Flexible Benefits

It's almost like giving yourself a raise!

You have the opportunity to participate in a voluntary benefit program that will save you money while providing you benefit coverage. It's called Flexible Benefits, and it's something you should know more about.

To better understand Flexible Benefits, it helps if you think of your total compensation as more than just your direct pay. You are compensated by a combination of direct pay and benefits. With a traditional compensation program, you receive a salary and a benefits package. After you pay taxes, you probably use a part of that salary to pay for some of your benefits through payroll deduction and pay for un-reimbursed health care expenses out of pocket.

With Flexible Benefits, you still receive a salary and a benefits package. The difference is that you can set aside some of your salary before taxes are taken out to pay your contributions to those benefits and/or contribute to a Flexible Spending Account (FSA). Then when your taxes are figured, they are lower. Paying for your benefits with pre-tax dollars increases your spendable income. It's almost like giving yourself a raise!

EXAMPLE: How pre-tax payment saves you money:

	After-tax	Pre-tax
Gross Income	$38,000	$38,000
Pre-tax contribution to benefits	0	2,500
Taxable income	38,000	35,500
Federal income tax	5,700	5,325
Social Security tax	2,907	2,716
After-tax payment of expenses	2,500	0
Spendable income	**$26,893**	**$27,459**

Increase your spendable income by $566! (assuming 15% marginal tax rate)

Use the Health Care FSA Tax Savings Estimator and Dependent Care Worksheet to estimate your savings.

Election Changes

Not allowed unless one of the following occurs:

Change in Status

- Legal marital status
- Number of dependents
- Employment status
- Work schedule
- Dependent eligibility
- Residence or worksite

Change in Cost or Coverage

- Change in your portion of the insurance premium
- Significant curtailment of coverage
- Addition or improvement of benefit option
- Change in coverage under spouse's employer's plan
- Loss of coverage under other group health coverage

NOTE:

Pre-tax dollars refer to what you pay before taxes are taken out.

QUESTIONS? Refer to the Frequently Asked Questions or call FCI customer service at 952-541-6366 or 800-333-5597 or visit www.flexcompensation.com

Frequently Asked Questions – Flexible Benefits

Q.1 Can I sign up for the plan at anytime during the year?

A. Generally, you can only sign up for the plan during the open enrollment period before the beginning of each plan year. During the open enrollment period, eligible employees should be provided with information about any plan changes and an enrollment form.

If you have a change in status (see Q/A #2) or experience a significant change in cost or coverage (see Q/A #4), 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.

Q.2 Can elections be changed during the plan year?

A. 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 and submit a new election for the remainder of the plan year *if the election change is "consistent" with the change in status event.* Following are the allowable change in status events:

- legal marital status (i.e. marriage, divorce, death of a spouse, legal separation or annulment)
- number of dependents (i.e. birth, adoption, death)
- change in residence of you, your spouse or dependent that affects eligibility for coverage (i.e. you move out of an HMO's service area)
- employment status of you, your spouse or a dependent (i.e. termination or commencement of employment, strike, leave of absence and 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, or student status changes)

Q.3 How do I know if an election change is "consistent" with the change in status event?

A. 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.

Q.4 Are there other circumstances other than "status changes" that trigger allowable election changes?

A. 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 judgment 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 cost 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 *do not* apply to the Health Care Reimbursement Account.

Q.5 What happens to elections during an FMLA leave?

A. 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 FSA 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.

Elections during FMLA Leave, cont'd.

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 accounts 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.

Health Care
Flexible Spending Account

Save Money While Paying for Health Care

Even if you have comprehensive health care coverage, you probably have out-of-pocket costs for medical, dental or vision expenses. There's a way you can pay these costs with pre-tax dollars. It's called the Health Care Flexible Spending Account (Health FSA), and it can save you significant money.

Health FSA – How it Works

If you incur eligible health care expenses that are not reimbursed by your medical, dental or vision coverage, you may be able to pay for some of those expenses with pre-tax dollars. That saves you money. You make an election to your account at the beginning of the year. Then, as you incur expenses, you submit a claim form and back-up documentation to the claims administrator for reimbursement.

MAKE YOUR ELECTION
Here's an example of how you might estimate your eligible expenses.

Estimate your expected out-of-pocket expenses for the upcoming year:

Your eyeglasses	$425.00
Spouse's contacts	225.00
Child's Orthodontia	850.00
Deductible for you, spouse, and child	750.00
Office visit & prescription co-pays	250.00
Estimated annual contribution to the Health FSA	**$2500.00**

(Divide $2500 by 26 to get your bi-weekly contribution: $96.15)

SAVE MONEY!
Here's how paying your medical expenses with pre-tax $$ saves you money.

	Without FSA	With FSA
Gross Income	$38,000	$38,000
Pre-tax contribution to HCRA	0	2,500
Taxable income	38,000	35,500
Federal income tax	5,700	5,325
Social Security tax	2,907	2,716
After-tax payment of expenses	2,500	0
Spendable income	**$26,893**	**$27,459**

Increase your spendable income by $566! (assuming 15% marginal tax rate)

You can use the Health Care FSA Tax Savings Estimator to estimate your savings.

Eligible Health Care Expenses

Insurance deductibles, co-pays and unreimbursed medical expenses, such as:

- Eye exams, glasses, and contacts
- Hearing aids and batteries
- Chiropractic care
- Mental health and chemical dependency treatment
- Routine physicals, lab work and x-rays
- Orthodontia
- Prescriptions, including insulin and birth control
- Special equipment such as crutches
- Contact lens cleaning solution, supplies
- Lasik eye surgery

Ineligible Expenses

- Medical expenses paid by your insurance plan
- Charges for cosmetic surgery or procedures
- Premiums for medical and dental insurance

NOTE:

What you don't use, you lose!

Estimate your expenses carefully. Any money left in your account at the end of the year must be forfeited, subject to limited carry-over or grace period rules. See your Summary Plan Description (SPD) for more information.

QUESTIONS? Refer to the Frequently Asked Questions or call FCI customer service at 952-541-6366 or 800-333-5597, or visit www.flexcompensation.com

Frequently Asked Questions
Health Care Flexible Spending Account

Q.1 Who makes the rules?

A. The Health Care Flexible Spending Account (Health FSA) is governed by the Internal Revenue Service. Certain things, such as the annual maximum election and the claims submission deadline, are set by your employer; but most of the "rules" are set by the IRS. A few of the rules are:

(a) expenses must be incurred during the period of coverage for which you made your election (expenses for dates of service before your effective date or after your termination date are not eligible).
(b) expenses are considered to be incurred on the date services are provided – not when the service or item is billed or paid for.
(c) you can't change your election unless you have a change in status (i.e. birth or adoption of a child, marriage or divorce, etc.).
(d) any balance in your account after the claim submission cut-off date for a plan year will be forfeited.
(e) expenses that are covered by insurance must be submitted to the insurance company first.
(f) expenses must satisfy the definition of "medical expense" as defined in the Internal Revenue Code.

Q.2 What is the IRS's definition of a medical expense?

A. A medical expense is an amount paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for treatments affecting any part or function of the body. The medical care expense must be primarily to alleviate or prevent a physical or mental defect or illness. Cosmetic procedures and other services for your general well-being do not meet this definition, and therefore are not eligible for reimbursement.

Refer to the Guide to Eligible Medical Expenses for a more detailed list.

Q.3 How much can I elect to a Health FSA each year?

A. There is an indexed statutory maximum on Health FSA elections that can change each year, but your plan may specify a lower maximum. Refer to the Summary Plan Description.

Q.4 When a claim is received, how much will be reimbursed?

A. 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.

Q.5 What if expenses exceed the amount elected?

A. You will be reimbursed up to the amount of your annual election. Any expenses that exceed the annual election amount will be denied.

Q.6 What documentation is necessary to make a reimbursement claim?

A. The expense must first be submitted to any available insurance plan for payment. After the insurance carrier has processed the charge, your portion of the charge can be submitted for reimbursement.

