

Frequently Asked Questions

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What is a Section 125 plan?

Internal Revenue Code § 125 provides guidelines to employers who wish to help employees pay for certain expenses, like health insurance and dependent care, with pre-tax dollars. A Section 125 plan, or "cafeteria plan", is a plan designed to allow employees to defer wages on a pre-tax basis in order to pay for insurance premiums, out of pocket medical expenses, and dependent care expenses.

What guidelines and requirements are stated in Internal Revenue Code § 125?

To adopt a Section 125 plan, employers must prepare and maintain a written plan document. Participation is limited to eligible employees as defined by the plan document. Employers may make contributions on behalf of employees. Employee contributions must be made through salary reduction agreement. Also, the plan must meet Internal Revenue Code requirements for election, enrollment, and non-discrimination, and the employer may be required to file IRS Form 5500 annually.

What are the enrollment election requirements for a cafeteria plan?

Participant elections must be made prior to any benefits becoming available. Most employers use the 30 day period preceding the plan year to complete enrollment. Please check with your employer for specific details.

What is a premium payment plan?

A premium payment plan is a simple salary reduction plan that permits employees to reduce their compensation by an amount equal to the contributions that are required to pay for the employee's share of the premiums under a group health insurance plan. Most commonly, premium conversion plans are used to convert the employee's share of health insurance premiums from after-tax dollars to pre-tax dollars. Premium conversion plans can also be used to permit employees to purchase other insurance on a pre-tax basis, such as life, disability, dental, vision, or accidental death and dismemberment insurance. Often such "supplementary" insurance programs are offered on an "employee pay-all" basis. By converting premium payment dollars from after-tax dollars to pre-tax dollars, premium conversion plans help employees purchase desired insurance benefits by effectively lowering the cost of the insurance.

What is the "period of coverage"?

The period of coverage for a flexible benefit plan is 12 months. An employer may have a short first plan year, or a short plan year in order to facilitate changing plan year start and end dates, but the period of coverage must be the entire short plan year. Employees cannot make mid-year election changes unless a qualifying status change event occurs. A flexible benefit program may not allow employees to participate only for periods during which they expect to incur medical expenses. An employee's period of coverage may also cease upon termination of employment if contributions stop and COBRA is not elected.

When are expenses considered to have been incurred?

Expenses are considered to be incurred when the actual services are performed. All services or items must be provided within the plan year in order to be reimbursed through a medical spending account or a dependent care assistance program. Billing dates and/or payment dates are irrelevant to determining when expenses are incurred. Reimbursement may occur outside the plan year, but only for services or items which were provided within the plan year.

Can I use my medical spending account to pay for insurance premiums other than through my employer's group health plan?

No. Group plan insurance premiums may be paid on a pre-tax basis, but any insurance coverage outside of the group plan is not an eligible medical spending account claim.

What happens if I don't turn in my claims before the end of the plan year?

Each group plan document specifies a "run-out" period. The "run-out" period allows plan participants to submit claims for services occurring within the plan year after the plan year has ended. Please check with your employer for specific run-out period information.

How do I submit a claim?

Flex participants can fax toll-free (877-424-3539), online (www.allegianceflexadvantage.com) or mail (ABPM, P. O. Box 4346, Missoula, MT, 59806) claim forms with supporting documentation. Reimbursement checks will then be either mailed to the participant's home address or automatically deposited in the participant's checking account. If you fax your claim and elect to have direct deposit, you will generally be reimbursed within three to five business days.

How is dependent care different from medical spending?

Dependent care expenses are more constant, and more easily planned. Medical expenses can occur unexpectedly, and so regulations provide for the full medical spending election amount to be available to the participant at any time during the plan year. This IRS regulation is called the uniform reimbursement rule.

What happens to the money if I have any left over at the end of the plan year?

Account balances remaining at the end of the year revert to the plan administrator, which is the employer. The employer is required to use any such funds only to offset benefits expenses. Make sure that you estimate your plan year expenses conservatively: don't budget what-ifs, but only those expenses you know will occur.

Can I claim my payments to the orthodontist?

Orthodontia claims may be submitted through a medical spending account for services that were performed within the plan year. Services performed prior to the start of the plan year are not reimbursable.

What is reimbursable through a medical spending account?

The Flex Advantage envelope provides a non-exhaustive listing of expenses which qualify for reimbursement through a medical spending account. Examples of expenses which do not qualify are also provided. IRS Publication 502 also gives examples of eligible Code § 213(d) medical expenses. IRS publication 502 can be found on the IRS web site (www.irs.gov).

Are over-the-counter drugs and medicines reimbursable through a flexible benefits plan?

