Augusta County Schools
Flexible Spending Accounts

Medical Reimbursement Account

Dependent Care Reimbursement Account

Information Handout

Employee Benefits Office
6 John Lewis Road
Fishersville, VA 22939
Phone: (540) 245-5126
Fax: (540) 245-5174

http://www.augusta.k12.va.us/benefits

Employee Fact Sheet

Flexible Spending Accounts
Medical Reimbursement Account & Dependent Care Account
Questions and Answers

Q. WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A. These accounts permit you to set aside money on a pre-tax basis, via payroll deduction, to pay for eligible medical and dependent care expenses. Examples of these are medical, dental, and vision expenses, certain over-the-counter medicines and supplies that are not covered by insurance or other benefit plans, or dependent care expenses for a dependent who is under age 13 or older if that dependent cannot physically or mentally care for him/herself.

Q. HOW DOES A FLEXIBLE SPENDING ACCOUNT WORK?

A. The amount that you elect to set aside is deducted from your paycheck before taxes are calculated and deducted. These monies are held in an account until you request reimbursement. A special MasterCard, referred to as a Benny Card, will be issued to each participant. The Benny Card gives you an easy, automatic way to pay for qualified health care expenses. If you choose not to use the Benny Card, after you have incurred an eligible medical or incurred and paid for a dependent care expense, you can request reimbursement using a claim form provided by the claims administrator. You may also be required to provide receipts with the date(s) of service and a description of the expenses. Reimbursement checks are issued on a weekly schedule. Claims are due in the administrator's office by 5 PM Tuesday for processing on Thursday.

Q. HOW DO I JOIN THIS PROGRAM?

A. You may participate in this program if you complete and submit an enrollment form as a new hire, during the Annual Open Enrollment period which takes place in November each year, or within 30 days of a status change event.

Q. HOW MUCH MAY I SET ASIDE IN THIS PROGRAM?

A. You may set aside up to $2,500 to pay for qualified medical expenses. You may set aside up to $5,000 ($2,500 if you are married and file separate tax returns) to pay for qualified dependent care expenses. Please note that these are separate accounts. You may elect to participate in one or both accounts. The money in one account cannot be used to pay for expenses related to the other account. Under IRS rules, you can be reimbursed up to your maximum election amount for qualified medical expenses even though you have not completed all of your contributions, however, you may only be reimbursed what you have contributed to date for qualified dependent care expenses.

Q. WHAT IS AN ELIGIBLE MEDICAL REIMURSEMENT ACCOUNT EXPENSE?

A. An eligible expense is a health-related expense for you and/or eligible family members (according to the IRS, this does not include domestic partners or the children of domestic partners unless they are an IRS dependent), that is not paid or reimbursed by a benefit plan. This includes office visit and prescription drug co-payments, deductibles, coinsurance, and certain over-the-counter medicines and supplies. (For examples of eligible medical expenses see the "Examples of Medical Reimbursement Expenses" list in this handout).

Q. WHAT IS AN ELIGIBLE DEPENDENT CARE ACCOUNT EXPENSE?

A. An eligible expense is money that you pay to an individual, day care facility, preschool, or day camp to care for your child who is under the age of 13 (or a disabled dependent over the age of 13) so that you (and your spouse, if married) can work, look for work, or go to school full time. The day care provider cannot be a dependent on your tax return or your child under age 19. A domestic partner and/or the children of the domestic partner are not considered a spouse or a dependent for the purposes of this Plan.

Q. WHAT IS THE EFFECT ON MY PAYCHECK IF I PARTICIPATE IN THIS PROGRAM?

A. Since the deduction from your paycheck is on a pre-tax basis, the effect on your check will vary based upon your tax bracket. Here is an example of how before and after tax deductions work.

