STATE OF TENNESSEE
DEPARTMENT OF FINANCE & ADMINISTRATION

FLEXIBLE BENEFITS

(Medical FSA, dependent care FSA [DC-FSA] and limited purpose FSA [L-FSA])

- State and Higher Education employees

PARKING/TRANSIT EXPENSE PLAN

- State employees* only

2017 Plan Year Summary

*The distinction of education employees and "state employees" is for the purposes of this plan document only

State of Tennessee
Department of Finance & Administration
Division of Benefits Administration

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NOTICE:
The Plan Administrator does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call Benefits Administration at 866.576.0029 or 615.741.4517.

Acronyms

ABC	Agency Benefits Coordinator
BA	Benefits Administration (Division of Benefits Administration within State of Tennessee, Department of Finance & Administration is Plan Administrator) 1-800-253-9981 Mon-Fri 8:00-4:30 pm CT
CDHP	Consumer Directed Health Plan
COBRA	Consolidated Omnibus Budget Reconciliation Act
DC-FSA	Dependent Care (daycare) Flexible Spending Account
FMLA	Family Medical Leave Act
FSA	Healthcare Flexible Spending Account
HIPAA	Health Insurance Portability and Accountability Act
HSA	Health Savings Account
IRC	Internal Revenue Code
IRS	Internal Revenue Service
L-FSA	Limited Purpose Flexible Spending Account
OTC	Over-the-counter

Introduction

This booklet is intended to provide a description of the Flexible Benefits Plan and the parking & transportation plan. If you have any questions regarding these benefits, contact your Agency Benefits Coordinator (ABC).
If you have questions about your medical FSA, DC-FSA, or L-FSA you may contact the claims administrator.

This document is also intended to be a cafeteria plan under Internal Revenue Code Section 125 and will be interpreted and administered to comply with the law and regulations under Code Section 125 as applied to the benefits subject to Code Section 125.

This document also constitutes the Dependent Care Flexible Spending Account that provides for reimbursement of expenses for dependent care expenses as permitted under Internal Revenue Code Section 129.

Finally, this document includes qualified transportation benefits as permitted under Internal Revenue Code Section 132.

Who is the Claims Administrator?
All FSA benefits described in this document (except parking & transit, which are only applicable to state employees) are administered by the state's contracted claims administrator. Contact information is: 1-855-288-7936 Mon-Fri 7:00 am-7:00 pm, Sat 9:00-2:00 pm CT
stateoftn.payflexdirect.com

For parking & transit expense questions, contact the Plan Administrator. 1-800-253-9981 Mon-Fri 8:00 am-4:40 pm CT Benefits.Info@tn.gov

Who is the Plan Administrator?
The plans described in this document are administered through the State of Tennessee Department of Finance & Administration, Division of Benefits Administration. Contact information is:
1-800-253-9981 Mon-Fri 8:00 am-4:40 pm CT Benefits.Info@tn.gov

What are the Flexible Benefits Plans available to employees under IRS Section 125 (cafeteria plans) and IRC Section 132 (certain fringe benefits)?

The State of Tennessee Flexible Benefits Plan is comprised of the following accounts:

Cafeteria plans (authorized under IRS Section 125)-

- The medical **flexible spending account** (FSA), which covers eligible out-of-pocket medical, behavioral health, dental, vision, and over-the-counter medical and pharmacy expenses (though OTC drugs/medicine items require a written prescription from your physician and must be validated by the claims administrator before payment). OTC supplies that are not medicines (e.g. bandages) do not require a prescription. Visit the claims administrator's website for a list of eligible and non-eligible expenses.

- The **limited purpose flexible spending account** (L-FSA), which covers eligible out-of-pocket dental and vision expenses. Plan members who enroll in a consumer directed health plan (CDHP) may not elect a medical FSA but may choose to enroll in the L-FSA.
- The **dependent care flexible spending account** (DC-FSA), which covers certain IRS-defined dependent care (daycare) expenses for qualifying dependents.

Fringe benefits offered to state employees (only) and authorized under IRC Section 132-

- The **parking & transportation/transit expense plan** (P&T) is available for state employees who wish to set aside up to $255 per month in a pre-tax funded account in order to pay for qualified parking and transit expenses while at work or commuting to/from their place of employment. University of Tennessee and Tennessee Board of Regents employees or TBR college and university employees are not participating employers in the parking and transportation expense plan; this benefit applies only to state employees.

Internal Revenue Code Section 125 governs the Flexible Benefits Plan and Internal Revenue Code Section 132 governs the Transit Expense Plan. Both of these plans are administered to comply with strict IRS regulations. The Employer's ability to offer these Plans to its employees depends upon the appropriate administration of the Plans.

Who is eligible for the plan?

Insurance-eligible employees of the State of Tennessee, the University of Tennessee campuses, or the various colleges, schools, and universities under the purview of the Tennessee Board of Regents are eligible to participate in the medical FSA, the DC-FSA, and the L-FSA. Only state employees may participate in the parking & transit expense plan.

New employees who are insurance eligible must enroll in the medical FSA, L-FSA and/or DC-FSA within 31 days of their employment, re-hire, or reinstatement. Coverage is effective on the first of the month following one full calendar month of employment (except for the University of Tennessee, which allows coverage to begin on the hire date). The IRS generally prohibits retroactive enrollments. Employees who become insurance eligible mid-year must enroll within 31 days of becoming eligible. Coverage is effective on the first of the month following one full calendar month of employment.

If you do not enroll during your new employee enrollment period for medical FSA, DC-FSA, or L-FSA, federal regulations require that you wait until an Open Enrollment period (usually during the month of October) for the next opportunity to participate (except for situations where you incur a "status change"). If you sign up for the plan during Open Enrollment **AND** you are on payroll on January 1, you will be able to start using the plan on January 1. State employees may enroll in the parking & transit expense plan at any time. For parking & transit (state employees only), the effective date will be the first of the month following the date that your parking & transit enrollment form is received by the Division of Benefits Administration.

What if I work less than a full calendar year?

If you anticipate dropping off the payroll at any time during the calendar year, you should take special care to understand how that change will affect your participation in the plan. For instance, if you do not incur enough healthcare, dental, vision or dependent care expenses before your coverage terminates, you may forfeit your existing contributions.

Will my enrollment in this program automatically continue from year to year?
If a state employee elects to participate in the parking & transit flex benefits plan, you will stay enrolled each year until you cancel your enrollment, and your payroll deduction amount will remain the same until you change it. However, for the medical FSA, L-FSA, or DC-FSA **you must enroll during Open Enrollment for each plan year in which you wish to participate. Re-enrollment does not occur automatically each year; you must take action to reenroll for the following year.** State employees will elect enrollment in Edison, while Higher Education employees will elect enrollment in the claims administrator's portal.

What is the purpose of the flexible benefits and parking/transit expense plan?
Getting the most from your paycheck—that is the idea behind the State's Flexible Benefits Plan and Parking & Transportation Plan. These plans allow you to pay for the employee-paid portions of your health and dental premiums for the state sponsored group insurance program plans, as well as certain medical, behavioral, dental, dependent care (daycare) and transportation out-of-pocket expenses, with money that is sheltered from taxes by deducting the funds from your pay before it is taxed. This means less of your pay is taxed. Your employer does not include health and dental insurance premiums as taxable income. You can further reduce your taxable income by deciding whether the medical FSA, L-FSA, DC-FSA and/or parking and transportation flex plans make sense for you and your family and enrolling in those plans that best fit your situation. ***Certain rules and guidelines apply to each benefit, so be sure you fully understand the programs before you choose to participate.***

Are there any risks involved in participating in this plan?
YES! UNDER CERTAIN CIRCUMSTANCES, YOU RISK FORFEITING PART OR ALL OF THE MONEY YOU HAVE CONTRIBUTED. In general, you will forfeit money if you do not incur enough eligible expenses to cover your contributions or if you fail to file a **complete** reimbursement request by the final deadline of the plan year. This risk of forfeiture is required by federal regulations. For more information on the forfeiture risk, see the applicable sections for the medical FSA, L-FSA, and DC-FSA. Generally, participants may carry over to the next plan year any unused balance in their medical FSA and limited purpose FSA (L-FSA) of $500 or less. Please see the section titled **If I have money left in my account at the end of the year, can it carry forward into the next year?**

What time period does the plan cover?
This document describes the plan as of January 1, 2017. The plan year runs January 1 through December 31. Generally, employees enroll during Open Enrollment prior to the beginning of the plan year. Employees who enroll or end their participation during the plan year due to a status change have a shorter period of coverage. An employee's period of coverage differs depending upon the type of account. For further information, see the applicable sections for the medical FSA, DC-FSA, L-FSA, and parking/transit (state employees only).

Does this plan affect my benefits from other employer benefit programs that are based on my

pay (e.g. Life Insurance)?
No. All benefits from your pay-related benefit plans are based on your gross pay without regard to any salary deduction amounts under this plan.

