LD&B
Benefits Administrators

FSA Frequently Asked Questions

GENERAL QUESTIONS

A1. What expenses can I submit for reimbursement?

In order to be considered for reimbursement, the expenses have to be incurred within the plan year and while you are an active participant in the plan (i.e. prior to your coverage termination date if you terminate mid-way through the year). Expenses are considered "incurred" at the time the services are provided – not when you are formally billed for or pay for the services.

A2. What documentation is necessary to make a reimbursement claim?

Health care claims must first be submitted to any available insurance plan for payment. After the insurance carrier has processed the charge, the participant's portion of the charge can be submitted for reimbursement.

Third party documentation of the expense (e.g., an Explanation of Benefits from insurance or an itemized provider bill) must accompany the claim. The plan administrator must be able to determine:

- the date(s) the services were rendered;
- the patient name;
- the nature of the services; and
- the amount due minus any insurance adjustments or provider discounts.

For dependent care claims, the same information is necessary except that there is, of course, no insurance information. Your plan may require that the claim include the tax ID number of the dependent care provider. Again, there must be third party documentation of the expense (e.g., an itemized bill or provider signature).

In addition, each claim for reimbursement (health or dependent care) must be accompanied by the participant's signed statement that the expense is eligible for reimbursement and that the expense has not been, or is not reimbursable from any other source.

A3. Can elections be changed during the plan year?

In general, once an election becomes effective, it can't be changed until the next plan year. However, there are a few exceptions to this rule. The most common exception is called a "change in status." When you have a change in status, you may revoke your election or submit a new election for the remainder of the plan year if the election is "consistent" with the change in status event. You have 30 days following a status change to submit a new election. Following are the allowable change in status events.

- Legal marital status (i.e., marriage, divorce, death of a spouse)
- Number of dependents (i.e., birth, adoption, death)
- Change in residence of you, your spouse or dependent that affects eligibility for coverage
- Employment status of you, your spouse or a dependent (i.e., termination or commencement of employment, leave of absence or other employment change that affects benefit eligibility)
- Dependent satisfies or fails to satisfy the eligibility requirements of a plan (i.e., the dependent reaches the limiting age for coverage).

A4. How do I know if an election change is "consistent" with the change in status event?

In general the consistency test is met only if an election change is due to a change in status that affects eligibility. For example, if you are divorced or your child ceases to be eligible for coverage under the Plan, the consistency test is met if coverage is cancelled for your former spouse or child. However, the consistency test is not met if coverage is cancelled for any other dependents covered by the plan whose eligibility was not affected by the change in status. Also, if coverage terminates because you, your spouse, or your child gains eligibility for coverage under another employer's plan, the consistency rule is met only if coverage for the affected individual becomes effective under the other plan.

A5. Are there circumstances other than "status changes" that trigger allowable election changes?

In addition to the change in status events listed in A3 above, you may change your election under the following circumstances: 1) to comply with a decree or judgement resulting from a divorce, separation, or change in legal custody; 2) if you or your dependent becomes entitled to Medicare; and 3) if the election change corresponds with a qualifying unpaid leave of absence or certain special enrollment rules that apply to health plans. Finally, certain changes in benefit costs or coverage may trigger election changes. For example, election changes are allowed if 1) a new qualifying benefit is added to the Plan mid-year; 2) the cost or coverage of a benefit significantly increases or decreases during the plan year; or 3) the election change corresponds with an election change made by your spouse or dependent under another employer sponsored plan (i.e., when the other employer plan operates on a different plan year). *Note that these cost and coverage rules <u>do not</u> apply to the Health Care Reimbursement Account.*

A6. Can I sign up for the plan at anytime during the year?

Generally, you can only sign up for the plan during the open enrollment period before the beginning of each plan year. However, if you have a change in status (see A3) you may be able to sign up for the plan during the plan year. New employees or employees who were not eligible during the open enrollment period may sign up for the plan at the time they become eligible to participate. Refer to the Summary Plan Description for this information. Other than these instances no mid-year enrollments are allowable.

