FLEXIBLE BENEFITS OFFERED BY OGB

What is a Flexible Benefits plan?

A flexible benefits plan allows you to pay for certain benefits before your money is taxed. For example, with a flexible benefit plan you can transfer money out of every paycheck and put it in a Flexible Spending Arrangement (FSA) **option** before its taxed. The FSA you choose allows you to set aside money, before it's taxed, to pay for health care, out-of-pocket expenses, dental and vision expenses and dependent care expenses. The FSA Visa Debit card is provided to pay for expenses at doctor's offices, hospitals, and pharmacies.

What options do I have?

If you're not enrolled in an OGB health plan, you can still take advantage of flexible benefits. We offer the following options: General-Purpose FSA; Limited-Purpose FSA; Dependent Care FSA.

What is a General-Purpose FSA?

The General-Purpose FSA (GPFSA) allows you to set aside money every month that you can use for out-of-pocket medical expenses like co-pays, deductibles, prescriptions, braces, crowns, dentures, contacts, eyeglasses, laser eye surgery and other costs. The benefit is that your money is set aside before it's taxed. So, enrolling in the GPFSA means you have more to spend on those expenses than you would if you waited and spent the money after it was in your paycheck and taxed. You must re-enroll each year to continue participation.

What is a Limited-Purpose FSA?

The Limited-Purpose FSA is a similar concept to the GPFSA, but like the name says, it's more limited. It can only be used for dental and vision expenses. You must re-enroll each year to continue participation.

Can I have a General-Purpose FSA and a Limited-Purpose FSA?

No. You can't be enrolled in both plans at the same time.

What are the General-Purpose and Limited-Purpose limits?

The limits for both the General-Purpose and Limited-Purpose are the same, minimum $600.00 and a maximum of $2,700.00. These limits are subject to change annually by the IRS.

What is the Dependent Care FSA?

A Dependent Care FSA allows you to set aside pre-tax money to pay for dependent care expenses while you're at work. That includes your young children under age 13 who reside in your household, in daycare or elderly or

disabled dependents, who cannot care for themselves. And like the other FSA options, **you must re-enroll each year**.

What are the Dependent Care limits?

The amount you can set aside for dependent care expenses is limited to: $2,500 for single parents or married couples who file taxes separately; and $5,000 for married couples who file jointly.

How does a Flexible Benefits plan work?

When you enroll in a flexible benefits plan, you agree to contribute a portion of your salary to pay for qualified benefits. Because you never receive that portion of your salary, it's not considered wages for federal income tax purposes. That money goes directly into the account you specify and can be used according to the IRS rules.

To be eligible, you must be an active, full-time employee. You have thirty (30) days from the date of hire to decide to enroll. If you do not enroll after 30 days of your hire date, you can enroll during next year's annual enrollment or after an IRS qualifying life event like childbirth or marriage.

Both the General-Purpose FSA and the Limited-Purpose FSA plan options also allow you to be reimbursed for medical expenses for your dependent children up to age 27.

You select an option and elect a contribution amount for the plan year. The minimum and the maximum are determined each year by the I.R.S. For 2020 plan year, the minimum was $600 and the maximum was $2,750 for the General-Purpose FSA and Limited-Purpose FSA. You will receive a Visa debit card, which is your FSA card, and it works like a debit card for your flexible spending account. Your pre-tax money is in your account and can be used to pay for eligible expenses at your doctor's office, pharmacy or other provider. The election is like a loan and monies are immediately available for the General-Purpose FSA and Limited-Purpose FSA. A per pay period amount is taken out of your check and placed into your account.

If I join the Flexible Benefits Plan, will I ever have to pay taxes on the money I put into the plan?

Generally, no. Flexible benefits contributions are reported as non-taxable wages and income on your W-2. If the IRS audits you, you will need to show total expenses and receipts from your service provider(s). So keep a copy of your reimbursement request forms and receipts for your records.

However, it is important to note: Your benefits may become taxable wages reportable on your W-2 Form if you fail to timely substantiate (verify) a debit card transaction as a qualifying medical expense or use your debit card for ineligible expenses.

What is “Automatic Enrollment” in the Flexible Benefits Premium Conversion?

When you enroll in one of OGB’s health plans, you automatically become a participant in the Flex Plan under the Premium Conversion option. The premium conversion option means that you pay for your health plan with pre-tax dollars, giving you more take-home pay in each paycheck. If you’re not enrolled in an OGB health plan, but enroll in another voluntary product, you will also become a participant in the premium conversion option. Once you enroll in the premium conversion option, you don’t have to re-enroll. You will stay enrolled until you choose to end your participation in an OGB health plan.

