

## **To All Full-Time and Part-Time Regular Employees Eligible For Health Insurance**

### **Flexible Spending Account (FSA)**

The unreimbursed Medical and/or Dependent Care Flexible Spending Accounts (FSA) allow employees to set aside a specific amount of tax-free dollars under the Internal Revenue Code (IRC) Section 125, thereby reducing your federal, Social Security, and Medicare tax liability. These tax-free dollars can be used to pay for unreimbursed medical, dental, and vision expenses including certain over-the-counter pharmacy items prescribed by a medical practitioner. The FSA account can also be used to pay dependent care expenses. Additional information about the FSA can be found at the HR/Internet web page and the portal.

### **Enrollment**

If you have predictable out-of-pocket expenses, you may want to consider an FSA. For the calendar year starting January 1, 2012, you may elect to put up to \$2,500 in an account for eligible medical, dental, and vision expenses and \$5,000 for dependent care expenses (thresholds may change annually based on IRS guidelines). Accounts established for 2012 can use tax-free dollar expenses incurred in 2012 as long as claims are submitted by March 31, 2013. While the FSA provides a great benefit to pay unreimbursed medical, dental, and vision bills with pre-tax dollars, it is important to note that any unused funds in the account will be forfeited annually.

To help you determine an appropriate amount of tax-free dollars, go to the HR/Internet web page and the portal for the FSA Deduction Worksheet. Determining the amount of unreimbursed out-of-pocket expenses from previous years will help you decide how much money you may want to set aside under the FSA per year. You will be able to change the amount annually.

The enrollment form can also be found at the HR/Internet web page and the portal. **For 2012, the form must be completed and received in Human Resources no later than January 9, 2012.** Any form received after January 9, 2012 will not be accepted and will be returned to the employee.

### **Information Sessions**

To help you better understand the FSA and the reimbursement process, representatives from Paychex, the company administering the plan, will be on campus on Thursday, December 8 and Friday, December 9 in Twin Lights II from 10:00 am to 3:00 pm. An information and enrollment session will be held each

hour; sessions will be transmitted to our other locations. If you want claim reimbursement done via direct deposit, bring a blank check with void written across it.

### **FSA Procedures**

- Each pay period, a predetermined dollar amount based on the annual amount you elected will be deducted pre-tax.
- The money is held by the College in a flexible spending account.
- Submit a claim to Paychex to receive reimbursement for your eligible expenses from your FSA after you pay your out-of-pocket medical, dental, vision, over-the-counter pharmacy items, and dependent care expenses.
- Reimbursement will be made by Paychex via direct deposit to your account or a check.

# FSA Reimbursement

## Medical Expenses

The following list identifies some of the common medical, dental, and health-related expenses that the Internal Revenue Service (IRS) considers to be deductible expenses. These expenses are eligible for reimbursement through your FSA provided that they are to diagnose, treat, or prevent an existing medical condition and you have not been reimbursed for them through any other benefits plan. Some of the following items may require a prescription, doctor's note, or additional certification from a medical provider to show expenses are reimbursable under a health FSA to the extent that they are to diagnose, treat, or prevent an existing medical condition.