There must be third-party documentation of the expense (e.g., an Explanation of Benefits Statement or itemized bill from the provider) that includes all of the following information:

- The date(s) services were rendered;
- The person for whom the services were provided;
- The charges for each service;
- A description of the services; and
- Insurance payments, if applicable.

In addition, each claim for reimbursement must be accompanied by your signed statement that the expense is eligible for reimbursement and that the expense has not been reimbursed from any other source, and you will not seek reimbursement from any other source.

Q.7 Are there examples of unacceptable documentation?

A. The following types of documentation do not contain all of the information necessary to reimburse a claim:

- Canceled checks
- Balance-Due Statements
- Credit Card Receipts
- Payment on Account Receipts
- Cash Register Receipts

Q.8 Can insurance premiums be reimbursed?

A. No. Federal law prohibits reimbursement of premiums through a Health FSA. This includes COBRA premiums and any expense that functions as a premium regardless of its label (e.g., vision service agreements).

Q.9 Is contact lens solution an eligible expense?

A. 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.

Q.10 How about laser eye surgery?

A. Yes. Radial Keratotomy and Lasik are eligible for reimbursement.

Q.11 Are dependents' health expenses reimbursable?

A. Yes. You may be reimbursed for eligible health expenses incurred by yourself, your spouse and other tax dependents.

Q.12 Where can I find a list of eligible expenses?

A. Refer to the Guide to Eligible Medical Expenses for a more detailed list. Also see IRS Publication 502, "Medical and Dental Expenses," available at www.irs.gov. Please note that this publication is written specifically for income tax purposes, and while it is a useful tool in determining eligible expenses, there are slight differences between what can be claimed on your income taxes and FSA eligibility.

Q.13 If there is money left over in a health care spending account can it be used for day care expenses?

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

Q.14 Do I have to pay the provider before I send in a claim for reimbursement?

A. No. Claims must include proof that the expense was incurred and that the insurance company has made final determination on the claim, but there is no legal requirement that you have paid the provider for the remaining balance of the bill.

Q.15 What's the deadline for filing my Health FSA claims?

A. Most Health FSA plans allow some time after the end of a plan year to submit claims for eligible expenses incurred during that year. See your plan materials or benefits manager for more information on your plan's claim filing deadline.

Q.16 What happens to my election if my employment terminates?

A. Health FSA coverage automatically terminates on the date of the last paycheck (or in some plans, on the last day of the month), and claims must be incurred before this date to be eligible for reimbursement. A claim is "incurred" on the date services are rendered – not when you pay for or are billed for the service. You may have the right to continue coverage under COBRA and submit claims beyond your original termination date (see Q/A #19).

Q.17 What happens to the money in the account if it is not used up by the end of the Plan Year?

A. Your plan includes a period following the end of the plan year during which claims incurred within the previous plan year can be submitted against prior year elections. The amount of time varies from plan to plan, but is usually 60 or 90 days following the end of the plan year. Refer to your Summary Plan Description for the appropriate information.

Money remaining after the end of this claims run-out period is forfeited (subject to limited grace period or carryover rules) and used to offset reasonable administrative expenses of the plan. See your Summary Plan Description (SPD) for more information. The best way to avoid a year-end forfeiture is to make a careful estimate of the un-reimbursed health care expenses you expect to have *before* making your annual Health FSA election.

Q.18 Can I be reimbursed for an expense incurred before the plan began?

A. No. You may only be reimbursed for expenses incurred while you are an active participant. Expenses incurred before the beginning of the plan year, before an election to participate, or after the end of the plan year are not eligible for reimbursement from that year's account.

Q.19 Can elections be changed during the plan year?

A. Once an election becomes effective, it can't be changed unless you have a change in status. The election change must be consistent with the change in status, and you must notify your plan administrator of your election change within 30 days of the change in status.

Q.20 How do COBRA continuation rights apply to Health Care accounts?

A. If the Health FSA 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 applies to other continuation coverage).

> **For example:** 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 months 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 FSA 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.

FLEXWorksheet

HEALTH CARE FSA TAX SAVINGS ESTIMATOR

This worksheet will help you estimate the tax savings that results from using a health care flexible spending account (HCFSA). Qualifying health care expenses may be reimbursed from your before-tax contributions to the health care flexible spending account (HCFSA) on a tax-free basis. Alternatively, health care expenses in excess of 10% of adjusted gross income can be deducted on Form 1040 Schedule E if you itemize deductions when you file your personal income tax return. Health care expenses reimbursed from an HCFSA cannot be claimed as itemized deductions. State income taxes, the Federal Earned Income Credit and the phase out of personal exemptions for high income individuals are not included in this analysis. Including state income taxes would increase the relative tax savings associated with the HCFSA.

In general, an expense must meet the IRS definition of medical care in order to be eligible for reimbursement from the HCFSA. Eligible expenses are amounts paid for the diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body, that are not reimbursed from another source such as insurance. Transportation expenses primarily for and essential to medical care may be eligible (Refer to your plan's SPD for specific exclusions). *Expenditures that are merely beneficial to one's general health are not eligible.* Some general examples of eligible health care expenses include the following (see the Guide to Medical Expenses, and Guide to OTC's for a more extensive list):

- Prescription co-payments & deductibles
- Coinsurance & Deductibles
- Dentist fees (excludes bleaching and cosmetic procedures)
- Doctor and emergency room co-payments
- Lasik surgery & prescription eyeglasses
- Orthodontics

Estimated Federal Income Tax and Social Security Savings from using the Health Care Spending Account.

	With Flex	Without Flex
A. Projected Adjusted Gross Income: Participant - [ ] Spouse - [ ]	$ 0	$ 0
B. Enter the amount of your Health Care Expenses reimbursed from the HCFSA for the plan year. Use the Health Care Worksheet to estimate your eligible expenses.	$	$ 0.00
C. New Adjusted Gross Income (Subtract B from A)	$ 0	$ 0
D. Estimated itemized deductions or the standard deduction ($12,600 for married filing jointly; $9,250 for head-of-household; $6,300 for married filing separately and single)	$	$ 0
E. Multiply number of Personal Exemptions times $4,000. (1 for yourself; 1 for your spouse; and one for each dependent) Number of Exemptions - [ ]	$ 0	$ 0
F. Taxable Income (Subtract lines D and E from C)	$ 0	$ 0
G. Federal Tax: Select filing status - [Married Filing Jointly]	$	$
H. Social Security Tax (Multiply the amount of your income shown on line C up to $118,500 by .0765 plus the amount over $118,500 by .0145 plus the amount over $250,000 by .009)	$	$
I. Total Taxes (add lines G and H)	$ 0	$ 0
J. Tax Savings (Subtract line I, Column 1 from Line I, Column 2)	$ 0	