How can I contact the flexible spending arrangement administrator, if I have a question about my account?

Discovery Benefits, Inc. (DBI) is OGB’s third-party administrator for the flexible spending arrangement (FSA). Participants may call DBI, toll-free at 1-866-451-3399, visit online at www.DiscoveryBenefits.com, or send a fax to 1-866-451-3245.

Can I have a General-Purpose FSA with a Health Savings Account?

No. However, you can elect to have a Limited-Purpose FSA for dental and vision only.

Does the FSA roll over to the next year?

No. You must enroll in a FSA every year. Additionally, unused contribution amounts do not carry over to the next Plan Year.

Do I have to pay an annual fee?

Yes. When you enroll in a FSA you also agree to pay the administrative annual fee, which is $34.80 annually divided equally per the number of pay periods in the Flex Plan Year.

What if I didn’t sign up during annual enrollment, but I get married or have a baby during the year and would like to have a FSA?

There are times when you may want to enroll in a General-Purpose (medical) or Dependent Care FSA in the middle of the year. Say you have a baby and want to start paying for daycare through a FSA. You can enroll in the middle of the year if you experience an OGB Plan Recognized Qualified Life Event. You have **30 days** from the date of your Qualified Life Event to enroll. The list of Qualifying Events is available on the OGB website, under Resources, and helps you to determine whether or not you can enroll in a FSA outside of annual enrollment.

What if I don't use all of my money? Do I get it reimbursed to me at the end of the year?

No. The I.R.S. has a "use it or lose it" rule for FSAs. Participants are encouraged to use their FSA monies during the Flex plan year which is January 1st through December 31st, and before the end of the Grace Period which is March 15th of the following year.

What is a Grace Period and Run-Out Period?

Two of the most important concepts to understand about FSAs are **the Grace Period and Run-Out Period**. Money in a FSA account should be used by the end of December for the calendar year enrolled. For example, if you enroll in a FSA during annual enrollment of 2019, you should use your funds by December of 2020.

But, there is a **Grace Period** following the Flex Plan Year that lasts until March 15th of each year, which allows you to use the previous year's flexible spending funds to pay for expenses incurred during the Grace Period. If you still haven't used the money in your account by the end of the **Grace Period**, you'll lose it.

The **Run-Out Period** lasts until April 30th for submitting claims. You have to have all your claims in by April 30th, to be able to cover your expenses with your previous year's money.

What happens after I enroll in a FSA and I want to get reimbursed?

The FSA Visa debit card will auto-substantiate for office providers and co-pays. See below for the process.
General-Purpose or Limited-Purpose FSA Reimbursement Process

- You received a green VISA debit card from Discovery Benefits Inc. – the FSA administrator for OGB. The funds are immediately available to use on your debit card after you validate the card.
- PIN numbers can be set up for your benefits debit card by calling Discovery Benefits' automated response system at 1-866-451-3399. Make sure you have your card available for reference:
  - option 1 to identify that you are a participant
  - option 2 to identify your plan
  - option 3 to select a PIN
- You've made an appointment to see the doctor about your knee hurting and get treated
- When paying your bill at the doctor's office, you swipe your green Visa debit card and ask for a receipt for the card and an itemized bill of your visit – keep these receipts to substantiate your claims
- You can send these receipts to substantiate your claim to Discovery Benefits in 3 ways:
  - **Fax** these receipts and itemized bill to Discovery Benefits at fax number 1-866-451-3245. For all other out of pocket medical expenses, Discovery Benefits' ***Out-of-Pocket Reimbursement Request*** form and fax receipts with the form to **1-866-451-3245**
  - **Mail** these receipts to Discovery Benefits **and** a completed Discovery Benefits' ***Out-of-Pocket Reimbursement Request*** form (only if you did not use your Visa debit card) and mail to:
    Discovery Benefits Inc.
    P. O. Box 2926
    Fargo, ND 58108-2926

- **Computer** – enter your claim information online; upload your receipts; and your reimbursement will be processed once your information is received.
- You will automatically receive a check for reimbursement unless you enroll in direct deposit. Signing up for free direct deposit through your online account at www.discoverybenefits.com will allow funds to be sent electronically to your checking or savings account. There is no reimbursement limit applied to direct deposit.