A7. What happens to elections during an FMLA leave?

If your employer regularly employs 50 or more individuals, your plan must comply with requirements of the Family and Medical Leave Act of 1996 ("FMLA"). FMLA provides you with additional rights regarding continuation and resumption of health benefits in the event of a qualified family medical leave. FMLA does not apply to dependent care reimbursement plans.

You can continue health benefits at the active employee rate during the FMLA leave or you can choose to drop health coverage during the FMLA leave and resume it upon return to active employment.

If you choose to keep health care spending account coverage during the leave, you must continue to pay for it. Your cost is the salary reduction amount. If your cafeteria plan includes an employer provided benefit credit, credits will continue to accrue to your account during the FMLA leave. There are three possible payment options during an FMLA leave. Your plan does not have to allow all three, but many do.

PREPAYMENT
You could prepay amounts that will become due during the leave out of one or more paychecks preceding the leave. Prepayment contributions can be taken from vacation and paid time off checks as well as regular paychecks. Prepayment contributions can be made on a pre-tax basis. This payment option could also be offered for dependent care spending accounts even though they are not subject to FMLA.

If your plan offers prepayment, it must also offer at least one of the other two payment options described below. Any pre-tax prepayments must be for coverage during the plan year in which the leave began.

PAY-AS-YOU-GO
You could pay amounts due during the leave as they occur. This option is similar to making COBRA payments, except that the amount due is only the active employee cost. These payments will be after-tax if the leave is unpaid. This option could also be offered for dependent care spending account even though they are not subject to FMLA.

CATCH-UP
If you agree in advance of the leave, you could pay for coverage out of one or more paychecks following your return to active employment. Payments can be pre-tax as long as they are for coverage during the same plan year in which the leave began. This option could also be allowed for dependent care spending accounts even though they are not subject to FMLA.

Your plan can offer catch-up as the only payment option, as long as the same rule applies to employees on non-FMLA leaves.

OPTIONAL REINSTATEMENT
You are not required to continue coverage during the FMLA leave. You can choose to terminate coverage when the leave begins and may choose to reinstate it upon return to active employment. This provision is available only for FMLA benefits and cannot be applied to dependent care spending accounts.

If you choose to terminate coverage during the leave, no claims for services rendered during the leave period are eligible for reimbursement. In this case, you do not make payments for coverage that would have become due during the leave, and your annual election is correspondingly reduced.

A8. What happens to my flex election if my employment terminates?

Premium Conversion elections automatically stop with the last paycheck. You will have the right to continue health (and in some states group life insurance) on an after-tax basis through COBRA. For information on what COBRA laws apply to group health and life coverage, refer to the Summary Plan Descriptions for those benefits.

Dependent Care Reimbursement contributions automatically stop with the last paycheck. There is no COBRA continuation provision that applies to Dependent Care. If money remains in the account, you may continue to submit claims for reimbursement for services rendered through the end of the plan year.

> For example: John Smith terminates employment on June 30. His dependent care account has a balance of $175. Smith becomes employed by another company and incurs work-related dependent care expenses in August. He can submit claims for the August expenses against his $175 available balance.

Health Care Reimbursement coverage automatically terminates on the date of the last paycheck (or in some plans, on the last day of the month), but you may have the right to continue coverage under COBRA (contact your Human Resources Department for more information). Unlike the rules that apply to dependent care spending accounts, claims incurred after termination of coverage are not reimbursable, unless you continue coverage. A claim is "incurred" on the date services are rendered. Claims incurred before termination of coverage are reimbursable regardless of whether you elect COBRA.

A9. What happens to the money in spending accounts if it is not used up by the end of the Plan Year?

If your plan design allows for a rollover, health care funds remaining in the plan (up to $500) will be rolled into the new plan year after the end of the run out period. If your plan does not allow for a rollover, any funds remaining in your account at the end of the plan year will be forfeited.

