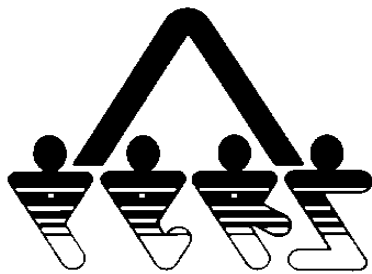


North Dakota Public Employees Retirement System



FlexComp Program Guide

NDPERS
PO Box 1657
400 East Broadway, Suite 505
Bismarck, ND 58502

Phone: (701) 328 - 3900 • (800) 803 - 7377
FAX: (701) 328-3920

www.nd.gov/ndpers

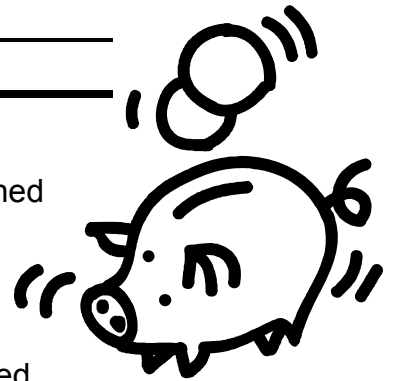
ELIGIBILITY



The FlexComp Plan is available to eligible employees of the State of North Dakota, participating District Health Units, and members of the Legislative Assembly. Employees of the university system and political subdivisions are excluded from participation in the plan. To be eligible, an employee must be 18 years of age, work at least 20 hours per week for at least 20 weeks per year and be in a permanent position that is regularly funded and not of limited duration.

FLEXCOMP PLAN

The FlexComp Plan is an employee benefit program established and administered under Section 125 of the Internal Revenue Code. It allows you to save taxes on the amount you pay for eligible insurance premiums, medical and dependent care expenses. Since the dollars you contribute to the plan are deducted before income and social security taxes are deducted, you will pay less tax, which means you may have more money to spend or save. However, you should be aware you are reducing the social security taxes paid, which could slightly reduce your social security benefits.



In exchange for the tax savings you receive, the IRS imposes strict regulations on the use of flexible spending accounts. It's important to carefully estimate the amounts you contribute. Please review [Important Points to Consider](#) in this publication.

ENROLLMENT



The plan year is January 1 through December 31. New employees who meet eligibility requirements have 60 days from their hire date to enroll in the plan. Each year NDPERS designates an annual enrollment season during which employees may enroll or discontinue their participation in the plan.

You may also enroll or change your election during the plan year if you experience a qualified [IRS Change of Status](#) and your enrollment or election change is consistent with, and on account of, the status change. You have 60 days from the change in status event to enroll, discontinue or change your election.

Participants may begin to incur eligible expenses on the effective date of their participation. New employees and employees who are enrolling because of a qualifying change in status will become a participant the month the first contribution is received. For employees enrolling during annual enrollment, participation in the plan will begin January 1.

FLEXCOMP BENEFITS



Employees may elect to participate in any combination of the three pre-tax accounts.

Premium Conversion

Allows you to pay, with pretax dollars through payroll deduction, certain premiums for various voluntary insurance products available through your employer.

The following are administered by NDPERS and the premiums are eligible for pre-tax deduction:

- Cigna Dental Insurance
- Superior Vision Insurance
- Prudential Life Insurance

The premium up to \$50,000 of employee supplemental life insurance coverage will automatically default to a pre-tax deduction unless you make an election to decline this action and pay the premium with after tax dollars. You must decline this action by signing the waiver in Part B of the FlexComp Enrollment form.

Please note, if you pretax your insurance premiums, you may not change or drop the coverage during the plan year unless you experience a qualified IRS Change of Status.

The premiums for other voluntary insurance products available for payroll deduction are:

- AFLAC
- Central United
- Colonial
- Conseco
- Total Dental Administrators
- USable

You may contact your agency payroll/human resource department for more information about the above plans.

Premiums that are not eligible for pre-tax treatment include, disability products and disability riders to cancer policies, unless tax reporting procedures have been adopted by the company, long term care insurance, premiums for term group life insurance in excess of \$50,000 on the employee and whole life insurance policies.

Medical Spending Reimbursement Account

You may redirect a portion of your salary for eligible medical expenses up to a plan year maximum of \$6,000. Requests for reimbursement from your medical spending account will be paid throughout the year according to your total annual medical spending election amount.