Dependent Care Reimbursement Process

- Dependent Care Flexible Spending Arrangement (DCFSA) reimbursement process with Discovery Benefits (DBI) is different
- DCFSA reimbursement process takes a little longer in the beginning, after the initial DCFSA deposit is posted in their system
- Afterwards, DCFSA reimbursement will be more frequent
- DBI does a weekly reimbursement sending the weekly amount that is stated on their ***Recurring Dependent Care Request Form***
- The ***Recurring Dependent Care Request Form*** can be found on the OGB website, under OGB Forms, under Flexible Benefits Plan
- Signing up for free direct deposit through your online account at www.discoverybenefits.com will allow funds to be sent electronically to your checking or savings account. There is no reimbursement limit applied to direct deposit.
- You can send the form in 2 ways to Discovery Benefits:
  1. Fax
     - Download, print and complete the form.
     - Fax the form along with your receipts to **fax number 1-866-451-3245**.
  2. Mail
     - Download, print and complete the form.
     - Mail the form along with your receipts to:
       Discovery Benefits Inc.
       P. O. Box 2926
       Fargo, ND 58108-2926

Can I enroll in a FSA during the middle of the year?

You can enroll in a FSA only after experiencing an OGB Plan Recognized Qualified Life Event provided for in the FSA Plan Document, or the Flexible Benefits Plan Summary, located on the OGB website. You have **30 days** from the Qualified Life Event to enroll.

Can I increase my FSA elected amount in the middle of the year?

Only if the annual elected amount is less than the annual maximum amount and only after experiencing an OGB Plan Recognized Qualified Life Event that is provided for in the FSA Plan Document, or the Flexible Benefits Plan Summary.

Can the out-of-pocket medical expenses for my wife and dependents be reimbursed through the General-Purpose FSA?

Yes, as long as they are your taxed dependents and you are enrolled in a GPFSA.

I am a state employee and my spouse is a state employee, can we each have a General-Purpose FSA?

Yes. However, you both cannot get reimbursed for the same receipts.

Where can I find a list of Qualifying Medical Expense?

EBIA FOR ELIGIBLE MEDICAL EXPENSES

The Employee Benefits Institute of America (EBIA) has created a Health Care Expenses Table for the Office of Group Benefits. This table lists services that are classified as a "qualifying expense", or "not a qualifying expense" by the IRS. Click here to be redirected to the table.

Can Rehired Retirees enroll into an FSA Plan?

Yes, as long as they are full-time active and the deductions comes from their active check.

Do I need to keep my receipts?

Yes, please save all receipts related to your FSA purchases. For some expenses, you may be required to provide additional information, including itemized receipts or explanation of benefits, to verify eligibility of the expense. Besides saving all receipts, be sure to provide them promptly when requested. If you fail to submit documentation when requested, the FSA plan administrator is required to declare those expenses ineligible and you'll have to reimburse your account.

How do I submit documentation?

The easiest ways to upload documentation are by logging in to your account at www.discoverybenefits.com or by using the free Discovery Benefits mobile app. If you choose to fax your documentation, please just be sure to include the receipt reminder for smooth processing.

What type of detail needs to be included in my documentation?

The IRS requires that participants provide:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)
- Name of merchant/provider

Why do I have to substantiate the services? Isn't it my money?

Yes, the money put in is yours to use for qualified expenses. However, in order to utilize this money without paying taxes you must follow the IRS rules. As such, the plan is required to substantiate claims for all debit card transactions. For debit card transactions that can be approved by one of the IRS approved electronic methods, you will not need to provide a receipt, but you will need to keep copies of all receipts for all services you use the debit card for.

How would I know if I need to substantiate a claim?

If Discovery Benefits doesn't receive enough detail from the provider when you use your benefits debit card, you'll receive a request for an itemized receipt.

What is the Substantiation Process?

1. Debit Card is swiped and the merchant is paid at this time
2. The claim is processed with Discovery Benefits, and is automatically run through our standard auto substantiation procedures (copay match, IIAS match, and recurring expense match)
    - If there is a match, the claim is approved and no action is needed
    - If not, the claim moves to #3
3. If the claim is not approved from #2, then it moves to a Pending Auto Substantiation status, to see if the claim will come on the debit card substantiation file feed
    - The claim remains in this status for 60 days to allow the file to process
    - If there is a match on the file, the claim is approved, and no action is needed
    - If not, the debit card follow up process begins with #4
4. The **First Receipt Reminder** is sent.
    - If documentation is sent in and is acceptable, the claim is approved, and there is no additional action needed
    - If no documentation is sent in, the claim moves to #5
5. 20 Days after the First Receipt Reminder is sent, the **Second Receipt Reminder** is sent
    - If documentation is sent in and is acceptable, the claim is approved, and there is no additional action needed
    - If no documentation is sent in, the claim moves to #6
6. 20 Days after the Second Receipt Reminder is sent, the **Overdue Notice** is sent
    - If documentation is sent in and is acceptable, the claim is approved, and there is no additional action needed
    - If no documentation is sent in, the claim moves to #7
7. 20 Days after the Overdue Notice is sent, the **Denial Letter with Request for Repayment** is sent
    - The claim is denied and the card for this specific plan year is suspended overnight

The **Request for More Information** is sent if the participant sends us documents, but we are not able to approve. The RMI adds a 30 day window to the above timeline.