Reset Form

Line G Filing Status and Taxable Income			
Married Joint		**Single**	
Taxable Income	**Tax**	**Taxable Income**	**Tax**
Not over 18,450	10% of taxable inc.	Not over 9,225	10% of taxable inc.
Over 18,450 but not over 74,900	1,845 plus 15% of the amount over 18,450	Over 9,225 but not over 37,450	922.50 plus 15% of the amount over 9,225
Over 74,900 but not over 151,200	10,312.50 plus 25% of the amount over 74,900	Over 37,450 but not over 90,750	5,156.25 plus 25% of the amount over 37,450
Over 151,200 but not over 230,450	29,387.50 plus 28% of the amount over 151,200	Over 90,750 but not over 189,300	18,481.25 plus 28% of the amount over 90,750
Over 230,450 but not over 411,500	51,577.50 plus 33% of the amount over 230,450	Over 189,300 but not over 411,500	46,075.25 plus 33% of the amount over 189,300
Over 411,500 but not over 464,850	111,324 plus 35% of the amount over 411,500	Over 411,500 but not over 413,200	119,401.25 plus 35% of the amount over 411,500
Over 464,850	129,996.50 plus 39.6% of the amount over 464,850	Over 413,200	119,996.25 plus 39.6% of the amount over 413,200
Head of Household		**Married Separate**	
Taxable Income	**Tax**	**Taxable Income**	**Tax**
Not over 13,150	10% of taxable inc.	Not over 9,225	10% of taxable inc.
Over 13,150 but not over 50,200	1,315 plus 15% of the amount over 13,150	Over 9,225 but not over 37,450	922.50 plus 15% of the amount over 9,225
Over 50,200 but not over 129,600	6,872.50 plus 25% of the amount over 50,200	Over 37,450 but not over 75,600	5,156.25 plus 25% of the amount over 37,450
Over 129,600 but not over 209,850	26,722.50 plus 28% of the amount over 129,600	Over 75,600 but not over 115,225	14,693.75 plus 28% of the amount over 75,600
Over 209,850 but not over 411,500	49,192.50 plus 33% of the amount over 209,850	Over 115,225 but not over 205,750	25,788.75 plus 33% of the amount over 115,225
Over 411,500 but not over 439,000	115,737 plus 35% of the amount over 411,500	Over 205,750 but not over 232,425	55,662 plus 35% of the amount over 205,750
Over 439,000	125,362 plus 39.6% of the amount over 439,000	Over 232,425	64,989.25 plus 39.6% of the amount over 232,425

This worksheet is intended to help you decide whether to participate in the health care account, but should be used with the understanding that it has limitations. Each individual's circumstances are unique, and the worksheet is not a substitute for competent tax advice. If you have questions, you should talk to your personal tax advisor.

NOTE: ALL TAX BRACKETS AND DOLLAR FIGURES SHOWN ABOVE ARE BASED ON 2015 RATES.

FLEXWorksheet

HEALTH CARE SPENDING ACCOUNT

Use this worksheet to estimate the health care expenses you expect to incur during the plan year, which will not be paid by insurance. Expenses incurred for your eligible dependents can be included. Remember, if you don't use it, you lose it (unless your plan has the $500 carryover - see your SPD).

Expense Categories	Sub-Category Amount	Category Total
Insurance Deductibles/Office Co-Pays		$ 0.00
Medical	$	
Dental	$	
Coinsurance Payments		$ 0.00
Medical	$	
Dental	$	
Vision Expenses		$ 0.00
Eye Exams	$	
Prescription Glasses/Sunglasses	$	
Contact Lenses and Solutions	$	
Laser Surgery	$	
Prescription Medications		$
Over-the-Counter Items-**medicines require prescription**		$
Dental Expenses (other than those included above)		$ 0.00
Preventative Care (cleaning, fluoride etc.)	$	
Restorative (fillings, crowns, root canal etc.)	$	
Orthodontia (Monthly payments x 12)	$	
Hearing Aid and Batteries		$
Chiropractic Fees		$
Mental Health Counseling Fees (Family and marriage counseling are not eligible)		$
Other		$ 0.00
	$	
	$	
	Total Annual Amount	$ 0.00
Divided by Number of Pay Periods Monthly (12)	**Pay Period Amount**	$ 0.00

Reset Form

*See the back of this form for a more complete list of eligible and ineligible expenses.

ELIGIBLE EXPENSES – Health Care Spending Account

In general, eligible expenses are those expenses you incur for medical care. Medical care means diagnosis, care, treatment or prevention of disease. Expenses incurred by you, your spouse (including legally-married, same-sex spouses) or your other eligible dependents that are not reimbursed from another source (such as insurance) are eligible for reimbursement.

- Acupuncture
- Alcoholism - payment to treatment centers
- Ambulance
- Artificial limbs
- Braille - books or magazines (excess cost over Non-Braille materials)
- Breast Pump and associated parts
- Chemical Dependency treatment
- Chiropractor's fees
- Crutches
- Dental treatment (inc. dentures, *orthodontia*)
- Doctor's fees (licensed medical practitioner)
- Diagnostic fees
- Guide dog and its upkeep
- Hearing aids and batteries
- Hospital services
- Insulin
- Insurance deductibles/co-payments
- In-vitro fertilization fees
- Laboratory fees
- Laser Eye Surgery
- Naturopathic Services
- Nursing Services
- Orthotic devices (if custom molded)
- Osteopathic fees
- Osmotic supplies
- Over-the-counter items **(non-medicinal)**
- Physical exams
- Pregnancy kits / Ovulation predictors
- Prescription drugs and medical supplies that are not otherwise excluded
- Psychologist fees
- Sterilization fees (or reversal)
- Surgical fees
- Therapy received as medical treatment
- Tuition at special school for handicapped
- Vision Expenses, including prescription glasses, contact lenses and cleaning supplies
- Weight-loss medications & programs (ONLY if to treat diagnosed medical condition)
- Wheelchair
- X-rays

INELIGIBLE EXPENSES – Health Care Reimbursement Account

- Birthing Classes/Lamaze/Doula services
- Breast pump accessories (i.e. special bottles, labeling lids, etc.)
- Chiropractic Service Agreements/Wellness Programs/Supplements
- Cosmetic prescriptions, procedures, supplies
- Court ordered exams/treatment
- Dental Bleaching & Veneers
- Diapers
- Exercise Equipment / Programs
- Expenses for which there is no diagnosis
- Family & Marriage Counseling
- Frames w/out prescription eyeglass lenses
- Health Club Dues
- Infant formula
- Insurance Premiums
- Naturopathic Supplies & Supplements
- Nutritional Supplements
- Special Bedding/Household Appliances
- Special Foods, even if medically necessary
- Toiletries
- Toothbrush/Toothpaste/Floss
- Vision Service Agreements
- Vitamins, one-a-day multiple
- Weight-loss medications & programs for general health

AND any other items that are primarily for personal use and/or general health

Guide to Eligible Medical Expenses

For purposes of Health Care reimbursement accounts, eligible expenses are amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, and for treatments affecting any structure or function of the body. Expenses must be primarily to alleviate or prevent a physical or mental defect or abnormality; they **do not** include expenses that are merely beneficial to one's general health. Expenses incurred by you, your spouse or your other eligible dependents that are not reimbursed from another source (such as insurance) are eligible for reimbursement.

The following table includes the most common expenses that are submitted for reimbursement. The Special Notes column is intended to more clearly define expenses that are marked as "maybe" in the Eligible column, or that simply require additional explanation. Also, remember that adequate third-party documentation must be supplied in order to verify the eligibility of any expense.

Type of Expense	Eligible?	Special Notes
Abortion	Yes	
Acupuncture	Yes	
Alcoholism, treatment of	Yes	
Alternative medical practitioners and associated dietary substitutes and medicines	Maybe	Consultation with a licensed or otherwise credentialed alternative healer may be eligible if to treat a specifically diagnosed medical condition. May require a **letter of medical necessity from a physician**. *Note that if the treatment is a food or substitute that the patient would normally consume as a part of daily nutrition requirements or for personal convenience or pleasure, the expense for that treatment would NOT be reimbursable.*
Ambulance	Yes	
Artificial limb	Yes	
Asthma treatments	Yes	
Autoette	Yes	
Babysitting & childcare	No	
Bedding, special (e.g., hypoallergenic for asthma patient)	No	
Bedwetting alarm, for child development	No	
Bedwetting alarm, for medical condition	Yes	Requires letter of medical necessity from a physician.
Birth control pills	Yes	
Birthing classes	No	
Bleaching, dental	No	
Braille books	Yes	Only the excess cost of same material in regular printed edition
Breast implant repair	No	Unless to treat toxicity or other medical condition
Breast pump	Yes	Breast pumps and associated supplies are eligible for reimbursement
Breast reconstruction following mastectomy	Yes	
Capital expenses	Yes	The amount paid for special equipment installed in the home, or for improvements, if their main purpose is medical care, is reimbursable. The cost of permanent improvements that increase the value of the property may be partly reimbursable: the cost of the improvement is reduced by the increase in the value of the property; the difference is a medical expense. If the value of the property is not increased by the improvement, the entire cost is included as a medical expense. Certain improvements made to accommodate a personal residence to a person's disabled condition do not usually increase the value of the residence and the cost can be included in full as a medical expense. These improvements include, but are not limited to, the following items: constructing entrance or exit ramps to your residence for wheelchair use; widening doorways for same; installing railing, support bars or other modifications to bathrooms; lowering or modifying kitchen cabinets and equipment; moving or modifying electrical outlets and fixtures; installing porch lifts and other forms of lifts but generally not elevators; modifying fire alarms, smoke detectors and other warning systems; modifying stairways; adding handrails and grab bars anywhere (whether or not in bathrooms); modifying hardware on doors; modifying areas in front of entrance and exit doorways; and grading the ground to provide access to the residence.
Car modifications	Maybe	The amount paid for special hand controls and other special equipment installed in a car for the use of a person with a disability is reimbursable. The amount by which the cost of a car specially designed to hold a wheelchair is more than the cost of a regular car is a medical expense. The cost of operating a specially equipped car is not reimbursable.