Some plans that don't allow the rollover may offer a grace period to incur services after the plan year ends and then a run out period to turn in expenses for reimbursement. Remember that an expense is "incurred" on the date the service is provided, not when you are billed or pay for it.

See your benefit plan materials or contact your Administrator at LD&B for more information on your specific plan design.

A10. Who makes the rules regarding the Flexible Spending Accounts?

Some rules, such as eligibility requirements and plan maximums (for the Health Care FSA) can be established by the Employer; however, most are dictated by the IRS.

A11. What happens to the employee's tax return at the end of the year?

For the Health Care account, you can't take expenses that are reimbursed under the Health FSA as itemized deductions on your Federal tax return.

For the Dependent Care account, you can't use the same expenses for the DCA and the Dependent Care Tax Credit. Remember that because the limit on eligible expenses for the tax credit is $6,000, many individuals who use the dependent

care FSA for the full $5,000 will be able to use the tax credit on qualifying expenses in excess of $5,000 (up to the $6,000 limit). *See the Dependent Care Spending Account Worksheet included in your enrollment packet and consult your tax advisor for additional help in determining what works best for you.*

HEALTH CARE SPENDING ACCOUNT

B1. Can insurance premiums be reimbursed?

No. Federal law prohibits reimbursement of premiums through a health care reimbursement plan. This includes COBRA premiums, individual insurance policy premiums, and any expense that functions as premium regardless of its label (e.g., vision service agreements).

B2. Is contact lens solution an eligible expense?

Yes. Contact lens solution and supplies are reimbursable through the plan. Contact lenses and the cost for eye exams are also eligible expenses for reimbursement.

B3. Are over-the-counter (OTC) items eligible for reimbursement?

OTC items are eligible under your plan ONLY if they are purchased to alleviate or treat a current or "imminently probable" personal injury or sickness. OTC medications must be prescribed by a doctor or other professional who is legally authorized to write a prescription and a copy of the prescription or letter of medical necessity must accompany your claim for reimbursement. Most non-medicinal OTC items (bandages, blood pressure monitors, contact lens solutions) do not require a prescription.

B4. Are breast pumps and supplies eligible for reimbursement?

Yes. Breast pumps and component parts such as storage bags/bottles and connectors are eligible. However, ancillary items (e.g. labeling lids, specialty bottles, breast pads, nursing bras, creams) are not eligible.

B5. I'm on a weight-loss program – is my food eligible for reimbursement?

No. While weight-loss programs are eligible with an appropriate letter of medical necessity from a physician, the special food that is often required or suggested as part of the program is not (even with the letter of medical necessity).

B6. Is massage therapy eligible?

Only if the massage is treating a diagnosed medical condition and you submit a letter of medical necessity from a physician. If the massage is for general health or well-being, it would not be eligible. Also, note that monthly membership fees to massage providers are not eligible – only the cost associated with the service itself is eligible.

B7. Are my dependents' and/or domestic partner's health expenses reimbursable?

You may be reimbursed for eligible health expenses incurred by yourself, your spouse and your eligible dependents. Expenses for domestic partners are eligible only in *very limited* circumstances. The domestic partner must meet the definition of a "qualifying relative" under the regulations that govern the spending accounts.

B8. Must the participant pay the provider before submitting for reimbursement?

No. Claims must include proof that the expense was incurred and that the insurance company has processed the claim, but there is no legal requirement that you need to have paid the provider for the remaining balance on the bill prior to requesting reimbursement.

B9. Can the participant be reimbursed for an expense incurred before the plan began?

No. You may only be reimbursed for expenses incurred while a participant in the plan. Expenses incurred before the beginning of the plan year, before an election to participate in the plan, or after the end of the plan year are not eligible for reimbursement.

B10. Is a canceled check adequate documentation?

No. A canceled check does not contain adequate information to be considered third party documentation of a claim.

B11. When a claim is received, how much will be reimbursed? What if expenses exceed the amount elected?

You will be reimbursed for the full amount of the eligible expense, up to the amount of your annual election minus any previous reimbursements for the plan year. Any expenses that exceed the annual election amount will be denied.

