

Flexible Benefits Plan

2010

Reference Guide

State of Arkansas Cafeteria Plan (ARCAP)



Accessing Your Benefits

FBMC Customer Care offers you a variety of resources to make inquiries about your benefits and Flexible Spending Accounts (FSAs), including information from the FBMC Web site, Interactive Voice Response (IVR) system and our Customer Care Center.

On the Web

Visit “www.myFBMC.com” to access FBMC’s home page. Use the navigational tabs along the top of the Web page to get answers to many of your benefits questions.

If you previously registered an e-mail address and password on FBMC’s Web site, you may continue using this information. If you haven’t registered, or if you registered prior to January 19, 2008, log in to the site as a first time user. Follow the link on the login page and register through the FBMC Premier Login.

Benefits

You can check your benefit status, read benefit descriptions, use our tax calculator and much more.

FSA Claims

Check the status of your FSA claims, download forms, get information about mailing and faxing your claim to FBMC and see transactions that need documentation.

FSA Information

View your FSA balance(s) and contributions or review monthly statements and your transaction history.

myFBMC CardSM Visa[®] Card

Please visit www.myFBMC.com to activate your myFBMC CardSM. You may also download a card fact sheet or claim form, read detailed instructions on proper card use and review our IIAS Store List to maximize card convenience.

Profile

Change your account profile, access your FBMC Member ID or select a new phone Personal Identification Number (PIN).

Resources

Browse through our extensive resource library, including: benefit materials, eligible medical and dependent care expenses, required documentation, Over-the-Counter drug listings and benefit tips.

FSA Forms

Download applicable forms for FSA reimbursement and Direct Deposit.

Over the Phone

FBMC’s 24-hour automated phone system, IVR, can be reached by calling 1-800-865-FBMC (3262). Allowing you to access your benefits any time, follow the voice prompts to find out information about your benefits such as:

- Current FSA Account Balance(s)
- Current active benefits
- FSA Claim Status
- Mailing Address Verification
- Obtain FSA claim forms
- Change Your PIN

Personal Identification Number (PIN)

To access the IVR system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN. After your initial login, you will be asked to register and select your own confidential PIN to access this system in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero.



Record PIN here.

Remember, this will be your PIN for IVR access.

If you forget your PIN, call Customer Care at **1-800-342-8017**.

Note: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.

2010 State of Arkansas Cafeteria Plan (ARCAP)

What's New

The myFBMC CardSM replaces the EZ REIMBURSE[®] MasterCard[®] Card for the 2010 plan year. **All employees who enroll in a Medical Expense FSA and/or Limited Medical Expense FSA participants will receive the myFBMC CardSM.** The myFBMC CardSM is a convenient reimbursement option that allows FBMC to electronically reimburse eligible expenses under your employer's plan and IRS guidelines. For more information, go to page 9.

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Enrollment at a Glance

Important Dates to Remember

Your Open Enrollment dates are:
October 1, 2009, through October 31, 2009.

Your Period of Coverage dates are:
January 1, 2010, through December 31, 2010.

Your Open Enrollment

Annual Enrollment is October 1, 2009, through October 31, 2009. Call Fringe Benefits Management Company (FBMC) Customer Care at 1-800-342-8017, Monday through Friday, 6 a.m. to 9 p.m., CST, or Telecommunications Device for the Deaf (TDD), 1-800-955-8771, for more information. October 31, 2009 is the last day during Annual Enrollment to submit your completed enrollment form to your department payroll/personnel officer.

Limited Medical Expense FSA

FBMC will offer a Limited Medical Expense FSA for employees who also wish to take advantage of a Health Savings Account (HSA). You may only participate in the HSA if you have chosen the HSA qualified High Deductible PPO medical coverage. **IRS guidelines prohibit employees from participating in an HSA and a traditional FSA simultaneously.** If you wish to take advantage of FSA tax savings and plan to participate in the HSA, you are required to choose a Limited Medical Expense FSA. **The myFBMC CardSM may also be used for a Limited Medical Expense FSA.**

Interactive Benefits

Information regarding your FSA is just a phone call away! Call Interactive Benefits 24 hours a day at 1-800-865-FBMC (3262) to review your FSA information and request forms.

Internet Access

Customer Care and other account information are available to you through the FBMC's Web site. Log on to **www.myFBMC.com** to use the navigational tabs to customer links. More details about the information available can be found on Page 2.

