

Mountaineer Flexible Benefits Benefit Coordinator Training Manual

Table of Contents:

1. Introduction	3
2. Annual Enrollment	4
Developing and Distributing Material	4
Conducting the Enrollment	5
Collecting Enrollment forms	6
Data Entry, Variation, & Posting	7
Benefit Notification	9
Confirmation Notices	9
Communicating Enrollment Results	9
3. Plan Maintenance	9
Payroll Interface	9
State Agencies & Universities & Colleges	11
Boards of Education & Non-State Agencies	11
4. Changes during the Plan year	13
New Hire Enrollment	13
Transfers	13
Correcting Demographic Information	14
Demographic Change Form	14
5. Change in Status Events	15
Open Enrollment under another employers plan	16
Coverage Changes and Dependent care	16
Employees on Leave	16
Life Events	17
Benefit Coordinators Role	17
6. Appeal Process	17
Overview	17
Administrative Error Change	19
Leave of Absence	20
Enrollment	20
FSAs	21
7. Compliance Services	22
COBRA & Retirement Notification	22
8. A Closer look at Flexible Spending Accounts	24
Contribution limits	24
Dependent Care FSA	24
Medical FSA	26
General FSA rules and guidelines	26

NOTICE: This Handbook is not intended to be all-inclusive. If conflicts exist between this handbook and the Internal Revenue Code or West Virginia Statutes or the Mountaineer Flexible Benefits Plan Summary Document, the Internal Revenue Code and the Statutes must be followed.

Mountaineer Flexible Benefits Plan

Special Note: This program is available to State Agencies, Universities & Colleges, participating Boards of Education, and participating Non-State Agencies.

1.Introduction

The Mountaineer Flexible Benefits Plan is sponsored by the West Virginia Public Employees Insurance Agency (PEIA) as a vehicle to provide additional benefits to eligible state employees and a tax savings to the participating employees and the state. The Plan qualifies as a Cafeteria Plan authorized by Section 125 of the Internal Revenue Code. FBMC Benefits Management, Inc. is the third party administrator of the Plan.

This manual is written by the staff at FBMC for Personnel Administrators, Benefit Coordinators and other state and county boards of education staff with responsibilities associated with the Mountaineer Flexible Benefits Plan. Its purpose is to communicate general information and procedures essential for implementation and ongoing administration of the Plan. It is important that staff at the state agencies, county boards of education, non-state agencies and their counterparts at FBMC have a clear understanding of the interface necessary to administer the Plan and the role each play to assure its accuracy and success.

In preparing this text our goal was to keep it simple and provide the reader with only the detail necessary to understand his/her role. Much of the text of this manual is written in a question and answer format. We hope you find it easy to use.

FBMC Contact Information:

Active Employee Correspondence:

FBMC Benefits Management, Inc.
P.O. Box 1878
Tallahassee, FL 32302
FBMC Service Center 1.844.559.8248

Retiree Correspondence:

FBMC Benefits Management, Inc.
P.O. Box 10789
Tallahassee, FL 32302
FBMC Service Center 1.844.559.8248

Note: When contacting the FBMC Service Center as a Benefit Coordinator,

please understand that the service center representatives can not provide specific member information due to HIPPA regulations. However, they can still assist Benefit Coordinators with plan specifics, procedures and rules. For specific member information, please follow the procedures listed throughout the manual.

1. Kayla Horton, FBMC Client Liaison @ 304.558.7850, Ext. 52627
Email khorton@fbmc.com & Fax #1-850-425-6220
2. Emily Hoffman, FBMC Account Manager @ 304.558.7850, Ext. 52652
Email ehoffman@fbmc.com & Fax #1-850-425-6220

Important Fax Information:

1. For **Active employees, new hires, transfers, open enrollment:** ATTN: Enrollment Processing Fax # 850.514.5803
2. For **Retirees:** ATTN: Direct Bill Fax # 850.514.5803
3. For **Change in Status:** ATTN: Change in Status Fax # 850.514.5803
4. For **Appeals:** ATTN: Appeals Fax #850.425.6220

2. Annual Enrollment

Developing and Distributing Material

FBMC is responsible for the production and distribution of the material used to promote the enrollment campaign and to educate employees on the benefits included in the Plan. All material is written in coordination with and is approved by PEIA.

Enrollment reference guides and enrollment forms are mailed by FBMC directly to employees' home addresses prior to the start of the enrollment. For Non-State Agencies, they are mailed to the agency for the agency to disperse.

In addition, FBMC maintains a limited inventory of material for use with new employee enrollment throughout the plan year. The Benefit Coordinator can call, reach out via email, or go to the onsite FBMC contact to request enrollment materials. Please provide them with the following information in your email to place your order:

Agency Name:

ATTN:

Address:

Phone number:

How many packets:

Specify Active or Retiree packets:

The contact information is:

1. Kayla Horton, FBMC Client Liaison @ 304.558.7850, Ext. 52627
Email khorton@fbmc.com & Fax #1-850-425-6220

Does FBMC handle everything or is there something I can do to assist?

From time to time, FBMC may develop payroll inserts, posters, or other material to promote the enrollment. Specific instructions will be provided to you regarding distribution or display, as applicable.

Conducting the Enrollment

As soon as the material is distributed employees start asking questions. Who is available to assist with their questions?

PEIA coordinates a series of Benefit Fairs throughout the state during the open enrollment period. FBMC participates in the Fairs and Enrollment Counselors are available to answer questions. Check the Benefit Fairs schedule on the back cover of your Mountaineer Flexible Benefits reference guide for a location and time near you.

For immediate assistance, please encourage employees with questions to contact FBMC's Service Center at 1-844-559-8248. Our representatives are trained on all aspects of the Mountaineer Flexible Benefits Plan and can address all employee questions.

Must all employees complete an enrollment form?

State employees who wish to participate in the Mountaineer Flexible Benefits Plan for the first time must complete an enrollment form indicating their benefit selections as a New Hire.