B12. If there is money left over in a health care spending account can it be used for day care expenses?

No. Federal law prohibits moving money from one spending account to another.

B13. How do COBRA continuation rights apply to Health Care accounts?

If your health care reimbursement plan is funded solely through employee pre-tax contributions, COBRA continuation must be offered if the amount available for reimbursement exceeds the amount payable for coverage through the end of the plan year. The maximum continuation period is only through the end of the current plan year (not 18, 29 or 36 months as applied to other continuation coverages).

> For examples: John Smith terminates with $750 remaining un-reimbursed from his annual election. Assume that his COBRA premium for the health care spending account is $102 per month and that two months remain in the plan year. Smith would have to pay a maximum of $204 (two month at $102) to receive a maximum of $750 in reimbursement. Smith must be offered COBRA continuation for his health care spending account. On the other hand, if there were eight months remaining in the plan year, Smith does not have an automatic right to COBRA because he would have to pay a maximum of $816 to receive a maximum reimbursement of only $750.

Your plan may allow COBRA even if your required premiums are more than your available balance, even though it isn't required by federal law. Also, if your health care reimbursement plan includes funding through a non-cashable employer credit, the plan may be required to extend COBRA to all potential qualified beneficiaries, regardless of account balance. In this case, the continuation period may extend beyond the end of the current plan year (to 18, 29 or 36 months).

Finally, your plan may allow you to make a single pre-tax payment from your final paycheck of the amount remaining to contribute for the plan year. Refer to the Summary Plan Description to determine if this policy has been adopted for your plan and the COBRA rules that apply.

B14. What happens to the employee's tax return at the end of the year?

For the Health Care account, you can't take expenses that are reimbursed under the Health FSA as itemized deductions on your Federal tax return.

B15. What is the difference between a Health Savings Account (HSA) and the Health Flexible Spending Account (FSA)?

HSA Contribution limits, eligibility requirements, and election change rules are all different than the traditional Health FSA, and are governed by the actual HSA contract and applicable IRS Regulations. You can only participate in an HSA if you are enrolled in a High Deductible Health Plan (HDHP). Also, the traditional Health FSA is considered "other disqualifying coverage" for the HSA, so you're not allowed to participate in both.

An HSA provides a tax break (either through pre-tax contributions under an employer-sponsored plan or on your income tax return if you contribute to an individual HSA) for certain eligible expenses. You may start or stop your HSA contribution, or increase or decrease your contribution, at any time as long as the change is effective prospectively (i.e., after the request for the change is received).

B16. How is a "Limited Purpose" Health FSA different than a traditional Health FSA?

The "Limited Purpose" Health FSA works just like a traditional FSA except that eligible expenses for reimbursement are limited to things that are not covered under a High Deductible Health Plan, such as dental and vision. You still get the pre-tax benefit, and the limited Health FSA won't disqualify you from participating in an HSA.

DEPENDENT CARE SPENDING ACCOUNT

C1. Can an employee use the dependent care tax credit and a dependent care spending account?

It is possible to use both a dependent care spending account and the dependent care tax credit. However, expenses reimbursed through a dependent care spending account offset dollar-for-dollar the maximum eligible expenses used to calculate the tax credit.
For example, if you have one child and if you are reimbursed $4,000 for dependent care expenses through this plan, you cannot use the tax credit because you must reduce the $3,000 tax credit maximum by your reimbursement, leaving a balance of zero.

However, in the above example, if you have two children, and had actually incurred $6,000 of expenses, you may use the tax credit. The maximum eligible Tax Credit expense for two children is $6,000, which you would then reduce by $4,000, leaving a remaining balance of $2,000. You would calculate your tax credit using an expense of $2,000.

Because the limit on eligible expenses for the tax credit has increased to $6,000 for two or more qualifying dependents, many individuals who use the dependent care FSA for the full $5,000 will now be able to use the tax credit on qualifying expenses in excess of $5,000 (up to the $6,000 limit).

C2. Is there a greater tax advantage through a dependent care spending account?