Making your benefits work for you – it's easy!

- Fringe Benefits Management Company (FBMC), your employee benefits administrator, along with your employer, offers you a wide selection of benefits to choose from during your Open Enrollment. FBMC specializes in tax-saving benefits administration, including Flexible Spending Accounts (FSAs), which may save you a significant amount of money.
- FBMC provides you with convenient ways to track your benefit transactions, including online review, telephone tracking and monthly statements.
- Before you sign up for an FSA, review the FSA guidelines and become familiar with how the program works, see how to save you and your family a significant amount of tax money. For more information, refer to the Flexible Spending Accounts section beginning on Page 6 of this Reference Guide.
- Submit your supporting documentation and completed **FBMC FSA Claim Form** (for paper claims) to FBMC for reimbursement processing. Once the plan year ends, you have a 90-day run-out period to submit your supporting documentation.

Premium Conversion

Premium Conversion deducts your insurance premiums from your gross pay before your taxes are calculated. You pay less taxes and have more spendable income.

The Arkansas Cafeteria Plan (ARCAP) is a tax-free method you use to pay for eligible benefits. You can pay your state employees' group health and life insurance premiums, dependent (child, adult and elder) care expenses and certain unreimbursed, out-of-pocket medical expenses tax-free through ARCAP. You can also pay your eligible payroll-deducted cancer and disability plans through ARCAP. Dependent term life insurance is not eligible for Premium Conversion.

You are automatically enrolled in Premium Conversion for your medical coverage and employee-only life insurance. If you do not want Premium Conversion, you must check the waiver block in Section C on your enrollment form.

Premium Conversion is automatic for the Cancer and Disability plans **only if you enroll on or before October 31, 2009.** If you enroll in either plan after this date, you will not be eligible for Premium Conversion until the next Annual Enrollment period.

If you decide to enroll in the eligible Cancer and Disability plans, an administrative fee will be paid by the following participating insurance companies.

- American Family Life Assurance Company (AFLAC)
- American Public Life Insurance Company
- Colonial Life & Accident Insurance Company

If you do not want Premium Conversion for the Cancer and Disability plans, you must check the waiver block in Section E on your enrollment form.

Eligibility Requirements

Period of Coverage

Your period of coverage corresponds to the upcoming 2010 Plan Year, January 1, 2010, through December 31, 2010.

Who is eligible?

Any actively employed, permanent employee of participating agencies, boards, commissions, institutions and Constitutional Officers, as well as all duly-elected legislators who are in budgeted positions and work at least 1,000 hours per year. Permanent employees are those whose employment is not seasonal or temporary, and whose actual performance of duty requires 1,000 or more working hours per year.

Former state and school employees who have participated in an FSA plan in the current plan year do not have a one-year waiting period.

New Employees

Newly hired employees will be eligible for participation in the Arkansas Cafeteria Plan (ARCAP), including a Dependent Care Flexible Spending Account (FSA), the first day of the month following one month's continuous employment. Employees must have completed one year of full-time continuous service as of the effective date of the plan to be eligible to participate in either of the Medical FSAs. If you reach your one-year eligibility during the plan year, you can enroll and begin contributing to the Medical FSA within 30 days of reaching eligibility.

Leave and Flexible Spending Accounts

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Except as otherwise provided by law and in accordance with your employer's plan(s), if you go on an employer-approved, unpaid leave of absence during the plan year, certain benefits will continue until your last ARCAP payroll deduction is received by Fringe Benefits Management Company after the start of your unpaid leave of absence. However, you may continue contributing to your Medical Expense FSA, on an after-tax basis, by contacting FBMC Customer Care. Within 30 days of going on an unpaid leave of absence, you must:

- consult your payroll/personnel officer for benefits continuation or call 1-800-959-3652 to obtain information on the FMLA and
- contact FBMC Customer Care at 1-800-342-8017 to apply for continuation, on an after-tax basis, of your Medical Expense FSA (you cannot continue contributing to your Dependent Care FSA).

Automatic Loss of Coverage

Your spouse or dependents become immediately ineligible for coverage under your group medical plan due to death or divorce, or if your dependent gets married, exceeds the age limit, or loses full-time student status. You must notify your Agency Personnel/Payroll Representative to amend your coverage to reflect this loss of eligibility and request a refund of any premiums paid. Depending on the circumstances, you may subject to imputed income for the value of premiums paid retroactively from the end date to the beginning of the plan year. Your requested change may only involve the individual who lost coverage and no one else. This automatic loss of coverage is outside the rules for Changes In Status otherwise outlined in this booklet. You also understand that potential liability exists to repay any benefits paid on behalf of individuals who have become ineligible.