For easier enrollment, during the annual open enrollment, please visit www.myFBMC.com and enroll online. Note: Online enrollment is only available during the Open Enrollment period. New Hires and Transfers throughout the year are to use the Mountaineer Flexible Benefits paper enrollment form and should be faxed to 1.800.514.5803 ATTN: Enrollment Processing. For Change in Status (CIS) throughout the year please use the Mountaineer Flexible Benefits paper enrollment form, mark the CIS box (top right corner of the form) and include the appropriate supporting documentation with the CIS request to prevent processing delays. This should be faxed to 1.800.514.5803 ATTN: CIS. Please remember when submitting a CIS to PEIA, if your employee's have Mountaineer Flexible Benefits you must also submit the FBMC enrollment form to FBMC following the procedure above.

There are several ways to approach an enrollment. Under current practice, any eligible employee who already participates in the Plan does not need to complete a new form during open enrollment as long as he/she wants current benefits to continue. If changes are necessary during any open enrollment period, a new form must be completed indicating adds, cancels, changes, etc. This is referred to as a *changes only* enrollment.

Collecting Enrollment Forms

If an Enrollment Counselor is onsite, he/she will collect completed enrollment forms and submit them to the Benefit Coordinator at the end of the day; or, employees will submit their completed enrollment forms directly to the Benefit Coordinator by the close of business the last day of Open Enrollment.

What does the Benefit Coordinator do with the forms?

The Benefit Coordinators should review the forms to ensure all information is complete and accurate before the forms are forwarded to Tallahassee. This process is very important for the accurate and timely creation of employee payroll deduction files and also the master files necessary for accounting and compliance reporting.

- The Benefit Coordinator reviews each form and first confirms that the employee is eligible for participation in the Mountaineer Flexible Benefits Plan. If not, the form should be rejected and the employee notified according to standard agency procedure.
- The Benefit Coordinator then completes the section in the bottom right corner designated "For Benefit Coordinator Use Only". *Special note: if any of the following information is unknown, the Benefit Coordinator should contact the State Auditor's Office, Payroll Division for assistance.*
 1. FEIN - Federal Employer Identification Number.
 2. 4 Digit Work Location - Four digit number identifying the agency or work location. For non-state agencies, please write your agency name on this line.
 3. Effective Date - During spring open enrollment, the date is July 1st of the current year. For new hires, the date is the first day of the month following enrollment.
 4. Number of Pay Periods - Number of times employee is paid per year.
 5. Gross Annual Salary - Budgeted yearly salary of the employee.
 6. Benefit Coordinator Signature - This signature indicates the reviewer's verification of the enrollment form information.
 7. Benefit Coordinator Phone and FAX # - This information allows FBMC to quickly contact an agency should questions arise regarding a form.
 8. Location Type: Select appropriate box.

Note: Please fax the form to FBMC @ 1.850.514.5803 ATTN: Enrollment Processing.

The forms have been reviewed for accuracy and the bottom section completed, what happens next? Where are the forms sent?

The Benefit Coordinator retains the yellow copy of the enrollment form and files according to standard agency procedure. If the pink copy is still attached, it should be returned to the employee for his/her records. For Open Enrollment, the forms are then bundled and sent to FBMC twice weekly. At the end of Open Enrollment, all remaining

forms should be sent to FBMC by the first week following Open Enrollment.

For New Hires throughout the year, the Benefit Coordinator should mail the forms to FBMC as they are received and reviewed.

Data Entry, Verification, and Posting

FBMC is responsible for all data entry of enrollment forms. Our data entry screens contain a number of system-generated edits to assure that plan requirements are strictly followed. We also employ a dual data entry system to assure accuracy. This means that the data entry specialists review and enter all data forms twice.

When bundled forms are received at FBMC, they are date stamped and batched for processing. The transmittal completed by the Benefit Coordinator is carefully reviewed and the number of forms received is confirmed.

Enrollment forms are data entered, verified, and posted to the master files daily throughout the open enrollment period. It is for this reason that we request that Benefit Coordinators submit forms twice weekly during this period.

How does FBMC handle common enrollment form errors or discrepancies?

Enrollment form errors or discrepancies can be detected manually by the data entry specialists or automatically through the system-generated edit feature. They must be resolved quickly before the final enrollment data is generated for the various providers and the client.

Standard Procedure:

- Contact the Benefit Coordinator by phone to explain the discrepancy and resolve.
- If the Benefit Coordinator is unavailable, modify the form to meet plan requirements or to match coverage level with premium amount selected.
- Correct the form in red ink; initial the change.
- Document the Service Center Inquiry screen with the details of the situation.
- Forward a copy of the revised form with a letter of explanation to the Benefit Coordinator.

Some Examples:

A typical discrepancy is one where **the coverage level does not match the premium amount** written on the form - the employee selected family coverage but entered a **single** coverage rate. Following the above procedure, we contact the Benefit Coordinator to confirm the correct choice of coverage level. If the Benefit Coordinator is unavailable after several tries, we select a coverage level to match the premium amount written on the form. The change is written in red ink by the specialist and then processed.

Another error is when the **Flexible Spending Account annual deduction amount is under the minimum or over the maximum allowable according to the plan.** The Benefit Coordinator is contacted and the plan maximum or minimum is explained. The

per pay amount is adjusted by FBMC to meet the plan requirements. The new amount is written on the form in red ink, initialed by the data entry specialist, and then processed.

In both examples, copies of the revised forms are sent to the Benefit Coordinators with a letter of explanation. The letter advises to contact FBMC by a specified date if questions or problems exist with the adjustment.

Each employee's Service Center inquiry screen is documented so that a history of events is detailed. Should the employee call FBMC, the Service Center representative has all pertinent information available to discuss the discrepancy and the solution with the employee and to assist the employee with any other needed adjustments.

How does FBMC handle forms if required information is missing?