In deciding whether the tax credit or a dependent care spending account will result in greater tax savings, you should consult a tax advisor. As a rule of thumb, if you are married filing a joint return and have two or more qualifying dependents, your family adjusted gross income will probably need to exceed $39,000 before the dependent care FSA will yield greater tax savings than the tax credit.

If you have only one qualifying dependent and your eligible expenses exceed $3,000, the Dependent Care FSA may yield greater tax savings, even at lower income levels. Eligible dependent care expenses for one dependent are limited to $3,000 for purposes of the tax credit and $5,000 for purposes of the Dependent Care FSA.

C3. What is the maximum that can be reimbursed each year for day care expenses?

The maximum dependent care reimbursement is the lesser of:

- $5,000 (or $2,500 if married, filing separately); or
- The earned income of the lower earning spouse.

C4. Does a day care provider have to be licensed?

No. The day care provider does not have to be licensed unless he or she provides care for more than six non-resident persons.

C5. Can a day care provider be a relative of the participant?

Yes, with some exceptions. The day care provider can be a relative, but cannot be 1) your spouse; 2) your child under 19 years of age; 3) any person you can claim as a dependent on your income taxes.

C6. Are day care expenses incurred during a maternity leave reimbursable?

No. Dependent care expenses incurred during maternity leave are not work-related, although they may be medically necessary. Only work-related dependent care expenses can be reimbursed through a dependent care spending account.

C7. Does the participant have to pay the provider first?

No. In order to be reimbursed, you must only provide a statement from the provider showing that the expense has been incurred. However, most providers will require payment at the time services are rendered.

C8. Can a canceled check be considered a receipt?

No. A canceled check does not contain adequate information to be considered a receipt. If the provider doesn't provide a bill or statement, they can complete a Verification of Expense on the back of the Dependent Care Claim Form.

C9. Must there be a claim submitted for every expense to be reimbursed?

Yes, a claim must be submitted for each expense for which you are requesting reimbursement. You may file a "recurring" claim one time at the beginning of the plan year that shows the date range for which services will be provided and the provider information. Once your recurring claim has been processed, LD&B will automatically reimburse you (via check or direct deposit) as funds in the account become available.

We will also accept claims throughout the plan year on any schedule (weekly, monthly, etc.) but they will only be reimbursed on your plan's specified reimbursement schedule. You cannot be reimbursed for future or projected expenses.

C10. How much will be reimbursed?

Dependent care claims will be reimbursed up to the amount of money accrued in your account as of the time the claim is processed. Reimbursement is limited to money already contributed to the account.

C11. Is pre-school or latch key an eligible expense?

Generally, both pre-school or latch key programs are eligible expenses. However, any educational expenses for education at the kindergarten level or above are not eligible.

C12. Can child support or dependent care garnishments be reimbursed?

No. Child support and daycare garnishments paid under a divorce or separation decree are not eligible for reimbursement. The custodial parent can claim work-related dependent care expenses. The non-custodial parent may be able to claim dependent care expenses if he/she is claiming the dependent on his federal income taxes that year.

C13. What happens to the employee's tax return at the end of the year?

The amount of the dependent care reimbursement will be shown on Form W-2 in Box 10 as non-taxable income. The amount of taxable income in Box 1 will not reflect any contributions made to the flexible benefit plan.

You should file your tax return as normal. However, if you are taking the dependent care tax credit or participating in a dependent care spending account, you must file Form 2441 and get a Form W-10 (proof of tax payer identification numbers) from each day care provider. Failure to comply with these reporting requirements may result in additional taxable income and interest.

C14. If the employee's spouse works part-time or is a student can they participate in the plan?

Yes. If your spouse works part-time, you can still be reimbursed for work related expenses incurred while both you and your spouse are working. If your spouse is a full-time student, and does not work, they will be deemed to have an income of $200 per month if you have one child or $400 per month if you have two or more children. The maximum election for dependent care reimbursement may be affected by the earned income of your spouse if they work part-time (see C3).