Chemical dependency treatment	Yes	
Childbirth classes	No	
Chiropractic	Yes	Nutritional supplements recommended by a chiropractor to treat a specific medical condition may be reimbursable with a **letter of medical necessity from a physician**. *Service agreements / wellness programs are NOT reimbursable.*
Christian Science practitioners	Maybe	Amounts paid to a credentialed Christian Science practitioner for services that are for medical care eligible for reimbursement. Note that detailed documentation is required that provides an explanation of the services provided and the medical condition that is being treated. Fees for other services are not reimbursable.
Contact lenses (including cleaning / soaking supplies)	Yes	
Contact lens insurance / warranty	No	
Contraceptives	Yes	
Cord blood, extraction and storage	No	Temporary storage, however, may be eligible for reimbursement if intended to treat an existing, specifically diagnosed medical condition. Requires a letter of medical necessity from a physician.
Cosmetic prescriptions / procedures / supplies	No	Unless to correct congenital abnormality, trauma injury or disfiguring disease.
Counseling -- Family	Maybe	Reimbursable only if treating a diagnosed condition in at least one family member. Requires a letter of medical necessity from a physician.
Counseling -- Group	Yes	
Counseling -- Individual	Yes	
Counseling -- Marriage	No	
Court-ordered exams/treatment	No	
Crutches	Yes	
Dental treatment	Yes	Excludes cosmetic procedures such as veneers and dental bleaching. Excludes personal use items like toothbrushes & floss. Also SEE Orthodontia.
Dentures	Yes	
Diabetic supplies	Yes	(e.g. needles, swabs, test strips)
Doctor visits & diagnostic fees	Yes	
Doula services	No	
DNA collection & storage	No	Temporary storage, however, may be eligible for reimbursement if it is part of diagnosing, treating or preventing a current or imminently probable medical condition. Requires a letter of medical necessity from a physician.
Drug addiction, treatment of	Yes	
Drugs		See Prescription Medications in this table, and the separate Guide to OTC's
Egg donor fees	Yes	Egg donor fee, agency fee, fee for donor's medical and psychological testing, and legal fees for preparation of the egg donor contract are eligible for reimbursement if to "treat" the egg recipient's medical inability to conceive.
Embryo storage fees	No	Temporary storage, however, may be eligible if part of an infertility treatment program. Requires a letter of medical necessity from a physician.
Electrolysis	No	Unless to treat diagnosed medical condition such as hirsutism.
Exercise equipment / programs	No	Typically not reimbursable. However, in very limited circumstances with a **letter of medical necessity from a physician** and with certification that the patient did not have the item or enter the program prior to being diagnosed, may be eligible for reimbursement.
Eye exams and prescription eyeglasses	Yes	Includes cleaning materials .
Eyeglasses, non-prescription	No	
Eyeglasses, sunglass clips	Yes	If custom-designed for prescription glasses. If non-prescription, not eligible
Family counseling	No	
Fertility treatments	Yes	
Fluoride treatment	Yes	
Frames without prescription eyeglass lenses	No	
Funeral expenses	No	
Guide dog	Yes	For use by a patient with a diagnosed medical condition. The cost of the animal, as well as its care and upkeep (including veterinary bills), is eligible for reimbursement.
Hair transplant	No	
Health club dues	No	Typically not reimbursable. However, may be eligible in *very* limited circumstances with a **letter of medical necessity from a physician** and with certification that the patient did not have a health club membership prior to being diagnosed.
Hearing aids and hearing aid batteries	Yes	
Hospital services	Yes	
Household help	No	
Hypnosis	Maybe	Only if to treat diagnosed medical condition. Requires a letter of medical necessity from a physician.
Illegal procedures, drugs or treatments	No	

Immunizations	Yes	
Infant formula	No	
Insurance Deductibles / Co-Payments	Yes	
Insurance premiums	No	
In-vitro fertilization	Yes	If part of an infertility treatment program. Requires a letter of medical necessity from a physician.
Laboratory fees	Yes	
Lactation consultant	Maybe	If there is a related medical condition that prevents a newborn from nursing, the cost of a lactation consultant may be eligible for reimbursement. Requires letter of medical necessity from a physician.
Lamaze classes	No	
Language training	Maybe	For child with dyslexia or other diagnosed medical condition. Regular school fees will not be eligible. Requires a letter of medical necessity from a physician.
Lasik eye surgery	Yes	
Learning disability, treatment of -- See Schools, Special		
Lodging associated with medical care	Yes	If the lodging is primarily for and essential to receiving medical care, the expense will be eligible for reimbursement for an adult patient only or for a minor patient and one adult. The limit is $50 per night.
Lumbar cushion	Maybe	If treating a diagnosed medical condition. Requires a letter of medical necessity from a physician if purchased at a non-medical facility.
Marriage counseling	No	
Massage	Maybe	Only if to treat a diagnosed medical condition. Requires a letter of medical necessity from a physician.
Maternity clothes	No	
Meals, at an inpatient facility, for the patient	Yes	
Meals, other	No	Other than for the patient, or other than an inpatient facility.
Medical alert bracelet	Yes	Standard metal; excess cost for gold or other metal is not eligible .
Medical records fees	Maybe	If necessary to transfer records to a new medical practitioner.
Medical services, general	Yes	
Medicines, over-the-counter		See separate Guide to OTC's .
Medicines, prescriptions		See Prescription Drugs.
Missed / cancelled appointments	No	
Midwife services	Yes	
Mouth guards		See Occlusal Guards.
Naturopathic fees	Yes	Expenses for consultation with a naturopathic practitioner are eligible. Medicines and other remedies may also be eligible, if treating a specific medical condition, and accompanied by a **letter of medical necessity from a physician**. *Note that if the treatment is a food or substitute that the patient would normally consume as a part of daily nutrition requirements or for personal comfort or pleasure, the expense for that treatment would NOT be reimbursable.*
Nebulizer	Yes	
Nursing home	No	
Nursing services	Yes	
Nutritional supplements	Maybe	Only if to treat a diagnosed medical condition. Requires a letter of medical necessity from a physician.
Nutritionist	Maybe	If primary reason for seeing the nutritionist is part of a treatment plan for a specific diagnosed medical condition.
OB/GYN Prepayments	Yes	However, these expenses are not reimbursable until the child is born.
Occlusal guard	Maybe	Yes - If to prevent night-grinding / treat bruxism. No - If worn for sports or other non-medical reason.
Optometrist services	Yes	
Organ donors' expenses	Yes	
Orthodontia	Yes	CAUTION: there are multiple methods of reimbursement. Please find out how your particular employer's plan is administered before making your FSA election.
Orthotic devices	Maybe	Yes, if custom-molded for the patient and purchased through a medical supply company. If purchased elsewhere, would required a letter of medical necessity from a physician.
Osmotic supplies	Yes	
Osteopath fees	Yes	
Over-the-Counter medications / items		See separate Guide to OTC's.
Oxygen	Yes	
Patterning exercises	Yes	For mentally handicapped child.
Peak flow meter	Yes	
Personal use items	No	Items that are used for general health and not to treat a specific diagnosed medical condition.