If *employee-completed* information is missing, FBMC contacts the Benefit Coordinator. If we are unable to reach the Benefit Coordinator, the form is returned to the employee with instructions to complete and return to FBMC by the first of June, so the elections are sent to the provider companies for the benefits to be effective the first day of the plan year. A copy of the form is also sent to the Benefit Coordinator.

NOTE: If a response is not received, the benefit selections will not be effective with the new plan year.

If *Benefit Coordinator-completed* information is missing, such as FEIN, agency code number, or number of pays, a call is placed to the Benefit Coordinator. We first verify the employee's eligibility, because typically when this information is not completed, a Benefit Coordinator has not seen the form. If eligible, the information is written on the form in red ink, and the Service Center Inquiry screen is documented. If the employee is not eligible, the form is mailed back to the Benefit Coordinator with a letter of explanation.

Supersede Forms - What are they and how are they handled?

An employee may change his/her mind about benefit selections during the open enrollment period after they have submitted an enrollment form. The Plan permits a change to be made as long as the employee submits a new enrollment form prior to the end of open enrollment. The second form is referred to as a **Supersede Form**.

In this case, the employee may submit a new form to his/her Benefit Coordinator. To avoid any confusion at FBMC, the Benefit Coordinator must write **SUPERSEDE** across the top of the enrollment form. The Benefit Coordinator reviews the form, all pertinent information is added as previously specified (see **Step 3 Collecting Enrollment Forms**), and the form is forwarded to FBMC.

Note: The number of supersede forms forwarded to FBMC should be clearly specified on the Transmittal Notice.

When a supersede enrollment form is received, FBMC replaces selections from the first form with selections indicated on the supersede form.

Benefit Notification

After enrollment forms have been posted, the benefit notification process begins. The process confirms to participating employees that FBMC has recorded the benefits the employee selected (or benefits the employee meant to select!) and that they are the benefits that will become effective with the new plan year. This is the final check in the data entry quality control process and the final chance for the employee to confirm benefit and payroll deduction information.

Confirmation Notices

Every employee who completes a paper enrollment form receives a Confirmation Notice from FBMC. Confirmation notices are printed and distributed by mail to their home address daily. The notice itemizes the benefits selected and the per pay amount to be deducted from the employee's paycheck.

The text of the Confirmation Notice instructs employees to carefully review the Notice and compare the information with their enrollment form; discrepancies are to be immediately brought to FBMC's attention by contacting Service Center at 1-844-559-8248.

Any changes or adjustments that must be made as a result of further research by FBMC and the employee will be communicated to the Benefit Coordinator.

Every employee who enrolls online during Open Enrollment will be prompted to print their own confirmation statement at the end of the sessions. After Open Enrollment, Benefit Coordinators will receive a secure email from FBMC with a copy of any of their employee's confirmation notice that enrolled online during open enrollment.

The schedule of benefits for all products can be located on www.myfbmc.com.

Communicating Enrollment Results

At the conclusion of the open enrollment period, FBMC communicates the enrollment results to each agency and organization so that payroll deductions can be set up for each participant of the Mountaineer Flexible Benefits plan.

For New Hires throughout the year, the Benefit Coordinator should keep and use the pink Payroll Officer copy of the enrollment form to set up payroll deductions for the employee in their system. When using a printed copy of the Mountaineer Flexible Benefits enrollment form, please make a copy of the form prior to sending it to FBMC for your agencies records.

3. Plan Maintenance

Payroll Interface

FBMC is responsible for managing the payroll deductions associated with the Mountaineer Flexible Benefits Plan. This includes the creation and maintenance of a dual-entry accounting system to track employee records and consolidated premium records. FBMC receives payroll deduction information for each plan participant,

reconciles all deductions received to deductions expected to be received, posts all reconciled deductions to the appropriate participant accounts, and remits payment to provider companies.

The payroll interface between FBMC, the Auditors Office, the various agencies and Boards of Education is the critical component in plan management. Before we discuss payroll, it is important to spend a few minutes discussing eligibility data.

What is meant by eligibility data?

The Mountaineer Flexible benefits plan identifies, within its plan documents, the eligibility requirements for the plan. Since only eligible employees can participate in the plan, it is important that FBMC, the Plan Administrator, receive accurate and timely updates of eligibility data for all eligible employees.

Note: Eligibility data is provided from the various Boards of Education and non-state agencies participating in the plan through the monthly bill; separate eligibility updates are not required.

Who provides this information to FBMC? How often is it needed? Is there a special format for the data?

Information Systems and Communications (IS&C) is responsible for updating the state agencies' information. The update is provided electronically using FBMC's standard layout.

Eligibility data must be provided to FBMC on the 1st of each month to assure a smooth administrative interface. It provides FBMC with the necessary demographic and employment information for each eligible employee.

How does FBMC receive payroll deduction data?

Payroll deduction information is provided to FBMC on either a pay period basis for all state agencies; or a monthly basis for the Boards of Education.

The Auditor's office forwards to FBMC an electronic file for each pay period. The information provides a record of deductions from all state employees who participate in the plan. The Boards of Education and non-state agencies track their deductions on a Remittance Summary Form and submit monthly to FBMC.

All eligibility data and payroll deduction data for the State Agencies and Universities are sent to FBMC electronically.

The monthly billing remittance summaries are mailed FBMC for processing.

**FBMC
ATTN: Accounting-WV
P.O. Box 1878
Tallahassee, FL 32302-1878**

How does FBMC receive the premium dollars that are deducted?

For State agencies and Universities/Colleges, after each payroll is run,

employee deductions for the Mountaineer Flexible Benefits Plan are totaled and a check is written by each agency and sent to PEIA for deposit.