If I used my card at a hospital or dental office, shouldn't my claim be automatically approved?

Unfortunately, not all expenses from a hospital or dental office are FSA-eligible. For example, some hospital gift stores sell flowers that could still be coded as "hospital" expenses, and some dental offices provide elective services like teeth whitening that could still be coded as "dental" expenses. Unfortunately, these are not FSA-eligible. By obtaining supporting documentation, we're able to verify the eligibility of the expense to maintain compliance with IRS regulations.

Can a FSA debit card transaction be declined when the provider swipes the card?

Yes. There are some situations in which a debit card transaction can be denied by a pharmacy or other location. This can happen if:

- You may be at an ineligible location
- You may be asking for more money than what you have elected and/or contributed
- Your card might have been temporarily suspended because your account is not in good standing OR because there is additional information required for previous transaction(s)
- The card might not have been correctly re-activated since being suspended for additional information subsequently received
- The valid location you are at has been identified in the system as an invalid location
- The card's magnetic strip has been compromised
- The merchant's "credit swipe machine" may be malfunctioning
- You have swiped the card yourself and indicated "debit" (which refers to a bank account card) rather than indicating "charge"

What should I do if my debit card is declined at the merchant's location?

You should go ahead and pay for the service and then contact the FSA plan administrator, Discovery Benefits, to determine if it is due to funds availability or card technicality. You can then submit a manual claim for reimbursement from your account.

How do I know how much is in my FSA account?

You can visit your FSA portal to view your account activity and current balance. Or you can call the FSA plan administrator, at 1-866-451-3399. It's a good idea to know your account balance before you make a purchase with your debit card.

How long is my debit card good for?

Your debit card is good for three years. So hang on to it. Even if you deplete this year's funds, you'll be able to use the card again next year when you re-enroll in the FSA plan.

What happens if I don't spend all of the money? Where does it go?

You will forfeit the money that remains in your account. Any excess funds are kept by the employer and can be used to offset the costs of administering the program. The IRS regulations require this, and do not allow employers to return the money to plan participants or to carry unused funds over to the next plan year.

Can I use my Health Care FSA to reimburse outstanding medical expenses from the prior year? (Special Note on Orthodontia)

No, expenses must be incurred during the current plan year. The only exception to this rule is orthodontics. You can use your FSA to cover payments made for braces, even if the braces were put on before the start of the current plan year.

Are expenses for orthodontia covered under the FSA?

Orthodontia expenses are eligible under the Health FSA. Most orthodontia is paid in monthly installments. The monthly payments within your plan year are eligible for reimbursement. We require a copy of the financial contract between you and the orthodontist. Also, the down payment is eligible as long as it is billed within your current plan year.

What do I need to submit for my orthodontia claim?

You will need to submit a copy of the orthodontia contract specifying start date, length of treatment, total cost for the treatment and the payment schedule.

What happens to my FSA if I terminate employment in the middle of a plan year?

You will have a specific amount of time, called the run-out period, during which you can submit claims that were incurred prior to your termination date. The run-out period for the prior plan year ends on April 30 of the subsequent year. For example, the run-out period for Plan Year 2020 ends April 30, 2021. You may not be reimbursed for any claims incurred after your termination date. However, you may be able to continue your Health Care FSA coverage under COBRA.

I don’t know how much I should contribute. What do most people do?

There is no amount that will be right for everyone. FSA elections vary greatly, depending on the individual participant and his or her particular situation. You should make your election by carefully examining your expected out of pocket health care expenses for the upcoming year.

Does my daycare provider need to be licensed in order to use the Dependent Care FSA?

No, you can use the Dependent Care FSA to cover expenses for anyone who watches your children while you and your spouse are working. It can even be a family member, as long as that person is not your tax dependent. The only rules that apply are that you must provide the Social Security number or Tax ID of your daycare provider, and that person must claim the income.

My spouse is a stay at home parent, can I use the Dependent Care FSA to pay for preschool?

No, the regulations state that care must be rendered so that both you and your spouse can be gainfully employed, look for gainful employment or attend school.

Can I transfer money from my Health Care FSA to my Dependent Care FSA?

No, you can use funds only for the purpose for which the election was initially made. IRS regulations do not allow funds to be transferred or commingled between accounts. So, the money in your Health Care FSA may only be used for health care expenses and your Dependent Care FSA may only pay for dependent care expenses.