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependent in your employer's plan, provided that you request enrollment within 30 days of the other coverage ending.

Terminating Employees (Except Retirement*)

Except as otherwise provided by law and in accordance with your employer's plan(s), terminating employees are covered during the plan year, until the payroll date following your last ARCAP payroll deduction, or until your coverage for the plan year expires (December 31, 2008). To continue certain benefits, within 30 days of your termination of employment you must:

- consult your payroll/personnel officer for benefits continuation or call 1-800-959-3652 to obtain information on the FMLA and
- contact FBMC Customer Care at 1-800-342-8017 to apply for continuation, on an after-tax basis, of your Medical Expense FSA.†

For additional information about continuing your coverage and the Consolidated Omnibus Budget Reconciliation Act (COBRA), please refer to the **COBRA Q&A** section on Page 13 of this booklet.

* Retirees are treated by FBMC as COBRA participants.

† Your employer's Medical Expense FSA Plan is not subject to COBRA continuation beyond the end of the plan year in which a COBRA-qualifying event occurs.

Flexible Spending Accounts

A Flexible Spending Account (FSA) is an account you set up to pre-fund your anticipated, eligible medical services, medical supplies and dependent care expenses that are normally not covered by your insurance. You can choose from two accounts: Medical Expense FSA and Dependent Care FSA.

Not only are your Medical Expense FSA funds available to you in one lump sum at the beginning of your plan year, but your FSA funds are deducted before federal and state taxes are calculated on your paycheck.

With either FSA, you benefit from having less **taxable** income in each of your paychecks, which means more **spendable** income to use toward your eligible medical and dependent care expenses.

Once you decide how much to contribute to your Medical Expense and/or Dependent Care FSA, the amount is deducted in small, equal amounts from your paychecks during the plan year.

Examples of how to use your FSA:

Example 1: Paying a co-payment and doctor/dental fees

After paying your co-payment and doctor/dental fees at a service provider's office, obtain an Explanation of Benefits (EOB) or detailed receipt of the completed services. Submit these documents, along with an FSA claim form to FBMC. Within five business days, FBMC will process your request and mail your reimbursement check to you or direct deposit your funds into the account of your choice.

Example 2: Paying for daycare services

Once you have paid for your child's daycare service, send a completed FSA claim form to FBMC, along with documentation showing the following:

- Name, age and grade of the dependent receiving the service
- Cost of the service
- Name and address of the service provider
- Beginning and ending dates of the service.

Your request will be processed within five business days and either mailed to you or deposited into the account you have chosen.

FSA Eligibility

Your Medical Expense Flexible Spending Account may be used to reimburse eligible expenses incurred by yourself, your spouse, your qualifying child or your qualifying relative. You may use your Dependent Care Flexible Spending Account to receive reimbursement for eligible dependent care expenses for qualifying individuals. **Please see the Flexible Spending Account FAQs at www.myFBMC.com.**

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Expense FSA. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

FSA Savings Example*

<i>(With FSA)</i>		<i>(Without FSA)</i>
\$31,000	Annual Gross Income	\$31,000
<u>- 5,000</u>	FSA Deposit for Recurring Expenses	<u>- 0</u>
\$26,000	Taxable Gross Income	\$31,000
<u>- 5,889</u>	Federal, Social Security Taxes	<u>-7,021</u>
\$20,111	Annual Net Income	\$23,979
<u>- 0</u>	Cost of Recurring Expenses	<u>-5,000</u>
\$20,111	Spendable Income	\$18,979

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

\$1,132!

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Annual Contribution Limits

For Medical Expense FSA:

Minimum Annual Deposit: None
Maximum Annual Deposit: \$5,000

For Dependent Care FSA:

Minimum Annual Deposit: None

The maximum contribution depends on your tax filing status.