	AFTER-TAX DEDUCTION	PRE-TAX DEDUCTION
Gross Pay	$1,000	$1,000
Flexible Spending Account Deduction		$ 400 ($100 medical/$300 dependent care)
Taxable Income	$1,000	$ 600
Taxes Withheld	$ 250	$ 150
Net Paycheck	$ 750	$ 450
Medical Expenses	-$ 100	*(reimbursed from account)*
Dependent Care Expenses	-$ 300	*(reimbursed from account)*
Net Income	$ 350	$ 450

Q. CAN I CHANGE MY DEDUCTION AMOUNT DURING THE YEAR?

A. According to the Internal Revenue Code, mid-year changes in your contribution amounts can only occur if you have a qualifying status change event (e.g. marriage, divorce, death, birth, adoption). The qualifying event must be consistent with the change you would like to make. You are required to notify the Benefits Department within **30 days** of the status change event, otherwise you will be unable to make any changes in relation to that qualifying event.

Q. IF I DON'T USE ALL OF THE FUNDS IN THE ACCOUNT CAN I USE THEM THE NEXT YEAR?

A. The Internal Revenue Code has special rules for this program. One of the rules is often referred to as the "use it or lose it" rule. According to the IRC, if there are funds left in your account at the end of the Plan year (for example you contributed $2,000 for medical reimbursement, but only spent $1,800), those funds will be forfeited. Therefore it is very important that you estimate your expenses accurately. However, under the "grace period" rule, eligible expenses that you incurred in the 2 ½ month period after the end of the plan year still qualify for reimbursement, providing you an additional opportunity to maximize your savings. The plan year is the calendar year. The grace period ends on March 15. You have a 2 month run out period to submit incurred expenses for reimbursement. The run out period ends May 15.

Q. WHAT IF I HAVE ADDITIONAL QUESTIONS?

A. If you have additional questions, you may contact:

LDB Insurance, Inc.
Stephanie Van Meter
205A South Liberty Street
Harrisonburg, VA 22801
Phone: (800) 366-3846 or (540) 438-4102
Fax: (866) 292-8331 or (540) 434-9670
E-mail: svanmeter@ldbinsurance.com
Website: http://www.LDBINSURANCE.com

EXAMPLES OF MEDICAL REIMBURSEMENT EXPENSES

Eligible for reimbursement if not paid by insurance

ELIGIBLE HEALTH CARE EXPENSE

Ace bandages
Acupuncture
Actifed
Allergy medication
Ambulance fees
Advil
Aleve
Alka Seltzer
Antacids
Anacin
Anti-diarrhea medicine
Bactine
Balmax
Bayer
Bandage tape
Band-Aids
Ben Gay
Benadryl
Bufferin
Burn creams
Blood pressure monitor
CPAP Machine
Calamine
Caladryl
Chiropractic
Chlor-Trimitron
Chloraseptic
Claritin
Copays
Cold medicine
Compound W
Condoms
Contac
Contraceptive foams
Contacts
Contact lens solution
Cortaid
Cough medicine
Crowns
Crutches
Dayquil
Deductibles
Desenex
Desitin
Dimetapp
Diabetic supplies
Diaper rash ointments
Doctor visits
Dulcolax
Dramamine
Drixoral
Excedrin
Ex-Lax
Eye drops
Eye exams
Fillings
First Aid creams
First Aid kits
First Aid supplies
Flexall
Gauze
Gaviscon
Gas-X
Glasses
Gyne-Lotrimin
Hearing aids
Hemorrhoid medication
Hydrocortisone
Immodium AD
Kaopectate
Lab work
Lactose intolerance pills
Lamisil
LASIK
Lotrimin
Laxatives
Little Colds
Little Noses
Maalox
Marazine
Micatin
Midol
Midwives
Mentholatum
Milk-o-Magnesia
Monistat
Mylanta
Motrin
Naturopathic Dr. Visits
Neosporin
Nicoderm
Nicorette
Nicotrol
Nicotine gum/patch
Nyquil
Orthodontia
Orajel
Pamprin
Pain relievers
PediaCare
Pepcid AC
Pepto-Bismal
Physical exams
Physical therapy
Pregnancy tests
Prenatal vitamins
Preparation H
Prescription drugs
Primatine Mist
Prilosec
Psychotherapy
Reading glasses
Riopan Plus
Robitussin
Rolaids
Root canals
Rubbing alcohol
Saline solution
Simply Cough
Sinus medication
Sudafed
Surgery
Syrup of Ipecac
Sterilization procedures
Sunscreen
Tagamet
Thera-Flu
Thermometers
Tiger Balm
Tinactin
Triaminic
Tums
Tylenol
Vaccinations
Vagisil
Visine
Vicks
X-Rays
Zantac

