

# Flexible Spending Accounts

## ...YOUR Questions Answered By:



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### ➤ What is a Flexible Spending Account (FSA)?

An FSA allows you to use pre-tax dollars to pay for qualifying health care and dependent care expenses. Participating in an FSA increases your take home pay, as your taxable income is reduced by your pre-tax deductions and you are not taxed on your reimbursement.

Example of How FSA Can Benefit an Employee\*

	Employee A Without FSAs	Employee B With FSAs
<b>Gross annual salary (before taxes)</b>	<b>\$32,000</b>	<b>\$32,000</b>
Medical FSA contribution	0	-500
Dependent care FSA contribution	0	-1,500
<b>Taxable salary*</b>	<b>32,000</b>	<b>30,000</b>
Taxes withheld (Federal, State, FICA)	-4,930	-4,477
Employee A Pays for medical & day care expenses	-2000	0(net)
<b>Remaining take home pay</b>	<b>\$25,070</b>	<b>\$25,523</b>

\*Assumes 15% federal taxes, 7.65% FICA taxes and the standard deduction for married filing jointly with three exemptions. Because no FICA is being withheld from the contributions you make to FSAs, Social Security benefits could be slightly reduced when available for retirement.

Both employees earn the same salary and have the same medical and dependent care expenses, but employee B has **\$453** more than Employee A in take home pay income. That's, because Employee B paid for the expenses with the tax-free deduction taken from his/her payroll checks throughout the year.

### ➤ How Does an FSA Work?

The annual amount you elect to contribute will be divided by the number of pay periods remaining in the year. Every pay period, your Employer will deduct these equal amounts from your payroll check on a pre-tax basis before, Federal, State (varies by State), and Social Security taxes are withheld from your salary. The money is held in your corresponding "Flexible Spending Account" until you submit receipts for eligible expenses; your reimbursement is non-taxable.

### ➤ Who Administers The Accounts?

Human Resource Administrators, Inc. (HRA, Inc.), a third party administrator, processes claims and provides individual consultation regarding the status of the account.

### ➤ How Do I Enroll?

Each year prior to the beginning of the plan year, your Employer will have a specified Open Enrollment Period. You will need to complete the Enrollment Form found at the back of this booklet and submit it to your Employer during this period of time since enrollment is required annually. FSA elections do not carry forward from year to year. If you or your spouse is enrolled in an HSA program you are not eligible to participate in the health care reimbursement portion of the Flexible Spending Account. **Unless you have a qualifying Change of Status during the year, you cannot make changes, such as increasing or decreasing your level of contributions.**

➤ **Qualifying FSA Expenses that May Assist You in Calculating Your Annual Out-of-Pocket Costs:**

A Flexible Spending Account allows you to receive reimbursements for medical expenses that are NOT reimbursed by insurance. Qualifying out-of-pocket medical, dental and vision expenses, as well as dependent care expenses are eligible. Listed below are some examples to help you estimate how much you might qualify for this year. This is not intended to be a comprehensive list.

QUALIFYING MEDICAL EXPENSES*	QUALIFYING DEPENDENT CARE EXPENSES*
<ul style="list-style-type: none"> <li>▪ Chiropractic Care</li> <li>▪ Co-payments</li> <li>▪ Contact Lenses/Solutions</li> <li>▪ Deductibles</li> <li>▪ Dental Treatment</li> <li>▪ Doctor Visits</li> <li>▪ Eye Exams</li> <li>▪ Glasses</li> <li>▪ Hearing Aids/Batteries</li> <li>▪ Hospital Services</li> <li>▪ Laser Eye Surgery</li> <li>▪ Mental Health Care</li> <li>▪ Orthodontics</li> <li>▪ Over-the-Counter Health Products</li> <li>▪ Prescription Drugs</li> </ul> <p><i>*Cosmetic procedures such as teeth bleaching or face lifts are not qualifying expenses.</i></p> <p><i>*Expenses that are reimbursed under your health care, dental or vision coverage are not qualifying expenses.</i></p>	<p>Your dependents must be -</p> <ul style="list-style-type: none"> <li>▪ A child under age 13 and living with you.</li> <li>▪ A child, spouse, or other dependent who is physically or mentally incapable of caring for himself/herself AND spends at least 8 hours a day in your household.</li> </ul> <p>You (if single) or you and your spouse (if married) must be -</p> <ul style="list-style-type: none"> <li>▪ Gainfully employed (working or looking for work)</li> </ul> <p>Your expenses can include-</p> <ul style="list-style-type: none"> <li>▪ Day care center expenses</li> <li>▪ Nursery/preschool expenses</li> <li>▪ Before/after school care</li> <li>▪ Babysitting expenses (provided the babysitter is not a relative under age 19 or a tax dependent of you or your spouse)</li> </ul> <p><i>*A dependent care credit is available on your annual Federal Income tax return. Whether you choose to participate in the Dependent Care reimbursement account or use the tax credit depends on your income, filing status, number of dependents, and annual daycare expenses. The final decision should be made after consulting with your tax advisor.</i></p>