Eligible Medical Expenses

Examples of eligible medical expenses include:

- Insurance co-payments, coinsurance and deductibles.
- Prescription co-payments and coinsurance.
- Optometry expenses not covered by insurance, including examinations, contact lenses, prescription eyeglasses, prescription sunglasses, and laser surgery to correct vision.
- Dental and orthodontia expenses not covered by insurance, including fillings, x-rays, exams, cleaning, extractions, dentures, braces.
- Requests for reimbursement of orthodontic expenses may be reimbursed as payments are required and paid during the plan year. You must submit a receipt from your provider identifying the payment for orthodontic services and include the patient name, date and amount of payment.

Ineligible Expenses

You cannot obtain reimbursement for:

- Costs incurred before coverage is effective or after coverage ends.
- Insurance premiums.
- Cosmetic products or procedures.
- Contact lens insurance and maintenance agreements, an eyeglass warranty, clip-on sunglasses.
- Exercise equipment, health club dues, personal trainers used to improve appearance or for general health.
- Massage therapy unless prescribed by a physician to treat a specific medical condition. [Requires a Letter of Medical Necessity.](#)
- The full cost of a chiropractic maintenance agreement.
- Marriage counseling services.
- Illegal operations or treatments.
- Travel your doctor told you to take for a rest or change.

Dependent Care Reimbursement Account

An employee may redirect a portion of their salary up to a maximum limit of \$5,000 for a single parent, \$5,000 for a married couple filing a joint tax return or \$2,500 for a married person filing a separate tax return. Requests for reimbursement from a dependent care reimbursement account will be paid according to the dollars available in your account to date.

Eligible Dependent Care Expenses

Day care expenses must:

- Be for the purpose of enabling you or you and your spouse to be employed.
- Be for a child under 13 years of age who is your dependent under Federal tax rules. The child must reside with the employee at least one-half of the taxable year.
- The dependent care account can also be used for the care of a spouse or a dependent over the age of 13 who is incapable of self-care. The adult dependent who is incapable of self care must live with the employee for more than one-half of the taxable year and not have more than \$3,200 per year in gross income.

Eligible Expenses may also include:

- Before or after school care.
- Registration fees if fee must be paid in order to obtain care.
- Day Camp
- Preschool/ nursery school
- Transportation expenses, if expenses are for transporting a child to or from a place where care is provided and transportation is furnished by the day care provider.
- Late “pick-up” fee

Ineligible Expenses

You cannot obtain reimbursement for:

- Costs incurred before coverage is effective.
- Food if billed separately from the dependent care expenses.
- Late payment fees.
- Kindergarten expenses that are primarily educational in nature, regardless of half or full day, private or public school, state mandated or voluntary. However, if your day care provides kindergarten that is run on the order of a nursery school, with the child’s education merely incidental to the care provided and the cost cannot be separated from the cost of the child care, the entire amount can be considered an eligible expense.
- Overnight camp

Dependent Care Reimbursement Account vs. Dependent Care Tax Credit

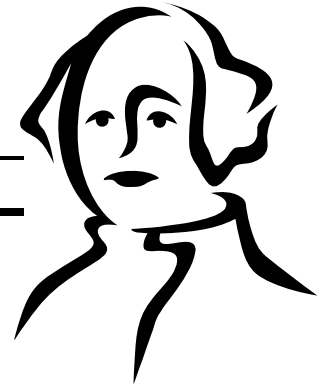
The dependent care reimbursement account is an alternative to taking a dependent care tax credit on your income tax return. You must choose whether to take the tax credit or enroll in the dependent care reimbursement account. The IRS will not allow you to receive two tax breaks on the same expenses.

The income level of you, or if married, you and your spouse, will determine whether the dependent care reimbursement account or the income tax credit is more favorable for you. Contact a qualified tax consultant for complete details.

Payments made to you from a dependent care account 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 the FlexComp Plan. You are required to file IRS Form 2441 with your tax return.

Please note that this is for general information only and is not intended to provide specific advice or recommendations. We suggest you consult your accountant or tax advisor with regard to your individual situation.