INELIGIBLE HEALTH CARE EXPENSE

These expenses are not reimbursable through a Health Care FSA.

Birthing coach
Breast pumps
Cosmetic surgery
Dental bleaching
Dental Veneers
Electrolysis
Family counseling
Gender Reassignment
Health club dues
Hygiene products
Hypoallergenic linens
Hypoallergenic pillows
Insurance premiums
Marriage counseling
Marijuana
Shampoo
Naturopathic medicines
Neck support pillows
Shoe Insoles
Sonicare products
Special shoes
Toiletries
meals/bars/shakes

DOCUMENTATION REQUIRED

Certain medical expenses are not reimbursable under a Health Care Flexible Spending Arrangement unless a licensed health care professional states that the service or product is medically necessary.

Acne treatment
Adult diapers
Airborne
Air purifiers
Custom Orthotics
Hormone therapy
Humidifiers
Massage therapy
Specialty foods
Supplements
Vitamins
Weight loss

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Medical Reimbursement Account

WORKSHEET

ESTIMATED MEDICAL EXPENSES (not reimbursed by insurance)	
Health insurance deductible	$
Co-Insurance (insurance paid 80%, you pay 20%)	$
Routine exams/physicals	$
Immunizations	$
Insulin	$
Laboratory	$
Therapy treatments	$
Wheelchair, crutches, splints, corrective devices	$
Prescription drugs	$
Office visits	$
Chiropractic visits	$
Other	$
Subtotal	***$***

ESTIMATED DENTAL EXPENSES (not reimbursed by insurance)	
Dental insurance deductible	$
Co-Insurance (insurance paid 80%, you pay 20%)	$
Examinations and cleanings	$
Fillings, crowns, and bridges	$
Dentures (including replacement)	$
Implants, in-lays, x-rays	$
Orthodontia	$
Other	$
Subtotal	***$***

ESTIMATED VISION EXPENSES (not reimbursed by insurance)	
Vision insurance deductible	$
Co-Insurance (insurance paid 80%, you pay 20%)	$
Vision examinations	$
Lenses and frames	$
Contacts	$
Other	$
Subtotal	***$***

TOTAL ESTIMATED EXPENSES (add all subtotal amounts)	**$**

PAY PERIOD AMOUNT: _____ ÷ _____ = _____

Estimated Annual Expense | Number of Pay Periods | Per Pay Period Amount

Dependent Care Reimbursement Account

WORKSHEET

The Dependent Care Reimbursement Account may be used to pay for dependent care services which allow you (and your spouse, if married) to work, look for work, or go to school full time. Your dependent must be under the age of thirteen (13) or over the age of 13 if the dependent is physically or mentally incapable of caring for himself/herself and can be claimed as a deduction on your Federal income taxes. The maximum amount you may elect is $5,000 per calendar year if you are married and filing a joint return (or $2,500 if you are single or if you are married filing separate tax returns). In the case of divorced parents, the child must qualify as a custodial parent's dependent. The maximum reimbursement you can claim will be your annual earned income, or your spouse's annual earned income, if less than yours. If your spouse is a full-time student or is physically or mentally incapable of caring for him/her, or medically disabled, he/she shall be deemed to have an annual earned income of $3,000 if you have one dependent and $6,000 if you have two or more dependents.

ESTIMATED DEPENDENT CARE EXPENSES:

January	$
February	$
March	$
April	$
May	$
June	$
July	$
August	$
September	$
October	$
November	$
December	$
TOTAL EXPENSES	$
Divide by number of pay periods (12 per year) for monthly total	$

In calculating your deduction amount please take into consideration that you should not claim non-work related expenses.