Which plans does this booklet describe?
This booklet is a description of plan features for the Flexible Benefit Plans and the Parking/Transit Expense Plan.

What if I have questions about the plan?
The state's contracted claims administrator for the medical FSA, L-FSA, and the DC-FSA, or your ABC can help you if you have specific questions about those plans. Their contact information is available on the Division of Benefits Administration website. You may also wish to consult with your tax advisor. Benefits Administration, the administrator of the parking/transit plan for state employees, can answer questions about that program for state employees.

Would converting part of my pay to the Flexible Benefits Plan or Transit Expense Plan cause my Social Security Benefits to be reduced?
Your Social Security benefits could be affected if your taxable earnings are less than the Social Security maximum covered wages. The laws affecting Social Security taxes and benefits are constantly changing, so it is difficult to predict how anyone might be affected. The decision becomes one of whether the current overall tax savings are more valuable to you than a possible reduction in Social Security benefits in the future. You may also wish to consult with the social security administration or your tax advisor.

Medical Flexible Spending Account

The Medical Flexible Spending Account (FSA) allows you to pay for certain unreimbursed medical, dental, vision, and over-the-counter expenses with up to $2,550 of pre-tax dollars. You participate in the program by enrolling during Open Enrollment. New employees must enroll within 31 days of their employment, re-hire, or reinstatement. Employees who become insurance eligible mid-year must enroll within 31 days of becoming eligible for the benefits. You must enroll each year during Open Enrollment for the following plan year in which you wish to participate**. Enrollment is not automatic.** You must take an active role in both re-enrolling each year *and* determining the contribution amount that is best for you. **There is no minimum annual enrollment amount; however, the maximum enrollment amount is subject to change each year per the IRS. For 2017, the maximum contribution amount allowed by the State and Higher Education institutions is $2,550.00**

When you enroll in this account, you must decide how much of your wages for the year you wish to contribute to this account to pay for medical, dental, vision or certain qualified, prescribed-by-a-physician over–the-counter (OTC) expenses that would otherwise be paid out of your pocket. These expenses may be for your spouse and other tax -qualified dependents as well as for yourself. **Plan your amount carefully since the amount elected is an irrevocable election for the plan year.**

The funds you contribute to the FSA will be deducted before taxes, and will be deducted in equal amounts from each paycheck you receive throughout the year. The full amount of your payroll deduction election will be available to you for use on January 1.

As you incur eligible medical, behavioral health, dental, vision, and qualified over-the-counter expenses for yourself, your spouse, and your qualified dependents, you can either use your FSA debit card (which will be issued to you by the state's FSA claims administrator) to instantly pay for eligible expenses or submit a claim for reimbursement by filling out a *Reimbursement Request Form* or completing the form on-line at the claims administrator's website or you may pay out of your own funds and request reimbursement.

What dependents are covered under the FSA?

For purposes of the FSA or L-FSA, the term "dependent" means a person who is defined as such under IRC Section 152 (as further defined under Code Section 105 (b)). Additionally any child to whom IRS Section 152 (e) (regarding divorced or separated parents) applies shall be deemed a dependent of the employee participating in the plan. This generally means that expenses incurred by the employee, the employee's spouse, the employee's child who has not attained age 27 as of the end of the employee's taxable year, or the employee's tax dependent for health coverage purposes may be reimbursed from the FSA or L-FSA. For this purpose a "child" is an individual who is the employee's son, daughter, stepson, stepdaughter, individuals adopted or placed for adoption with the employee, and eligible foster child.

Additionally the FSA or L-FSA will comply with any Qualified Medical Child Support Order ("QMCSO"). The plan will have in place reasonable procedures for determining the qualified

status of a medical child support order and administer those provisions.

What expenses qualify for pre-tax reimbursement under the FSA?
This account enables you to be reimbursed for eligible out-of-pocket medical, behavioral health, dental, vision, and certain qualified, prescribed by a physician over-the-counter drug/medicine expenses incurred by you and your tax qualified dependents. Eligible expenses are *generally* those permitted by Section 213(d) of the Internal Revenue Code; that is, expenses which would qualify as a deductible expense on your income tax return. For reference, IRS Publication 502 also gives information on eligible expenses for tax returns. Remember that not all items listed in Section 213(d) are reimbursable under the FSA (e.g. insurance premiums, which were already taken out of your paycheck before taxes were calculated). In addition, the following conditions must apply:

- You cannot be reimbursed for the expense by **any** insurance plan or in **any** other manner
- You cannot deduct the expense on your income tax return
- You cannot be reimbursed for long-term care expenses
- You cannot be reimbursed for the cost of other health care coverage
- The expense must be incurred during your period of coverage

Here are some examples of expenses that may be reimbursed from your FSA:

- Deductibles and co-payments (not premiums) from the state-sponsored medical or dental plans
- Orthopedic shoes/arch supports
- Orthodontia and other dental expenses
- Transportation expenses for medical care
- Hearing aids
- Chiropractic services
- Nursing care
- Chemical dependency services
- Medical equipment and supplies
- Prescription drug copayments or coinsurance
- Wheelchairs
- Ambulance service
- Prescription eyeglasses or contact lenses
- Psychiatric care
- Contact lens cleaning solutions and supplies
- Over-the-counter drugs to treat a medical condition with a prescription

The following expenses are specifically excluded from reimbursement (representative list only, not meant to be all-inclusive):

- Air Conditioners (wall units or central air systems)
- Whirlpools
- Gym Memberships

- Veneers

Refer to eligible healthcare expenses from IRS Publication 502 or stateoftn.payflexdirect.com
Some of these may be covered with a letter of medical need from your physician

Guidelines Effective January 1, 2011 - Federal Health Care Reform changed how and what type of over-the-counter (OTC) drugs can be reimbursed through the FSA. The FSA administrator will not reimburse OTC medicine without a prescription. You will be required to provide evidence of a prescription for over the counter medications and supplies before the FSA claims administrator will consider these for reimbursement.

When is an expense incurred? You incur an expense on the date that the service is provided, not when the expense was paid. .

What is my period of coverage?
If you enroll during Open Enrollment, your period of coverage under the FSA begins on January 1. If you enroll mid-year, your period of coverage begins on the event date or the date you enroll, whichever is later. The IRS generally prohibits retroactive enrollments. Your period of coverage continues through the calendar year if you continue participation in the plan. If you terminate participation prior to the end of the plan year, your period of coverage ends on your termination date.

Are insurance premiums eligible for pre-tax reimbursement under this account?
No. Insurance premiums are not eligible for reimbursement from the FSA. Remember that health and dental premiums deducted from your check are already taken pre-tax. The IRS prohibits insurance premiums from being reimbursed through an FSA.

Can I change the amount I am contributing to the FSA during the year?
Generally, no—you cannot begin, stop, or change your election during the year. The election you make during Open Enrollment is irrevocable and you must decide at that time how much you wish to contribute to your FSA for the upcoming year. However, there are some exceptions to this rule as specified in the federal regulations that allow a change or mid-year enrollment.

What status changes allow mid-year election changes?
According to federal rules, a status change occurs when a change in one or more of the following categories **affects eligibility for insurance coverage**:

- **Change in employee's legal marital status**
    - Marriage
    - Divorce, legal separation, annulment, death of spouse
- **Change in number of employee's dependents**
    - Birth, adoption, or placement for adoption
    - Death of dependent
- **Change in employment status of employee, spouse, or dependent that affects eligibility**

        - Termination or commencement of employment
        - strike or lockout
        - commencement of or return from an unpaid leave of absence
        - a change in worksite
        - switching from salaried to hourly, union to non-union or full-time to part-time (or vice versa)
        - incurring a reduction or increase in hours of employment
        - any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit
- Return to work from unpaid leave of absence (If an FSA election was made prior to the commencement of your unpaid leave of absence and you continued and paid your FSA while on the unpaid leave, that original election is reinstated upon your return to work unless another status change occurred allowing an election change.)
- Termination and rehire within 30 days (The original FSA election amount at time of termination is reinstated)
- Termination and rehire after 30 days – employee can make new elections (the new election cannot be less than the amount the employee had contributed through payroll contributions nor less than the amount the employee had been reimbursed for eligible expenses)
- Commencement or termination of employment by employee, spouse or dependent that triggers ineligibility (terminated employee may not decrease election). Coverage is revoked unless COBRA is elected.

- **Event causing employee's dependent to satisfy or cease to satisfy eligibility requirements**

- Attaining a specified age
- Family Medical Leave Act (FMLA) leave
- Judgments, decrees or orders
- Entitlement to Medicare or Medicaid (not Medical Assistance)

Important qualification: You may use the status change as a reason to start or adjust your contribution amount during the year if, and only if, the mid-year election change is consistent with the status change that affects eligibility for insurance coverage under the plan.

