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**Employee Benefit Systems** Third Party Administration Services

# Flexible Spending Account (FSA)

## What is a Flex Plan?

- Set aside a portion of your pre-tax income into a Flex Spending Account or a Dependent Care Account.
- These accounts can be used towards medical expenses or dependent care throughout the year.
- Money is taken out pre-tax so you end up taking more money home!

| Your Paycheck Without a Flex Plan | | Your Paycheck With a Flex Plan | |
|---|---|---|---|
| Salary | $2000 | Salary | $2000 |
| FICA/federal/state taxes | - 500 | Insurance Premiums | - 100 |
| | | Health & Daycare expenses | - 300 |
| Adjusted earnings | $1500 | | |
| Insurance Premiums | - 100 | Adjusted earnings | $1600 |
| Health & Daycare expenses | - 300 | FICA/federal/state taxes | - 400 |
| **Net pay without Flex Plan** | **$1,100** | **Net pay with Flex Plan** | **$1,200** |
| | | **Net tax savings with a Flex Plan** | **$100** |

## How does a Flex Plan Work?

- Elect the amount you wish to allocate.
- Tally up your qualified expenses for the upcoming year for yourself, your spouse, and your children.
- After money is put into your account you will be reimbursed for qualified expenses by using your Flex debit card or by filing a claim with an attached copy of the receipt.
- Annual election can only be changed for a qualifying life event.

## Medical Expenses Covered

- Transportation expenses to visit doctor
- Eye glasses and contact lenses
- Dental expenses, including cleaning
- Podiatrists
- Prescription drugs
- Medical devices prescribed by a physician
- Co-payments required by your medical plan
- Home care expenses for you and your dependents
- Medical Testing and laboratory expenses
- Nutritionists when prescribed by a physician
- Physical therapy
- Acupuncture
- Hearing aid and batteries
- Psychiatric and psychological services
- Medical or surgical procedures not covered by insurance

## Advantages of the Debit Card

- "Cashless transactions"
  - Instead of paying for eligible expenses and waiting to be reimbursed, the debit card pays the expense directly from your Medical or Dependent Care Account.
- Some debit card transactions may require receipt verification.

## Dependent Care

- You can be reimbursed for up to $5,000 ($2,500 for a married employee filing separate tax returns) of dependent care expenses each plan year.
- Qualified dependents include:
  - Children age 12 and under
  - Disabled spouse
  - Dependents who are physically or mentally incapable of self-care and regularly spend at least 8 hours each day in the taxpayer's household.

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EBS M007 (12/2013)

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# Eligible Expenses for Flexible Spending Accounts

## ELIGIBLE MEDICAL EXPENSES

Money set aside in this account may be used to pay for medical expenses not paid for by insurance such as deductibles, co-payments and coinsurance amounts. Employees may also use the money to pay expenses not paid by insurance such as vision and dental services. The money may not be used to pay health insurance premiums, cosmetic surgery, cosmetic items or items that improve "general health".

- Transportation expenses to visit the doctor
- Eye glasses and contact lenses
- Dental expenses, including cleaning
- Podiatrists
- Prescription Drugs
- Medical devices prescribed by a physician
- Co-payments required by your medical plan
- Home care expenses for you and your dependents
- Medical testing and laboratory expenses
- Nutritionist when prescribed by a physician
- Physical therapy
- Acupuncture
- Hearing aids and batteries
- Psychiatric and psychological services

## ELIGIBLE OVER-THE-COUNTER ITEMS

- Band aids
- Birth control
- Braces & supports
- Catheters
- Contact lens supplies & solutions
- Denture Adhesives
- Diagnostic tests and monitors
- Elastic bandages & wraps
- First aid supplies
- Insulin & Diabetic supplies
- Ostomy Products
- Reading glasses
- Wheelchairs, walkers, canes
- Thermometers
- Breast pump

## DEPENDENT CARE

- IRS Regulation limits the amount you can contribute to the dependent care account to $5,000 for a single parent with children, $5,000 for a married parent filing jointly, and $2,500 for a married parent filing separately.
- Eligible dependent care must be for the purpose of allowing the employee, or the employee's spouse, to be gainfully employed or to attend school full-time
- Dependent Care expenses must be incurred before being reimbursed
- Qualified dependents are:
  - Children age 12 and under
  - Disabled spouses or,
- Dependents who are physically or mentally incapable of self-care and regularly spend at least 8 hours each day in the taxpayer's household

### ELIGIBLE DEPENDENT CARE EXPENSES

- Daycare
- Nanny
- Preschool
- Before and After School Care
- Summer Day Camp
- Care for mentally or physically handicapped dependent(s) of any age