A.E.D. for home use	Diabetes supplies and test strips	Ovulation monitor
Alcoholism treatment	Diagnostic/screening services	Oxygen equipment
Ambulance services	Drug addiction treatment facilities	Physical exam
Astigmatic keratotomy	Fertility treatments	Podiatrist
Bandages	Guide dog/care	Prescription medication
Blood pressure monitors	Hearing aids/batteries/repairs	Prescription sunglasses
Braille books and magazines <i>(to extent prices exceed the prices of regular books and magazines)</i>	Hospital services	Prosthesis <i>(artificial limbs)</i>
Car equipped for disabled person <i>(to extent price exceeds the price of regular car)</i>	Hot/cold packs and heating pads	Rental of medical equipment
Clinic charges	Insulin	Rewetting eye drops
Contact lenses/solutions	Laboratory fees	Shipping costs <i>(medical care items)</i>
Co-pays and deductibles	Lasik eye surgery/ radial keratotomy	Smoking cessation prescriptions
Crutches	Lead-based paint removal to treat lead poisoning	Special education for physically or mentally disabled family member
Dental retainer	Lodging for medical care	Sperm storage fees <i>(temporary)</i>
Dentist's fees <i>(not cosmetic)</i>	Medical monitoring/testing devices	Sterilization
Denture adhesives	Medical records fees	Surgery/treatments
Dentures/dental implants/partials	Midwife expense <i>(medical care)</i>	Telephone <i>(for the deaf)</i>
Doctor's fees <i>(not cosmetic procedures)</i>	Nurses' expenses and board	Thermometer
Eye exam/prescribed eyeglasses	Nursing care	Transplants
Eyeglass repairs for Rx glasses	Obstetrical services	Transportation for essential care
	Orthodontia <i>(contract required)</i>	Vasectomies <i>(and reversals)</i>
	Osteopath, licensed	Wheelchairs
		X-ray fees

# Expense Summary

## Over-the-Counter Expenses

The following list identifies some of the common over-the-counter expenses that the Internal Revenue Service considers to be deductible expenses to diagnose, treat, or prevent an existing medical condition. Effective January 1, 2011, over-the-counter medicines and drugs (other than insulin) are no longer eligible for reimbursement under a medical flexible spending account unless prescribed by a medical practitioner.



Acne medications	Hemorrhoid creams/suppositories
Allergy medications	Herbal supplements
Allergy nose sprays	Lactose intolerance pills
Antacids	Laxatives
Antifungal medications	Medicated rubs/muscle creams
Anti-gas treatments	Menstrual cycle medications
Antihistamines	Motion sickness medications
Anti-itch treatments	Pain relievers/analgesics
Antiseptic first aid sprays	Spermicides
Calcium supplements	Toothache/teething pain relievers
Cold medicines	Vitamins/minerals
Contraceptives	Wart removal treatments
Cough medicines/drops/syrups	Weight loss/dietary supplements
Decongestants	Yeast infection creams
Digestive aids	
First aid kits/supplies	
Gingivitis mouthwash/treatments	

## Dependent Care Expenses

Child care services will qualify for reimbursement from the Dependent Care reimbursement account if they meet these requirements:

- The child must be less than 13 years old and must be your dependent under federal tax rules (Section 152(a)(1) of the Internal Revenue Code). Note: If your child turns 13 during the year, you can stop your contribution at that time.
- The services may be provided inside or outside your home, but not by someone who is your minor child or dependent for income tax purposes (for example, an older child).
- If the services are provided by a day care facility that cares for six or more individuals at the same time, it must be a qualified day care center that complies with federal, state, and local laws.
- The service must be incurred to enable you, or you and your spouse if you are married, to be employed, be looking for employment, or be a full-time student.
- The amount to be reimbursed must not be greater than \$5,000, your earned income, or your spouse's earned income, whichever is less.
- Services must be for the custodial care of the dependent, not for education, meals, etc.

Allowable Dependent Care expenses include payments to the following when they meet the above criteria:

- Au pair
- Child care centers
- Day camp
- Family day care providers
- Babysitters
- Nursery schools
- Caregivers for a disabled dependent or spouse who lives with you
- Household services, provided that a portion of these expenses are incurred to ensure a qualifying dependent's well-being

This is not an enrollment form. This worksheet is intended to guide you through the enrollment process. This worksheet will help you calculate your applicable expenses and how much money would be in an FSA deduction each pay period.

### Medical/Dental/Vision Reimbursement Account

#### Annual Medical Expenses, such as:

Deductibles and co-pays \$ \_\_\_\_\_  
Routine physical exams \$ \_\_\_\_\_  
Prescriptions\* \$ \_\_\_\_\_  
Chiropractic care \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_

\*Effective January 1, 2011, the cost of over-the-counter (OTC) medicines and drugs (other than insulin) are no longer eligible for reimbursement under a medical flexible spending account unless prescribed by a medical practitioner.