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

Flexible Spending Accounts

Medical Expense FSA

A Medical Expense FSA is used to pay for eligible medical expenses which aren't covered by your insurance or other plan. These expenses can be incurred by yourself, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Note: Budget conservatively. No reimbursement or refund of Medical Expense FSA funds is available for services that do not occur within your plan year and grace period.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Ineligible Expenses

For Medical Expense FSA:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

For Dependent Care FSA:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as after school care, baby-sitting fees, daycare services, nursery and preschool. Eligible dependents include your qualifying child, spouse and/or relative.

Partial List of Eligible Dependent Care Expenses*

After school care
Baby-sitting fees
Daycare services
In-home care/au pair services
Nursery and preschool
Summer day camps
Elder care services

Note: Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

FSA Fund Availability

For Medical Expense FSA:

Once you sign up for a Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage. Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

For Dependent Care FSA:

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

What is my maximum annual deposit for a Dependent Care FSA?

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

Note: Eligible dependent care expenses must be incurred in order to allow the member and spouse (if any) to work or actively look for work. Special provisions exist for full-time students and those physically or mentally incapable of self-care.

Flexible Spending Accounts

Requesting Reimbursement

For a Medical Expense FSA:

You can use your Medical Expense FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

To request reimbursement, simply fax or mail a correctly completed FSA claim form along with the following:

- an invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided or
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost and
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the invoice or bill for the service.

* EOBs are not required if your coverage is through a HMO.

For a Dependent Care FSA:

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Remember that for timely processing of your reimbursement, your payroll contributions must be current.

Requesting reimbursement from your Dependent Care FSA is easy. Simply fax or mail a correctly completed FSA claim form along with documentation showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Note: Cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for either Medical Expense or Dependent Care FSA reimbursement.

Send all FSA reimbursement claims to:

Fax toll-free: 1-888-800-5217

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Important FSA Notes:

- You have a **90-day run-out period** (ending March 31, 2011) after your plan year ends to submit reimbursement requests for all eligible FSA expenses incurred DURING your plan year.
- You may, however, continue using only your Medical Expense FSA during the **grace period**, which is two months and 15 days after the end of your plan year. Be sure to submit your grace period claims before the end of your 90-day run-out period.
- Claims will be processed in the order in which they are received by FBMC, and your accounts will be debited accordingly. (This is true for both paper claims and myFBMC CardSM Visa[®] Card transactions.) If you have funds remaining in an account from the prior plan year, these funds will be used first until exhausted. Then, subsequent claims will be debited from your new plan year balance.

Appeal Process

If you have a request for a mid-plan year election change or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request to **Employee Benefits Division, P.O. Box 15610, Little Rock, AR 72231-5610 — Attn: ARCAP Appeals**, within 60 days of the date of your denial letter.

If you have an FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request to **Fringe Benefits Management Company (FBMC), P.O. Box 1878, Tallahassee, FL 32302-1878** within 30 days for review.

Your appeal must include:

- the name of your employer
- the date of the services for which your request was denied
- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal and supporting documentation will be reviewed upon receipt. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and the IRS' regulations governing the plan.

Be certain you obtain and submit all required information with each FSA reimbursement request.

myFBMC CardSM Visa[®] Card

The myFBMC CardSM Visa[®] Card is issued by UMB.



The myFBMC CardSM is a convenient reimbursement option that allows FBMC to electronically reimburse eligible expenses under your employer's plan and IRS guidelines.

The myFBMC CardSM replaces the EZ REIMBURSE[®] MasterCard[®] Card for the 2010 plan year. **All employees who enroll in a Medical Expense FSA and/or Limited Medical Expense FSA participants will receive the myFBMC CardSM.** Because it is a payment card, when you use the myFBMC CardSM to pay for eligible expenses, funds are electronically deducted from your account.

myFBMC CardSM advantages

You can use the myFBMC CardSM for your eligible Over-the-Counter (OTC) expenses at drugstores. Other advantages include:

- **instant reimbursements** for health care expenses
- **instant approval** of most OTC and prescription expenses, as well as some medical, vision and dental (others require documentation)
- **no out-of-pocket expense** and
- **easy access** to your account funds.

Note: You **cannot** use the myFBMC CardSM for cosmetic dental expenses or eye glass warranties.

Reminder: The Limited Medical Expense FSA can only be used for vision and dental.

Using the myFBMC CardSM

For eligible expenses, simply swipe the myFBMC CardSM like you would with any other credit card. Whether at your health care provider or at your drugstore, the amount of your eligible expenses will be automatically deducted from your Medical Expense FSA. Over-the-Counter and prescription purchases the card will only be accepted at IIAS merchants. For all other qualified expenses, such as medical and dental co-payments, the myFBMC CardSM will function normally. To find out if a pharmacy or drugstore near you accepts the card, please refer to the **IIAS Store List** at **www.myFBMC.com**.