Your flexible spending account (FSA) has been expanded. The IRS recently issued Revenue Ruling 2003-102 and IR-2003-108 authorizing the reimbursement of over-the-counter medicines and drugs through FSAs. Over-the-counter medicines and drugs which are used to alleviate or treat a sickness or injury, such as pain relievers, antacids, and cold and flu medicines are reimbursable. Vitamins and dietary supplements purchased and used to promote general good health remain ineligible expenses. OTC receipt documentation should include the name of the drug or medicine, the date of purchase, and the cost. Click here to see standards and examples.

Can travel expenses related to medical treatment be reimbursed through a flexible benefits plan?

Yes. Amounts paid for transportation primarily for, and essential to, medical care. Instead of actual car expenses, one can deduct 14 cents per mile in 2004 for a vehicle used to obtain medical care. Parking fees and tolls can also be deducted, as well as bus, taxi, train, or plane fare. Lodging is limited to \$50.00 per eligible individual per night. Meals are not reimbursable unless included in the cost of a hospital stay.

Who pays for the cafeteria plan benefits?

Most cafeteria plans are set up to be funded only with before-tax contributions made through payroll deductions from participants. No contributions are required by the employer, although the employer can elect to make a contribution on behalf of all participants.

Are there any employees that cannot participate in a cafeteria plan?

Partners in a partnership, sole proprietors, and greater than 2% owners of a Subchapter S Corporation cannot participate in a cafeteria plan.

Will future legislation affect the advantages of cafeteria plans?

HR 4279, a bill which would amend IRS Code § 125, was passed by the House on May 12, 2004. A key provision of the bill would allow up to \$500.00 of unused health flexible spending account funds to be carried forward to the next plan year. While the bill must still be passed by the Senate and signed by the president, the House passage demonstrates an increasing awareness and understanding of flexible benefits by members of Congress. The effective date of the legislation is proposed as January 1, 2004, so it is possible that rollovers could begin as early as December 31, 2004. It is important to note, however, that the bill may not become law by that date, and could be modified or bundled with other health care bills prior to passage. Also important is that the bill does not include rollover provisions for dependent care or premium only dollars, but is strictly related to health flexible spending dollars.

What are Flexible Spending Accounts?

Flexible Spending Account (FSA) plans enable employees to set aside money, on a pre-tax basis via salary reduction, to pay for certain expenses. Two types of spending accounts that are permitted under Section 125 of the IRS code are for medical care and dependent care

A medical spending account reimburses employees for eligible healthcare expenses that are not covered or reimbursed under the employer's health plan. Typically, these include deductibles, co-payments and uninsured expenses such as dental expenses, eyeglasses or hearing exams.

Medical spending accounts are funded by employee salary reductions and/or employer contributions. Health expenses that have been (or will be) paid or reimbursed through a group or individual health care plan cannot be reimbursed, nor can employees take itemized deduction on their income tax returns for any medical expense reimbursed through a medical spending account. Employees cannot receive reimbursement for premiums paid for any health insurance coverage outside the group plan (for example, premiums for a spouse's group plan).

The employer determines the maximum contribution allowed for the account at the beginning of the plan year, and each participant may contribute an amount each plan year up to that maximum. In many cases, the maximum reimbursement is limited by the participant's salary deferrals or employer contributions. By providing the necessary documentation (usually the bill or receipt), participants submit requests for reimbursement from the funds in the group flexible spending account.

A dependent care assistance program allows employees to pre-tax qualified dependent care expenses that are incurred so that they may work. Expenses for care provided inside or outside a taxpayer's home may be claimed for two types of qualifying individuals. One group of qualifying individuals is dependents age 12 and under who are the employee's tax dependent. A special rule applies to divorced parents. An employee can submit claims for a child if he or she is the custodial parent, even if the non-custodial parent has the dependency tax exemption. Another group of qualifying individuals is other tax dependents, incapable of self-care, who regularly spend at least eight hours per day in the taxpayer's home. A disabled or elderly dependent might qualify as part of this group.

Eligible care only includes the cost of services for the individual's well-being and safety; it does not include the cost of clothing, entertainment or food unless such items are incidental and cannot be separated from the cost of the care provided. Employment taxes paid to the employee in connection with salary paid to a service provider may be an eligible expense. The dependent care center outside of an employee's home must comply with applicable state and local laws. A plan cannot reimburse payments made to an employee's child, acting as a provider, who is under 19 years of age.

There is a limit on the amount of expenses that can be paid through a dependent care account. The limit is equal to the smallest of the following:

- * \$5,000, if the participant is married and files a joint federal tax return or is a single parent.
- * \$2,500, if the participant is married and files a separate federal tax return
- * The employee's earned income
- * The spouse's earned income.

Two important rules to consider when developing medical spending and dependent care accounts are the (1) uniform reimbursement rule and (2) the use-it-or-lose-it rule:

(1) The Uniform Reimbursement Rule.