DEPENDENT CARE TIPS AND QUIDELINES

The Dependent Care Reimbursement Account may be used to reimburse you for the expenses associated with providing care and services for your dependents while you are at work.

WHO IS A QUALIFIED DEPENDENT?

- Your dependent under the age of 13 and whom you claim as an exemption on your Federal tax return.
- Your dependent over the age of 13 and whom you claim as an exemption on your Federal tax return if the dependent is physically or mentally disabled and cannot care for himself/herself.

*Domestic partners are not considered a spouse or dependent. Children of a domestic partner are not considered a dependent for purposes of this Plan.

WHAT ARE ELIGIBLE EXPENSES?

- Day care expenses enabling you (and your spouse if married) to work, look for work, or attend school full time.
- Babysitters, dependent care centers, pre-kindergarten/nursery schools, after-school care or extended day programs, summer day-camps (if the primary purpose of the expense is custodial in nature and not educational).

WHAT EXPENSES CANNOT BE REIMBURSED?

- Any expense that you intend to claim as a credit for Federal tax purposes.
- Educational expenses for a child in kindergarten or higher grade.
- Food, clothing, shelter, insurance, medical treatment, transportation, or extra charges for diaper changing (if charged separately from dependent care expenses).
- Expenses that are incurred when you (or your spouse, if married) miss work due to illness, vacation, or paid holidays.
- Day care expenses if you are married and your spouse is not working or a full-time student.
- Overnight camp expenses.
- Babysitting amounts paid to your child under the age of 19 or any relative who can be claimed as a tax dependent on your Federal tax return.

UNDER WHAT CIRCUMSTANCES CAN YOU CHANGE YOUR ELECTION?

- Marriage, divorce, legal separation, or annulment.
- Death of a spouse or the covered dependent.
- Birth, adoption, or placement for adoption or foster care of a dependent.
- Change in employment status of the employee, spouse, or dependent that affects eligibility (commencement of employment, termination of employment, change in hours, strike or lockout, or change in worksite).
- Gain or loss of dependent status (e.g. dependent becomes eligible or ineligible due to a change in age gain/loss of student status, marriage or similar circumstance).
- Change in residence of employee, spouse, or dependent that affects eligibility.
- FMLA leave (some other medical leaves may qualify for an election change).

Notes: The qualifying status change event must be consistent with the change you make in your election. The Employee Benefits Office must be notified and the forms completed within 30 days of the qualifying status change event.

These are guidelines for the Plan. The Plan Document and the Internal Revenue Code will dictate the actual plan operations. Copies of the Plan Document and Summary Plan Description for Augusta County School Board Flexible Benefits Plan are located at www.augusta.k12.va.us/benefits.

LD&B Insurance Agency, Inc.

DIRECT DEPOSIT AUTHORIZATION

Please complete this form if you prefer to have your FSA reimbursement deposited directly into your bank account rather than receive a check.

PLEASE ATTACH A VOID CHECK HERE

DEPOSIT SLIPS NOT ACCEPTED

- **INSTRUCTIONS**
  1. PLEASE PRINT ALL INFORMATION CLEARLY.
  2. Attach a void check if you designate a checking account. DO NOT SUBMIT A DEPOSIT SLIP. If you designate a savings account, attach a completed Savings Account Direct Deposit Form from your financial institution.
  3. Please sign and date the form. Omission of signature will delay processing.
  4. Mail completed form to the address indicated at the bottom of the page.
  5. Notify LD&B Insurance Agency, Inc. of any account changes or account closings.

Direct Deposit authorization requires that all account and bank routing numbers be verified for accuracy before any funds are transferred. Claims submitted during the 10-day verification period will be reimbursed with a check. After the verification period, reimbursements will be posted to your bank account on the scheduled reimbursement date. You will receive an Explanation of Benefits and a new Claim Form through the mail.