### INELIGIBLE EXPENSES

- Payment to your spouse
- Payment to your child who is under 19 at the close of the tax year
- Overnight camps
- Sports camps
- Private schools
- Kindergarten

## WHEN EXPENSES MUST BE INCURRED

- After the adoption of the plan, the effective date and employee enrollment
- During a participants "period of coverage"
  - Usually the plan year – 12 months, except for short plan years
  - Includes COBRA coverage period
- Medical expenses are "incurred" when the medical care is provided that give rise to the expense
  - Not when the employee is formally billed, charged for, or pays for the medical care
- Participants cannot reimburse expenses incurred after health FSA participation ends
  - For participants with COBRA, health FSA participation ends when COBRA periods ends



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## How Much Do You Spend?

In order to help you estimate your annual out-of-pocket expenditures, we have included a listing of potential medical or health related expenses that qualify for reimbursement under an EBS Flex Plan. For a complete list of eligible expenses please visit the EBS website, www.ebs-tpa.com.

| Deductible Medical Expenses | Your Annual Estimated Amount |
|---|---|
| Ambulance | $ |
| Arch supports | $ |
| Artificial limbs | $ |
| Birth Control Pills (by prescription) | $ |
| Blood tests | $ |
| Blood transfusions | $ |
| Braces | $ |
| Chiropractor | $ |
| Contact Lenses | $ |
| Contraceptive devices (by prescription) | $ |
| Crutches | $ |
| Dental Treatment | $ |
| Dermatologist | $ |
| Diagnostic fees | $ |
| Drug addiction therapy | $ |
| Drugs (prescription) | $ |
| Elastic hosiery (prescription) | $ |
| Eyeglasses | $ |
| Guide dog | $ |
| Gynecologist | $ |
| Hearing aids and batteries | $ |
| Hospital bills | $ |
| Hydrotherapy | $ |
| Insulin treatment | $ |
| Lab tests | $ |
| Lodging (away from home for outpatient care) | $ |
| Neurologist | $ |
| Obstetrician | $ |
| Ophthalmologist | $ |
| Optician | $ |
| Optometrist | $ |
| Oral surgery | $ |
| Organ Transplant (including donor's expenses) | $ |
| Orthopedic shoes | $ |
| Oxygen and oxygen equipment | $ |
| Pediatrician | $ |
| Prenatal care | $ |
| Prescription medicines | $ |
| Psychiatrist | $ |
| Psychologist | $ |
| Special school costs for the handicapped | $ |
| Sterilization | $ |
| Therapy equipment | $ |
| Transportation expenses (relative to health care) | $ |
| Vaccines | $ |
| Vasectomy | $ |
| Vitamins (if prescribed) | $ |
| X-rays | $ |

## Eligible Over-the-Counter Expenses

The following are examples of the OTC items that will remain available without a doctor's prescription.

| | |
|---|---|
| Band-aids | $ |
| Birth Control | $ |
| Braces & Supports | $ |
| Catheters | $ |
| Contact Lens Supplies & Solutions | $ |
| Denture Adhesives | $ |
| Diagnostic Test & Monitors | $ |
| Elastic Bandages & Wrap | $ |
| First Aid Supplies | $ |
| Insulin & Diabetic Supplies | $ |
| Ostomy Products | $ |
| Reading Glasses | $ |
| Wheelchairs, Walkers, and Canes | $ |
| Total: | $ |



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## Section 125 FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

### Employee Information

☐ Open Enrollment ☐ New Hire Hire Date _____ Effective Date _____

Employer Name _____ Date of Birth _____

Employee Name _____ Social Security Number _____

Home Address _____ City _____ State _____ Zip _____

Email _____ Telephone _____

(all notifications will be sent via e-mail)

☐ I elect not to participate in the Section 125 Flexible Spending Account for this Plan Year (Skip to signature at bottom of form).

### Flexible Spending and Dependent Care Agreement

☐ **General Purpose ( all qualifying medical expenses) OR** ☐ **Limited Purpose (vision and dental expenses only).**

You must select a Limited Purpose Account if you, your spouse, or dependents make contributions to a Health Saving Account (HSA) or receive HSA contributions from anyone else.

- **Medical Reimbursement Account** $ _____ (Per Pay) x _____ (#Pays/Year) = $ _____ (Plan Year Election) (do not round)
  Maximum medical per year $ _____
- **Dependent Care Reimbursement Account** $ _____ Per Pay) x _____ (#Pays/Year) = $ _____ (Plan Year Election) (do not round)

Maximum Dependent Care year of $2,500 if married filing separately or $5,000 if single or married filing jointly, if more than $2,500 is elected, my signature on this agreement, certifies I am single or married filing a joint income tax return with my spouse.