➤ **Are All Kinds of Over-the-Counter (OTC) Health Products and Medicines Reimbursable?**

Effective January 1, 2011, OTC medicines and drugs cannot be reimbursed without a doctor's prescription. There is currently no definitive list that describes which OTC drugs are subject to this requirement and which are not. However, below is a preliminary list of some OTC drugs for which a prescription will be required on and after January 1, 2011.

OTC Medicine or Drug - Requires Rx	
Antacids	Digestive aids
Allergy and sinus medications	Feminine anti-fungal/anti-itch
Anti-biotic products	Hemorrhoidal preps
Anti-diarrheals	Laxatives
Anti-gas	Motion sickness medication
Anti-itch and insect bites	Pain Relief
Baby rash ointments and creams	Respiratory treatments
Cold sore remedies	Sleep aids & sedatives
Cough, cold and flu medications	Stomach remedies

OTC Health Product - No Rx Required	
Adult incontinence products	Heat wraps
Birth Control Products (i.e. condoms, pregnancy tests)	Heating pads, hot water bottles
Catheters	Insulin and diabetic supplies
Denture adhesives	Medicine dropper/spoon
Diabetic testing and aids	Nebulizers
Diagnostic tests and monitors	Orthopedic aids
Elastic bandages and wraps	Ostomy products
Eye care and contact lens supplies	Reading glasses
Family planning kits	Smoking deterrents
First aid supplies (i.e. Band-Aids)	Support/braces (i.e. ankle, knee, wrist therapeutic glove)
Health monitors (i.e. blood pressure, thermometers)	Syringes
Hearing aid batteries	Wheelchairs, walkers and canes

➤ **My Qualifying Expense Totals**

Total Out-of-Pocket Medical Expenses	\$	*
Total Dependent Care Expenses	\$	*

\*Use these amounts you have entered above to calculate your FSA annual election amount. Complete the Enrollment Form at the end of this packet.

### ➤ **How Do I Get My Reimbursements?**

Upon submission of a claim to Human Resource Administrators, Inc. a check will be mailed to your home unless you choose to have the reimbursement go directly into your checking or saving account. To authorize direct deposit, please complete the “Stop Running to the Bank” form included in this booklet.

### ➤ **Can I View My Account Information On-line?**

Yes. You can view your account information by visiting [www.HRAdministrators.com](http://www.HRAdministrators.com) and clicking on the myRSC link. You will need to know your Social Security Number and customized Employer Code in order to establish a personal Login ID. Please contact Human Resource Administrators, Inc. or your Employer for your Employer’s Code.

### ➤ **What If I Terminate During The Plan Year?**

Upon termination with your employer, you may submit claims with a date of service incurred prior to your end of coverage for a specified duration of time as stated in your Summary Plan Description.

### ➤ **What If I Don’t Use All The Money In My Account?**

It is important to accurately determine your qualifying expenses for the year. After the Run-Out Period of a plan year, any amounts not used to provide benefits will be forfeited and may not be paid to you in cash.