For participating Boards of Education and Non-state agencies, after all Adjustment Forms and the Remittance Summary Form have been completed and totaled, a check is written by the 10th of the following month. The check(s) should be made out to: WV-Mountaineer Flexible Benefits. The address is as follows:

**FBMC
ATTN: Accounting-WV
P.O. Box 1878
Tallahassee, FL 32302-1878**

FBMC has the eligibility, payroll deduction information, and the premium dollars, what happens next? What is meant by the *reconciliation process*?

Note: The reconciliation process is different for state agencies, the Boards of Education and non-state agencies; therefore, we will address each separately.

State Agencies & Universities/Colleges

FBMC creates employee-based *master files* at the conclusion of each open enrollment period based on the employees' elections. When payroll deduction data is received it is used to create temporary files that are then compared to the master files. A discrepancy report is generated that lists records that do not match the master files. The Account Specialist researches the differences and makes any **known** adjustments by searching each employee's Service Center Inquiry screen.

How does the Benefit Coordinator assist with the resolution?

If a refund cannot be processed through payroll, FBMC can assist with arranging for direct refund to the Benefit Coordinator or employee. The request must be submitted by the Benefit Coordinator, with written assurance that any returned pre-tax salary reductions will be adjusted on the employee's W-2 at end of year.

Participating Boards Of Education & Non-State Agencies

Reconciliation of these payroll deductions is handled via the **Bill for the Month**. This monthly bill is electronically remitted to each county board or non-state agency approximately 10 business days prior to the beginning of the month in which deductions will be taken.

What does the bill look like?

The bill consists of three parts:

- Part one is labeled the **Bill for the Month**. It identifies each participant's social security number, name and other critical plan benefit information.

The bill contains space to be used as a work sheet to identify by participant any changes needed.

- Section two is an **Adjustment Form for the Month** that is used to consolidate the changes from the worksheet and to communicate changes or adjustments to FBMC. Please utilize this document for communicating all changes in employment status, clearly specifying the employee name/ID, status (termination, retirement, deceased, etc. and date of event).
- The final section is the **Remittance Summary Form**. When completed, the total remittance amount from this form should equal the actual deductions taken for the month, adding or subtracting any adjustments.

What are the specific steps to be taken for reconciliation?

Step one

After all payrolls have been generated for the month, total the actual deductions taken for all benefit categories and pay cycles.

Step two

Compare the employee totals to those on the **Total Bill** line on the Remittance Summary Form.

Step three

In most cases, the totals should agree. If the two totals are equal, your payroll system is balanced to the bill and the reconciliation is complete. You may complete the remittance and reporting process as shown in *steps six*. If the two totals are not equal, proceed to *step four*.

Step four

Verify that all employees who have deductions for the month are listed within the main sections of the bill. Also verify that the amount actually deducted for Dependent Care Flexible Spending Accounts and other miscellaneous deductions match what is on the bill. *Note: The monthly amount listed on the bill should equal the total monthly deduction taken.*

When an individual discrepancy between the bill and the actual deduction is identified, the discrepancy must be documented on the FBMC adjustment form as described below. The adjustment form requires the following information for each employee with a deduction change:

SSA Number - the employee's Social Security number

Subscriber Name - the employee's last name followed by first name or first initial

Plan Date - the effective date of the change

CHG CD - any one of the change codes shown at the bottom of the adjustment form

PAY / YR - the number of payrolls during which Plan deductions are taken (10, 12, 18, 20, or 24 pay cycle)

Plan Code - The plan code for each type of deduction (e.g. DEPR for Dependent Care accounts, MISC for miscellaneous)

Comments - space provided for any additional explanation not covered by the change codes shown on the form

Employee Amount - the contribution from the employee to the Plan

Employer Amount - Not Applicable

If there are multiple entries for an employee, the Social Security number and name does not need to be repeated.

Step five

After all adjustments to the bill have been entered on the Adjustment Form(s), transfer the employee totals from the Adjustment Form(s) to the Remittance Summary Form (shown in the section 5). Calculate the total remittance amounts on the bill's Remittance Summary Form and verify that the amounts match the total employee deductions remitted. Make a copy of the payroll deposit (check) that will be forwarded to FBMC, keep for your records, and verify the deposit amount matches the total employee deductions remitted.

Step six

Please mail, no later than the 10th of the following month, all Adjustment Forms and the Remittance Summary Form to the address below. Check(s) should be made out to WV-Mountaineer Flexible Benefits.

FBMC

ATTN: Accounting-WV

P.O. Box 1878

Tallahassee, FL 32302-1878

4.Changes during the Plan Year

New Hire Enrollment

The Mountaineer Flexible Benefits Plan permits new hires to join the plan throughout the plan year. Employees complete and submit enrollment forms to their Benefit Coordinator.

The Benefit Coordinator confirms the employee's eligibility and completes the Benefit Coordinator section in the lower right corner of the form. The completed enrollment form is then forwarded to FBMC. For a more detailed discussion, please refer to **Step 3 Collecting Enrollment Forms**.

The effective date for all new hires is the first of the month following enrollment.

Employee Transfer

When an employee transfers, it is the **employees** responsibility to provide their current benefits to the new agency.

In the event that the new employee is unsure of his or her current benefits, the employee needs to contact the old agency to confirm coverage.

Eligible Transfers include:

1. When an employee transfers from an agency that participates with the Mountaineer Flexible Benefits Plan to another agency that participates with the Mountaineer Flexible Benefits Plan, then the employee needs to complete the enrollment form and mark it "Transfer" (in the top right corner of the form).
2. When an employee transfers from an agency that does not participate with the Mountaineer Flexible Benefits Plan to another agency that participates with the Mountaineer Flexible Benefits Plan, then the employee needs to complete the enrollment form and mark it "New Hire" (in the top right corner of the form).

Note: The employee's new agency Benefit Coordinator needs to complete the "Benefit Coordinator Use Only" box (on the bottom right corner of the form) in order for the form to be processed.

Ineligible Transfers:

If an employee transfers from an agency that participates with the Mountaineer Flexible Benefits Plan to an agency that does not participate with the Mountaineer Flexible Benefits Plan, they will need to follow the procedure for terming employees' benefits.