If you have an employment change that affects your benefits eligibility through the state-sponsored health insurance plans, you can submit an enrollment form to Benefits Administration. **You can only make changes prospectively (going forward from the date of the event), and the change is effective on the first day of the pay period in which the form was received.**

For example, if you elect $1,000 effective on January 1 and on June 1 get married and increase your election by $500, you will now have a total election of $1,500. The additional $500 can only be used for expenses incurred from June 1 through December 31. If the status change allows a reduction in your FSA election, your new election amount cannot be less than the amount you have

been reimbursed through the plan or contributed to the plan.

Further, any changes in status must be permitted under the Internal Revenue Code.

What about mid-year enrollment for new employees?
New employees who are insurance eligible must enroll within 31 days from the date of employment, re-hire, or reinstatement. Employees who become eligible mid-year must enroll within 31 days of becoming eligible.

How do I submit requests for reimbursement?
Eligible FSA expenses can be reimbursed by (1) entering reimbursement requests on-line at the FSA claims administrator's website, (2) completing the paper reimbursement request Form, or (3) using your flexible spending account debit card for automatic payment at participating vendors (remember to keep receipts!).

The first option is to enter your reimbursement request online. After entering the request online, the documentation to substantiate the request can then be uploaded to the claims administrator's website or faxed or mailed to them (see the section on acceptable documentation). All on-line claims entry must be completed, and documentation uploaded and/or received by the claims administrator by the plan year claim submission deadline of April 30th of the following year. Up to $500 (maximum) of unused funds in the medical FSA and L-FSA may be carried over into the next plan year.

If you do not upload the documentation to the website, after checking your documents for accuracy and legibility, fax or mail them to the claims administrator. **Be sure to keep copies of all documents submitted**. This will ensure you have adequate records to support your claim in the event of an IRS inquiry, or should your envelope be lost in the mail. **Be sure to submit all necessary documentation.**

If you prefer, the second option for receiving reimbursement for your eligible FSA expenses is to complete a *Reimbursement Request Form. Be sure to complete the form in its entirety, making sure to sign and date it before submitting the form either via fax or mail.* Attach a statement from the provider indicating the date the service was provided, a description of the service, and the charge for the service (see the section on acceptable documentation). Reimbursement forms are available on the claims administrator's website.
If you submit requests for reimbursements either on-line or using the reimbursement form, expenses will be reimbursed to you weekly if you are a University of Tennessee employee; all other higher education and state employees are reimbursed daily. If you do not receive reimbursement within two weeks of submitting your request and you have not been notified of the denial of your claim, contact the claims administrator.

The third way to access funds is to use your flexible spending account debit card. The debit card will reimburse up to the available FSA balance, including any carried over funds, if applicable. When the card is used, the merchant is paid the full amount of the charge (not to exceed the account balance) and your FSA is reduced by the same amount. When you use your debit card for reimbursement, you are certifying that the debit card is being used only for eligible medical

expenses for yourself and/or your eligible dependents and that the expenses paid with the card have not been and will not be reimbursed by another health plan. **You should not use the debit card to pay for expenses whose date of service is from a previous plan year, regardless of the billing date by the provider.** If you do so in error, please contact the claims administrator for assistance.

Using the Flexible Spending Account debit card correctly

You must acquire and retain documentation for any expense paid with the debit card (e.g. itemized invoices or Explanation of Benefits statements) in case you are asked to verify the expense (per IRS Regulations). The advantage to the debit card is that you do not have to pay out of pocket and then wait for reimbursement. **It does not eliminate the IRS requirement for documentation and does not make the process paperless.** If you use your flexible spending account debit card for an eligible purchase and later return that item, the merchant should return the amount to that debit card. If the merchant does not credit your debit card but rather refunds you directly, you are responsible for the overpayment. You will need to contact the claims administrator to explain the situation and make arrangements to repay your account. Remember, use of the debit card for FSA eligible expenses does not absolve you of responsibility to comply with IRS rules and regulations.

Providing debit card transaction substantiation

If the claims administrator requires additional information regarding a debit card purchase, they will send you a letter requesting additional information. You will have 21 days to respond to their request. If the claims administrator does not receive a response from this first inquiry, a second request will be sent to you. You will be given an additional 21 days to respond to their second request. If you do not respond to this second request, your debit card will be de-activated. To have the debit card reactivated, you must respond to the claims administrator's letter and supply the requested information. As an IRS approved flexible benefits administrator, remember that the claims administrator is required to receive substantiating documentation from plan members for expenses before processing and allowing payment. If the requested information is not provided to the claims administrator by the timeframes described above, you will need to either repay the amount of that debit card transaction or submit a substitute claim to offset the amount. In addition, if your card is on hold for a debit card transaction and you submit a manual claim for reimbursement, your claim will automatically be used to offset the transaction for which the card is on hold (as long as the on hold transaction and the date of service on the manual claim occurred in the same plan year). Further, if the FSA claims administrator contacts you to request substantiating documentation for a claim and you do not provide the requested information in a timely manner, your debit card may be placed on hold until such documentation is provided. This means that your debit card will not work when you attempt to use it at a pharmacy, physician's office or similar. If the substantiation, repayment, or offset is not provided, the amount may be included as wages on your W-2.

Acceptable documentation

Acceptable documentation is an itemized receipt or Explanation of Benefits (EOB) that reflects the actual date of service or product purchase, description of service or product, and patient portion of the charges. Please note that the following **are not** sufficient forms of documentation for most expenses: cancelled checks, copies of checks, cash register/credit card receipts, credit card

statements, predetermination or estimate of insurance benefits forms, balance forward statements, and balance due statements.

Should you lose your card, if it is stolen or if you need additional cards for dependents, a replacement card will be provided one time at no cost. You can order additional cards beyond the first replacement for a fee.

Over-the-Counter (OTC) Medicines
Federal Health Care Reform changed how reimbursement can be made for eligible over-the-counter (OTC) medicines. Effective January 1, 2011 the FSA will no longer reimburse over-the-counter (OTC) medicines without a prescription. The debit card will work only in certain situations for over-the-counter prescriptions. In case your OTC product with prescription is not accepted at the pharmacy, you will need to file a claim with the FSA claims administrator for reimbursement, and provide a copy of the prescription from your physician.

Other over-the-counter medicine reimbursements must be made using either the paper reimbursement form or by completing the on-line request for reimbursement through the claims administrator's website. A copy of the doctor's prescription must accompany either method.

How are expenses paid through the FSA?
When you incur an eligible medical, dental, vision, or over-the-counter expense and submit the claim to the claims administrator, payment will be deducted from your account.

The plan will pay the lesser of:

- The amount of the expense you are submitting, or
- The total amount you have elected to contribute to your FSA for the year (plus applicable carry over funds), reduced by any previous claims paid from the account during the plan year.

Is there a minimum reimbursement request amount?
If you are submitting requests for reimbursement either on-line or using the reimbursement form, there is no minimum reimbursement amount. The debit card also has no minimum reimbursement amount. **There is no need to wait until the end of the year to submit reimbursement requests.** The entire amount for which you enrolled is available from the first day of your participation during the plan year.

Can I get cash out of my account for reasons other than expense reimbursement?
No. Under federal rules, you can only get money out of the account for reimbursement of eligible expenses. In addition, amounts deposited in one account cannot be used to reimburse expenses from another account.

What is the last date I can submit a request for reimbursement?
The deadline for submitting reimbursement requests for the current plan year, whether submitted by mail, fax, or online, is ***April 30th of the following year***. **All reimbursement requests must be entered with documentation uploaded and/or paper claims successfully faxed or mailed by this date.** Requests for reimbursement postmarked or faxes received after the deadline will not be

processed. If submitting your reimbursement request on the claims administrator's website, after completing the reimbursement request online, follow the directions to fax or mail in your documentation. Be sure to keep a copy of your online confirmation of submission. **All necessary documentation must be submitted to the claims administrator by the plan year deadline of April 30th.**

If I have money left in my account at the end of the year, can it carry forward into the next year?
Yes, up to a certain amount. In accordance with IRS regulations and effective with the 2017 plan year, the FSA now includes a carryover feature. The IRS allows up to $500 to carry over from one plan year to the next. Therefore, if you are an active participant in the 2017 FSA plan on December 31, 2017 any funds in your account up to and including $500 of unreimbursed money will carry over from your 2017 FSA to be used in 2018. If your balance at the end of the plan year is greater than $500, any funds remaining in the account over the $500 carryover limit **will be forfeited**. These are IRS rules. However, if you carryover funds from one plan year to the next and participate in a CDHP in the next year, you will not be eligible to contribute to an HSA.

Should I be concerned about forfeiting money if I cannot claim it?
You should be fully informed of the rules and regulations so that your risk of forfeiture is minimized. In addition, estimating your expenses carefully should help you avoid forfeitures. However, even if you forfeit money, you still may come out ahead. For example, if you would otherwise pay 30 percent in federal, state, and social security taxes, it is fair to say that you save 30 percent on any expenses you pay with pre-tax dollars through this plan. Therefore, if you deposit $1,000 into your account and you forfeit $100, you are still $200 ahead because you have saved approximately $300 in taxes.