IMPORTANT Points to Consider



Below are listed four important points that you should consider when participating in the FlexComp Plan:

1. **Change in Participation** IRS regulations require that once you elect to participate, your payroll deductions may not be stopped or changed until the start of the next plan year. The only exception is if you experience a qualified [IRS Change of Status](#).
2. **Grace Period** Amounts remaining in a participant's medical spending and/or dependent care account at the end of the plan year can be used to reimburse expenses that are incurred between January 1 and March 15 of the new plan year under the following conditions:
 - Coverage under the Flexcomp plan must be in effect on the last day of the plan year on December 31.
 - You must indicate on the FlexComp Reimbursement Voucher that you want expenses received during the grace period reimbursed from any balance remaining in your account(s) from the previous plan year. If you select this option, expenses incurred during the "grace period" and approved for payment will be reimbursed first from any amount available in the prior plan year. If expenses exceed the account balance, you will then be reimbursed from your current plan year account(s), if applicable.
 - If you do not indicate on the reimbursement voucher that you want expenses received during the "grace period" reimbursed from any account balance remaining from the previous plan year, your claim will be paid from the plan year in which expenses were incurred. No adjustment will be made to your account(s) to reprocess the claim.
 - Grace period effect on Dependent Care Expense Accounts: There may be taxable income to an individual if reimbursements from the dependent care expense account exceed IRS permitted amounts in a calendar year. We suggest you consult your accountant or tax advisor with regard to your individual situation.
3. **Separate Accounts** You may participate in either or both flexible spending accounts. Because the Medical Spending and Dependent

Care Accounts are separate, you may not use money from one account to cover expenses in the other.

4. **Use or Lose** The deadline to file claims is four months after the plan year ends on December 31, or April 30. Any amounts remaining in either your Medical Spending or Dependent Care Reimbursement accounts after April 30 are forfeited.

IRS CHANGE IN STATUS EVENTS



In most circumstances, your annual election amounts or any insurance premiums you are having payroll deducted pre-tax cannot be changed. You may be able to change your election if you have a qualifying life event resulting in a change in status and your election change is consistent with the event prompting the change.

If you go on a leave of absence, military leave, or a leave covered by the Family and Medical Leave Act (FMLA), your medical spending and dependent care contributions and pre-tax insurance premiums may be made as follows:

- Under the pre-pay option, you may pay the amounts due while on leave on a pre-tax basis by having the total contribution due payroll deducted prior to your leave.
- Under the pay-as-you-go option, contributions may be made on a pre-tax basis from any taxable compensation, such as annual leave or sick leave that is paid during the leave period.
- Under the catch-up option, NDPERS will continue coverage during an unpaid leave. Upon return from leave, a participant will “catch-up” missed contributions with pre-tax payroll deductions for remainder of the plan year.
- You may elect not to participate in the plan while on leave. If you elect not to participate while you are on a leave of absence, you will not be entitled to receive reimbursement for services incurred beyond the last day of the month a contribution is received. Upon return from leave, you may reinstate your coverage that was in effect prior to your leave or reinstate the coverage less the contributions that were missed during the leave.

Qualifying life events that may allow you to change your current election include:

- Your legal marital status changes through marriage, divorce, death, legal separation or annulment.
- Your number of dependents changes because of birth, adoption (or placement for adoption), or death.

- There is a change in your employment status or the employment status of your spouse or any dependents. The employment status change must affect eligibility under this plan or a plan maintained by the employer of your spouse or dependent due to termination of employment or a change from full-time to part-time or part-time to full-time employment. Your election change must correspond with the gain or loss of coverage.
- A dependent satisfies or ceases to satisfy the eligibility requirements of the Flexcomp plan. This may allow you to make a corresponding change to increase or where appropriate, decrease coverage under this plan for the dependent.
- If you are served with a judgment, decree or court order. This includes divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for your child. It would allow you to make an election change to your Medical Spending Account. The change is allowed in order to provide coverage for the child if the order requires coverage under your plan; or cancel coverage for the child if the order requires your former spouse to provide coverage.
- You, your spouse, or any of your dependents become eligible or lose eligibility for coverage under Medicare or Medicaid. Your election change must correspond with the gain or loss of coverage.
- Your dependent care expenses change due to a provider rate change. This includes both increases and decreases in expenditures. However, you may only make a change if the provider is not your relative.
- Change in dependent care providers. You may make an election change to reflect the cost of the new provider. It is also considered a provider change and election decreases are allowed when your child is no longer eligible for childcare or is only in after-school care due to entering kindergarten or first grade.