Physical Therapy	Yes	
Physicals (routine / annual)	Yes	
Physicals (sports)	No	
Pre-payments for future treatment	No	
Prescription drugs, U.S.A.	Usually	However, if there is a cosmetic or general health component (i.e. weight-loss medications, or prescriptions such as Retin-A that can be used for wrinkle treatment or Propecia that can be used for male pattern baldness), the drug will generally not be reimbursable, or will require a letter of medical necessity from a physician to verify the diagnosed medical condition that is being treated.
Prescription drugs from another country	No	Drugs from another country that are not considered "legal" in the U.S. (having not passed FDA approval for use or importation) are not eligible for reimbursement.
Preventive care screenings	Yes	Since typically to discover or diagnosis potential health problems.
Prosthetics	Yes	
Psychiatric care	Yes	
Psychoanalysis & Psychologist fees	Maybe	Will be reimbursable if primarily for treatment of a diagnosed medical condition, and a letter of medical necessity from a physician may be required. If services are provided for general improvement of mental health or stress relief, the expenses are not reimbursable.
Radial keratotomy	Yes	
Sales tax	Yes	Sales tax on an otherwise eligible item or service is eligible for reimbursement.
Schools, special residential	Maybe	Payments made to a residential school or program to treat behavioral, emotional and/or addictive conditions may be eligible for reimbursement if the primary purpose of the school or program is treatment of a specifically diagnosed medical condition. Note that there can be a certain educational component, but it must be secondary to the medical / treatment component. A letter of medical necessity from a physician would be required to document the specific medical condition and to certify the nature of the school.
Special schools, non-residential	Maybe	Payments made to a special school for a mentally impaired or physically disabled person are eligible for reimbursement only if the school has resources that are geared specifically to persons with that mental or physical disability, AND the main reason for attending the school is to treat the disability. For example, the cost of a school that teaches Braille to a visually-impaired person or teaches lip-reading to a hearing-impaired person is reimbursable. A letter of medical necessity from a physician would be required to document the specific medical condition and to certify the nature of the school and reason for attending.
Scuba mask with prescription lenses	Maybe	The cost of the mask itself is not reimbursable; however, the difference in cost between a standard mask and the cost of a mask with prescription lenses may be eligible for reimbursement if properly documented.
Shipping and handling fees	Yes	Shipping & handling on an otherwise eligible item or service is eligible for reimbursement.
Smoking cessation programs and prescription drugs	Yes	
Sonicare toothbrush	No	Even if recommended by a dentist.
Special foods	No	
Sperm / ova storage	Yes	Temporary storage, however, may be eligible if part of an infertility treatment program. Requires a letter of medical necessity from a physician.
Sterilization procedures	Yes	
Surgery	Yes	
Surrogacy expenses	No	
Tanning	No	Typically not reimbursable. However, in rare cases, with a letter of medical necessity from a physician, this may be considered treatment for medical care (e.g. a patient with severe psoriasis or excema).
Teeth whitening	No	
Telephone, equipped for hearing-impaired person	Yes	Cost of special equipment only.
Television, equipped for hearing-impaired person	Yes	Cost of special equipment only.
Toiletries	No	
Transplants, organ	Yes	Does not include hair transplants.
Transportation to receive medical care	Yes	If transportation is primarily for and essential to receiving medical care, the cost may be eligible for reimbursement. If there is any personal component to the travel, the expense will not be reimbursable.
Trips to receive medical care	Yes	See Transportation above.
Umbilical cord, freezing & storage	No	Temporary storage, however, may be eligible for reimbursement if intended to treat an existing, specifically diagnosed medical condition. Requires a letter of medical necessity from a physician.

Varicose vein treatment	Maybe	In most cases, this is considered a cosmetic procedure. However, in some cases, it may be eligible if there are other associated medical conditions associated with the varicose veins.
Vasectomy / vasectomy reversal	Yes	
Vision correction procedures	Yes	Lasik / Radial Keratotomy.
Vision expenses	Yes	Includes exams, prescription glasses & contacts, cleaning supplies. DOES NOT include warranty, non-prescription glasses/sunglasses, frames only without prescription lenses.
Weight-loss programs	Maybe	If treating a diagnosed medical condition, the program fees for weight-loss programs are eligible for reimbursement. A letter of medical necessity from a physician will be required to document the medical condition. The cost of food associated with the programs IS NOT reimbursable.
Wheelchair	Yes	
Whirlpool treatment	No	Unless to treat diagnosed condition such as rheumatoid arthritis.
X-ray fees	Yes	

Guide to Over-The-Counter (OTC) Items

Federal HealthCare Reform laws require that expenses for over-the-counter (OTC) medicines & drugs (with the exception of insulin) are not eligible for reimbursement, unless they are accompanied by a doctor's prescription.

MEDICINAL OTC's that are not eligible without doctor's prescription:

- Acid controllers
- Allergy & Sinus
- Antibiotic products
- Anti-diarrheals
- Anti-gas
- Anti-itch & insect bite
- Antiparasitic treatments
- Baby rash ointment/creams
- Cold sore remedies
- Cough, cold & flu
- Digestive aids
- Feminine anti-fungal/itch
- Hemorrhoidal preps
- Laxatives
- Motion sickness medicines
- Nasal Strips
- Pain relief
- Respiratory treatments
- Sleep aids & sedatives
- Smoking cessation products
- Stomach remedies

NON-MEDICINAL OTC items that are ELIGIBLE:

- Bandages
- Carpal tunnel wrist supports
- Contact lens supplies and solutions
- Condoms
- Crutches
- Diabetic supplies
- Diagnostic equipment (e.g. blood pressure monitors, blood sugar test kits, etc)
- Gauze pads
- Hot/cold packs for injuries
- Incontinence supplies
- Ovulation predictors
- Pregnancy tests
- Reading glasses
- Thermometers

INELIGIBLE OTC items:

- Cosmetics
- Medicated shampoos/soaps
- Moisturizers & face creams
- Personal hygiene items
- Special food & food replacement
- Suntan lotion
- Toiletries
- Toothbrushes & toothpaste
- Vitamins & supplements (unless accompanied by letter of medical necessity for particular condition)

In general, OTC items are reimbursable in "reasonable" quantities. You should therefore only purchase and submit quantities that could reasonably be used to treat a presently-existing or imminently probable condition. Similar to a three-month supply of prescriptions, a good rule of thumb is three packages. Stock-piling is prohibited.

You must be able to provide adequate documentation to verify the eligibility of the item. Detailed cash register receipts are acceptable documentation. The receipts MUST contain the date, dollar amount, and specific product name in order to be considered for reimbursement. No miscellaneous (i.e., "pharmacy" or "OTC special") receipts will be accepted, even if accompanied by a box-top or label; and a designation by the pharmacy or merchant isn't necessarily enough to verify that an item is eligible. For OTC medicines & drugs, as shown at the top of the page, remember that you must also include a doctor's prescription in order to have the item considered for reimbursement.

Dependent Care Flexible Spending Account

Save money while paying for daycare

If you pay someone to care for your children under age 13 or another eligible dependent while you work, the Dependent Care Flexible Spending Account (FSA) may help save you money because you can pay for certain eligible expenses with pre-tax dollars. If you are married, your spouse must be employed, a full-time student or incapable of self-care in order to be eligible to participate. You can elect up to $5,000 (the maximum for a family) or $2,500 if married and filing separately.

Dependent Care FSA - How it Works

You make an election to your account at the beginning of the year, and your employer sets aside that amount each pay period before taxes are figured. Then, as you incur expenses during the year, you submit a claim form and documentation to the claims administrator for reimbursement. Remember that your annual election can't be changed unless you experience a change in status.