What happens to forfeited money?
IRS rules allow forfeited funds to be used by the employer to help offset the expense of administering the plan. The state's claims administrator does not profit from forfeitures. Rather, these funds remain with the employer group as the plan administrator of the FSA benefits for state employees and higher education employees. Any forfeited funds are used by the employer group for administrative costs associated with operating the FSA plans.

What if I terminate employment during the year and still have money left in my account?
If you terminate employment during the year, your period of coverage under the FSA will end on your termination date. Expenses incurred only during your period of coverage can continue to be submitted for reimbursement until 90 days after your termination date.

Tips to Prevent Forfeiture If You Over-Estimate:

By December 31st of each year (for you and your family),

- Get eye exams
- Buy a pair of glasses or prescription eyeglasses
- Stock up on contact lenses
- Get your teeth cleaned

- Fill prescriptions early, before the end of the year if able

Expenses incurred after your termination date will not be reimbursed.

Federal regulations (COBRA), allow you to continue participation in the FSA and L-FSA by electing to continue contributions to the plan through monthly payments, on an after-tax basis. You will receive notification of your right to continue and how to make the appropriate election upon termination of employment.

What if the account holder or employee dies during the plan year?
Eligible expenses that are incurred up to the date of a participant's death may be reimbursed for the participant and covered eligible dependents. All claims for the participant or a dependent must be for the date of death or prior, and must be filed within 90 days after the participant's date of death. Any funds remaining in the account after the 90 day period will be forfeited. If the covered spouse or dependent elects COBRA coverage on the FSA through the claims administrator and pays the required monthly premiums to the claims administrator, claims may continue to be incurred by the spouse and any dependents until the end of the plan year or until funds from the healthcare FSA are exhausted.

What rules apply if I choose to continue participating in the FSA after ending my employment with the State of Tennessee or a participating higher education institution?

1. You must be qualified. The following people qualify for continuation:
An employee (and any covered dependents) whose coverage would otherwise end due to: (1) termination of employment for a reason other than gross misconduct (2) reduced hours.

An employee's surviving spouse and/or children, whose coverage would otherwise end due to the employee's death, divorce or children who lose their dependent status.

Exception: Continuation is not available to any employee, spouse, or dependent who as of the date of the status change has "overspent" the FSA. An account is overspent when more dollars have been reimbursed than have been deducted from a participant's paycheck as of the status change.

2. You must pay the monthly cost. A person who elects continuation will be required to pay the entire cost of the continued coverage plus any administrative fees that your employer (state or higher education institution) has been paying to the claims administrator on your behalf. For instance, if you have a bi-weekly payroll deduction of $25.00 then the monthly COBRA premium due to the claims administrator would be $50.00 plus any additional administrative fee charged by the claims administrator.

3. Your continuation period is limited. Continued coverage under the FSA will end on the earliest of the following dates for qualified persons described above:
a. The end of the plan year, December 31, (see exception below); or

b. The end of the period for which a contribution is paid, if the required contribution is not paid on a timely basis; or

c. The date this plan is terminated, if ever.
Please see the end of this section for the **Formal COBRA Notice for FSA Participants**.

What happens if I take a leave of absence or a voluntary reduction of hours?
If during the leave of absence you continue to receive regular pay, sick pay, or vacation pay from the State of Tennessee or a participating higher education institution, your contributions to and coverage under the FSA will continue. If you are in an active pay status then you will stay enrolled until you terminate or at the end of the plan year.

When you return to work, you can change your election amount due to a qualified status change, if applicable. Otherwise, your remaining pledge balance will be recalculated based on the number of paychecks remaining in the year and payroll deductions will resume. The event of returning to work is not a qualifying reason to make a change in your election. The election change must be consistent with the status change. Your deductions will be adjusted to reflect the new amount. **If you had a qualified status change and wish to change your FSA election upon returning to work, you must complete a Flexible Benefits Family Status Change Application to adjust your election. This form must be received by Benefits Administration within 31 days of your return to work date.**

What will happen to my FSA when I retire?
When you retire, your period of coverage will end on your retirement date and any unclaimed funds will be forfeited. You are also eligible to enroll in COBRA. You cannot change your annual election amount at this time, and once you have retired, you cannot enroll during Open Enrollment for the following year. Details of COBRA eligibility for groups other than retirees is discussed later in this document.

If you want to extend your participation in the FSA when you retire
You can elect and pay **COBRA continuation payments** until you can submit expenses for the election amount. Extending your period of coverage will give you more time to incur eligible expenses, thus providing you with more opportunity to claim reimbursements from your account. If you elect to pay COBRA payments through the balance of the plan year in which you retire, you may be eligible to have up to $500 of the unused balance in your account carry over to the new plan year. In this situation, the funds may be used on dates of service up to 18 months following your retirement date, or until the funds are depleted - whichever occurs earliest.

If you choose to terminate your FSA
If you decide to terminate your account, your last day of coverage is your retirement date. If you have not incurred enough expenses to meet or exceed the balance remaining in your account, those funds will be forfeited. Expenses incurred after the period of coverage has ended are not eligible for reimbursement. (Even if you have contributed money and not used it, you cannot be reimbursed for a claim that takes place after your coverage period.)

Are pre-tax reimbursements through this plan better than tax deductions or tax credits on my tax return?
On your federal tax return, only your uninsured medical, behavioral health, dental and vision expenses in excess of 10 percent of your adjusted gross income are deductible. However, under the FSA, up to $2,550 of your uninsured medical, behavioral health, dental, vision and over-the-counter expenses can be paid with pre-tax dollars. In addition, under current law, you

don't pay Social Security taxes on dollars directed to your FSA. Therefore, if you expect to incur uninsured medical and dental expenses, paying for them through the FSA is likely to be more advantageous than taking a deduction for those expenses on your tax return – particularly if your medical expenses paid out-of-pocket do not exceed 10 percent adjusted gross income (AGI).

Who is responsible if I get reimbursed by this plan and also get reimbursed from another source and/or claim a reimbursed expense on my tax return?
You are. Duplications of reimbursements, attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally will incur any penalties. Your employer does not monitor your personal income tax and other financial affairs, and will not attempt to do so. You should maintain adequate records to support your claims in the event of inquiry by the IRS and keep copies of all documentation sent to the claims administrator.

My spouse has a High Deductible Health Plan (HDHP) and wants to contribute to an HSA with his/her employer. Can I enroll in FSA and maintain my spouse's eligibility in the HSA?

In this situation you may only enroll in a limited-purpose FSA. IRS rules surrounding a HDHP stipulate that in order to be eligible to contribute to an HSA, the individual cannot have access to, or enroll in, a FSA. You can, however, elect to have a "limited purpose" FSA (L-FSA) that can be used to reimburse up to $2,550 in eligible dental or vision expenses. This L-FSA allows your spouse to still maintain HSA eligibility. If you want to enroll in the L-FSA, you may do so each fall during the Annual Enrollment period or within 31 days of your hire date.

In addition, if your eligible dependent is employed elsewhere and is eligible to contribute to an HSA and their expenses could potentially be submitted under your or your spouse's FSA that is not limited to dental or vision expenses through the end of the year they turn 26, your dependent is not eligible to make or receive HSA contributions.

Formal COBRA Notice for FSA Participants
Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this Plan will be entitled to the opportunity to elect a temporary extension of FSA coverage (called "COBRA continuation coverage") when coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

For the FSA and L-FSA, COBRA coverage will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the

annual limit elected by the employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for FSA or L-FSA COBRA coverage that will be charged for the remainder of the plan year.

1. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

2. Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or for retirees, in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

4. What is the Procedure for Obtaining COBRA Continuation Coverage?

Accept the continuation of coverage information when you receive it from the Claims Administrator and agree to pay all costs associated with COBRA continuation coverage as charged by the claims administrator.

5. What is the Election Period and How Long Must It Last?

The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family

members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

6. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) The end of employment or reduction of hours of employment,

(b) Death of the employee,
(c) For retirees, commencement of a proceeding in bankruptcy with respect to the employer, or
(d) Enrollment of the employee in any part of Medicare.

The Plan Administrator will notify the Claims Administrator that the qualifying event has occurred.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

7. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the

Plan Administrator or its designee, as applicable.