A change in election is allowable and consistent with IRS regulations only if the change in status results in the employee, or their spouse or dependent, gaining or losing eligibility for coverage under the employer's plan. The election change must correspond with the gain or loss of coverage.

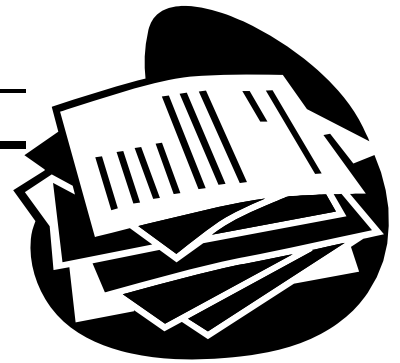
If the change in status event is the birth of a child, and the employee is a participant in the plan at the time of birth, the effective date of coverage is the date of birth. If the change in status event is for reasons other than the birth of a child and the employee is a participant in the plan, the

effective date of coverage is the first appropriate pay period following the receipt of the election form.

If an employee is not enrolled in the FlexComp plan prior to the change in status event, the effective date of coverage is the date the first payroll contribution is received.

You must submit a **FlexComp Change in Status** form within 60 days of the change in status event.

TERMINATION OF EMPLOYMENT



CONTINUATION OF COVERAGE IN A MEDICAL SPENDING REIMBURSEMENT ACCOUNT (COBRA)

If you transfer to an employer group not on the NDPERS administered FlexComp Plan, retire, terminate employment, or lose eligibility due to a classification change during the year, you will be offered COBRA continuation coverage through the end of the plan year. You will have sixty (60) days from the date the notice of your right to continue coverage is provided you to elect continuation coverage. Unless you elect COBRA, your coverage will end on the last day of the month of your separation from service.

If participation terminated due to a separation of service and you return to state employment within 30 days in the same plan year, your election will be reinstated as it was immediately prior to the separation of service.

If you return to state employment after 30 days in the same plan year, you may not participate in the plan for the remainder of the year. You may continue to file claims for qualifying expenses and be reimbursed from your account for services received while you were a participant in the plan.

Employees who elect COBRA continuation coverage are permitted to pre-tax their COBRA premium and pre-pay the premium through the end of the plan year from their final paychecks.

COBRA payments may also be paid with after tax dollars by personal check or money order throughout the plan year. If you elect to pay for COBRA coverage with after tax dollars, your premium will be the amount currently being payroll deducted, plus a 2% administrative charge.

COBRA coverage will be extended to the end of the current plan year but may terminate sooner if the premiums are not paid within 30 days of their due date which is the 1st of every month.

If you have paid your premium through the end of the year on December 31, and have a balance in your account, you have the option to have eligible expenses incurred during the "grace period" from January 1 through March 15 of the new plan year reimbursed from the balance.

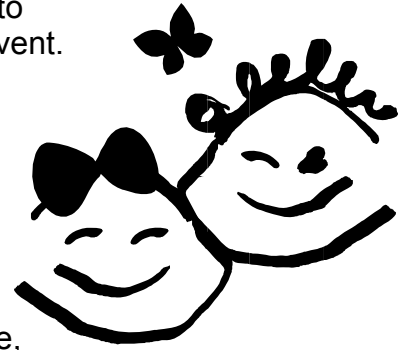
If you become widowed, divorced, or legally separated or your dependent child ceases to be a dependent under the terms of the plan, your spouse or dependent(s) may have the right to continuation coverage. It is the

responsibility of the person seeking continuation coverage to contact NDPERS within 60 days of the occurrence of the event.

DEPENDENT CARE REIMBURSEMENT ACCOUNT
(No COBRA Continuation Coverage Offered)

If you transfer to an employer group not on the NDPERS administered Flexcomp plan, retire, terminate employment, or lose eligibility due to a classification change, your contributions will cease and payroll deductions will stop after the last day of the month of your separation of service. You may continue to file claims for qualifying expenses incurred during the plan year until you have been reimbursed the remaining balance in your account, if any.

The final day for accepting claims from either your Medical Spending or Dependent Care reimbursement account for services received while you were a participant is four months after the plan year ends on December 31 or April 30.



