Kellogg Community College

A Guide to Your Flexible Spending Account

A Balanced Approach To Saving Time And Money

Flexible Spending Accounts

Making the most of your money.

What if you could make your earnings stretch further? A Flexible Spending Account (FSA) can help you to do just that. Kellogg Community College offers you an opportunity to participate in two FSA programs: A Healthcare FSA and a Dependent Care FSA. An FSA is a tax-effective, money-saving option that will help you pay for qualified healthcare expenses that aren't covered by your medical plan, and for dependent care services necessary to enable you to work.

Here's how an FSA works:

- **Eligible medical expenses.** Use pre-tax dollars to pay for eligible medical care expenses not reimbursed by a medical plan. All IRS code 213(d) expenses are eligible, including deductible, coinsurance, copays and expenses above usual and customary limits, as well as out of pocket expenses on prescription drugs, dental, vision, hearing and orthodontic care. Certain over-the-counter items may qualify too.
- **Dependent care costs.** Pre-tax dollars can be set aside for day care type expenses for eligible children or adults. Expenses are eligible if they're for the care of a person under age 13, or an older dependent who is unable to care for themselves. They must regularly spend at least eight hours a day in your home.
- **Restricted Healthcare Reimbursement Accounts.** Restricted FSA's are also available with certain high deductible healthcare plans. The Restricted Flexible Spending Account is for Dental and Vision expenses only. If you have a Health Savings Account (HSA) you only qualify for the Restricted FSA, you may not enroll in the regular FSA.

Maximize your savings potential.

You will gain the most savings from your FSA if you plan carefully. When you enroll in an FSA, you designate in advance the amount of money you wish to have deducted from your salary and deposited into your FSA over the length of a year. To do this, you must estimate in advance the annual costs you want your FSA to cover.

If you underestimate, you will deplete your FSA before the end of the year, losing some of your tax-savings potential. If you overestimate and there is money left in your FSA at the end of the year, you will unfortunately forfeit this money. The IRS' rule of thumb is "Use or lose."

Important note! While it probably is not possible to precisely anticipate your eligible FSA costs, Meritain Health provides two calculation worksheets to help you: "FSA Worksheet and Eligible Expenses Guide" and "Dependent Care FSA Determination." These worksheets are located in this kit, and include examples of eligible and ineligible expenses that can be applied towards your Healthcare and Dependent Care FSAs.

The Bottom Line:

An FSA saves you money. Pre-tax deductions mean that your payroll taxes (federal, state and Social Security) are decreased and your take-home pay is increased. Your gross earnings are adjusted to account for the amounts withheld, and your tax percentage is applied to a lower amount of income. You maximize your spendable income. And that's a goal we all share.

These materials were created to help you understand the benefits available to you. This is not a Summary Plan Description and is not intended to replace the benefit summary or schedule of benefits contained within the Plan. If any provision of these materials is inconsistent with the language of the Plan, the language of the Plan will govern. Meritain Health is not an insurer or guarantor of benefits under the Plan.

Frequently Asked Questions About FSAs

If I have a question about my FSA, whom should I call?

You can contact your dedicated service team for help with claims questions, or for more information about your benefits. The phone number for Customer Service is 1.800.748.0003.

What is the maximum amount of money I can contribute in each plan year?

You may contribute up to $2,500 towards the healthcare portion of your FSA. For dependent care, the IRS allows a contribution of up to $5,000 per calendar year, or $2,500 if you are married and filing separate tax returns.

What if I want to change my election mid-year?

IRS regulations do not allow you to stop, start or change your contributions at any time during the plan year UNLESS you experience a qualified change in status, such as a change in marital status, number of dependents or employment status. Keep in mind that the election change must be consistent with the event.

How do I file a claim?

Fill out a claim form and attach your healthcare and/or dependent care receipts. Claim forms are available inside this packet. Additional forms are also available on the college's Human Resources Web page.

How often can I submit reimbursement requests?

Claims can be submitted at any time; however, your employer has chosen to issue checks weekly on Fridays. Claims need to be received by Meritain Health at least 3 business days prior to this date.

How will I know what my FSA balance is?

You can access your account balance online at www.myMERITAIN.com. Statements are also sent out quarterly.

What if I have more expenses during the plan year than I have contributed at that time?

The annual amount you have elected for healthcare costs is available to you at the beginning of the plan year. The amount available for reimbursement for dependent care is limited to the balance in your account.

What if I terminate employment?

Reimbursement can only be requested on healthcare expenses incurred before the date of your termination, unless you qualify and elect continuation of coverage under COBRA. You will have 60 days following the date of termination (including retirement) to submit your FSA claims.