8. When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any health plan reimbursement account (FSA) to any employee.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

9. What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

COBRA Continuation Coverage may extend up to 18 months. If you elect to continue coverage AND make all contributions for the plan year in which the Qualifying Event occurred AND have funds remaining in your account at the end of this plan year, the maximum coverage period for COBRA Continuation is 18 months after the Qualifying Event. If a qualified beneficiary on an 18-month COBRA extension is determined by the Social Security Administration (SSA) to have been disabled at any time during the first 60 days of COBRA coverage, the former employee and covered dependents may be eligible to continue coverage for an additional 11 months with an increase (150 percent of the total monthly premium) in payment after the 18th month. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage due to the same initial qualifying event, those nondisabled qualified beneficiaries will also be entitled to this 11-month disability extension. Dependents already insured may continue coverage under COBRA for 18 months based on the events listed for employees. Furthermore, dependents may continue coverage for an additional 18 months — maximum of 36 months — if coverage is lost due to one of the following events:

- The employee’s death
- The employee and spouse divorce
- A dependent child is no longer eligible as a dependent (over age 26 unless incapacitated)

For FSA and L-FSA, participants with underspent accounts can receive FSA and L-FSA COBRA

coverage only through the end of the plan year in which the COBRA qualifying event occurs. However, qualified beneficiaries who continue COBRA coverage through December 31 of that plan year may carry over up to $500 of unused FSA and L-FSA amounts remaining at the end of the plan year, in accordance with the carry-over provisions set forth in this document, until the end of the 18, 29, or 36 month maximum COBRA coverage period that applies under the other medical plan or until the amounts are used up, if earlier.

10. Does the Plan Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

11. Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Other Than Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

12. What is Timely Payment for payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than 45 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

13. How is My Participation in the FSA/L-FSA Affected?

You can elect to continue your participation in the FSA for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the FSA if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only

claimed $150, you may elect to continue coverage under the FSA. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above) to provide this benefit.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Claims Administrator.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

State of Tennessee
Division of Benefits Administration
312 Rosa L. Parks Ave, Suite 1900
Nashville, TN 37243

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Dependent Care Flexible Spending Account (DC-FSA)

The Dependent Care Expense Account (DC-FSA) allows you to pay for certain dependent care (daycare) expenses with up to $5,000 of pre-tax dollars. You participate in this program by enrolling during Open Enrollment. New employees must enroll within 31 days of employment, re-hire or reinstatement. Employees who become insurance eligible mid-year must enroll within 31 days of becoming eligible. **You must enroll each year during Open Enrollment for each plan year in which you wish to participate. Re-enrollment does not occur automatically each year; you must take an active role to reenroll for the following year.**

Important Note: The DC-FSA is for daycare type expenses. It does **not** cover medical or dental expenses for your tax-qualified dependents. Unreimbursed medical/dental expenses for your tax qualified dependents fall under the Flexible Spending Account (FSA).
When you enroll in the DC-FSA, you decide how much of your wages you wish to direct to this account to pay your dependent care (daycare) expenses while you are at work. There is a $5,000 **family maximum** per tax year. The amount you contribute to the DC-FSA will be deducted in equal amounts from each paycheck you receive throughout the year. You may only submit dependent care eligible expense claims as funds are deducted from your paycheck and posted to your DC-FSA. In other words, the full amount of your annual payroll deduction election **will not** be available to you for use on January 1.

There is no minimum reimbursement amount**.** Special rules apply to children of divorced or separated parents and to married parents who are filing separate income tax returns. Persons in either of these circumstances should obtain the instructions to IRS Form 2441 and consult their tax advisor.

As you incur eligible dependent care (daycare) expenses, fill out a *Reimbursement Request Form* (found on the claims administrator's website*)*, itemize your expenses including the name and Tax ID# of your dependent care provider (or social security number for an in-home provider), and either enter the information online, scan and upload the documentation or fax or mail it to the claims administrator. A reimbursement check will be mailed to your home or deposited directly in your bank account if you have signed up for direct deposit. (See the section titled **How do I submit requests for reimbursement?**)

Who is a qualified dependent under the DC-FSA?
You may incur expenses for a "Qualifying Individual"; that is
--a person under age 13 who is your qualifying child under the Internal Revenue Code (in general, the person (1) must have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling, or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
--your spouse who is physically or mentally incapable of caring for himself or herself, has the same principal abode as you for more than half the year; or
--a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half the year, and is your tax dependent under the Internal Revenue Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Internal

Revenue Code's definition).

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. Contact the Claims Administrator for more information.

If the expenses are incurred for a Qualifying Individual who is not under age 13 who is your qualifying child, then the Qualifying Individual must spend at least 8 hours per day in your household.

In addition, a qualified dependent must meet both of the following conditions**:**
1. Your home is the dependent's "principal abode" for more than one half of the year. *Special rule for child of divorced or separated custodial parent*. The child of a divorced or separated employee who has custody (more than 50% of the time) of the child is treated as a qualifying child of the employee.
2. He or she must be a citizen or resident of the United States or a resident of Canada or Mexico.

The qualified dependent cannot be the qualified dependent of any other taxpayer in the taxable year.

How much would the plan's tax savings increase my take-home pay?
Let's say a married employee, Pat, files jointly, and has a salary of $44,000 per year with two children. Pat's spouse also works and earns an annual salary of $38,000. Pat elects to contribute a total of $5,000 per year ($208.33 from each of 24 paychecks) to her DC-FSA. And, let's say Pat gets reimbursed for expenses equal to the amount Pat contributes during the year. The chart below illustrates Pat's savings under the plan.

Using the plan to pay dependent care (daycare) expenses on a pre-tax basis increases Pat's spendable pay by $1,485 per year. However, please note that without the plan, Pat would be eligible for a dependent care credit on her income tax return, and the tax advantages of the credit may outweigh the tax advantages of being reimbursed for dependent care expenses on a tax-free basis under this plan. See IRS Publication 503 *Child and Dependent Care Expenses* and/or consult with your tax advisor.

Sample Annual Tax Savings Comparison

	Without the plan	With the plan
Gross Salary	$82,000	$82,000
Pre-tax dependent care contribution	-	(5,000)
Adjusted gross income	82,000	77,000
Estimated income tax	(12,617)	(11,514)
Social Security (FICA) tax	(6,273)	(5,891)
Spendable income	63,110	59,595
Dependent care expenses paid after tax	(5,000)	-
Spendable income after taxes	58,110	59,595

and dependent care expenses

What dependent care (daycare) expenses qualify?
The expenses must be necessary to permit you to be gainfully employed. If you are married, your spouse must be working in a job for pay or actively seeking employment, or be a full-time student, or be physically or mentally unable to care for himself/herself.

Expenses incurred while you are on paid leave, such as maternity leave, may be eligible for reimbursement under the plan if you are physically unable to care for your children while on such leave. An individual who is gainfully employed is not required to allocate expenses during short, temporary absences from work, such as for vacation or minor illness, when the care-giving arrangement requires the employee to pay for care during the absence. For this purpose, IRS regulations establish a "safe harbor" under which an absence of up to two consecutive calendar weeks is treated as a short, temporary absence.

The cost associated with kindergarten is not allowable since it is educational. Summer programs may be eligible for reimbursement under the plan as long as they are for custodial care. In general, if the institution providing the services documents them as *education,* they are not eligible. (A tuition charge on a bill will be deemed an educational expense.) If the institution provides you with documentation separating educational from other expenses, the child care expenses will be eligible. Be sure to consult with the claims administrator if you have any questions about this issue. The cost of schooling for first grade or higher is not eligible for reimbursement under the plan. However, the cost of care provided before and after school is eligible.

If you have a regular dependent care (daycare) arrangement where you must pay a set weekly amount, even if you or your dependent are on vacation or are ill and your dependent is not receiving care, you may include those payments as an eligible expense under the plan. Expenses incurred for summer day camps are eligible as long as they are custodial in nature and not educational. Summer camp expenses involving any overnight stays are not eligible.

Only eligible expenses you incur during the plan year can be reimbursed.

When should I start, or increase contributions to, my DC-FSA for an expected baby?
This is an important question. If you or your spouse is pregnant during the Open Enrollment period, or if you or your spouse is a new hire, it is best *not* to include anticipated expenses for the child in your election. This holds true for an adoption as well. **Wait to enroll in, or increase contributions to, a DC-FSA when the mother returns to work or the adoption takes place.**

Often times, parents find that their needs and plans change in unanticipated ways after the birth of a baby or adoption. For example, the mother may not return to work as soon as expected. If this happens to you, and deductions are already coming out of your check, you may not be able to change your election and may end up forfeiting money.

When is an expense incurred?

You "incur" an expense on the date that the service is received, not when you receive or pay the bill.

What is my period of coverage?
If you enroll during Open Enrollment, your period of coverage under the DC-FSA begins on January 1. If you enroll mid-year, your period of coverage begins on the event date or the first day of the pay period in which the form is signed and received by Benefits Administration, whichever is later. Your period of coverage ends on December 31 whether or not your deductions continue until the end of the year.

What is the maximum amount of dependent care expenses that may be reimbursed through the DC-FSA?
The calendar year maximum for this plan is $5,000 in dependent care (daycare) expenses for one or more dependents. This is a family maximum set by the IRS, so if your spouse also participates in a dependent care expense account, your $5,000 maximum must be reduced by your spouse's dependent care contribution for the year.