Two cards will be sent to you in the mail; one for you and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date.

Remember, you can go to **www.myFBMC.com** to activate your card, see your account information and check for any outstanding Card transactions.

Payback through payroll will be used for card transactions that are not substantiated by claims. The card also may be deactivated if claims are not turned in. Participants will also have to pay for expenses that are not determined to be eligible expenses.

When do I send in documentation for a myFBMC CardSM expense?

You must send in documentation for all myFBMC CardSM transactions, except transactions made at an IIAS merchant. When requested, you must send in documentation for these transactions. Documentation for a card expense is a statement or bill showing:

- name of the patient
- name of the service provider
- date of service
- type of service (including prescription name) and
- total amount of service.

Note: This documentation must be sent with a **Claim Form** and cannot be processed without it. Like all other FSA documentation, you must keep your myFBMC CardSM expense documentation for a minimum of one year, and submit it to FBMC when requested.

If you fail to send in the requested documentation for an myFBMC CardSM expense, you will be subject to:

- withholding of payment for an eligible paper claim to offset any outstanding myFBMC CardSM transaction
- suspension of your myFBMC CardSM privileges
- payback through payroll
- the reporting of any outstanding myFBMC CardSM transaction amounts as income on your W-2 at the end of the tax year.

Is there a grace period when using the myFBMC CardSM?

An IRS Revenue Notice permits a "**grace period**" of two months and 15 days following the end of your 2010 Plan Year for a Medical Expense FSA. (The grace period ends on March 15, 2011.) **During the grace period, you may incur expenses and submit claims for these expenses.** Claims will be processed in the order in which they are received by FBMC, and your accounts will be debited accordingly. (This is true for both paper claims and myFBMC CardSM transactions.) If you have funds remaining in an account from the prior plan year, these funds will be used first until exhausted. Then, subsequent claims will be debited from your new plan year account balance. After March 15, the myFBMC CardSM can only deduct money from the current Plan Year. Therefore, if you wish to submit prior year expenses during the portion of the Claim Run-Out Period from March 15 through March 31, you must use a paper claim form.

What agreement am I making when I use the myFBMC CardSM?

For more information about the myFBMC CardSM, see the Cardholder Agreement that accompanies it.

Limited Medical Expense FSA

For HSA Participants Only

Annual Contribution Limits

For Limited Medical Expense FSA:

- Minimum Annual Deposit: None
- Maximum Annual Deposit: \$5,000

What is a Limited Medical Expense FSA?

A Limited Medical Expense FSA is designed specifically for employees who wish to take advantage of a Health Savings Account (HSA), while continuing to enjoy the tax savings expected from an FSA. Much like a Medical Expense FSA, funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free.

However, the funds in a Limited Medical Expense FSA can only be used for dental and vision expenses. Your HSA is designed to be used for all other medical-related expenses. A partial list of eligible Limited Medical Expense FSA expenses can be found on this page.

Aside from these minor differences, a Limited Medical Expense FSA follows the same procedures for reimbursement as a Medical Expense FSA.

Whose expenses are eligible?

Your Medical Expense FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a **qualifying child** if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- have not provided more than one-half of their own support during the taxable year (and receive more than one-half of their support from you during the taxable year if a full-time student age 19 to 24 at the end of the taxable year).

An individual is a **qualifying relative** if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year **or**
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Expense FSA.

Partial List of Medically Necessary Eligible Expenses*

- Contact lenses (corrective)
- Dental fees
- Eyeglasses
- Guide dogs
- Optometrist fees
- Orthodontic treatment

Note: Budget conservatively. No reimbursement or refund of a Limited Medical Expense FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year.

When are my funds available?

Once you sign up for a Limited Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible expenses at the start of your deductions.

FSA Worksheets

Use the worksheets below to determine how much to deposit in your FSA. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

Medical Expense FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES[†]

Health insurance deductibles \$ _____

Coinsurance or co-payments \$ _____

Vision care[†] \$ _____

Dental care[†] \$ _____

Prescription drugs \$ _____

Travel costs for medical care \$ _____

Other eligible expenses \$ _____

TOTAL \$ _____

DIVIDE by the number of paychecks you will receive during the plan year (i.e., 12, 24, 26).* \$ _____

This is your pay period contribution. \$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

[†] Remember to calculate only dental and vision expenses if you choose to participate in a Limited Medical Expense FSA.