### Direct Deposit Authorization (Complete only for a new Direct Deposit Authorization or a change in Bank Account).

☐ I hereby authorize Employee Benefit Systems to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. This authorization shall remain in force until revoked by me. I have read and understand the information on this form regarding direct deposit of reimbursements

Account Number _____ Transit ABA Routing # _____

Account Type: ☐ Checking ☐ Savings This agreement is: ☐ New ☐ Change ☐ Cancel

Name of Bank: Bank Phone:

### Employee Authorization

☐ I agree to have my gross salary redirected, in accordance with Section 125 of the Internal Revenue Code, to contribute in the amounts indicated above. I understand that contributions to my reimbursement account(s) can only be reimbursed to me for eligible expenses incurred within each plan year. For example, funds in the Medical Reimbursement Account cannot be used for reimbursement of dependent care expenses. I further understand that if I do not use the funds in my reimbursement account(s) during the plan year, those funds cannot be paid to me, they will be forfeited. When ever payments have been made with the Debit Card in excess of the maximum amount of payment, the Claims Administrator and the Employer have the right to recover such payments from the employee. I understand and agree that the Claims Administrator and Plan Administrator have the discretionary authority to decide whether or not a particular expense is eligible. I will use my Flex Debit card for eligible expenses only. I recognize that any expenses in excess of the maximum payment or ineligible expenses erroneously charged to my Flex Debit Card represent an overpayment of my salary or wages and that I must repay my Employer that money immediately. My Employer may deduct any erroneous claims payments or Flex Debit Card charges from my salary or wages. If my employment is terminated for any reason, the entire amount of any unpaid erroneous charges will be immediately due and payable and my Employer, without any other notice, may apply the debt against any amounts my Employer may owe me. By accepting and using my Flex Debit Card, I am agreeing to the terms and conditions contained in the Cardholder Agreement, including any amendments thereto, which will govern the use of the Card.

I have read and understand the above agreement. I authorize my employer to redirect my salary according to this agreement and I will review my paycheck to verify that my employer has made appropriate withholding consistent with my election.

This salary redirection agreement for my reimbursement account(s) and/ or the Pre-Tax Premium Payments will continue until:

- I terminate employment with the employer listed above; or
- I have a qualifying status change (see Summary Plan Description) and I modify this agreement consistent with the change; or
- The end of the current plan year; or
- My employer terminates, suspends, or modifies this plan or the benefits under the plan.

**Employee Signature:** **Date:**



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# ADDITIONAL DEBIT CARD REQUEST FORM

## EMPLOYEE INFORMATION

Company Name

Participant Name (First, MI, Last) | Social Security Number

Participant's Address | City | State | Zip

Daytime Phone Number | E-mail Address

## ADDITIONAL CARD INFORMATION

* Please complete the following information for each additional card request. The individual(s) need to be at least 18 years of age per MasterCard Rules and Regulations.

### Spouse Information

Name (First, MI, Last) | Social Security Number | DOB (MM/DD/YY)

Address | City | State | Zip

### Dependent(s) Information

Dependent Name (First, MI, Last) | Social Security Number | DOB (MM/DD/YY)

Address | City | State | Zip

Dependent Name (First, MI, Last) | Social Security Number | DOB (MM/DD/YY)

Address | City | State | Zip

Dependent Name (First, MI, Last) | Social Security Number | DOB (MM/DD/YY)

Address | City | State | Zip

## PLAN PARTICIPANT SIGNATURE

By accepting and using my Debit Card, I am agreeing to the terms and conditions contained in the Cardholder Agreement, including any amendments thereto, which will govern the use of the Card.

Participant Signature | Date



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# FLEX Request for Reimbursement

**Submit by email**
**flex@ebs-tpa.com**

**Submit by Fax**
**Fax: 888-511-3743**
**# of pages: _____**

**Please complete all sections - please check the following box if this is a re-submission.** ☐ Re-submission

| | |
|---|---|
| **Name:** | **Social Security Number or EE ID number:** |
| **Home Address:** | **Employer:** |
| **City:** **State:** **Zip:** | **Daytime phone:** |
| ☐ Check here if this is a new address | **Email Address:** |

**Flexible Spending Account Reimbursement-**Attach an itemized receipt, an Explanation of Benefits, or other verification (originals or photocopies) of each expense claimed, indicating the service(s) provided, date(s) of service, and corresponding charges. **Credit card receipts, cancelled checks, balance forward statements are not eligible forms of documentation.**

| Person Receiving Care | Relationship | Date of Service | Description of Expense | Care Provider (Name of Doctor, Clinic, Hospital) | Amount Claimed |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Dependent Care Reimbursement-**Attach an itemized receipt or other verification of each expense claimed, indicating the service(s) provided, date(s) of service, and corresponding charges. This documentation is not needed if care provider's certification is obtained below.