If you are married and you and your spouse file separate federal income tax returns, not more than $2,500 of dependent care expense reimbursements for services provided during the year will be exempt from your tax. Any excess must be declared on your tax return as taxable income.

If you are married, reimbursements from your DC-FSA that exceed the earnings of the lower-paid spouse for the year must be reported as taxable income for that year. For example, if you receive $3,600 of dependent care reimbursements for expenses for services provided during a year and your spouse only earned $3,000 that year, the $600 excess must be declared as taxable income. This will be reported when you file your tax returns using forms 1040 and 2441.

For income tax purposes, the statement you receive each time you get a reimbursement check from the plan will show the amount you actually received from your DC-FSA for expenses incurred during the year. You should keep all receipts and you will need this information when you file your taxes and you will need to file Form 2441 with your 1040 tax return (or Schedule 2 with your 1040A return) to report the name of your care provider to the IRS.

Expenses that your spouse incurs while actively seeking employment are considered expenses that enable him or her to be gainfully employed. However, because of the statutory earned income limits, if your spouse does not find a job and has no earned income for the year, you may not qualify to receive reimbursements. And, if your spouse has worked for part of the year, the maximum income exclusion may be reduced as a result of your spouse's lack of earnings.

Here is an example: Let's say John is married to Susan, both of whom have full time jobs. John earns $60,000 per year, while Susan makes $35,000. They have always used John's employer (i.e. The State) to reimburse dependent care expenses for their child. A couple of months into the New Year, Susan is laid off. She looks for a new job but is not able to secure employment. At the end of the year, her earned income is only $2,500. However, during the year, John and Susan incurred $3,000 in child-care expenses while Susan was seeking employment and preparing resumes, contacting employers, going to job fairs, etc. Although John's DC-FSA allows him to be

reimbursed for expenses incurred while actively looking for work, the statutory income limit nevertheless limits the amount that can be reimbursed to $2,500.

In order to have your dependent care (daycare) expenses reimbursed on a tax-exempt basis from this plan, you will have to give the name, address, and taxpayer identification number of your provider to the IRS when you file your federal income tax form. This requirement also applies if you are taking a dependent care credit on your personal tax return.

What qualifies as a dependent care eligible expense?
Daycare centers and private daycare providers in your home or outside of your home qualify as a provider of daycare.

In order to qualify as eligible expenses, the amounts you spend on dependent care must meet the following IRS rules:

- You may be reimbursed for charges for care services either inside or outside your home for eligible dependents under the age of 13. Services must be for the physical care of the child and must not be provided by a spouse or dependent.
- You may be reimbursed for charges for the care of a dependent adult or child who is mentally or physically incapable of self-care. To be eligible, services may not be provided by a spouse or dependent and the eligible dependent must regularly spend at least eight hours per day in your household.
- You may not use the Dependent Care Reimbursement Account to pay for a dependent's healthcare expenses. The account may not be used by a non-custodial parent to pay for child care or child support payments.
- If you use the Dependent Care Reimbursement Account to pay for care or claim the Child or Dependent Care Tax Credit, you will need to file Form 2441 with your 1040 tax return (or Schedule 2 with your 1040A tax return) to report the name of your care provider to the IRS.

Can I change the amount I am contributing to my DC-FSA during the year?
Generally, no—you may not begin, stop, or change your contribution amount during the year. You must decide during Open Enrollment how much you wish to direct to your DC-FSA during the coming year. However, there are some specified status changes in the federal regulations that allow changes or mid-year enrollment status changes. Otherwise, flexible benefit enrollments are irrevocable during the plan year.

What status changes allow mid-year adjustments to my participation?
According to federal rules, a status change occurs when a change in one or more of the following categories affects eligibility for insurance coverage as described below:

- **Change in employee's legal marital status**
    - Marriage
    - Divorce, legal separation, annulment, death of spouse
- **Change in number of employee's dependents**
    - Birth, adoption, or placement for adoption
    - Death of dependent
- **Change in employment status of employee, spouse, or dependent that affects eligibility**

- Termination or commencement of employment
- strike or lockout
- commencement of or return from an unpaid leave of absence
- a change in worksite
- switching from salaried to hourly, union to non-union or full-time to part-time (or vice versa)
- incurring a reduction or increase in hours of employment
- any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit
- Unpaid leave
- Termination and rehire within 30 days (amount of election at the time of termination must be reinstated unless another event has occurred that allows a change)
- Termination and rehire after 30 days – employee may make new elections (the new election cannot be less than the amount the employee had contributed through payroll contributions nor less than the amount the employee had been reimbursed for eligible expenses)
- Commencement or termination of employment by employee, spouse, or dependent that triggers eligibility

- **Event causing employee's dependent to satisfy or cease to satisfy dependent eligibility requirements**
    - Attaining a specified age
    - Becoming single or getting married
    - Becoming or ceasing to be a student
    - Family Medical Leave Act (FMLA) leave
    - Significant dependent care cost increase or decrease – **Note:** No change can be made when the cost increase or decrease is imposed by a dependent care provider who is a blood relative of the employee.
    - Addition or elimination of dependent care account through spouse's plan
    - Change in coverage of spouse or dependent under other employer's plan (dependent care account)

Important note – Any changes in status must be permitted under the Internal Revenue Code.

What about mid-year enrollment for new employees?
New employees who are insurance eligible must enroll within 31 days of employment, re-hire, or reinstatement. Employees who become insurance eligible must enroll within 31 days of becoming eligible. The effective date of coverage is prospective. Retroactive enrollment is prohibited.

How do I submit requests for reimbursement?

Eligible DC-FSA expenses can be reimbursed by (1) entering reimbursement request on-line at the claims administrator's website or (2) completing the Reimbursement Request Form located on the claims administrator's website.

Enter your reimbursement request online and either upload the documentation to the website or fax or mail the documentation to the claims administrator. If you do not upload the documentation to the website, after checking your documents for accuracy and legibility, you may fax or mail them to the claims administrator. Be sure to keep copies of all documents submitted. All on-line claims entry must be completed, and documentation uploaded and/or received by the claims administrator by the plan year claim submission deadline of April 30th of the following year.

If you prefer, you may receive reimbursement for your eligible DC-FSA expenses by completing a *Reimbursement Request Form. Be sure to complete the form in its entirety, making sure to sign and date it before submitting the form.* The Reimbursement Request Form along with documentation can be faxed or mailed to the claims administrator.

Be sure to keep copies of all documents submitted. This will ensure you have adequate records to support your claim in the event of an IRS inquiry, or should your envelope be lost in the mail.

Be sure to submit all necessary documentation so that it is received by the claims administrator by the plan year claim submission deadline of April 30th of the following year.
You cannot be reimbursed for daycare expenses until after expenses have been incurred (after the end of the week or month for which you are submitting expenses). Reimbursements will be made daily, with the exception of the University of Tennessee, which will be weekly.

What is the last date I can submit requests for reimbursement?
Your final reimbursement request for expenses incurred during the plan year ***must be*** received by the claims administrator by the plan year claim submission deadline of April 30th of the following year. **There is no carryover provision for the DC-FSA, so any funds remaining in your account after April 30th will be forfeited per IRS rules.** Requests for reimbursement or faxes received after the deadline will not be processed and any **money remaining in your account will be forfeited** as required by federal law.

How are dependent care expenses paid through the DC-FSA?
When you incur an eligible dependent care expense you can pay your provider by utilizing the claims administrator's online feature to pay your provider directly from your account. You may also pay for eligible expenses with cash, check or your personal credit card, then submit a claim to pay yourself back. You can even have your claim payment deposited directly into your checking or savings account. The claims administrator even offers a mobile app that allows you to manage your account, view alerts, and snap a photo of your receipts and upload them to submit claims.

The plan will pay the lesser of:

- The amount of the expense you are submitting, or
- The total amount that has been contributed to your DC-FSA to date, reduced by any previous claims paid from the account during the plan year.

If there is not enough money in your DC-FSA to pay all the expenses you have submitted during a payment period, the excess expenses will be carried forward and paid from the deposits you make in subsequent periods.

Can dependent care expenses be paid with the debit card?
No, the debit card may only be used to pay for eligible expenses of the medical FSA or the L-FSA.

Is there a minimum reimbursement request amount?
There is no a minimum reimbursement amount. **There is no need to wait until the end of the year to submit reimbursement requests.**

Can I get cash out of my account for reasons other than expense reimbursement?
No. Under federal rules, you may only get money out of the account for reimbursement of eligible expenses. Also, amounts deposited in one account cannot be used to reimburse expenses from another account.

If I have money left in my account at the end of the year, can I carry it forward into the next year?
No. Expenses incurred during one plan year cannot be reimbursed with money contributed in another plan year. Furthermore, according to federal law, any funds remaining in your account at the close of the plan year will be forfeited. (See the section titled **What is the last date I can submit a request for reimbursement?** for more detail regarding the final deadline.)