#### Annual Dental Expenses, such as:

Deductibles and co-pays \$ \_\_\_\_\_  
Routine check-ups \$ \_\_\_\_\_  
Orthodontia \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_

#### Annual Vision Care Expenses, such as:

Exams \$ \_\_\_\_\_  
Eyeglasses \$ \_\_\_\_\_  
Contact lenses, solutions, cleaners \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_

**Total Estimated  
Medical/Dental/Vision Expenses** \$ \_\_\_\_\_ ÷ \_\_\_\_\_ = \$ \_\_\_\_\_  
Annual Amount (cannot exceed company max.) # of Pay Periods\* Per Pay Period

### Dependent Care Reimbursement Account

#### Annual Dependent Care Expenses:

Payment to a dependent care facility  
or individual \$ \_\_\_\_\_  
Payment to other care providers \$ \_\_\_\_\_

**Total Estimated  
Dependent Care Expenses** \$ \_\_\_\_\_ ÷ \_\_\_\_\_ = \$ \_\_\_\_\_  
Annual Amount (cannot exceed \$5,000 IRS max.) # of Pay Periods\* Per Pay Period

**Total Per-Pay-Period Reduction** \$ \_\_\_\_\_  
(Add total estimated medical/dental/vision expenses and total estimated dependent care expenses.) Total Per Pay Period

\*Weekly, 52 pay periods • Biweekly, 26 pay periods • Semimonthly, 24 pay periods • Monthly, 12 pay periods



SECTION 1 - EMPLOYEE INFORMATION (print)

Company Name \_\_\_\_\_ Office/Client Number \_\_\_\_\_
Employee Name \_\_\_\_\_ Employee Telephone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
Social Security Number \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
E-mail Address \_\_\_\_\_

SECTION 2 - ENROLLMENT OPTIONS (select one)

[ ] New Enrollment or Annual Enrollment Changes
Date of Hire \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Notes: New enrollments will be effective on the first payroll of the month following the date the eligibility requirements are met.
Annual enrollment changes will be effective on the first payroll following January 1.

[ ] Debit Card
Dependent's name (if applicable) \_\_\_\_\_

Notes: Participants may only request a debit card if their employer has selected the service. If the debit card option is selected and the Plan does not offer the debit card service, no card will be requested. Refer to your Summary Plan Description for plan features.

Participants may choose only one dependent.

[ ] Change In Status
Date of Event \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Note: If Change in Status has occurred, changes in enrollment and supporting documentation must be submitted to the Employer within 30 days of the event.

- [ ] Dependent care cost provider changes
[ ] Dependent satisfies or ceases to satisfy dependent eligibility requirements
[ ] Birth/Death of spouse or dependent, adoption or placement for adoption
[ ] Spouse's employment commenced/terminated
[ ] Status change from full-time to part-time or vice versa by employee or spouse\*
[ ] Eligibility or Ineligibility of Medicare/Medicaid
[ ] Change from salaried to hourly or vice versa\*
[ ] Marriage/Divorce/Legal Separation
[ ] Unpaid leave of absence by employee or spouse
[ ] Return from unpaid leave of absence by employee or spouse
[ ] Termination of employment (you will be de-enrolled)

\* These changes are allowable only if eligibility is affected.

SECTION 3 - ENROLLMENT ELECTION

[ ] Annual Medical/Dental/Vision Election \$ \_\_\_\_\_ (UME) [ ] Annual Dependent Care Election \$ \_\_\_\_\_ (DCA)
Maximum \$5,000.00

DCA is issued for custodial care of a dependent, not for medical expenses of a dependent.

Note: To calculate your per-pay-period deduction, divide your annual amount by the number of pay periods remaining in the plan year.

