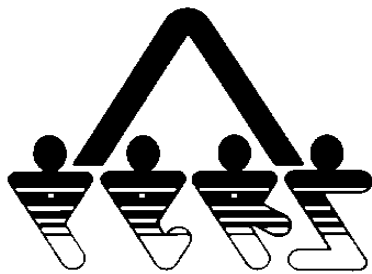


North Dakota Public Employees Retirement System



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

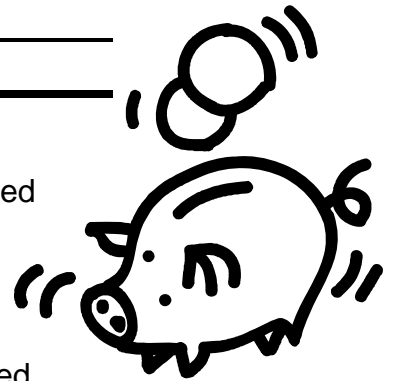
ELIGIBILITY



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 a tax favored program and is 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 significant tax breaks 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 booklet.

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 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, certain premiums under various voluntary insurance programs available for payroll deduction through your employer.

The Cigna dental plan, Ameritas vision plan and Prudential life insurance plan are administered by NDPERS. For Information about the plans see [CIGNA Dental Plan Handbook](#), [Vision Plan Handbook](#), or [Group Life Insurance Plan Handbook](#).

The payroll deduction up to \$50,000 of employee supplemental life insurance coverage will automatically default to a pre-tax deduction unless the employee makes an election to decline this action and pay the premium with after tax dollars. The employee 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 coverage during the plan year unless you experience a qualified IRS Change of Status.

Other voluntary insurance products available through payroll deduction are:

AFLAC
Central United
Colonial
Conseco
Total Dental Administrators
Useable

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 (See [Eligible Expenses or Over-the-Counter Reimbursement Guide](#) for a more detailed listing)

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, contact solutions, 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.
- Eligible medicines or products purchased Over-the-Counter.

Special Rules for Orthodontic Treatment

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 as 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; e.g. facelifts, skin peeling, teeth whitening, sclerotherapy, electrolysis, unless a physician substantiates the procedure is medically necessary and not for cosmetic purposes.
- 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 (see [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

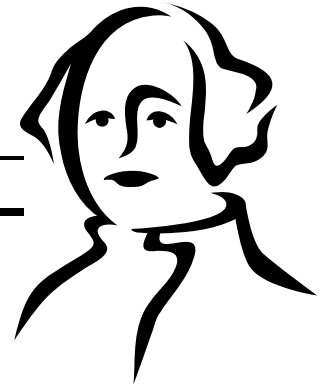
Reimbursement Account. The IRS will not allow you to receive two tax breaks on the same expenses.

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 Schedule 2 with your IRS Form 1040A or Form 2441 with your IRS Form 1040 to support the amount redirected for the plan year.

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:

Grace Period Amounts remaining in a participants 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 must be in effect on the last day of the plan year on December 31.
- You must indicate on the FlexComp Reimbursement Voucher SFN 16868 if 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.

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

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.

Change in Participation 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**.

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. If you change employment status from full-time to part-time or part-time to full-time, your election change must correspond with the gain or loss of coverage. If your spouse or dependents have an employment status change that affects eligibility under their employer's plan, and coverage is lost, then you may increase coverage under this plan. If the status change results in your spouse or dependents gaining coverage under their employer's plan, you may decrease coverage under this plan.
- One of your dependents satisfies or ceases to satisfy the requirement for coverage under the Health Insurance Plan for unmarried dependents due to attainment of age, a change in student status, or marital status would allow you to make a corresponding change to increase or 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.