Correcting Demographic Information

Any time an employee's information is incorrect with FBMC, you will need to fax a copy of the enrollment form to [850.514.5803](tel:850.514.5803) Attn: Enrollment Processing. On your fax cover letter you will make a note advising the request you need to make. I.e., per the form, please update DOB.

If the participant made an error on the form, please make a note on your cover sheet requesting that the DOB be corrected to _____.

Demographic Change Form

When an employee needs to update demographic information, such as:

- Change of Address,
- Name change ONLY,
- Phone number
- Email address

The demographic change form can be found on the myFBMC website. Please note: No changes to benefits will be made using this form.

5. Change in Status (CIS) Events

Employees may change a benefit election upon the occurrence of a valid CIS event but only if the change is made on account of, and corresponds with, a CIS that affects their own, their spouse's or their dependent's coverage eligibility. Assuming that these general consistency requirements are satisfied, if the CIS event affects eligibility for a particular coverage, a corresponding change can be made to the same type of coverage. IRS regulations further clarify that a valid CIS event must result in the employee, spouse or dependent gaining or losing eligibility for coverage (eligibility for CHIP coverage is not an IRS qualifying event), or for a particular coverage option such as managed care or indemnity.

The employee must complete and submit a Change in Status Form within 60 days of the qualifying event. FBMC will determine if the CIS meets IRS regulations. Employees should call FBMC Service Center at 1-844-559-8248 for more information if their change results from a valid CIS event. Employees may also contact Service Center at **FBMCServiceCenter@fbmc.com** existing benefits will be stopped or modified (as appropriate) at the first of the month immediately following approval and completion of processing. Except for election change requests resulting from birth, adoption or placement for adoption, premiums for retroactive coverage will be made on a post-tax basis upon approval by FBMC.

The following five events constitute valid changes in status:

- Change in your legal marital status, including marriage, death of spouse, divorce, legal separation (if recognized by state law) or annulment.
- Change in number of tax dependents, including marriage, birth, death, adoption or placement for adoption. Existing dependents can also be added whenever a dependent gains eligibility as a result of a valid CIS event.
- Change in employment status that affects coverage eligibility of employee, your spouse or your dependent, including: termination or commencement of employment, a switch between full-time and part-time status and vice versa, a strike or lockout, commencement or return from an unpaid leave of absence, change in work schedule such as an increase or decrease in the number of hours of employment, change from salaried to hourly status and vice versa, a change in work site.
- Change (the gain or loss) of spouse's or dependent's eligibility status, such as attainment of a specified age, student status, marital status, or any similar circumstances that satisfy or cease to satisfy the eligibility requirements under the plan providing the coverage.
- Change in place of residence of employee, spouse or dependent.

We begin this section with a caution: **changes to payroll deduction amounts are not discretionary.** Plan deductions, as indicated on pre-tax enrollment forms, must be taken unless some other deductions take priority (for example: retirement, hospitalization, garnishment, legal judgment) or there are not sufficient funds from which

to take a deduction.

The reason for the caution is that the Mountaineer Flexible Benefits Plan qualifies as an IRS Section 125 Cafeteria Plan. As such, the Plan must follow all rules and regulations associated with Section 125, as well as any additional requirements written in the Plan Documents specifically for the Mountaineer Flexible Benefit Plan. According to IRS Code, once an employee completes an enrollment form and directs a specific payroll contribution to be allocated to specific benefits on a pre-tax basis, the amount or the benefits cannot be altered during the course of the plan year unless a *qualifying event*, as defined by the IRS, has occurred.

Employees can change their pre-tax benefit election(s) or vary the salary reduction amounts they have selected during the plan year under limited circumstances as provided by the employer's plan and established IRS guidelines. A partial list of categories from which the IRS and The Mountaineer Flexible Benefits Plan permit election changes during a plan year are:

Open Enrollment under Other Employer's Plan

You may make an election change when your spouse or dependent changes coverage(s) during Open Enrollment under his or her employer's IRC Section 125 cafeteria plan if:

- If their employer's plans permit mid-year election changes under this event
- His or her employer's cafeteria plan year is different from your employer's plan year
- The change you wish to make is not to a Medical Expense FSA arrangement where a change in coverage or cost is not permitted.

Coverage Changes and Dependent Care

You may make a corresponding election change when you replace one dependent care provider with another. If a cost change results when you change dependent care providers, you may increase or decrease your salary reduction amount. No change can be made when a dependent care provider who is your relative by blood or marriage imposes a cost increase or decrease.

Employees on Leave

Approved Medical Leave: if you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications), your premium deductions will continue through the Mountaineer Flexible Benefits Plan as long as you receive a salary. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Call FBMC at 1-844-559-8248 for further information.

Approved Nonpaid Leave: you can continue to receive coverage for certain benefits for the duration of your leave if you pay your premium to FBMC on an after-tax basis. If you have not maintained a current premium status while on leave, you will be required

to resatisfy eligibility requirements when you return to active status, except as otherwise provided by law. Call Service Center at 1-844-559-8248 for further information on billing if you go on leave. You may also contact Service Center at **FBMCServiceCenter@fbmc.com**.

Life Events

Life Events is a post-tax product included as a companion to the plan and is not restricted by IRS rules; however, changes must be made in coordination with Trustmark, the underwriter of the benefit. All changes or inquiries after enrollment must be directed to Trustmark. In the event an employee is terminated, the employee has the option of contacting Trustmark to establish a direct billing process. *Note: Trustmark no longer offers new LifeEvents policies. Employees who currently have LifeEvents may continue their coverage.*

Trustmark Customer Service: 1-800-918-8877.

Benefit Coordinator's Role

If an employee has a qualifying event as indicated, how do they apply for a Change in Status? What role does the Benefit Coordinator play?