MAKE YOUR ELECTION

Assume that you will pay $100 per week for child-care for 48 weeks next year (remember to exclude vacation and other time away from work), and you are on a bi-weekly pay cycle:

Annual contribution to DCFSA $4800.00

Divide $4800 by 26 to get your bi-weekly DCFSA contribution: $184.62

NOTE: You cannot claim a tax credit on your income tax return for dependent care expenses reimbursed through this account. In some cases, the tax credit may be more beneficial. A worksheet is available to help you determine which is best, but you may also want to ask a tax advisor.

Eligibility Requirements

Eligible Dependents

- Your dependent children under age 13
- A spouse or other dependent who lives with you and is unable to care for himself or herself and whose principal residence is your home

Eligible Providers

- A "dependent care center," facility that provides care for more than six non-resident individuals, and receives a fee, payment, or grant for providing such services
- An independent caregiver who cares for less than seven individuals who do not reside with the caregiver
- Your children who are age 19 and over

Eligible Expenses

- Only expenses that enable you (and your spouse, if you are married) to be gainfully employed are eligible
- Care that is primarily for medical or educational in nature is not eligible

QUESTIONS? Refer to the Frequently Asked Questions or call FCI customer service at 952-541-6366 or 800-333-5597 or visit www.flexcompensation.com

Frequently Asked Questions
Dependent Care Flexible Spending Account

Q.1 Who makes the rules?

A. The Dependent Care Flexible Spending Account (FSA) is governed by the Internal Revenue Service. Certain things, such as the claims submission deadline, are set by your employer; but most of the "rules" are set by the IRS. A few of the rules are:

(a) expenses must be incurred during the period of coverage for which you made your election (expenses for dates of service before your effective date or the beginning of the plan year are not eligible).

(b) expenses are considered to be incurred on the date services are provided – not when the service or item is billed or paid for.

(c) you can't change your election unless you have a change in status (i.e. birth or adoption of a child, marriage or divorce, etc.) or a change in cost or coverage.

(d) any balance in your account after the claim submission cut-off date for a plan year will be forfeited.

Q.2 What is the maximum that can be reimbursed each year for day care expenses?

A. 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.

Q.3 Must there be a claim submitted for every expense to be reimbursed?

A. Yes. You may submit claims on any schedule but they will only be reimbursed on your plan's specified reimbursement schedule. In addition, you cannot be reimbursed for future or projected expenses.

Q.4 What documentation is necessary to make a reimbursement claim?

A. There must be third party documentation of the expense (e.g., a formal billing statement from the daycare provider) that shows the date the service was rendered, the child or other eligible dependent for whom the service was rendered, and the amount charged for the service. If your provider does not have a formal billing statement, he or she can simply fill out the Verification of Dependent Care Expenses on the back of the claim form.

In addition, each claim for reimbursement must be accompanied by your signed statement that the expense is eligible for reimbursement and that the expense has not been reimbursed from any other source, and that you will not seek reimbursement from another source.

Q.5 How much will be reimbursed?

A. 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 minus any previously paid claims.

Q.6 Does a daycare provider have to be licensed?

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

Q.7 Can a daycare provider be a relative of the participant?

A. 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.

Q.8 Are daycare expenses incurred during a maternity leave reimbursable?

A. 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.

Q.9 Can child support or dependent care garnishments be reimbursed?

A. 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 not claim dependent care expenses through this account unless the child is physically placed with him or her for a portion of the year.

Q.10 Is pre-school or latch key an eligible expense?

A. Generally, both pre-school and latch key programs are eligible expenses.

Q.11 What about kindergarten?

A. Generally, educational expenses at the kindergarten level and above are not eligible for reimbursement. However, full-day kindergarten is becoming more popular and in some instances is partially reimbursable. The key is whether there is any educational curriculum associated with the "extra" half-day.

If there is an educational curriculum, the charges would not be reimbursable. If there is no educational curriculum and no state funding, and the parent is charged for the extra half-day, those expenses would be reimbursable.

Q.12 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.

Q.13 Can I use the dependent care tax credit and a dependent care FSA?

A. It is possible to use both a Dependent Care FSA 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).

Q.14 Is there a greater tax advantage through a dependent care FSA?

A. In deciding whether the tax credit or a Dependent Care FSA will result in greater tax savings, you can use the Dependent Care Worksheet but you may also want to 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 purposes of the Dependent Care FSA.

Q.15 What happens to my tax return at the end of the year?

A. The amount of the dependent care deductions 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 FSA, 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.

Q.16 If my spouse works part-time or is a student, can I still participate in the plan?

A. 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 $250 per month if you have one child, or $500 per month if you have two or more children. The maximum election for dependent care reimbursement may be effected by the earned income of your spouse if they work part-time.

Q.17 What happens to my election if my employment terminates?

A. Dependent Care FSA contributions automatically stop with the last paycheck. If there is money left in the account, you may continue to submit eligible 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.

Q.18 What happens to the money in the account if it is not used up by the end of the Plan Year?

A. Your plan includes a period following the end of the plan year during which claims incurred within the previous plan year can be submitted against prior year elections. The amount of time varies from plan to plan, but is usually 60 or 90 days following the end of the plan year. Refer to your Summary Plan Description for the appropriate information.

IRS Regulations require that any money remaining after the end of this claims run-off period is forfeited. Forfeitures are used to offset reasonable administrative expenses of the plan. Funds remaining after all administrative expenses have been reimbursed become "experience gains."

Q.19 Can elections be changed during the plan year?

A. In general, once an election becomes effective, it can't be changed until the next open enrollment period unless you have a change in status or a change in cost or coverage. The election change must be consistent with the change in status, and you must notify your plan administrator of your election change within 30 days.

FLEXWorksheet

DEPENDENT CARE SPENDING ACCOUNT

You may utilize the Dependent Care Tax Credit (DCTC) when you file your federal income tax return or your qualifying dependent care expenses may be reimbursed from your contributions to the dependent care flexible spending account (DCFSA) on a before-tax basis. Both options will result in tax savings; however, the specific way in which taxes are reduced differs, and which option is better for you depends on your individual circumstances.

The DCTC applies to $3,000 of dependent care expenses for one child, $6,000 for two or more children. The DCFSA maximum remains at $5,000. You may find through use of this worksheet that a blended approach will maximize your tax savings. For instance, two children in daycare costing $7,000 would allow you to use DCFSA for $5,000 of the expenses and DCTC for $1,000 of the remaining expenses ($6,000 is the maximum allowed when calculating tax savings).

This worksheet will help you compare options. The process described below involves comparing the total federal income tax savings (including Social Security) resulting from use of DCFSA with the tax savings resulting from the DCTC. Note that state income taxes and the Federal Earned Income Credit are not included in this analysis. Including state income taxes would increase the relative tax savings associated with the DCFSA. If you qualify for the Earned Income Credit, the DCRA may be more tax effective than the Tax Credit, even at lower incomes.

In general, eligible expenses are those that you incur for daycare that enables you (and your spouse**, if you are married) to work. If you or your spouse are not employed, you must either be actively seeking employment or be a full-time student in order to claim dependent care expenses. Eligible Dependents are your children under age 13, or a spouse** or other dependent who is incapable of caring for himself or herself and whose principal residence is your home. Pre-School, latch-key programs, and day camps that substitute for your regular daycare are examples of eligible expenses. Registration fees & deposits are reimbursable, but only after the period for which the fee or deposit is paid begins. Educational expenses at the kindergarten level or higher, overnight camp, special activity fees, and transportation fees are examples of ineligible expenses.

** Spouse includes legally married same-sex spouses

STEP 1. Estimate Federal Income Tax and Social Security Savings from the Dependent Care Spending Account.