- **PARTICIPANT INFORMATION**

First Name _____ Last Name _____ Social Security Number _____ - _____ - _____

Daytime Telephone (____) _____ - _____ Employer Name _____

- **BANK INFORMATION**

Check only one: ( ) Set-up Direct Deposit for:
( ) Checking (attach a void check above)
( ) Savings (attach a Savings Account Direct Deposit Form from your financial institution)

( ) Change Account Information

( ) Cancel Direct Deposit

Full Bank Name _____ Telephone _____

Bank Routing Number (9-digit number on lower left of check) _____

Bank Account Number (to 17 digits) _____

IMPORTANT

- The designated account must be in your name
- Processing of your Direct Deposit information will be delayed if you do not include both the bank account number AND the bank routing number. Call your bank if you are unsure of your account information

- **AUTHORIZATION**

I hereby authorize LD&B Insurance Agency, Inc. to initiate credit entries for depositing my Flexible Spending Account reimbursements into my account designated above and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until LD&B Insurance Agency, Inc. has received written notification from me of its termination in such time and in such manner as to afford LD&B Insurance Agency, Inc. a reasonable opportunity to act on it.

Employee Signature _____ Date _____

Mail to: LD&B Insurance Agency, Inc. ● 205-A South Liberty Street ● Harrisonburg, VA 22801
Telephone: (540) 433-2796 ● (800) 366-3846

******Form must be received within 30 days after start of plan year.***

FLEX ENROLLMENT FORM

For the Plan Year _____ to _____

PLEASE PRINT

Name _____ Employer _____

Address _____ Email _____

_____ Social Security # _____

Indicate below the options in which you would like to participate.

I authorize my employer to make the following salary reductions:

☐ **Health Care Reimbursement Account**

I elect to have an annual amount of amount of $_____, which equals $_____ per pay period, reduced from my salary before taxes to reimburse me for eligible health care expenses which I incur during the plan year specified above.

☐ **Dependent Care Reimbursement Account**

I elect to have an annual amount of amount of $_____, which equals $_____ per pay period, reduced from my salary before taxes to reimburse me for eligible dependent care expenses which I incur during the plan year specified above. Reimbursement from this and other dependent care plans for which you may be eligible is limited to $5,000 per year, or $2,500 per year if you are married filing separately. Reimbursement is further limited to your earned income or your spouse's earned income, whichever is less.

I understand that:

- I cannot change this election during the plan year unless I have a change in family status.
- Any amounts remaining in my reimbursement accounts at the end of the year will be forfeited.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous elections and will terminate on the earlier of: (1) the end of the plan year, (2) when I am no longer a qualified employee eligible to participate in the plan, (3) termination of the plan.
- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I further understand, with regard to Benny Card transactions, that:

- Once I receive my Benny Card, I will only use it for payment of qualifying health ad dependent care FSA expenses for myself or eligible dependents.
- Any expense that I pay with the Benny Card will not have been reimbursed, not will I be seeking reimbursement, under any other plan or program of benefit coverage.
- I must save all invoices and receipts for any expenses I pay with the Card and upon request, will submit these documents for review by the plan.
- Each time I use or permit my Benny Card to be used for payment, I will renew and reaffirm the "My Use of Card Promises" that I will receive with the Benny Car.

LD&B is not allowed to discuss your account with your spouse or dependents (18 or older) unless you sign this form and list them below. This is due to the HIPAA regulations. To allow LD&B to release information to your spouse or dependents (18 or older) regarding processing claims, content of claims, account balances and any other information regarding your accounts, please list them below.

Signature _____ Date _____

Spouse _____

Dependent (18 or older) _____ Dependent (18 or older) _____

To Be Completed By Employer

Eligibility Date _____ Salary Reduction To Begin On Payroll Date _____

Accepted By _____ Date _____

LD&B INSURANCE AGENCY, INC. ● Flexible Benefits Division ● 205 A South Liberty Street ● Harrisonburg, VA 22801 ● (540) 433-2796