The Benefit Coordinator has the employee complete the paper enrollment form and mark it CIS in the top right corner. Then, they fax the completed CIS form, supporting documentation to FBMC @ 1.850.514.5803 ATTN: CIS. FBMC must receive the CIS form and supporting documentation within 60 days of the qualifying event.

FBMC's Change In Status Specialist reviews the form, the documentation attached and either approves or denies the change based on the validity of the triggering event and the consistency of the event to the requested change. IRS regulations are strictly followed. If there is any doubt about the appropriate action, the Specialist seeks legal opinion. The IRS is contacted as necessary.

An approved change is immediately processed and made effective the first of the following month (excluding birth/adoption or court order). A copy of the approved form is faxed to the Benefit Coordinator.

Finally, a copy of the CIS form is attached to the employee's original enrollment form at FBMC. The Benefit Coordinator makes any appropriate adjustments based on instructions from FBMC.

6.Appeals Process

Overview

What is it and how does it work?

Generally speaking, an appeals process is a mechanism to allow an employee to request a variance to the established policy or to request that a decision be reconsidered based of further research and discussion due to extenuating circumstances. An appeals process is not required by IRS Code or by any other rules or regulations related to Flexplans; however, the Mountaineer Flexible Benefits Plan

provides for an appeals process.

FBMC Benefits Management, Inc. handles all appeals requests and grants or denies each appeal on behalf of the Plan. We employ an Appeals Specialist who handles all paperwork and who convenes and leads an Appeals Panel to review all requests. The panel consists of three to five FBMC managers, and a representative from FBMC's Compliance or Legal Department. Panel members are selected based on their expertise in benefit management as well as, their knowledge of IRS rules and regulations.

Many appeals requests will be unique and will be handled on a case-by-case basis; however, each decision reached will begin to set precedent for similar future requests. For this reason, we require written rather than verbal requests; we document in writing all decisions to grant or deny appeals requests; and we maintain a filing system by employee name, cross-referenced by the type or category of request.

What are some typical appeals requests?

- *Enrollment cutoff date was missed:* I missed the open enrollment period because I was out of town; I was told I have to wait until the next open enrollment period. I want to enroll now.
- *Challenge of established rules:* 1) My reimbursement request was rejected because I didn't provide receipts. My notification and signature should be enough to process the request. 2) I submitted a request for a Family Status Change because I changed day care providers and am paying a lower weekly rate. My change was denied as ineligible and I want it to be reconsidered.
- *Grace period cutoff date was missed:* I missed the grace period by two days and now I'm out \$320 in my reimbursement account. But it wasn't my fault; it was my healthcare provider.
- *Misinformation was provided:* 1) The Enrollment Counselor told me sports camps were eligible for reimbursement. 2) My supervisor told me I didn't have to complete a new form if I wanted my benefits to stop.

Does FBMC have some guidelines to use when granting or denying a request?

Errors are considered for change earlier in the plan year rather than later to avoid any perception of *benefit shopping*. (Benefit shopping is strictly prohibited by IRS Section 125 Code.)

Decisions are reached objectively and are influenced only by IRS requirements and similar past requests.

Decisions are reached in which any reasonable person with knowledge of the rules and regulations governing the plan would agree.

Decisions in direct violation of IRS guidelines, or the plan documents, are avoided unless it can be documented that the circumstances were not the fault of the employee. For example, confirmed misinformation provided during enrollment.

Finally, we will not put the entire plan in jeopardy. When in doubt, we contact the

IRS for guidance.

What should an employee be instructed to do? How long does it take? What is the Benefit Coordinator's role?

When an employee wishes to request a variance to established policy or to request that a decision be reconsidered based on further research and discussion due to extenuating circumstances, they should contact FBMC's Service Center at 1-844-559-8248 to discuss the request.

The FBMC Service Center will instruct the employee to submit the request in writing, including any documentation that would support the employee's view of the situation.

The Appeals Specialist processes the paperwork and convenes the Appeals Panel. A decision is reached to approve or deny the request and the employee is notified in writing. All decisions are final.

The entire process takes approximately 30 days from receipt of the written request. Any changes are effective the first of the month following the decision. All paperwork becomes part of the employee's permanent file. Any changes are indicated in red ink on the employee's enrollment form and the event is recorded in the Inquiry File for future reference.

The Benefit Coordinator makes any appropriate adjustments based on instructions from FBMC.

Administrative Error Change

An administrative error change is made to a deduction amount to correct a situation such as described below.

What are some examples of administrative changes?

Error in making a benefit selection: 1) I selected a Dependent Care Spending Account on the form by mistake and didn't realize the error until my reimbursement request for medical expenses was rejected as ineligible. I don't even have kids! 2) I wanted family coverage, but incorrectly inserted a single coverage rate. 3) I want to reduce my Spending Account per pay contribution because I didn't calculate my annualized amount correctly.

- A data entry specialist and control specialist incorrectly enters an enrollment form. This is rare but can occur if the form is not entirely legible or if the form is faint in ink color.
- It is determined that an entire agency or work location received incorrect advice about a benefit or about completing a form.
- The availability of an area network of providers is deemed to be insufficient to provide the benefit offered and selected.

Does FBMC follow any specific guidelines?

Errors are considered for change earlier in the plan year rather than later to avoid

any perception of *benefit shopping*. This is particularly true with the Mountaineer Flexible Benefits Plan because employees receive and are instructed to thoroughly review Confirmation Notices.

The decision to make a change must pass the reasonable test: Would any reasonable person with knowledge of the rules and regulations governing the plan agree with the decision?

Trends are observed carefully and decisions are reached objectively after careful research. As with the Appeals Process, decisions in direct violation of IRS guidelines are avoided. When in doubt, we contact the IRS for guidance.

What is the process when an error is identified or a situation occurs that qualifies as an Administrative Error Change?

The Benefit Coordinator must submit a request for FBMC to correct an Administrative Error. The request must validate the request based on clear and convincing evidence of the error and provide specific instructions for the corrective action.