| Dependent Receiving Care | Relationship | Age | Dates of Care | Care Provider (Name and SSN or T.I.N.) | Amount Claimed |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

I certify that the dependent care expenses shown above are valid.
**Signature of Dependent Care Provider:** _____ **Date:**_____

**Employee Certification:** I request reimbursement from my Employee Reimbursement Account(s) for the expenses itemized above. I certify that the expenses for which reimbursement is requested under the reimbursement account(s) were for services received either by me or my eligible dependent(s). I also certify that I or my eligible dependent(s) have received the services described on the dates indicated, and these are my out-of-pocket expenses that qualify as valid expenses under the plan and the Internal Revenue Code. I certify that I have not been reimbursed for the itemized expenses and that I will not seek reimbursement under any other plan covering health benefits. I also certify that these expenses are to alleviate a medical condition and not just merely beneficial to my general health. I understand that if I, my spouse, or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else, I must have a Limited Purpose Medical Reimbursement Account which can only pay qualifying expenses related to vision and dental care. I further understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. To the best of my knowledge and belief, my statements on this form are complete and true.

**Employee Signature: (REQUIRED)**_____ **Date:**_____



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# GUIDELINES FOR ELIGIBLE REIMBURSMENT

**General Guidelines**

Employee Reimbursement Accounts are a part of Section 125 of the Internal Revenue Code that governs the tax status of Flexible Benefit Plans. Eligibility for pre-tax reimbursement is covered in Code Sections 105 /106 (Accident/Health Plans) and Section 129 (Dependant Care).

- Reimbursement will be made directly to you; you are responsible for paying your provider.
- According to the Internal Revenue Code, if you apply for reimbursement of expenses that the IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and certain penalties may apply.
- Ineligible expenses include overpayments of reimbursable expenses, expenses that have already been paid from some other source, expenses for other than vision and dental services under a Limited Purpose Medical Reimbursement Account, and expenses not eligible for reimbursement as described by the Plan or as provided by the IRS.
- If you have a General Purpose Medical Reimbursement Account, none of you, your spouse, or dependents are eligible to make contributions to or receive contributions in an HSA.
- Cafeteria plans may only reimburse expenses incurred in the plan year. An expense is incurred when the service that gives rise to the expense is provided, when the expense is paid is irrelevant.
- For specific detail on claim filing, reimbursement, and review procedures, please reference your Summary Plan Description.

**Medical Expense Reimbursement**

Eligible expenses are qualified medical, dental and vision expenses that are not eligible for reimbursement from any other source.

- Expenses that can be reimbursed under your health insurance plan should not be included on this form.
- Expenses for services which are not medically necessary (i.e. cosmetic) should not be included on this form.
- You may be reimbursed for expenses for yourself, your spouse, and your dependents, as defined in the Internal Revenue Code.
- Only qualifying expenses related to vision and dental care will be paid or reimbursed from a Limited Purpose Medical Reimbursement Account.
- Eligible expenses and services are detailed on the EBS website at www.ebs-tpa.com

**Dependent Care Reimbursement**

- Expenses to provide care for your eligible dependents may qualify for reimbursement. Eligible dependents include your qualifying child under age 13, your disabled spouse or disabled qualifying child who lives with you for more than half the year, and a disabled qualifying relative who lives with you for more than half the year, for whom you provide over half his or her support.
- To be eligible, you must be working while your dependents receive care. If you are married, your spouse must be a wage earner or a full-time student for at least 5 months during the year, or is disabled and unable to provide for his or her own care.
- Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed. Covered expenses include licensed day care centers or individuals other than your dependents who provide care for your children in or outside your home.
- You will be required to provide the name, address, and social security (or other tax I.D.) number of your day care provider on your federal income tax forms at year end.
- If claims submitted are greater than the balance in your dependent care account, reimbursement will be limited to your account balance. The un-reimbursed amount will carry forward to subsequent months in the plan year; you need not resubmit.
- IRS regulations limit the amount of reimbursement expense for dependent care to the lower of the annual earned income of you or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns $200 per month for one dependent or $400 per month for two or more dependents.
- An additional IRS Regulation limits the amount you can contribute to the dependent care account to $5000 for a single parent with children, $5000 for a married parent filing jointly, and $2,500 for a married parent filing separately.
- Under IRS Regulations, qualified individuals can receive a tax credit for dependent care costs. This credit can be claimed on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the Dependent Care Reimbursement Account. The maximum amount that can be used for the tax credit is reduced by the amount you use from the Dependent Care Reimbursement Account.



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