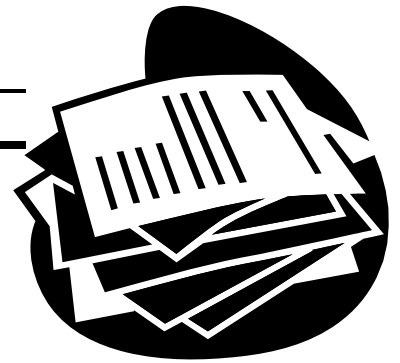
A change in election is allowable and consistent with IRS regulations only if the change in status results in the employee, or their spouse or dependent, gaining or losing eligibility for health coverage under either the Flexcomp Plan or health plan of the employee or the employer of their spouse or dependent and the election change corresponds with that 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 reason 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.

Form **SFN 53511 FlexComp Change in Status** must be completed and submitted to NDPERS within 60 days of the change in status event. Forms are available or on our web site at www.nd.gov/ndpers.

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 or terminate employment during the plan 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 to you to elect continuation coverage. Unless you elect COBRA, your coverage will end on the last day of the month in which you terminate your employment.

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 file claims for qualifying expenses and be reimbursed from your Medical Spending account for services received while you were a participant in the plan.

If you elect COBRA continuation coverage, the remaining program contribution payments must be paid with after tax dollars by personal check or money order in equal payments through the end of the plan year. Your premium will be the amount currently being payroll deducted, plus a 2% administrative charge.

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

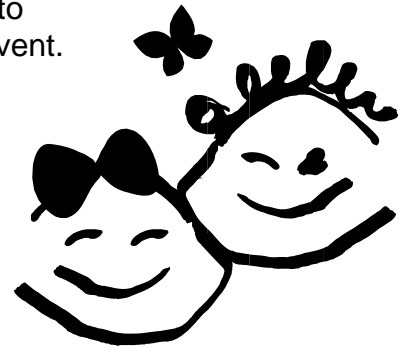
If you have paid your premium through the end of the year on December 31, you will have the option to have eligible expenses incurred during the "grace period" from January 1 through March 15 of the new plan year reimbursed from the balance. You will have four months after the plan year ends or until April 30 to submit claims. Any amount remaining in your medical spending reimbursement account after the April 30 claims filing deadline is forfeited.

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.

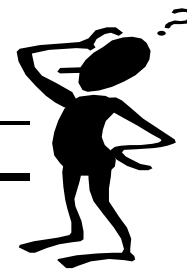
DEPENDENT CARE REIMBURSEMENT ACCOUNT
(No COBRA Continuation Coverage Offered)

If you terminate employment your contributions will cease and payroll deductions will stop after the last day of the month in which you terminate. 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 is four months after the plan year ends on December 31 or until April 30.



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 pre-taxed?
- A.** The payroll deduction 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.** Can I change my election during the year if unexpected medical expenses arise after the start of the plan year?
- A.** 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](#). Unexpected medical expenses for whatever reason do not allow an employee to change their election to increase or decrease their medical spending amount.
- 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?
- A.** See [Important Points to Consider](#)
- Q.** How do I request to have “grace period” expenses reimbursed from my previous plan year account balance?
- A.** See [Important Points to Consider](#)
- Q.** Will 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.** 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.** 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 SFN 16868](#), 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.** Can I be reimbursed for massage therapy, weight loss or exercise programs, dietary supplements/herbal remedies?
- A.** The Internal Revenue Service requirement for reimbursement of products and/or services that may have both a medical purpose and a personal or general health purpose is to require a medical practitioner’s note stating the medical diagnosis, the specific treatment needed, and how the treatment will alleviate the medical condition. NDPERS has developed a form to assist you and your medical practitioner in providing the information we need in order to process claims for these types of products/services. [Form SFN 58432 FlexComp Letter of Medical Necessity](#) is available on our website.

Your medical practitioner can also submit a statement on his or her own letterhead, as long as the letter includes patient name, diagnosis and recommended treatment, how treatment will alleviate the diagnosis or symptoms, and the duration of the treatment.

A letter from your medical practitioner is required each plan year.

- 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 size paper. Use blue or black ink for completing your form.

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, and for treatments affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness. Only the portion of the expense you owe after insurance has paid can be claimed.

The following is a partial list of some eligible expenses and may be used as a guide.