Leave Of Absence

An employee who goes on leave of absence during any plan year may continue his/her Mountaineer Flexible Benefits plan benefits by paying the premiums directly, on an after-tax basis.

What benefits are eligible for continuation? How does an employee pay directly?

All benefits, including the two Flexible Spending Accounts, can be continued by the employee while on leave.

It is important to note that if an employee elects **not** to continue his/her benefits while on leave, the IRS forbids reentry into the plan until the next open enrollment period following the return from leave. The exception to this rule relates to benefits that must be reinstated following a return *from family medical leave*.

All personal payments by employees who are on leave should be sent to the Benefit Coordinator to keep track of the employees payments while on leave. Then, the Benefit Coordinator needs to complete a Mountaineer Flexible Benefits Personal Pay Summary form (Email the FBMC onsite contact if you need a copy of this form) and submit the check to:

FBMC
ATTN: Accounting-WV
P.O. Box 1878
Tallahassee, FL 32302

Enrollment Appeal

If you have an enrollment change or request for a mid-plan year election change, you have the right to appeal the decision by sending a written request for a review within 30 days of the initial denial.

Your appeal must include:

- The name of your employer
- Your contact information, including an e-mail address so that you may be contacted easily and timely
- Why you believe your request for a variance should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt and its supporting documentation. 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.

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

For appeals involving your enrollment elections or mid-year changes: FBMC Attn: Enrollment Appeal; Mail Slot 79 PO Box 1878 Tallahassee, FL 32302-1878

FSA Appeal

Appeal Process

If you have a reimbursement claim denied, in full or in part, you have the right to appeal the decision by sending a written request for a review within 30 days of the initial denial.

Your appeal must include:

- The name of your employer
- Your contact information, including an e-mail address so that you may be contacted easily and timely
- Why you believe your request for a variance should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal.
- If your appeal is the result of a denied reimbursement request, you must also include, the date of the services for which your request was denied, a copy of the denied request, and the denial letter you received

Your appeal will be reviewed upon receipt and its supporting documentation. 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.

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

To appeal a denied reimbursement request: WageWorks Claims Appeal Board P.O. Box 991 Mequon, WI 53092-0991 Fax number: 877.220.3248

7.Compliance Services

COBRA & Retirement Notification

The landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed by Congress in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

COBRA contains provisions giving certain former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available for specific *qualifying events*.

Can all benefits be continued?

The following Mountaineer Flexplan benefits can be continued under COBRA:

Benefit Description	Provider Company
Pre-tax Vision Care Plans	MetLife
Pre-tax Hearing Plan	EPIC
Pre-tax Indemnity Dental Care Plans	Delta Dental of WV
Pre-tax Medical Expense Flexible	WageWorks

What are the *qualifying events* under COBRA?

Qualifying events are certain events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of qualifying event determines who is qualified and defines the required amount of time that a plan must offer the health coverage under COBRA. It is important to note that qualifying events differ for employees, spouses and dependents.

The types of qualifying events for **employees** are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

The types of qualifying events for **spouses** are:

- Termination of the covered employee's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered employee
- Covered employee becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

The types of qualifying events for **dependent children** are the same as for the spouse with one addition: Loss of "dependent child" status under the plan rules.

Is there a simple chart to use to understand the various events and the periods of coverage?

Yes.

Qualifying Events	Who Qualifies For COBRA?	For How Many Months?
Termination	Employee, Spouse, Dependent Child	18*
Reduced Hours	Employee, Spouse, Dependent Child	18*
Employee entitled to Medicare	Spouse, Dependent Child	36
Divorce/legal separation	Spouse, Dependent Child	36
Death of covered employee	Spouse, Dependent Child	36
Loss of "dependent child" status	Dependent child	36

** Note: In the case of individuals who qualify for Social Security disability benefits, special rules apply to extend coverage an additional 11 months.*

What is the notification process regarding an employees termination or retirement?

In the event of termination of employment, the **employer** notifies FBMC via the normal billing process for County Board of Education and participating non-state agencies and via the payroll deduction / eligibility file for state employees.

When a Plan participant terminates his or her employment, all pre-tax benefits will cease on the last day of the month in which the employee is terminated. The Plan prohibits participants from making subsequent payments to the Plan unless they exercise their rights under COBRA.

Note: When an employee terms or retires, make sure when reporting to FBMC that you specify if the employee is terming or retiring. This is key information for the continuation of benefits.

The **employer** is required to notify FBMC in the event of an employee's death, reduction in hours, or Medicare eligibility within 30 days of the qualifying event.

What is FBMC's process to continue the benefits?

When the employee or employer notifies FBMC of the qualifying event, PayFlex forwards by regular mail a COBRA Notification of Rights letter and an application form. The employee has sixty days to complete and return the application form to PayFlex.

Upon receipt of the application, PayFlex will send an initial bill to the employee that

will be effective from the date coverage is lost. Premiums from the interim period are included on the bill and must be paid to keep the coverage in force under COBRA. The employee is given the option to make payments monthly, quarterly, semi-annually, or annually.

Benefits will remain in effect throughout the coverage period as long as premiums are paid. As a courtesy, PayFlex notifies each COBRA participant thirty days prior to the time that COBRA benefits are discontinued.

Once benefits are selected under COBRA can they be changed?

The initial application is the only opportunity that the employee will have to select benefits for continuation under COBRA. However, once selected, the employee can discontinue all or part of the benefits selected at any time during the *coverage period*.

What about rate changes?

If rate changes occur during the annual open enrollment period, employees who are continuing benefits under COBRA will be notified of the rate increase or decrease. Unless the employee chooses to drop the benefit(s), the change will become effective with the start of the new plan year and the employee's COBRA bill will be adjusted accordingly.