	With Flex	Without Flex
A. Projected Adjusted Gross Income: Participant - [ ] Spouse - [ ]	$ 0	$ 0
B. Dependent Care Expenses Enter the lesser of: 1)your anticipated dependent care expenses, 2) $5,000 ($2,500 if married filing separately) or 3) the earned income of the lower earning spouse. Earned income means income from employment such as wages, salaries and tips. If your spouse is a full-time student or incapable of self-care, you can assume an earned income of $250/month for one qualifying individual or $500/month for two or more qualifying individuals.	$	$ 0.00
C. New Adjusted Gross Income (Subtract B from A)	$ 0	$ 0
D. Estimated itemized deductions or the standard deduction ($12,600 for married filing jointly; $9,250 for head-of-household; $6,300 for married filing separately)	$	$ 0
E. Multiply number of Personal Exemptions times $4,000. (1 for yourself; 1 for your spouse; and one for each dependent) Number of Exemptions - [ ]	$ 0	$ 0
F. Taxable Income (Subtract lines D and E from C)	$ 0	$ 0
G. Federal Tax: Select filing status - [Married Filing Jointly]	$	$
H. Social Security Tax (Multiply the amount of your income shown on line C up to $118,500 by .0765 plus the amount over $118,500 by .0145 plus the amount over $250,000 by .009)	$	$
I. Total Taxes (add lines G and H)	$ 0	$ 0
J. Tax Savings (Subtract line I, Column 1 from Line I, Column 2)	$ 0	

Reset Form

For Step 1, Line G

Filing Status and Taxable Income					
Married Joint		Head of Household		Married Separate	
Taxable Income	Tax	Taxable Income	Tax	Taxable Income	Tax
Not over 18,450	10% of taxable inc.	Not over 13,150	10% of taxable inc.	Not over 9,225	10% of taxable inc.
Over 18,450 but not over 74,900	1,845 plus 15% of the amount over 18,450	Over 13,150 but not over 50,200	1,315 plus 15% of the amount over 13,150	Over 9,225 but not over 37,450	922.50 plus 15% of the amount over 9,225
Over 74,900 but not over 151,200	10,312.50 plus 25% of the amount over 74,900	Over 50,200 but not over 129,600	6,872.50 plus 25% of the amount over 50,200	Over 37,450 but not over 75,600	5,156.25 plus 25% of the amount over 37,450
Over 151,200 but not over 230,450	29,387.50 plus 28% of the amount over 151,200	Over 129,600 but not over 209,850	26,722.50 plus 28% of the amount over 129,600	Over 75,600 but not over 115,225	14,693.75 plus 28% of the amount over 75,600
Over 230,450 but not over 411,500	51,577.50 plus 33% of the amount over 230,450	Over 209,850 but not over 411,500	49,192.50 plus 33% of the amount over 209,850	Over 115,225 but not over 205,750	25,788.75 plus 33% of the amount over 115,225
Over 411,500 but not over 464,850	111,324 plus 35% of the amount over 411,500	Over 411,500 but not over 439,000	115,737 plus 35% of the amount over 411,500	Over 205,750 but not over 232,425	55,662 plus 35% of the amount over 205,750
Over 464,850	129,996.50 plus 39.6% of the amount over 464,850	Over 439,000	125,362 plus 39.6% of the amount over 439,000	Over 232,425	64,989.25 plus 39.6% of the amount over 232,425

Step 2. Determine Dependent Care Tax Credit

A. Based on your projected family adjusted gross income, select the appropriate tax credit % from the table at the right. _____%

B. Qualifying Dependent Care Expenses: $ _____
Enter the lesser of:
(1) your actual expenses,
(2) $3,000 for one child or $6,000 for two or more children,
(3) the earned income of the lower earning spouse. (See Step 1, B3)

C. Estimated Tax Credit (multiply line A times line B) $ 0
(Note: Cannot exceed Federal Tax calculated for Step 1, Line G, column 2 –"Without Flex")

Tax Credit Table

Adjusted Gross Income	% Credit
< 15,000	35%
15,001 – 17,000	34%
17,001 - 19,000	33%
19,001 - 21,000	32%
21,001 –23,000	31%
23,001 – 25,000	30%
25,001 – 27,000	29%
27,001 – 29,000	28%
29,001 – 31,000	27%
31,001 - 33,000	26%
33,001 – 35,000	25%
35,001 – 37,000	24%
37,001 – 39,000	23%
39,001 – 41,000	22%
41,000 – 43,000	21%
> 43,000	20%

Step 3. Compare the Tax Savings Estimated in step 1, Line J with the Tax Credit Estimated in Step 2, Line C:

FSA Savings - $0 **Tax Credit Savings -** $0

This worksheet is intended to help you decide whether to participate in the dependent care account, but should be used with the understanding that it has limitations. Each individual's circumstances are unique, and the worksheet is not a substitute for competent tax advice. If you have questions, you should talk to your personal tax advisor.

NOTE: ALL TAX BRACKETS AND DOLLAR FIGURES SHOWN ABOVE ARE BASED ON 2015 RATES.

Reset Form

Guide to Eligible Dependent Care Expenses

Eligible expenses are those incurred for the care of a qualifying dependent that allows the employee (and spouse, if married) to be gainfully employed. If you or your spouse are not employed, you must either be actively seeking employment or be a full-time student in order to claim dependent care expenses. The main purpose of the service must be the dependent's care and well being, and must be incurred for the purpose of allowing you to go to work.

The following table provides general information about eligible dependents, services, and providers.

Eligible Dependents

- Your children under the age of 13 whose principal residence is your home
- A spouse or other dependent who is incapable of self-care and whose principal residence is your home

Eligible Services

- Before-school and after-school programs
- Nanny / Au Pair (agency fees paid up-front to employ a caregiver may also be eligible if required to obtain the services, but may be pro-rated over the duration of the employment contract)
- Preschool
- Registration fees and deposits, but only after the period for which the fee is paid begins
- Summer day camp programs can be reimbursed, but summer educational programs (such as the cost of sending a child to a private school) are not reimbursable
- Before-school and after-school programs

Ineligible Services

- Babysitting expenses for care of your dependents during your non-work hours
- Camps, overnight – *even if the daytime & nighttime charges are broken out separately*
- Care that is primarily educational in nature **(i.e. kindergarten and above)**
- Care that is primarily medical in nature
- Care for children while you are on maternity leave or otherwise not working, unless you are incapable of self-care during that time (physician's certification would be necessary to verify)
- Transportation expenses
- Fees for **supplies, clothing, entertainment, field trips and special activities** that can be separated from the standard cost of the custodial care

Provider Limitations

- Payments to the employee's child who is under age 19 at the close of the year are *not* eligible.
- Payments to any tax dependent of the employee or the employee's spouse are *not* eligible.

- Payments to other relatives of the employee are eligible.
- If care is provided at a dependent care center, the dependent's principal residence must be your home in order for the expenses to be eligible.
- If care provider is unlicensed, the provider must be caring for less than six individuals who do not live with the provider in order for the expenses to be eligible. Note that some states have licensing requirements that are stricter than this federal requirement.

Important Information About Benny®

Your Card for Better Benefits

Making a great plan even better!

Participation in your Health Care Flexible Spending Account (Health FSA) gives you many important benefits, including lower taxable income and the ability to pay for eligible expenses in tax-free dollars. The Benny Card enhances these benefits by making your FSA much easier and more convenient to use.

Before the Benny Card, you'd have to submit a claim and then wait for your reimbursement. With the Benny Card, this process is handled for you -- there's **no wait for reimbursement**.

For example, suppose you have a $20 co-payment due on a prescription drug purchase. Simply present your Benny Card to the pharmacist. When the card is swiped, that $20 expense is automatically deducted from your Health FSA account. That's all there is to it!

Eligible expenses

You can use your Benny Card to pay for health care expenses that:

- Are eligible for reimbursement under your Health FSA; and
- Are **not covered** or reimbursed by any medical plan, dental plan, prescription drug plan, or other health insurance.

You can check your benefit plan materials or contact your FCI Benefits Administrator for more information about eligible expenses under your Health FSA.

Remember these important points when using your Benny Card:

Account Information: You can access your personal Benny Card account by logging on to www.flexcompensation.com.

Save your receipts: Save your receipts and other documentation for all Benny Card transactions. This is important, because the IRS requires documentation for these transactions.