Acupuncture

Alcoholism and Drug Addiction Treatment

Ambulance

Birth Control Pills and Devices

Chiropractic Care

Co-payments/Co-insurance/ Deductibles

Counseling, Psychiatric Care, Psychoanalysis, Psychologist

Dental Services

Eyeglasses, Contact Lenses, Vision Care, Eye Surgery

Hearing Aids and Batteries

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.

Transportation Expenses Transportation to another location to receive medical care is 24¢ per mile for 2009. To submit a claim for mileage expenses, submit a personal statement that includes how many miles were traveled, name and location of medical facility, patient name, and date of service. List the dollar amount requested on your claim form.

Over-the-Counter Medicines and Products- See the [OTC Reimbursement Guide](#) for more details

Prescription Drugs

Preventive Care Screenings

Smoking Cessation Program and Medications

OVER-THE-COUNTER DRUGS OR PRODUCTS Reimbursement Guide



Eligible OTC expenses include medicines or products that alleviate or treat injuries or illness. The following list of OTC drugs or products can be reimbursed by submitting a detailed receipt showing the product name. If your receipt does not show the product name, you must also include a copy of the product label or container cover.

Acne Treatment Products
Allergy Prevention and Treatment Products/Antihistamines/Asthma Medicines
Analgesics/Antipyretics/NSAIDS
Antacids
Anticandial Medicines and Topical Products
Antidiarrheal and Laxatives
Cold Sore/Fever Blister Products/Medicated Lip Products
Cold/Flu/Decongestant/Sinus Remedies
Contact Lens Supplies
Contraceptive/Family Planning Products
Cough Suppressants or Expectorants
Dehydration Products for Infants and Children
Denture Care Products
Diaper Rash Products
Ear Drops/Ear Wax Removal Products
Eye Drops/Eye Patches/Reading Glasses
First Aid/Medical Supplies/Joint Supports/Ace Wraps/ Thermometers
Foot Care Products/Arch, Insole Supports/Corn, Callous, Bunion, and Blister Treatments/Athlete's Foot Products
Hemorrhoidal Preparations
Home Diagnostic Test Kits/Blood Pressure Equipment/ Diabetic Supplies
Lactose Intolerance Products
Menstrual/Migraine Relief/Motion Sickness Products
Psoriasis Products
Sleeping Aids
Smoking Cessation Products
Sunburn Relief Products
Topical Antibiotic/Steroid Products
Wart Removal Products

PRODUCTS OR SERVICES THAT REQUIRE A LETTER OF MEDICAL NECESSITY FROM YOUR MEDICAL PRACTITIONER

SFN 58432 FLEXCOMP PLAN LETTER OF MEDICAL NECESSITY

Dual Purpose Over-the-Counter products and services that may have both a medical or general health purpose require a letter of medical necessity from your medical practitioner in order to be considered eligible. The letter must include the diagnosis or symptoms for which you, your spouse or dependent are being treated along with specific information on how the product or service is intended to alleviate symptoms or improve function. The letter must be submitted with every claim or you must include a notation on the claim form that there is a letter on file. A letter from your medical practitioner is required each plan year.

The following is a partial list of products and or services and may be used as a guide.

- **Adaptive Equipment** to assist you with activities of daily living for persons with a specific illness, injury, trauma, or condition.
- **Dietary, nutritional and herbal supplements, vitamins and natural/homeopathic medicines** are not eligible if they are merely beneficial for general health. However they may be eligible if recommended by a physician to treat a specific condition.
- **Exercise Equipment, Fitness, Weight Loss Programs** if recommended by a medical practitioner to treat a specific condition. Payments to attend meetings or participate in weight loss or exercise programs can be reimbursed on a per-treatment basis by submitting an itemized receipt. Payment receipts are not sufficient. The cost of special food purchased as part of a weight loss program is not eligible.
- **Hydrotherapy/Massage Therapy** if prescribed by your medical practitioner for a specific illness, injury, trauma, or condition.