OVER-THE-COUNTER DRUGS & MEDICINES
Reimbursement Guide



Beginning January 1, 2011, over-the-counter (OTC) drugs and medicines will be considered ineligible expenses unless you obtain a prescription from your physician. A “prescription” means a written or electronic order for the medicine or drug issued by a licensed healthcare practitioner. The prescription must be submitted with your first claim. Thereafter, you can include a notation on your claim form that there is a prescription on file. The prescription must be renewed each plan year.

This list is to assist you and your physician in providing the information we need to ensure that the expense meets IRS and NDPERS claims processing guidelines. This list is for informational purposes only and may not be considered a legal interpretation of IRS section 125 regulations.

- Acid Controllers
- Acne Medicine
- Allergy & Sinus
- Antibiotic Products
- Anti-Diarrheals
- Anti-Gas
- Anti-itch & Insect Bite
- Antiparasitic Treatments
- Baby Rash Ointment/Creams
- Cold Sore Remedies
- Cough, Cold & Flu
- Digestive Aids
- Feminine Anti-Fungal/Anti itch
- Hemorrhoidal Preps
- Laxatives
- Motion Sickness
- Pain Relief
- Respiratory Treatments
- Sleep Aid and Sedatives
- Stomach Remedies



ELIGIBLE EXPENSES FOR REIMBURSEMENT FROM A MEDICAL SPENDING ACCOUNT

A medical spending account can be used to reimburse medical expenses for the diagnosis, treatment, or prevention of disease. Some medical expenses will require a letter of medical necessity from your physician. The letter must be submitted with your initial claim. Thereafter you can include a notation on the claim form that there is a letter on file. A letter of medical necessity must be renewed each Flexcomp plan year.

The following is a partial list of some eligible expenses and may be used as a guide only. It may not be considered a legal interpretation of IRS Section 125 regulations.

Acupuncture

Adaptive equipment to assist with activities of daily living for person with a specific illness, injury, trauma, or condition. A letter of medical necessity is required

Alcoholism and Drug Addiction Treatment

Ambulance

Birth Control Pills

Chiropractic Care

Counseling, Psychiatric Care, Psychoanalysis, Psychologist

Dental Services/Orthodontia

Diabetic Supplies

Dietary, nutritional, herbal supplements, fiber supplements, vitamins, natural/homeopathic medicines if recommended by a physician to treat a specific medical condition. A letter of medical necessity is required.

Eyeglasses, Contact Lenses, Vision Care, Eye Surgery

Exercise, Fitness, Weight Loss Programs if recommended by a physician to treat a specific medical condition or injury. A letter of medical necessity is required

Fertility Treatments

Health Screenings

Hearing Aids and Batteries

Hydrotherapy/Massage Therapy if recommended by a physician to treat a specific medical condition or injury. A letter of medical necessity is required.

Insurance Co-payments/Co-insurance/Deductibles

Lodging The cost of lodging up to \$50 per night while away from home to receive medical care is reimbursable if the following conditions are met:

- The lodging is primarily for and essential to medical care.
- The medical care is provided by a doctor in a hospital or medical care facility.
- The lodging is not lavish or extravagant.
- There is no significant element of personal pleasure.
- Expenses for food and beverage are not eligible

To submit a claim for lodging expenses, provide a personal statement that includes the patient name, date and reason for travel along with an itemized statement. If you are submitting a claim for lodging expenses along with your documentation for medical care, no personal statement is needed.

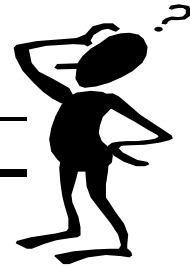
Medical Services for qualified expenses provided by physicians or other licensed healthcare providers

Mileage to travel and receive medical care may be reimbursed at 16.5¢ per mile for 2010 and 19¢ per mile for 2011. To submit a claim for mileage expenses, provide a personal statement that includes reason for travel, date of service, patient name, provider name and address, and total miles traveled. If you are submitting a claim for mileage expenses along with your documentation for medical care, no personal statement is needed except total miles traveled. List the dollar amount on your claim form.

Over-the Counter Drugs & Medicines with a prescription issued by a licensed healthcare practitioner

Prescription Drugs

FREQUENTLY ASKED QUESTIONS



Q. What if I already participate? Do I have to re-enroll?

A. To continue your participation, employees are required to enroll each year during the annual enrollment season.

Q. What if I don't want my employee supplemental life insurance premium pre-taxed?

A. The premium deduction for up to \$50,000 of employee supplemental life insurance coverage will automatically default to a pre-tax deduction. To decline this action and pay the premium with after tax dollars, you will need to sign the waiver in Part B of the enrollment form.