## QUICK SUMMARY

### ➤ **Rules for Both Dependent and Medical Accounts**

- You cannot submit a claim unless you are participating in the Flexible Spending Account Plan.
- You can be reimbursed only for eligible expenses incurred\* during the coverage period in which your contributions are made. Expenses incurred\* during the Grace Period can be reimbursed if so stated in the Summary Plan Description.
- Effective January 1, 2011, per IRS regulations over-the-counter medicines and drugs will no longer be considered an eligible expense unless you have a doctor’s prescription. Over-the-Counter health products are still eligible for reimbursement.
- You can submit a claim at any time during the plan year and for a specified duration of time after the plan year as described in the Summary Plan Description.
- If you terminate employment, you can submit a claim for a specified duration of time after the date of termination as stated in the Summary Plan Description as long as the service occurred before your date of termination.
- Money in one account can not be used for expenses incurred in another account. For instance, any unused amounts left in the medical account can not be used to reimburse dependent care expenses.
- You cannot receive payment from any other source for expenses reimbursed by claim, and you certify that you are not eligible to bill any other source for the reimbursed expenses.
- If you have received reimbursement for expenses, you cannot claim the expenses for income tax purposes.
- You cannot bill for a service period that begins in one plan year and ends in the next plan year. File two reimbursement claims, one for each plan year covering the period during that plan year.
- Complete ALL the information on the claim form for each amount claimed for reimbursement.
- Attach copies of itemized bills from service providers or the Explanation of Benefits Form from Insurance Carriers to the claim.
- Make a photocopy of the claim for your records.
- Submit the Claim with attached receipts according to the procedures provided. (See the “How To Submit Your FSA Claim” on the next page.)

### ➤ **Dependent Care Expenses**

- You can use a Dependent Care Spending Account only if you pay dependent day care expenses to be able to work. Your day care services can take place either inside or outside of your home. If you are married, your spouse must also work, go to school full time, or be incapable of self-care for you to be eligible.
- Only dependents living with you (a) under the age of thirteen or (b) adults or children thirteen years or older who are mentally or physically incapable of self-care are covered.
- If your plan includes the Grace Period provision, please be advised that the amount not used for services incurred\* prior to the end of the plan year will need to be reduced from the amount contributed to the next plan year. Your Maximum Contribution Amount can not be more than \$5,000 per calendar year if your tax filing status is married filing jointly and or single head of household or \$2,500 per calendar year if your tax filing status is 'married filing separately'.
- You cannot claim expenses if the service provider is your child or stepchild and are under age 19 or if you claim the service provider as a dependent for Federal income tax purposes. To be reimbursed, you must include the facility’s name, address, and tax identification number or the Social Security number of the individual providing the dependent day care service. Overnight camps or educational schooling is not covered.
- The maximum amount you can be reimbursed during the time you are covered in the Plan Year can not exceed the salary reduction amounts you have elected and made under the Dependent Care Assistance Plan less any previous reimbursements paid.

\*Incurred means the date services are rendered.

# HOW TO SUBMIT YOUR FSA CLAIM

In order to receive reimbursement from your Flexible Spending Account for medical and dependent care expenses, you must submit a completed Claim Form to Human Resource Administrators, Inc. Please follow the guidelines below. **IMPORTANT REMINDER:** Upon termination with your employer, you may submit claims with a date of service incurred prior to your date of termination only for a specified duration of time as stated in your Summary Plan Description.

## To CLAIM MEDICAL EXPENSES

1. Complete the *Medical Care Expense Claims* portion of the Claim Form.
2. Attach receipts, itemized bills or EOB's to support each expense. All documents must provide the following information:
  - Name of Service Provider (ex. Dr. Smith, ABC Hospital, XYZ Pharmacy, etc.).
  - Date of Service – Must occur during the Plan Year or during the Grace Period if so stated in the Summary Plan Description; Date of payment is not acceptable.
  - Nature of Service – Description of service performed or product purchased.
  - Name of Person Cared For.
  - Amount Charged for service or products – do not include amounts covered by insurance.
  - **Prescription drug receipts** must show date filled (not paid), prescription name, person for whom the drug is prescribed and charged amount. Cash register receipts alone are not acceptable.
  - **Over-the-Counter receipts** must indicate the name of the purchaser (or the name of the person for which the prescription applies) the date, the amount of the purchase and the Rx number. (This would be the prescription stub from the pharmacy.) - **OR** - If the customer receipt does not indicate an Rx number then a copy of the doctor's prescription must accompany the customer receipt when submitting the claim.
3. Sign and date the Claim Form. Mail or fax Claim Form and receipts to HRA, Inc.