Here's an example:

- You make $1,500 in gross salary each month and choose to participate in an FSA.
- You decide to have $400 of your earnings deducted monthly to pay for premiums, eligible medical expenses and dependent care costs.
- That means you would be taxed on only an adjusted income of $1,100. Your taxes would be decreased and your take-home pay increased by $100 a month.
- That represents a savings of nearly 7% of earnings.

What if I still have money in my FSA at year's end?

Legislation governing FSAs includes a "use or lose" feature, so unused funds are lost at the end of the plan year. Please review the "FSA Reminders" page within this kit, for the FSA claim filing deadline.

FSA Reminders

Group number:
140264

Plan year:
January – December

FSA Reimbursement checks:
Mailed to your home weekly on Fridays.

Claim submission deadline:
3 business days (by Tuesday) prior to check processing date.

Healthcare FSA maximum:
$2,500

Restricted Health Care FSA maximum:
$2,500.

Dependent Care FSA maximum:
$5,000 per household or $2,500 per spouse if filing separate tax returns.

Claim forms:
A completed claim form must accompany every claim. Claim forms are available inside this packet. Additional forms are also available on the college's Human Resources Web page.

End of the year run-out for FSA and RFSA:
FSA claims can be submitted up to 60 days after the end of the plan year for expenses incurred through December 31st of the previous year.

Terminated employee claim filing deadline:
You will have 60 days following the date of termination (including retirement) to submit claims *incurred while employed at Kellogg Community College*.

Election changes:
The IRS does not allow changes in your annual election unless you have a qualified change in status. You need to notify your employer within 30 days of any qualified status change.

For online claim status inquiry, log on to www.myMERITAIN.com.

- You will be supplied a member ID and PIN.
- Click on the link for "Create a new user account."
- Enter in group ID number (140264).
- Fill in name, member ID, zip code, group number, e-mail address and member type.
- Set up your username and password.

Claim submission.

Mail FSA claim forms and attachments to:

Meritain Health
P.O. Box 30111
Lansing, MI 48909

Or fax to:

1.888.837.3725

For additional plan information:

For additional plan information refer to your summary plan description, contact your Employee Benefits Department, or contact the Meritain Health FSA Department at:

1.800.748.0003

The Right Balance: Look Over The Counter!

Guidelines for over-the-counter (OTC) medications and supplies for Flexible Spending Accounts (FSAs).

The Internal Revenue Service (IRS) allows FSA reimbursement for certain OTC items. To confirm whether or not an item is allowable before it's purchased, you may contact Meritain Health toll free at **1.800.748.0003** or visit www.irs.gov.

PPACA note: Beginning January 1, 2011, OTC items that contain a medication or drug will no longer be eligible for reimbursement through your FSA, without a doctor's prescription. This requirement will take place based on the date the items are purchased and not based on your plan year. In other words, starting January 1, 2011, you must first obtain a prescription for any OTC medications or drugs in order to obtain reimbursement from your FSA, regardless of when the plan year ends. OTCs that do not contain medications or drugs, will not require a prescription.

In order for the OTC medicine and/or drug to qualify as a prescription, there must be a written or electronic order that meets the legal requirements of a prescription in the state in which the medical expense is incurred, and that the prescription is issued by an individual who is legally authorized to issue a prescription in that state.

How do I know which OTCs *will* require a prescription?

OTCs that will require a doctor's prescription include, but are not limited to the following:

- Acid controllers
- Allergy and sinus
- Antibiotic products
- Anti-diarrheals
- Anti-gas
- Anti-itch and insect bite
- Antiparasitic treatments
- Aspirin, ibuprofen, pain relief
- Baby rash ointments/creams
- Bandages that contain antibiotic ointment
- Cold sore remedies
- Cough, cold and flu
- Digestive aids
- Hemorrhoidal preps
- Laxatives
- Motion sickness
- Respiratory treatments
- Sleep aids and sedatives
- Stomach remedies

Please note: *the above list contains examples of certain items, and should not be considered as a full listing.*

Here are some helpful tips:

- If you have a prescription for an OTC medicine or drug, you must pay out of pocket at the point of sale and then submit a manual claim requesting reimbursement.
- You can continue to use your FSA funds to purchase OTC items that do not contain a medicine or drug (for example: bandages without antibiotic ointments, splints, cold/hot packs, rubbing alcohol, thermometers, etc.).
- Insulin may continue to be reimbursed with or without a prescription.
- FSA balances are "use or lose", so remember to consider these new OTC regulations when estimating the dollar amount that you put in your FSA for the next plan year.