Dependent Care FSA Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Daycare services \$ _____

In-home care/au pair services \$ _____

Nursery and preschool \$ _____

After school care \$ _____

Summer day camps \$ _____

ELDER CARE SERVICES

Daycare center \$ _____

In-home care \$ _____

TOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year. \$ _____

DIVIDE by the number of paychecks you will receive during the plan year (i.e., 12, 24, 26).* \$ _____

This is your pay period contribution. \$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

**DIRECT DEPOSIT - No one likes waiting for their money, why are you?
FSA reimbursements are deposited into the checking or savings account of your
choice within 48 hours of claim approval, and Direct Deposit has no fees!**

Changing Your Coverage

Changing your FSA during the Plan Year

Within **30 days** of a qualifying event, you must submit a Change in Status (CIS)/Election Form and supporting documentation to your employer. Upon the approval of your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). However, if your FSA election change request is denied, you will have **30 days**, from the date you receive the denial, to file an appeal with your employer. For more information, refer to the "Appeal Process" section on Page 8. Visit www.myFBMC.com for information on rules governing periods of coverage and IRS Special Consistency Rules.

Changes in Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes:

Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none">• the other employer's plan has a different period of coverage (usually a plan year) or• the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical Expense FSA plan.

† Does not apply to a Dependent Care FSA plan.

COBRA Q&A

What is continuation coverage?

Federal law requires that most group health plans, including Medical Flexible Spending Accounts (Medical Expense FSAs), give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan.

How long will continuation coverage last?

For Medical Expense FSAs:

If you fund your Medical Expense FSA entirely, you may continue your Medical Expense FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, **if** you have not already received, as reimbursement, the maximum benefit available under the Medical Expense FSA for the year. For example, if you elected a Medical Expense FSA benefit of \$1,000 for the plan year and have received only \$200 in reimbursement, you may continue your Medical Expense FSA for the remainder of the plan year or until such time that you receive the maximum Medical Expense FSA benefit of \$1,000.

If your employer funds all or any portion of your Medical Expense FSA, you may be eligible to continue your Medical Expense FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special continuation rules for employer-funded Medical Expense FSAs. If you have questions about your employer-funded Medical Expense FSA, you should call Fringe Benefits Management Company (FBMC) at 1-800-342-8017.

For More Information

This *COBRA and Retiree Q&A* section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer. You can get a copy of your summary plan description from **FBMC**.

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

Keep Your Address Updated

In order to protect your family’s rights, you should keep your employer and FBMC 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 your employer and FBMC.

Beyond Your Benefits

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Customer Care at 1-800-342-8017 for an approximation.

Notice of Administrator's Capacity

This notice advises Flexible Spending Account participants of the identity and relationship between your employer and its Contract Administrator, Fringe Benefits Management Company (FBMC). FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the Flexible Spending Account plans offered herein. FBMC will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against FBMC than would otherwise be afforded to you by law.

FBMC Privacy Notice

4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of Customer Care and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.myFBMC.com. You have a right to a paper copy at any time. Contact FBMC Customer Care at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Benefits Directory

State of Arkansas

Department of Finance and Administration,

Employee Benefits Division

Mon- Fri, 8 a.m. - 4:30 p.m. CST

877-815-1017 (toll free)

www.arbenefits.org

Fringe Benefits Management Company

FBMC Customer Care

Mon - Fri, 6 a.m. - 9 p.m. CST

1-800-342-8017

Flexible Spending Accounts

Automated Services

24 hours a day

1-800-865-FBMC (3262)

www.myFBMC.com

myFBMC CardSM Visa[®] Card

Lost or Stolen Card

24 hours a day

1-888-462-1909

Dispute Line

FBMC Customer Care Center

Mon - Fri, 6 a.m. - 9 p.m. CST

1-800-342-8017

Activation

24 hours a day

www.myFBMC.com

1-888-514-6845

FBMC

Premier Benefits Solutions

Contract Administrator

Fringe Benefits Management Company

P.O. Box 1878 • Tallahassee, Florida 32302-1878

Customer Care 1-800-342-8017 • 1-800-955-8771 (TDD)

www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