The IRS's regulations require that the full year's reimbursement amount for eligible medical expenses for a medical spending account must be available at all times during the plan year (This rule does not apply to dependent care accounts). The maximum amount subject to reimbursement during the year must be reduced by prior reimbursements during the plan year. This amount cannot be tied to the contributions the employee has made to the medical spending account for the coverage period, nor can the payment schedule for the payment of medical spending account contributions be based on the rate or amount of covered claims incurred during the coverage period. This prohibits the acceleration of premiums if claims are being incurred faster than premiums are being collected.

Insufficient contributions by short-service employees place the employer at risk. The philosophy behind the uniform reimbursement requirement is to treat medical spending accounts like true insurance by shifting risk to the employer.

(2) The "Use-or-Lose" Rule.

The IRS's regulations require that all money contributed to a flexible spending account in any plan year can only be used to reimburse qualified expenses incurred during that plan year. Money not used to reimburse eligible expenses incurred during the plan year is forfeited. This "use-it-or-lose-it" rule requires employees to forfeit any money that is left in their account at the end of the plan year. The unused portion of a participant's pre-tax accounts may not be paid to the participant in cash or by use of any other benefit.

Amounts forfeited because of the use-or-lose rule give rise to experience gains. Since experience gains are determined by taking into account reasonable administrative cost forfeitures subsidize the administrative costs of the cafeteria plan to the extent such expenses are paid by the plan. Forfeitures should also be able to be used to offset losses arising when other employees' flexible spending account reimbursement exceeds his or her contributions. Finally, the forfeited portion of the account that causes an experience gain may be allocated among participants or used to reduce premium costs.

How do I know how much I have in my account?

A medical spending account allows participants to submit claims and be reimbursed up to the full amount of their annual election at any time during the plan year. Dependent care account claims are reimbursed only to the extent that an individual's account is funded. Each claim reimbursement mailed summarizes account activity and account balance. Participants can also request a password to the Allegiance web site, and access account information on line. The web site address is www.allegianceflexadvantage.com. Once on the site, click on online services, then employee login, then first time users. Enter your social security number, your birth date, and your group number. The group number can be found on the flex explanation of benefits in the upper right hand corner, or on your confirmation letter in the upper left hand corner. Last, enter your e-mail address and click on submit. A letter containing your password will be mailed to you at your home address within 24 hours.

Participants can also call the Allegiance toll-free number (877-424-3570) and use the Interactive Voice Response program. At the prompts, press "2" and then "6." Participants will then be instructed how to access account information. Additionally, participants are notified approximately two months prior to the end of the plan year if they have unclaimed flex dollars.

What if I don't want to be a participant anymore?

Participation election and determination of amounts to be withheld pre-tax is made at the beginning of eligibility and at the beginning of each plan year thereafter. Once an election is made, it cannot be changed unless a qualifying change of status event allows a change, and then any changes to elections must be on account of and consistent with the status change.

Generally, a change of status event allowing a change involves a change in the participant's number of tax dependents, or a change in the employment status of the participant or the participant's spouse. Consult your flexible benefits Summary Plan Description for specific details regarding change of status events.

What are Qualified Transportation Fringe Benefit Plans?

Internal Revenue Code § 132 provides guidelines that permit an employer to subsidize its employees' transportation and parking costs. Code § 132 also allows employees to use pre-tax dollars to pay for transportation and parking expenses. The most common transportation fringe benefit plan design is the compensation reduction plan. An employer may permit employees to set up a transportation expense reimbursement plan that works much like a dependent care assistance program. A transportation expense reimbursement plan allows employees to pre-tax qualified transportation expenses that are incurred so that they may work. Code § 132 states that three qualified transportation fringe benefits may be included in a plan: vanpooling, transit passes, and parking.

Commuter highway vehicle transportation (vanpooling) requires a highway vehicle with a seating capacity of six or more adults (not including the driver) where at least 80% of the mileage use for a year can be reasonably expected to be for the purpose of transporting employees between their place of residence and their place of employment. Also, the number of employees carried must be at least half of the seating capacity of the vehicle (not including the driver).

Transit passes include any pass, token, fare card, voucher, or similar item that entitles the employee to transportation on mass transit facilities. Code § 132(f)(3) states that cash reimbursement for transit passes is only allowed "if a voucher or similar item which may be exchanged only for a transit pass is not readily available for direct distribution by the employer to the employee."

Qualified parking includes parking provided to employees at or near their workplace. The employer may pay for qualified parking directly to a parking lot operator, by reimbursement to the employee, or provide parking on premises that it owns or leases.

The maximum exclusion for parking expenses is \$215.00 per month for 2007. For vanpooling and transit passes expenses combined, the limit is \$110.00 per month for 2007. 2006 limits were as follows parking expenses \$205.00, vanpooling and transit passes expenses combined \$105.00.

Code § 132 transportation fringe benefit plans are completely separate from and have much more lenient election requirements than Code § 125 cafeteria plans. In many cases, employees may change pre-tax elections monthly. Check with your employer for specific details.