Should I be concerned about forfeiting money if I can't claim it?
You should be fully informed of the rules and regulations so that your risk of forfeiture is minimized. In addition, estimating your expenses carefully should help you avoid forfeitures. However, even if you forfeit money, you may still come out ahead. For example, if you would otherwise pay a total of 30 percent in federal, state, and social security taxes, it's fair to say that you save 30 percent on any expenses you pay with pre-tax dollars through this plan. Therefore, if you deposit $1,000 into your account and you forfeit $100, you're still $200 ahead because you've saved approximately $300 in taxes.

What happens to forfeited money?
Forfeited money is retained by the employer group to help offset the expense of administering the plan. The claims administrator does not profit from forfeitures.

What if I terminate employment during the year and still have money left in my account?
If you terminate employment during the year, your period of coverage under the DC-FSA will end on your termination date. Expenses incurred only during your period of coverage can continue to be submitted for reimbursement until 90 days after your termination date.

What will happen to my DC-FSA when I retire?
If you terminate employment while participating in a DC-FSA and you have money in your account, you will forfeit those funds. You should spend any funds in your account prior to terminating employment.

What if the account holder or employee dies during the plan year?
Eligible expenses that are incurred up to the date of a participant's death may be reimbursed for the participant and covered eligible dependents. All dependent care claims must be on or before the participant's date of death, and must be filed within 90 days after the participant's date of death. Any funds remaining in the account after the 90 day period will be forfeited.

What happens if I take a leave of absence?
If during the leave of absence you continue to receive regular pay, sick pay or vacation pay, your contributions to and coverage under the DC-FSA will continue. You may discontinue DC-FSA contributions during the leave if your dependent care expenses during that time would not qualify for reimbursement. To discontinue DC-FSA contributions during your paid leave, please complete a Flexible Benefits Family Status Change Application form found on Benefits Administration's website: http://www.tn.gov/finance/article/fa-benefits-forms.

Are there any general guidelines as to whether pre-tax reimbursements through this plan are better than tax deductions or tax credits on my tax return?
Due to the increasing complexity of the Federal and state tax codes, deciding which of these two options is most advantageous is a very complex issue. Generally, *the more taxable income a person has, the greater the likelihood that the DC-FSA will result in the greatest tax advantage.* However, there are other factors to consider, such as the number of eligible dependents you have, or the amount of qualifying dependent care expenses you incur. If you have one eligible dependent, up to $3,000 of qualifying expenses may be used to calculate the credit, alternatively, you could set aside up to $5,000 in the DC-FSA. If you have two or more eligible dependents, up to $6,000 of qualifying expenses may be used to calculate the credit, while you can still only set aside up to $5,000 in the DC-FSA. For more information, consult with a qualified tax advisor or professional.

Your own tax advisors should be consulted to help you determine whether the tax credit or paying dependent care expenses through the plan on a pre-tax basis is better for you. Neither the plan administrator, your employer, nor the claims administrator is permitted to give advice about personal income tax matters.

A detailed explanation of how dependent care expenses may be used for federal tax credit purposes can be found in IRS Publication 503.

What is the federal dependent care tax credit? Can I use it as well as this plan for dependent care expenses?
This tax credit is a percentage of your eligible dependent daycare expenses, up to $3,000 per year for one dependent and $6,000 for two or more dependents. The actual percentage depends on your income level. For more information, you should consult your qualified tax professional.

What about earned income tax credits (EIC)?
Earned income tax credits are available to lower income tax payers. Under current law, three different credit amounts apply, depending on whether the taxpayer has one, two or more, or no

qualifying children.

Participating in the DC-FSA *could* affect the amount of your earned income credit. For more information about EIC see IRS Publication 596.

Who is responsible if I get reimbursed by this plan and also get reimbursed from another source and/or claim a reimbursed expense on my tax return?
You are. Duplications of reimbursements, attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally will incur any penalties. Your employer does not have the means to monitor your personal income tax and other financial affairs, and will not attempt to do so. You should maintain adequate records to support your claims in the event of inquiry by the IRS and keep copies of all documentation sent to the claims administrator.

Limited purpose Flexible Spending Account (L-FSA)

Eligible state and higher education employees may choose to enroll in a limited purpose flexible spending account. This type of FSA allows for reimbursement or payment of qualified **vision and dental expenses (only)**. No medical payments are allowed from this type of FSA.

While anyone may enroll in this plan and contribute up to $2,550 in pre-tax funds, those state group insurance program enrollees who enroll in a consumer directed health plan (CDHP) – also known as a high deductible health plan (HDHP) may find the L-FSA particularly attractive. For instance, if you are enrolled in a CDHP you must pay all plan expenses up to your plan's applicable deductible and then you are responsible for coinsurance. When you enroll in a CDHP, a health savings account (HSA) is opened for you with the state group insurance program's contracted partner for HSA services. Because you and/or your employer may fund your HSA with pre-tax dollars, you are not allowed to open a regular healthcare FSA. This is called "double dipping" and it is not allowed per IRS rules. However, for plan members or those with families who anticipate large dental (e.g. orthodontia) or vision expenses during the year or possible certain vision or dental expenses not covered by insurance (e.g. LASIK), you may fund up to $2,550 in your L-FSA to pay for those expenses. The full amount of your payroll deduction election will be available to you for use on January 1.

Expenses may be paid at many dental and vision providers using your L-FSA debit card or you may go online and pay your provider by utilizing the claims administrator's online feature to pay your provider directly from your account. Or you may pay for eligible expenses with cash, check or your personal credit card, then submit a claim to pay yourself back. You can even have your claim payment deposited directly into your checking or savings account. The claims administrator even offers a mobile app that allows you to manage your account, view alerts, and snap a photo of your receipts and upload them to submit claims.

If I have money left in my account at the end of the year, can it carry forward into the next year?
Yes, up to a certain amount. In accordance with IRS regulations and effective with the 2017 plan year, the L-FSA now includes a carryover feature. The IRS allows up to $500 to carry over from one plan year to the next. For example, if you are an active participant in the 2017 FSA plan on December 31, 2017 and contributed your full election amount, up to $500 of unreimbursed money will carry over from your 2017 L-FSA to be used in 2018. If your balance at the end of the plan year is greater than $500, any funds remaining in the account over the $500 carryover limit **will be forfeited**. These are IRS rules.

Should I be concerned about forfeiting money if I cannot claim it?
You should be fully informed of the rules and regulations so that your risk of forfeiture is minimized. In addition, estimating your expenses carefully should help you avoid forfeitures. However, even if you forfeit money, you still may come out ahead. For example, if you would otherwise pay 30 percent in federal, state, and social security taxes, it is fair to say that you save 30 percent on any expenses you pay with pre-tax dollars through this plan. Therefore, if you deposit $1,000 into your account and you forfeit $100, you are still $200 ahead because you have saved approximately $300 in taxes.

What happens to forfeited money?
IRS rules allow forfeited funds to be used by the employer to help offset the expense of administering the plan. The state's claims administrator does not profit from forfeitures. Rather, these funds remain with the state as the plan administrator of the FSA benefits for state employees and higher education employees. Any forfeited funds are used by the state for administrative costs associated with operating the FSA plans.

What if I terminate employment during the year and still have money left in my account?
If you terminate employment during the year, your period of coverage under the L-FSA will end on your termination date. Expenses incurred only during your period of coverage can continue to be submitted for reimbursement until 90 days after your termination date. You would be eligible to continue participation under the federal COBRA benefit laws, but you would be required to pay the monthly cost associated with maintaining an open account with the claims administrator. For more details, see the earlier question "**What rules apply if I choose to continue participating in the FSA after ending my employment with the State of Tennessee or a participating higher education institution?"**

What if the account holder or employee dies during the plan year?
Eligible expenses that are incurred up to the date of a participant's death may be reimbursed for the participant and covered eligible dependents. All claims for the participant or a dependent must be for the date of death or prior and must be filed within 90 days after the participant's date of death. Any funds remaining in the account after the 90 day period will be forfeited. If the covered spouse or dependent elects COBRA coverage on the limited purpose FSA through the claims administrator and pays the required monthly premiums to the claims administrator, claims may continue to be incurred by the spouse and any dependents until the end of the plan year or until funds from the limited purpose FSA are exhausted.

Parking & Transportation Reimbursement Plan (applies to state employees only)

The Parking & Transportation (P&T) Reimbursement Plan (for state employees only) is another way to get the most money from your paycheck. The plan allows you to pay for qualified work-related transportation expenses with money that is sheltered from taxes by deducting the funds from your pay before it is taxed. Since less of your pay is taxed, you should come out ahead at the end of the year. This plan is governed under Section 132 of the Internal Revenue code and therefore, certain rules and guidelines apply, so be sure you fully understand the program before you choose to participate.