SECTION 4 - AUTHORIZATION

I hereby elect to participate in the Flexible Spending Account for the Plan Year \_\_\_\_ / \_\_\_\_ / \_\_\_\_ . Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. I cannot change or revoke this election at any date prior to the next plan year unless I experience a change in status (also referred to as a qualifying event). If, during my next enrollment period, I do not complete and return a new election form during my enrollment period, I will be treated as having elected to continue my employee election as set forth in this election form for the next plan year. As a participant, I understand that all guidelines regarding enrollment are set forth in the Summary Plan Description.

Reduction of Pay

- I understand that my pay will be reduced each pay period by the amount of my required contribution for the benefit option(s) I have elected until this agreement is amended or terminated. The reduction in my pay under this agreement will be in addition to any reductions under other agreements or benefit plans.
I understand that my pay reduction will be automatically adjusted if my required contributions change while this agreement is in effect and that the plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy provisions of the Internal Revenue Code.

- I agree to notify my Employer if I believe that any expense for which I have received reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer for any liability Employer may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
I understand that I will forfeit any balances I have at the end of the year for which I have no eligible expenses to submit.

FSA with an HSA

- If I have a Flexible Spending Account in conjunction with a Health Savings Account (HSA), I may only submit medical expenses under the Unreimbursed Medical portion of my Flexible Spending Account for dental, vision, and preventative care. My HSA may be used to pay for any remaining HSA-qualified medical expenses.

Reimbursements

- I understand that my Employer will hold my contributions for payment of eligible expenses incurred within the Plan Year and that reimbursement will be available only for qualifying expenses.

Employee Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ENROLL or REVISE ENROLLMENT at https://benefits.paychex.com or on the FSA Information Line by dialing 1-877-244-1771, Flexible Spending option. MAIL or FAX to Paychex, Section 125 Department, 1175 John Street, West Henrietta, NY 14586 • Fax: 585-389-7349







**Flexible Spending Account  
Direct Deposit  
Enrollment Form for FSA Claims**

Use this form to enroll in the Direct Deposit service for your Flexible Spending Account (FSA). With Direct Deposit, your FSA reimbursements will be deposited electronically into your bank account rather than sent to you as paper checks. Use this form if you are enrolling for the first time in Direct Deposit or if you are changing the account that will receive your reimbursements.

**Instructions:**

- Complete the Required Information section.
- Complete the Direct Deposit Information section.
- Sign and date the bottom of the form.**
- Make a copy of this form and retain for your records.
- Return this form and supporting documentation to:

**Fax 585-389-7003**

**Mail** Paychex, Inc.  
Attn: FSA Claims  
1175 John Street  
West Henrietta, NY 14586

Required Information	
<i>PLEASE PRINT</i>	
Name	_____
Social Security No. (last 4 digits)	_____
Address	_____ _____
E-mail Address	_____
Employer Name	_____
<input type="checkbox"/> New Account	<input type="checkbox"/> Change Account

**Direct Deposit Information**

I authorize my employer to deposit my FSA reimbursements to the following bank account (select one):

- Checking Account Number \_\_\_\_\_
- Savings Account Number \_\_\_\_\_
- Chase Pay Card *Plus* Account Number \_\_\_\_\_

Attach one of the following (select one) and indicate the name of the bank.

- Voided check (deposit slips are not accepted)
- Bank letter or specification sheet  
*(See your local bank representative.)*

Bank Name \_\_\_\_\_

**Attach a voided check here.**

**IMPORTANT:** A voided check, bank letter, or specification sheet must be attached. The card carrier (C-6105) must be attached for the Chase Pay Card *Plus*.

Authorization	
_____	Date ____/____/____
SIGNATURE	

Paychex Use Only	
Entered by	_____
Approved by	_____
Date	____/____/____
Client BIS ID	_____

For questions about completing this form, call Paychex Employee Services at 877-244-1771.