**Please note:** Because OTC medications can be purchased "off-the-shelf", you may choose to have the OTC medications dispensed through the pharmacy as you would a regular prescription (thereby receiving an Rx number). Or, you may purchase medicines over-the-counter and submit a paper claim with a receipt and a copy of the prescription. In either case, the prescription should include the name of the prescribed OTC item, the date the prescription begins and the number of refills allowed, if applicable.

NOTE: **Canceled checks or credit card receipts** are not accepted as adequate documentation.

## To CLAIM ORTHODONTIC EXPENSES

SAMPLE WORKSHEET AND GUIDELINES AVAILABLE ON OUR WEBSITE

Please visit our website for an example of how the Orthodontic Election portion is calculated by plan year. You may use this worksheet if certified by the provider along with a signed and dated claim form to seek reimbursement. **ONCE EACH PLAN YEAR**, we need a copy of the original TREATMENT contract made with your orthodontist to initiate any pre scheduled payments with a signed and dated Claim Form.

1. Complete the *Medical Care Expense Claims* portion of the Claim Form. See *instructions above*.
2. Sign and date the Claim Form. Mail or fax Claim Form and receipts to HRA, Inc. for review.

NOTE: **Reimbursement for the entire expense "up-front" is not allowable since orthodontic treatments usually span over several plan years. Scheduled payments will be made in accordance to services incurred in the current Plan Year or Grace Period if so stated in the Summary Plan Description.**

## To CLAIM DEPENDENT CARE EXPENSES

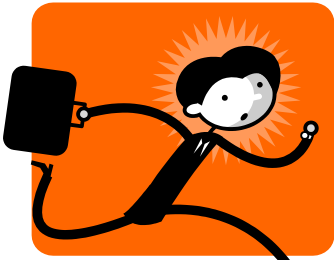
1. Complete the *Dependent Care Expense Claims* portion of the Claim Form.
2. Attach receipts to support your expenses—**OR**—Have the daycare provider sign the claim form. If you choose to attach receipts, all receipts must provide the following information:
  - Name and Address of Service Provider.
  - Taxpayer Identification Number (EIN)—**OR**—Social Security Number of Service Provider,
  - Date(s) of Care – Services must be provided during the current Plan Year or Grace Period if so stated in the Summary Plan Description.
  - Name of Person Cared For.
  - Amount Charged for care – paid amount are not acceptable.
3. Sign and date the Claim Form. Mail or fax Form and receipts to HRA, Inc. for review.

NOTE: **Canceled checks or credit card receipts** are not accepted as adequate documentation. **Expenses that are pre-paid will not be reimbursed until AFTER the date of actual care.**

MAIL or FAX Claim Form & Receipts to:  
Human Resource Administrators, Inc.  
PO Box 8, Center Valley, PA 18034  
FAX: (610) 282-4216

Questions or Need More Claim Forms?  
Go to [www.hradministrators.com](http://www.hradministrators.com)  
Click on **Forms**, then **Participants**  
or call us at (610) 282-4215

*All claims received by Friday (5:00 p.m. EST) will be processed by the following Friday.*



# Stop Running to the Bank!

**PLEASE NOTE:**  
Only complete the form if: 1.) this the first time you are applying for direct deposit OR  
2.) you are changing the account to which you reimbursement is going.