The P&T Reimbursement Plan allows for reimbursement for eligible parking & transit expenses for parking and mass transit. Some examples of eligible expenses are out-of-pocket costs that you pay for parking and bus pass expenses, vanpool expenses, and/or light rail while commuting to and from work. Claims processing for the parking & transit reimbursement program is handled by the Division of Benefits Administration.

Who is eligible for the plan?

Any State of Tennessee employee who has transit expenses may participate in the P&T Reimbursement Account.

How it works

Unlike Medical and Dependent Care Flexible Benefits Accounts, there is no requirement for new employees to enroll within 31 days of being hired and there is no annual enrollment period for employees. A state employee may enroll in a Transportation Account and/or a Parking Account at any time during employment. An employee may enroll by accessing the completing and accessing the appropriate form at http://www.tn.gov/assets/entities/finance/benefits/attachments/1020.pdf and faxing to 615-741-8196. If you sign up for the plan during Open Enrollment **AND** you are on payroll on January 1, you will be able to start using the plan on January 1. State employees may enroll in the parking & transit expense plan at any time. For parking & transit (state employees only), the effective date will be the first of the month following the date that your parking & transit enrollment form is received by the Division of Benefits Administration.

Will my enrollment in this program automatically continue from year to year?

Yes. Once you enroll in the Parking & Transit reimbursement program, you will stay enrolled until you decide to disenroll.

Filing Claims and Getting Reimbursed

When you have incurred transportation or parking expenses, submit a Transportation and Parking Reimbursement Request Form to Benefits Administration along with a receipt from the service provider that includes the date of service, the name of the provider and the amount charged. Canceled checks, credit card statements and bank statements are not acceptable as a receipt of the service incurred. You may submit a P&T claim by emailing it to Benefits.Info@tn.gov or faxing it to 615-741-8196.

Sample Paycheck Comparison

	Without the PDA	With the PDA
Gross salary	$28,000	$28,000
Bus pass expenses paid	0	(300)
Taxable compensation	$28,000	$27,700
Estimated income tax (2014 Federal and State)	(3,179)	(3,118)
Social Security (FICA) tax	(2,142)	(2,119)
Compensation after tax	$22,679	$22,463
Bus pass expenses paid after tax	(300)	0
Spendable income after taxes and bus pass expenses	$22,379	$22,463

Employees who have an available account balance in a Transportation or Parking Account as of December 31st will have until April 30th of the following year to claim the remaining funds. However, the expenses must have been incurred within the year just ending. Previous year fund balances unclaimed by April 30th will be rolled to an active current year account of the same type to be used for current year expenses. Any prior year claims submitted after April 30 will be denied.

Payroll Deduction Account (PDA)

Is there a limitation on the amounts of transit expenses that may be deducted on a pre-tax basis?
Yes, and these limits are subject to change by the IRS each year. For 2017, the limits are **$255 per month for qualified parking expenses** and **$255 per month for qualified transportation expenses.** Participants' elections will not be monitored by Benefits Administration or the State; it is your responsibility to ensure that you do not exceed the maximums allowed by law.

How are payments for payroll deducted transit expenses handled?
For state employees, the amount of your parking and transit flexible benefits election will be withheld from each of your paychecks throughout the year. You will submit claims to Benefits Administration by emailing it to Benefits.Info@tn.gov or faxing it to 615-741-8196.You may roll funds from one month to the next, but you may only claim funds that have been deducted from your paycheck and posted to your P&T reimbursement account.

Can I change my PDA?
Yes, you can cancel or change your participation in the PDA at any time.

What if the account holder or employee dies during the plan year?
Eligible expenses that are incurred up to the date of a participant's death may be reimbursed for that employee. All claims for the employee must be for the date of death or prior, and must be filed within 90 days after the participant's date of death. Any funds remaining in the account after the 90 day period will be forfeited.

Notice of Privacy Practices

PRIVACY OF PROTECTED HEALTH INFORMATION

HIPAA Compliance The plan will comply with all applicable provisions of HIPAA (as amended by the HITECH Act) and its' implementing regulations with respect to the programs under this plan to which the HIPAA Administrative Simplification Rules Apply.

State of Tennessee Insurance Committee Certification of Compliance

Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the State of Tennessee Insurance Committee (sponsor) unless the State of Tennessee Insurance Committee certifies that the Plan Document has been amended to incorporate this article and agrees to abide by this article.

10.02 Purpose of Disclosure to State of Tennessee Insurance Committee.

(A) The plan and any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the State of Tennessee Insurance Committee only to permit the State of Tennessee Insurance Committee to carry out plan administration functions for the plan not inconsistent with the requirements of HIPAA and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the State of Tennessee Insurance Committee of plan participants' protected health information will be subject to and consistent with the provisions of Sections 10.03 and 10.04 of this article.

(B) Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the State of Tennessee Insurance Committee unless the disclosures are explained in the privacy practices notice distributed to the plan participants.

(C) Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the State of Tennessee Insurance Committee for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the State of Tennessee Insurance Committee.

10.03 Restrictions on State of Tennessee Insurance Committee Use and Disclosure of Protected Health Information.

(A) The State of Tennessee Insurance Committee will neither use nor further disclose plan participants' protected health information, except as permitted or required by the Plan Document, as amended, or as required by law.

(B) The State of Tennessee Insurance Committee will ensure that any agent, including any subcontractor, to which it provides plan participants' protected health information, agrees to the restrictions and conditions of the Plan Document, including this article, with respect to plan participants' protected health information.

(C) The State of Tennessee Insurance Committee will not use or disclose plan participants' protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the State of Tennessee Insurance Committee.

(D) The State of Tennessee Insurance Committee will report to the plan any use or disclosure of plan participants' protected health information that is inconsistent with the uses and disclosures allowed under this article promptly upon learning of such inconsistent use or disclosure.

(E) The State of Tennessee Insurance Committee will make protected health information available to the plan or to the plan participant who is the subject of the information in accordance with 45 C.F.R § 164.524.

(F) The State of Tennessee Insurance Committee will make plan participants' protected health information available for amendment, and will on notice amend plan participants' protected health information, in accordance with 45 C.F.R § 164.526.

(G) The State of Tennessee Insurance Committee will track disclosures it may make of plan participants' protected health information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(H) The State of Tennessee Insurance Committee will make its internal practices, books, and records relating to its use and disclosure of plan participants' protected health information available to the plan and to the U.S. Department of Health and Human Services to determine the plan's compliance with 45 C.F.R. Part 164, Subpart E "Privacy of Individually Identifiable Health Information."

(I) The State of Tennessee Insurance Committee will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all plan participant protected health information, in whatever form or medium, received from the plan or any health insurance issuer or business associate servicing the plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any participant who is the subject of the protected health information, when the plan participants' protected health information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all plan participant protected health information, the State of Tennessee Insurance Committee will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any plan participant protected health information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(J) The State of Tennessee Insurance Committee will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the group health plan.

(K) The State of Tennessee Insurance Committee will ensure that any agent, including a subcontractor to whom it provides this information, agrees to implement reasonable and appropriate security measures to protect the electronic protected health information.

(L) The State of Tennessee Insurance Committee shall report to the group health plan any security incident of which it becomes aware.

10.04 Adequate Separation between the State of Tennessee Insurance Committee and the Plan.

(A) The following employees or classes of employees or other workforce members under the control of the State of Tennessee Insurance Committee may be given access to plan participants' protected health information received from the plan or a health insurance issuer or business associate servicing the plan:
(1) Employees within the State of Tennessee Department of Finance and Administration, Benefits Administration who have the responsibility for administering the plan.
(2) Other employees or subcontractors designated by the State of Tennessee Insurance Committee. This list includes the class of employees or other workforce members under the control of the State of Tennessee Insurance Committee who may receive plan participants' protected health information relating to payment under, health care operations of, or other matters pertaining to the plan in the ordinary course of business.

(B) The classes of employees or other workforce members identified in Section 10.04 (A) of this article will have access to plan participants' protected health information provided to the State of Tennessee Insurance Committee by the plan only to perform the plan administration functions that the State of Tennessee Insurance Committee provides for the plan.

(C) The classes of employees or other workforce members identified in Section 10.04 (A) of this article will be subject to the appropriate personnel policies of the State of Tennessee regarding disciplinary action for any use or disclosure of plan participants' protected health information provided to those employees by the State of Tennessee Insurance Committee in its capacity as plan sponsor in breach or violation of or noncompliance with the provisions of this article. The State of Tennessee Insurance Committee will promptly report such breach, violation or noncompliance to the plan, as required by Section 10.03 (D), (J) and (K) of this article, and will cooperate with the plan to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose protected health information may have been compromised by the breach, violation or noncompliance.

Please see the State Insurance Program Notice of Privacy Practices at http://www.tn.gov/assets/entities/finance/benefits/attachments/hipaa.pdf for additional information on your HIPAA privacy rights.