Use it properly: It's your responsibility to use your Benny Card for eligible Health FSA expenses only. You can't use it for dependent care expenses, or at non-health related locations such as gas stations, convenience stores, or restaurants.

Introducing the Benny™ Card!

Using your Health Care Flexible Spending Account (Health FSA) just got a lot easier. Introducing the **Benny Card** – the fastest and most convenient way to pay for eligible Health FSA expenses.

It works like a credit card

Your Benny Card draws on the value of your annual Health FSA election amount. You can use it just like a credit card to pay for eligible Health FSA expenses.

It's automatic

Any health-related location that accepts MasterCard© will also accept your Benny Card. When you go to the doctor or pharmacy, simply use your Benny Card to pay for an eligible expense. That's it – no more waiting for reimbursement.

Watch for it

If you enroll, you'll receive your Benny Card shortly before the start of the plan year. Be sure to activate and sign your card before using it for the first time.

QUESTIONS? Refer to the Frequently Asked Questions or call FCI customer service at 952-541-6366 or 800-333-5597 or visit www.flexcompensation.com

Frequently Asked Questions – the Benny™ Card

Q.1 What should I do when I get my Benny Card?

A. Before using it for the first time, you should sign your Benny Card and activate it by calling the toll-free number provided on the back of the card. You can also activate your card online at https://flexcompensation.LH1ondemand.comYou'll need to set up a username and password if this is your first visit to the website.

By signing and activating your Benny Card, you are certifying that you'll use it only for eligible Health Care Flexible Spending Account (Health FSA) expenses.

Q.2 Where can I use my Benny Card?

A. You can use your Benny Card at any **health-related** location (pharmacy, dentist, doctor, chiropractor, etc.) that accepts MasterCard©. You can't use your Benny Card at non-health related locations such as gas stations, convenience stores, restaurants, etc.

NOTE: In some cases, only prescriptions covered by your employer's health plan can be "charged" on your Benny Card at a pharmacy. Over-the-counter items and prescriptions eligible under a spouse's medical plan must be submitted manually. In addition, vision expenses from discount stores like Target and WalMart must be submitted manually because they are generally run through the pharmacy register.

Q.3 Can I use my Benny Card to make an on-line purchase?

A. Yes. You can use your Benny Card to make an on-line or mail-order purchase, as long as it is for an eligible expense and is obtained through an eligible health care provider. Remember to keep the itemized billing statement because you may be asked to send it in to FCI later (See Q/A 6 & 7 below)

Q.4 Should I select "Debit" or "Credit"

A. The Benny Card is actually a "stored-value" card. If you want to enter a PIN# that you have set up, select "debit." If you want to sign for your transaction, enter "Credit." Note that you can't get cash with the Benny Card.

Q.5 What are my responsibilities and obligations when using my Benny Card?

A. It's your responsibility to use your Benny Card properly. Each time your card is swiped, you are certifying that the transaction is for an eligible Health FSA expense. (See Q/A #6)

Q.6 What are eligible Benny Card expenses?

A. You can use your Benny Card to pay for eligible **health care** expenses only. You can't use it for Dependent Care Reimbursement Account expenses.

Q. 6
cont'd

An expense must meet these conditions before it can be considered eligible:

- The expense must be eligible for reimbursement under your Health FSA *for the current plan year*; **and**
- The expense has not been reimbursed (and you will not seek reimbursement for it) under any other health care benefit plan or insurance.

Each time you use your Benny Card, you are certifying that the transaction meets the above conditions.

Q.7 Should I save my receipts and other documentation for Benny Card transactions?

A. Yes. Under IRS rules, you must be able to provide documentation for each Benny Card transaction should you receive a request. The only exceptions to this requirement are for prescription drugs and office visit copayments under **your employer's** (not your spouse's) plan.

Q.8 How does the documentation requirement work?

A. After you use your Benny Card for a transaction, you will receive a request for the back-up documentation from Flex Compensation (except as noted above in Question #7). If you don't return the required documentation, the transaction will be considered an ineligible expense. **The documentation must contain the provider name; patient name; date of service; description of the service; and amount of expense – just like the documentation you submit for a manual claim.**

Q.9 What happens if I use my Benny Card for an expense that is determined to be ineligible?

A. If you use your Benny Card to pay for an expense that is determined to be ineligible, you must reimburse the plan. This also applies if you don't return the required documentation for a Benny Card transaction.

If you don't reimburse the plan, the plan is required to take action to recover the ineligible expense. This may include cancellation of your Benny Card, reduction of a subsequent eligible claim, deduction from your pay, or prohibiting you from participating in future plan years.

Q.10 How can I avoid an ineligible expense?

A. You can avoid ineligible expenses by:

- Checking your benefit plan materials to ensure that a given expense is eligible for reimbursement under your Health FSA;
- Using your Benny Card only at health-related locations; and
- Saving your receipts and requesting itemized documentation for each Benny Card transaction.
- NOT using your card to pay for a service that was actually incurred in a prior plan year.

Q.11 What if my Benny Card balance won't cover a transaction?

A. If your Benny Card balance is less than the transaction amount, the transaction will be denied when the card is swiped. In this case, you can ask the clerk to charge only the amount of your Benny Card balance, and pay the remainder in cash.

Q.12 How is my Benny Card balance determined?

A. Your initial Benny Card balance is equal to your annual Health FSA election for the plan year minus previous reimbursements.

For example, suppose you elect to put $1,200 in your Health FSA for the 2014 plan year. In this case, your initial Benny Card balance for the 2014 plan year is $1,200. That $1,200 balance is then reduced by each Benny Card transaction you make or manual claim that you submit during the 2014 plan year.

Q.13 Can my Benny Card balance carry over from year to year?

A. Your Benny Card account balance may carryover from year to year under limited circumstances. See your SPD for more information.

Most Health FSA plans allow some time after the end of the plan year to submit claims for eligible expenses incurred during that year, but you SHOULD NOT use your Benny Card to pay for expenses from last year. (*Remember that an expense is "incurred" on the date the service is provided, not when you are billed or pay for it.*) All claims submitted after the end of the plan year must be submitted manually to FCI.

Q.14 Is there a deadline for using my Benny Card each year?

A. Yes. While you can technically use your card on the last day of the plan year, it sometimes takes transactions up to a week or more to "settle" and post to your account. Therefore, we strongly suggest that you discontinue using your card two weeks prior to the end of the year. This will help avoid having a transaction post to your new year account and create an ineligible transaction (if this happens, you'll be required to re-pay or offset that transaction). You can submit manual claims for any remaining expenses you incur during the current plan year, and begin using your card again on the first day of the new year.

Q.15 How can I access my Benny Card account?

A. You can access your current Benny Card account by logging into Employee Accounts at https://flexcompensation.LH1ondemand.com and following the instructions provided.

Q.16 How can I report a lost or stolen Benny Card?

A. You can report a lost or stolen Benny Card and request a replacement by contacting your FCI Benefits Administrator at 952-541-6366 or 800-333-5597. The cost of a replacement card is $10 and will be deducted from your account balance.

Q.17 Can a Benny Card transaction be declined when the provider swipes the card?

A. Yes. There are some situations in which a Benny Card transaction can be denied by a pharmacy or other location. This can happen if:

- You use your card before it is activated.
- Your Benny Card account balance is less than the transaction amount.
- You use your card at a pharmacy for any expense *other than* a pharmacy co-pay / co-insurance amount under your employer's medical plan. *Note: this means that OTC drugs*

Q.17
Cont'd

and vision expenses at a Target or Wal-Mart Pharmacy will be denied and must be submitted manually.

- The pharmacy doesn't process the prescription properly before swiping the Benny card.
- The merchant is not a non-health-related facility (e.g., a gas station)
- The provider's transaction machine is coded improperly with a non-health-related Merchant Category Code.
- AVS Decline: Some merchants use Address Verification Services and will enter all or part of a participant's address when processing the transaction. If the address does not match the information stored for your Benny Card, the transaction may be declined.
- The expiration date entered by the merchant does not match the expiration date stored for your Benny Card.