What is a Flexible Spending Account?

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. When you enroll in your employer sponsored Flexible Spending Account, your contributions are not subject to Federal, FICA and most state taxes. This means you bring more home more money in your paycheck!

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

*Figures above are for illustration purposes only. Actual Savings and tax rates may vary

How does an FSA work? Each year prior to the beginning of the plan year, you will need to make an annual election for medical and/or dependent care expenses by completing an enrollment form during the specified Open Enrollment Period. Enrollment is required annually, FSA elections do not carry forward from year to year. 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. 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.**

How should I estimate my expenses? You should think about how much you spend in qualifying health and dependent care expense each year. This can be your annual election amount that you can elect during Open Enrollment. If this is the first time enrolling in the plan, elect a little less than you have estimated to ensure you will use all of your funds.

Are there limits I should be aware of? For the Health FSA each employer decides the maximum you can elect during open enrollment. The overall IRS limit for plan years starting January 1, 2017 or after is $2,600. Please consult your Summary Plan Description for plan limit information. For Dependent Care FSA the maximums are limited to the smaller of the following 1) $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' 2) your "earned income" for the year or 3) if you are married at the end of the taxable year, your spouse's earned income.

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, **if so stated in your enrollment material and Summary Plan Description**, you can carryover up to $500 of unused funds to the new plan year. Any amount over $500 will be forfeited. In addition, money in one account cannot be used for expenses incurred in another account. For instance, any unused amounts left in the Health FSA cannot be used to reimburse dependent care expenses.

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What are eligible Health FSA expenses? A Health 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 general health products and prescribed over-the-counter medicines. This list is intended to be used as a quick reference of potentially eligible medical expenses and does not guarantee that an expense will be eligible. Please see your plan documents to verify what expenses are reimbursable under your plan. In addition to the list below, there are over 150 additional items or expense types that are considered potentially eligible. These may require prescriptions or a letter of medical necessity when submitting a reimbursement request.

Eligible Medical Expenses

- Acupuncture
- Ambulance
- Breast pumps
- Co-insurance amounts
- Dental services & procedures
- Diabetic supplies
- Flu Shots
- Hospital services
- Lab Fees
- Obstetrical expenses
- Physical exams
- Preventive care screenings
- Radial keratotomy
- Speech Therapy
- Vaccines
- Allergy Treatments (if prescribed)
- Body Scans
- Chiropractors
- Co-payments
- Diagnostic items/services
- Eye examinations, eyeglasses equipment and materials
- Immunizations
- Lactation consultant
- Orthodontia
- Physical Therapy
- Prosthesis
- Screening tests
- Transplants
- X-ray fees

For a more comprehensive list, please view Eligible & Ineligible Expense List on our website www.HRAdministrators.com

Eligible Over-the-Counter Medical Supplies

Arthritis gloves
Adult incontinence products (e.g. Depends)
Birth control products (e.g. prophylactics) (if allowed by your plan) Contact lens solution
Denture adhesives
First aid supplies (e.g. Band-Aids)
Hearing aids and batteries
Heating Pads
Supports/braces (e.g. ankle, knee, wrist, therapeutic glove)

Eligible Over-the-Counter Drugs & Medicines

(requires a prescription)

Anti-fungal medications
Cold sore medication
Diaper Rash ointments
First Aid Creams
Gastrointestinal aids (e.g. antacids, anti-diarrhea medicines, laxatives)
Pain Relievers (e.g. aspirin, Tylenol, Advil, Motrin)
Wart remover medications

What are eligible Dependent Care FSA expenses? A Dependent Care FSA allows you to receive reimbursement for dependent care expenses (e.g. child care) for a qualified person. These expenses enable you and, if married, your spouse to be gainfully employed, look for work, or attend school full time.

Qualifying Dependents

Dependent child under the age of 13 and for whom you can claim a tax exemption

Souse or dependent who is physically or mentally incapable of self-care, lives with you for more than half of the year, and for whom you can claim a tax exemption

The qualified person must spend at least 8 hours per day in your home

Eligible Dependent Care Expenses

Day care center expenses
Day camps
Nursey/preschool expenses
Before/after school care
Babysitting expenses inside or outside your home (provided the babysitter is not a relative under age 19 or a tax dependent of you or your spouse)
Adult care
Overnight camps and educational schooling CANNOT be reimbursed

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Can I view my Account information online? Visit www.HRAdministrators.com and click on the Resource Service Center (myRSC) 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. In addition, you can now view your account on your smart phone by visiting iTunes App Store or Google Playstore and search for "myRSC" to download and install the free app.

How do I access my FSA? You can use your mySourceCard (if offered) or submit a claim for reimbursement.

mySourceCard

(Health FSA only)

Use at qualified merchants providing medical products and services such as doctors, dentists, labs, hospitals, vision centers and certain drugstores.

Always save your itemized receipts, the IRS requires Human Resource Administrators, Inc to receive substantiation for certain transactions.

Submit a claim/substantiation

Online – log in to myRSC.com, click on the "Online Claims Entry" link or the icon and follow the on screen instructions

myRSC Mobile App – download the myRSC app from ITunes or Google Play, use myRSC log in and follow on screen instructions

Mail/Fax/e-mail – complete a claim form, attach itemized receipts and submit to Human Resource Administrators, Inc.

- For the Health FSA, you will receive the full amount claimed for qualifying expenses up to your annual election amount regardless of the level of contributions made to your account. You can be reimbursed only for eligible expenses incurred (date the services are rendered) 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.

- With regard to the Dependent Care FSA, the maximum amount you can be reimbursed during the time you are covered in the Plan Year cannot exceed the salary reduction amounts you have elected and made under the Dependent Care Assistance Plan less any previous reimbursements paid.

- All claims received by Friday (5:00 p.m. EST) will be processed by the following Friday. 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 Direct Deposit Form.

- If you terminate 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

Questions?

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ACH Authorization Form

CREDIT/DEBIT Authorization Form

Please note that it is not necessary to fill out a form if you have done so in the past, unless you are requesting a change of account information or you are requesting to cancel your direct deposit agreement. You are not required to submit a new form each plan year.

Name of Employer: _____ Last 4 Digits of Social Security # _____

Employee Name: _____

Daytime Phone Number: _____ E-mail Address: _____

Please indicate the type if agreement being authorized by placing an "**X**" next to the appropriate field

☐ New Authorization ☐ Change in Account Information ☐Cancel Authorization

Bank Name: _____

Nine Digit Routing Number: _____ Account Number: _____

Type of Account: ☐ Checking ☐ Savings

Please provide a voided check OR copy of a check if available for checking accounts
A copy of a deposit slip for savings accounts

Attach Voided Check Here

I hereby authorize Human Resource Administrators, Inc. to initiate credit entries or debit entries to correct errors to my account with the Financial Institution indicated above. 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: _____

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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. The exclusion from income for payments is limited to the smallest of the following 1.) $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' 2.) your "earned income" for the year or 3.) if you are married at the end of the taxable year, your spouse's earned income.

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:
Annual Maximum: $2,600							
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.