You can have your FSA / HRA Reimbursement directly deposited into your checking or savings account by following the two steps below:

1. Complete the form below.
2. Mail or Fax to:  
Human Resource Administrators, Inc.  
PO Box 8  
Center Valley, PA 18034  
Fax (610) 282-4216

*If you have questions, please call Amy Urmy: (610) 282-4215 ext. 105*

## AUTHORIZATION FOR AUTOMATIC REIMBURSEMENT DEPOSIT

COMPANY NAME: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_

LAST 4 DIGITS OF EMPLOYEE'S SOCIAL SECURITY NUMBER: \_\_\_\_\_

\_\_\_\_\_ FIRST TIME APPLYING OR \_\_\_\_\_ CHANGE TO ACCOUNT INFORMATION

I hereby authorize Human Resource Administrators, Inc. to initiate credit entries or debit entries to correct errors, to my \_\_\_\_\_ checking account or \_\_\_\_\_ savings account indicated below and the Depository named below to credit or debit the same to such account.

**\*\*An actual voided check OR copy of a check must be attached for checking accounts.\*\***  
**\*\* An actual deposit slip must be attached for savings accounts.\*\***

**Attach Voided Check Here**

This authority will remain in full force and effect until Human Resource Administrators, Inc. has received written notification from me of its termination in such time and in such manner as to afford Human Resource Administrators, Inc. a reasonable opportunity to act on it. I understand that I will not receive written confirmation of such deposits from Human Resource Administrators, Inc. Please note that the ACH transactions will be *initiated* within the reimbursement cycle. It generally takes 2-3 business days for the transaction to be processed.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# FLEXIBLE SPENDING ACCOUNT BENEFIT ENROLLMENT FORM



Employer Name: \_\_\_\_\_ SS # \_\_\_\_\_ Division: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Plan Year: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_, Zip Code: \_\_\_\_\_ E-mail: \_\_\_\_\_

To elect amounts for the next plan year, please enter an appropriate new ANNUAL deduction amount. DO NOT ROUND UP OR DOWN. With regard to Dependent Care, please be advised the amount not used for services INCURRED prior to the end of this plan year, will need to be reduced from the amount contributed to the next plan year. Maximum allowable amount per calendar year is \$5,000.00 or \$2,500.00 (if married and filing separately).

Benefit Description	Plan Year Election Amount (do not round up or down)	Number of payrolls during the plan year	Per Pay Deduction (divide Annual deduction by number of payrolls)	MID-YEAR USE ONLY By Authorized Representative			
				Election Amount (no rounding)	Number of payrolls remaining	Per Pay Deduction (divide Annual deduction by remaining payrolls)	
FSA Medical Spending							Effective date is:
<b>Annual Limit:</b>							
FSA Dependent Care							First pay deduction will begin:
Annual Limit: \$5,000							

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage shown above. Such reductions, considered as benefit elective contributions under the plan, will start with my first paycheck dated after the first of the plan year (for mid-year hires your effective date) and will continue for each pay period until this agreement is amended or terminated. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code.

**Please note, any expenses incurred during the current plan year plus the Grace Period after plan year end must be submitted prior to the end of the Run Out period as defined in your Summary Plan Description. Any unused balances will be forfeited.**

I understand if I terminate employment I may submit claims with a date of service incurred prior to the end of coverage date for a specified duration of time as stated in your Summary Plan Description.

If I have the mySourceCard debit card, I understand that it can only be used for eligible medical expenses. In addition, I certify that all claims paid with the mySourceCard have not been reimbursed and I will not seek reimbursement from any other plan covering health benefits.

I understand effective January 1, 2011, per IRS regulations over-the-counter medicines and drugs will no longer be considered an eligible expense unless I have a doctor's prescription. Over-the-Counter health products are still eligible for reimbursement.

I have read the Summary Plan Description with the Plan information Summary given to me by my Employer. This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as listed on the Status Change Matrix I received with the Summary Plan Description.

**To Authorize Participation:** I hereby certify the above information to be correct and true and choose to participate in the plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please return Enrollment Form to your employer's Human Resource Department no later than \_\_\_\_\_.  
You must complete this form to participant in the new plan year. Thank you.