swipe of the Pre-paid Benefits Card.

Only the cost of eligible medical products and services permitted under IRS Code Section 213 and the State of Connecticut MEDFLEX Plan Document are eligible for reimbursement. If these medical products and services include expenses that can be provided for both a medical and cosmetic, capital expenditure, personal, living and/or family purpose, a Medical Necessity Form Letter must be submitted along with your MEDFLEX Claim Reimbursement Form.

Health care services must be "incurred" before you file a claim for reimbursement. IRS guidelines stipulate that "expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expense and not when the patient is formally billed, charged for or pays for the medical care." The date of medical service must occur within the plan year to be eligible for reimbursement. If expenses are for orthodontia, an orthodontia contract must be submitted with your first plan year claim. If your payment plan is monthly, you may submit a reimbursement request after each monthly payment is due. If your entire treatment is pre-paid, the amount will be pro-rated and reimbursed over the course of the orthodontia treatment.

You may use the Benny™ Prepaid MasterCard® Card at qualifying medical merchant locations where a MASTERCARD™ credit card is accepted. The Benny Prepaid Benefits Card may only be used at those locations which have a health-care related merchant category code. Examples of qualified locations include those who use an Inventory Information Approval System (IIAS) include: physician's offices, pharmacies, dental offices, grocery and discount stores, hospitals and vision centers. Qualified locations with an IIAS will only allow the Card to purchase items identified as eligible expenses. If your purchase has both eligible and ineligible expenses, the location will only accept the Benny Card for the eligible expenses. Ineligible expenses must be paid via another method. You can not use your Prepaid Benny Card at locations that do not use an IIAS.

Regardless of the form of reimbursement (Prepaid Benefits Card or other form of payment) IRS provisions stipulate that all expenses be substantiated; however, many transactions are automatically substantiated by the card system using one of the below IRS-approved substantiation methods:

- ✓ Recurring Expense – Recurring transactions will be processed and approved without recurring documentation after the initial transaction's substantiating receipts or other documentation have been reviewed and approved. Documentation requests will not be required so long as the subsequent recurring expense equals the same amount, duration and provider as the initial transaction.
- ✓ Co-pay Matching – The expense specifically matches your health plan's co-pay. For example, if the healthcare provider office visit co-pay is $15 and your payment for the office visit was $15, a substantiating receipt may not be required.
- ✓ IIAS Approved – Your FSA-eligible products are purchased at a location that uses the IIAS. In the unlikely event that your card payment is denied at a location that uses the IIAS, you will be required to submit substantiating documentation in order to received reimbursement.

If your expense is not automatically substantiated, PBS will request additional supporting documentation via an email or letter request. Acceptable Supporting documentation includes:

- An Explanation of Benefits (EOB) from the insurance carrier indicating the patient name, date of service, and out-of-pocket expenses associated with claim.

● An itemized statement from the service provider for expenses not covered by insurance. The statement must include: (1) the patient's name; (2) date of service; (3) description of procedure; (4) physician name and (5) the service charge.

● Prescription Drugs – A statement from the pharmacy indicating: (1) pharmacy name; (2) patient name; (3) date of prescription fill; (4) patient cost (ex. co-pay); (5) Rx number and; (5) name of drug.

● Eligible Over-the-Counter (OTC) Medications – After January 15, 2011, Health FSA Pre-Paid Benefit Cards can be used to purchase certain over-the-counter medicines or drugs at drug stores and pharmacies, at non-health care merchants that have pharmacies and at mail order and web-based vendors that sell prescription drugs, if: (1) prior to purchase, (i) the prescription (as defined in Notice 2010-59) for the over-the-counter medicine or drug is presented (in any format) to the pharmacist; (ii) the over-the-counter medicine or drug is dispensed by the pharmacist in accordance with applicable law and regulations pertaining to the practice of pharmacy; and (iii) an Rx number is assigned; (2) the pharmacy or other vendor retains a record of the Rx number, the name of the purchaser (or the name of the person for whom the prescription applies), and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements; (3) all of these records are available to the employer or its agent upon request; (4) the Pre-Paid Benefit Card system will not accept a charge for an over-the-counter medicine or drug unless an Rx number has been assigned; and (5) the requirements of the guidance defined by IRS are satisfied. If these requirements are met, the Pre-Paid Benefit Card transaction will be considered fully substantiated at the time and point-of-sale.