Q. If my spouse and I both work for the State of North Dakota, can we both enroll?

A. Yes, both of you will be allowed to enroll in the FlexComp plan. If you both decide to enroll, each of you will have your own account and payroll deduction. Each of you will need to determine your own annual maximum up to \$6,000 for medical spending reimbursement. You cannot submit a claim that your spouse has already filed and been reimbursed for, so careful planning and claim monitoring is important. Even though you may both enroll in the Dependent Care account, you are limited to an annual family maximum of \$5,000.

Q. The Patient Protection & Affordable Care Act (PPACA) has made some changes with regard to dependent eligibility. What are these changes?

A. Dependent eligibility rules for employees participating in a medical spending account have been extended to allow you to cover your adult children that no longer meet the requirements of dependent. The extension of coverage applies to your son, daughter, stepson, stepdaughter, legally adopted and eligible foster children. It is not necessary that your child be a student, be financially supported by you, or reside with you. Both married and unmarried children can now qualify as a dependent, but coverage does not extend to any spouse of your child or to grandchildren. You may now be reimbursed for qualified healthcare expenses for these individuals through age 26. Eligibility ceases January 1st of the calendar year in which the family member will turn 27.

Q. Can I change my election during the year if unexpected medical expenses arise after the start of the plan year?

A. Generally no. The IRS requires that once you elect to participate, your payroll deductions may not be stopped or changed until the start of the next plan year. The only exception is if you experience a qualified [IRS Change of Status](#).

Q. What happens to my remaining Medical Spending and Dependent Care Account balances if I accept another state job, terminate my employment or retire during the plan year?

A. See [Termination of Employment](#).

Q. What is the grace period? How do I request to have “grace period” expenses reimbursed from my previous plan year account balance?

A. See [Important Points to Consider](#)

Q. How can I be kept current regarding the status of my account(s)?

A. You may view your account balance, claim activity, claim history and payment history for the medical and dependant care spending accounts using the PeopleSoft portal. If you do not have access to the portal, you can contact the NDPERS office for assistance.

Q. What documentation do I need to provide the Plan Administrator to be reimbursed for expenses I incur?

A. You must complete and sign a [FlexComp Reimbursement Voucher](#), attach the required documentation, and return it to NDPERS. The acceptable forms of documentation to submit along with the completed claim form are listed with the form instructions. Forms are available on our web site. www.nd.gov/ndpers

Q. When will I receive payments from my account(s)?

A. During the course of the plan year you may submit requests for reimbursement of expenses you have incurred. Expenses are considered “incurred” when the service is provided, not when it is paid with the exception of orthodontic payments. Expenses must be submitted no later than 4 months following the end of the plan year on December 31. The final day for accepting claims for the plan year is April 30.

Q. PPACA has new requirements for reimbursement of Over-the Counter (OTC) drugs. Is it true that I need to get a prescription from my doctor in order to have OTC drugs and medicines reimbursed from my medical spending account?

A. Beginning January 1, 2011, currently eligible OTC medicines or drugs (e.g. acne medicines, allergy and cold medicines, antacids, etc.) will not be eligible for reimbursement from your medical spending account unless you obtain a prescription for the item from your physician. A “prescription” means a written or electronic order for the medicine or drug issued by a licensed healthcare practitioner. The prescription must be renewed each plan year.

Q. Can I be reimbursed for massage therapy, weight loss or exercise programs?

A. Massage therapy, weight loss or exercise programs can be reimbursed from a medical spending account if they are recommended by a physician to treat a specific medical condition or injury. A letter of medical necessity is required to include patient name, diagnosis, recommended treatment and duration. A letter of medical necessity must be renewed each plan year. Payments to attend meeting or participate in weight loss or exercise programs will be reimbursed on a per treatment basis by submitting an itemized receipt. Payment receipts are not sufficient documentation. The cost of special food purchased as part of a weight loss program is not eligible.

Q. Are photocopies of the insurance Explanation of Benefits (EOB), itemized statements, receipts, etc. acceptable?

A. Yes, however to avoid claims processing delays, DO NOT use staples, tape or highlighters on your forms or receipts. All statements and receipts should be copied on 8 ½ X 11 inch single sided paper. Use blue or black ink for completing your form.