8.A Closer Look at Flexible Spending Accounts

A Flexible Spending Account (FSA), also known as a Reimbursement Account, is an account established with tax-free employee contributions, for reimbursement of employee out-of-pocket dependent care or health care expenses. These accounts are governed by IRS guidelines for Section 125, and 219, 105 and 129 Code. IRS Publications 502 and 503 can also be used to provide some basic guidelines for eligibility of expenses; however, it is important to note that these publications were produced primarily for the use of individual tax return submission and cannot be used independently to determine expense eligibility for Section 125 FSA plans. Because of this, claims must be substantiated with detailed documentation of the services.

The plan allows employees to direct a portion of their salary through payroll reduction to an FSA. Taxes are then calculated only on the salary remaining after the allocations to the FSA are taken out, creating a lower tax liability. For a more specific explanation of how these accounts work, please refer the employee to the enrollment materials or the FBMC Service Center at 1-844-559-8248.

Contribution Limits

The IRS provides specific contribution limits and allows each plan to provide additional limits as deemed appropriate. Since the limits may change from time to time, refer to the Enrollment Booklet or the plan documents for specifics.

Dependent Care Flexible Spending Account

To be qualified as a dependent care expense, the expense must be for the care of the qualifying dependent, and must be incurred to allow the employee (and if the

employee is married, the employee's spouse) to work or actively look for work. The spouse is considered to be working if he/she is a full-time student. The employee's/spouse's employment can be for others or in one's own business. The spouse can be either full or part time; however, the employee (or spouse) must have earned income from the work.

Expenses for extra-curricular activities (such as, computer, ballet or tumbling lessons) food, clothing, registration fees, overnight camps or sports camps are not eligible. However, if expenses for the meals cannot be separated from the dependent care expenses and are included in the total amount listed on the receipt, then the expenses become reimbursable. Please refer to your enrollment materials, or contact FBMC's Service Center at 1-844-559-8248, for clarification of questionable expenses.

The services must be incurred prior to reimbursement. This means that if the employee pays at the first of the month for an entire month of services, the reimbursement cannot be made until the end of the month. However, the employee may request reimbursement for a portion of the expense as the service period passes by separating the dates of service into weeks and prorating the expense for each week on the reimbursement request form. The original receipt should be attached to the request (the employee should keep a photocopy of the original receipt). The request can be submitted weekly or bi-weekly, as the service date ends. For example, if an employee pays \$300.00 per month for childcare, the employee can complete a reimbursement request more frequently, if desired, (weekly, biweekly or monthly), as long as the requests are made after the date of service.

The IRS requires that claims be substantiated by an independent third party; thus all requests for reimbursement must be accompanied by documentation of the expense. A dependent care receipt must include the following information:

- Date(s) the service was incurred (beginning and ending dates).
- Service provider's name.
- Service provider's address.
- Amount of expense.
- Federal Tax ID or Social Security number of the service provider. If the provider is tax exempt, this should be noted on the reimbursement request. If the individual service provider does not have a Social Security number, a Green Card number will suffice.
- If the service provider is an individual, his/her signature is required on each receipt
- A signature is not required for a printed receipt from a Day Care provider.
- It is important to remember that the **ending date of service must have passed** to be eligible for reimbursement.

A qualified dependent:

- The employee's dependent under age 13. The employee must claim the dependency exemption when filing his/her tax return.

- Any other dependent, regardless of age, who is physically and/or mentally incapable of self-care, even if the employee is not able to claim the dependency exemption because that person has income equal to, or exceeding, the exemption amount. According to IRS guidelines, physical or mental incapacity is not being able to dress, clean or feed oneself. In addition, any individual who requires constant supervision to prevent self-inflicted injury or injury to others is considered to be "incapable of self-care".

Medical Flexible Spending Account

To be eligible for reimbursement from a Medical FSA, the amounts spent for services must be for medical care. The determination as to what constitutes medical care depends on the nature of the services rendered, not upon the experience, qualifications, or title of the person rendering the service. ***The services must be for the diagnosis, cure, treatment or prevention of disease or for the purpose of affecting the structure or function of the body.*** Those expenses which may be for the purpose of improving one's appearance or merely for the individual's general health will require a written, signed statement from the attending physician as to the purpose of the treatment. Orthodontia is a primary example of such an expense and does require submission of a "Proof of Medical Necessity" letter.

IRS Publication 502 can provide some general guideline as to the types of expenses, which are reimbursable.

General FSA Rules and Guidelines

- Funds deposited in a Dependent Care FSA cannot be used to reimburse medical expenses.
- Expenses reimbursed from an FSA cannot also be claimed on the employees' tax return.
- Expenses paid in advance cannot be submitted for reimbursement until after the services have been rendered.
- Dependent Care FSA reimbursements will be paid to the limit of the amount in the employee's account when the reimbursement check is written. Any balance will be paid as money is credited to the account.
- Medical expense reimbursement requests will be paid to the limit of the employee's annual election amount, less any prior reimbursements made during that plan year.
- There is a 120-day run-out period after the plan year during which the employee may continue to submit claims for expenses, which were incurred during the employees' period of coverage. After the 120-day run-out period, funds remaining in the accounts will revert to the State of West Virginia.
- FSA requests must be postmarked by October 31st, to be eligible for reimbursement. This corresponds to the plan's *run-out period*.
- Each FSA plan participant will receive a monthly statement of account activity.
- If an employee loses or destroys an FSA reimbursement check, he/she

should contact the FBMC Service Center and request that a stop payment be issued for the check. FBMC will not place a stop payment on an FSA check until ten business days after the check was issued. The complete process takes approximately two weeks before a replacement check is issued.

- Customers will receive a Reimbursement Request Form with their Confirmation Notice after Open Enrollment and with each reimbursement check.

NOTICE: This handbook is not intended to be all-inclusive. If conflicts exist between this handbook and the Internal Revenue Code or West Virginia Statutes or the Mountaineer Flexible Benefits Plan Summary Document, the Internal Revenue Code and the Statutes must be followed.