Over-the-Counter drugs and medicines not meeting the above requirements will require a Medical Necessity Form Letter to determine reimbursement eligibility. You may download a Medical Necessity Form Letter from the OSC web site at http://www.osc.state.ct.us/empret/indxhlth.htm, the PBS web site at www.ctpbs.com, or by contacting PBS at 1-866-906-8023.

In order for your claim to be reimbursed you must retain copies of all itemized receipts for eligible expenses. It is recommended that all receipts be retained for at least 3 years after the close of the plan year in which the expense has been incurred. Keep in mind that IRS regulations stipulate that cancelled checks, balance forward statements, and credit card and/or cash receipts cannot be used to substantiate expenses (itemized cash register receipts are acceptable substantiation for eligible over-the-counter expenses not requiring a Letter of Medical Necessity Form).

Note that missing or lost receipts will result in a claim denial. If you are unable to secure a replacement receipt or use your Prepaid Benefits Card for expenses that are deemed

ineligible, your claim will be denied and you will be required to reimburse the plan with post-tax dollars. If you fail to do so, your Benny Prepaid Card will be de-activated and/or the Administrator will offset the amount of the ineligible expense from your later substantiated claims until the full amount is repaid.

In those cases where you are unable to use your Prepaid Benefits Card or if you prefer the manual reimbursement method, you must first pay for your MEDFLEX expenses, then submit a Claim Reimbursement Form to PBS for processing. Claim Reimbursement Forms may be downloaded through the PBS web site and must be submitted directly to PBS for reimbursement by mail or through the use of the on-line facility at www.ctpbs.com. If you choose the manual reimbursement method, you may request your MEDFLEX reimbursements be paid via direct deposit. Simply access the PBS web site: www.ctpbs.com to enroll in this option.

USE IT OR LOSE IT RULE

You have until March 31st of the following year to submit claims for eligible expenses incurred during the prior plan year. Under the IRS "Use It or Lose It" rule unspent funds in your MEDFLEX account over $500 will be forfeited at the end of the run-out period. These remaining funds will stay in your MEDFLEX account and can be used for eligible expenses incurred during the following year, even if you have not enrolled. Post March 31 balances of $25 or less will be forfeited if the member has not enrolled in MEDFLEX for the most recent plan year.

Termination

If you terminate employment or have an employment status change that makes you ineligible to participate in the plan, your participation will end. Expenses for services rendered after the termination date (or status change) will be ineligible for reimbursement unless you are eligible for and elect COBRA continuation under the plan.

Upon termination or a qualified participant or beneficiary status change event, you or your beneficiary may be entitled to COBRA continuation coverage under the MEDFLEX. You or your beneficiary may receive reimbursement for qualified medical expenses incurred after termination or qualified event provided that plan contributions and a 2% administrative fee are paid on an after-tax basis. COBRA must be elected within 60 days of the COBRA notice. The participant must have a positive balance in the MEDFLEX account, continuation coverage for the remainder of the plan year must equal or exceed the remaining account balance. Please refer to the Summary Plan Description or contact PBS at 1-866-906-8023 for additional eligibility and enrollment information.

ADDITIONAL ASSISTANCE

To learn more of the specific requirements of the Medical Flexible Spending Account Program please access the OSC web site: https://www.osc.ct.gov/empret/medflex/index.html or the PBS web site: www.ctpbs.com and click on the Education Center Box. You may also contact PBS toll free at 1-866-906-8023 or by mail at:

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