FSA Reimbursement Made Easy!

The IRS requires proof that you received medical services before claims can be reimbursed by your Flexible Spending Account (FSA). Follow these guidelines to receive prompt payment:

Expenses if you DON'T have automatic rollover, and other medical expenses.

Submit a completed and signed FSA claim form with these attachments:

A copy of the Explanation of Benefits (EOB). All claims must be submitted to your insurance company or healthcare plan before you request FSA reimbursement.

Estimates for services that haven't been received can't be accepted.

OR

A receipt for copays

- Your office visit copay receipt must show the amount paid and the date of service.
- Your prescription drug copay receipt must show the name of the drug, amount paid, the date of purchase and the name of the patient.

Credit card receipts, cancelled checks, or cash register receipts can't be accepted for copays.

OR

Over-the-counter (OTC) items.

- Itemized cash register receipts are acceptable for OTC items/supplies that do not contain a medicine or drug.
- Effective January 1, 2011, if the OTC item contains a medicine or drug, you will need to submit a cash register receipt as well as a **doctor's prescription.**
- A customer receipt issued by a pharmacy which identifies the name of the purchaser (or the name of the person to whom the prescription applies), the date and amount of the purchase and an Rx number.

OR

An itemized statement from your healthcare provider if you don't have insurance coverage (for example, for dental or vision services).

Special note on orthodontic care.

Submit a copy of the service agreement or contract with your first FSA claim. For future claims, submit a copy of your payment coupon or itemized bill with your completed claim form. An EOB isn't required, even if you have dental insurance.

Questions? Contact customer service toll free at 1.800.748.0003.

Claim submission.

Mail FSA claim forms and attachments to:

Meritain Health
P.O. Box 30111
Lansing, MI 48909

Or fax to:

1.888.837.3725

Prescriptions for OTCs.

In order to obtain FSA reimbursement for OTCs that contain a medicine or drug, you must first obtain a prescription from your doctor.

Make sure the OTC prescription includes the following:

- Patient name
- Name of the OTC item
- Date prescribed (the prescription will be valid for one year from this date)

FSA Worksheet and Eligible Expenses Guide

Estimating Your Healthcare Expenses.

The planning worksheet below can help you estimate your eligible healthcare expenses that may not be covered under your company's group insurance plan. Remember, all eligible healthcare expenses for you, your spouse and your eligible dependents are reimbursable from your Healthcare FSA.

Medical Expenses	*Estimated Plan Year Expenses*
Copays	$____________
Deductibles	$____________
Lab fees	$____________
Physical exams	$____________
Physician fees	$____________
Prescription drug expenses	$____________

Dental Expenses	
Copays	$____________
Deductibles	$____________
Dentures	$____________
Examinations	$____________
Orthodontia	$____________
Restorative work (crowns, caps, bridges)	$____________
Teeth cleaning	$____________
Other dental expenses	$____________

TOTAL COLUMN 1 $____________

Vision Expenses	*Estimated Plan Year Expenses*
Contact lens supplies	$____________
Copays	$____________
Deductibles	$____________
Eye examinations	$____________
Prescription contact lenses	$____________
Prescription eyeglasses or sunglasses	$____________
Other medical expenses	$____________

Other Expenses	
Acupuncture or chiropractic	$____________
Hearing aids	$____________
Immunization fees	$____________
Psychiatrist, psychologist, counseling*	$____________
Other eligible expenses	$____________

TOTAL COLUMN 2 $____________

TOTAL COL 1 $________ **+ TOTAL COL 2** $________ **= TOTAL ESTIMATED EXPENSES** $____________

* *Allowed for treatment of physical or mental disorder (e.g. depression, alcohol or drug treatment). A diagnosis is necessary for reimbursement.*

Examples of costs your Healthcare FSA may cover:

- Copays, deductibles, and out-of-pocket costs.
- Acupuncture as a treatment.
- Certain alcoholism and drug addiction treatment costs.
- Artificial teeth or dentures.
- Braille books for visually impaired.
- Certain residential improvements to accommodate the disabled.
- Eye examinations, contact lenses (including cleaning and maintenance supplies) and eyeglasses.
- Guide dogs for sight or hearing impaired persons.
- Car controls for disabled drivers.
- Hypnosis to treat illness.
- Lead-based paint removal.
- Learning disability tuition/therapy.
- Psychological or psychiatric care.
- Nursing home expenses.
- Certain medical transportation.

Important note! Reimbursement for certain services listed above is subject to specific requirements. Call the IRS toll free at 1.800.829.3676, or visit www.irs.gov, to obtain a copy.

Dependent Care FSA Determination

Dependent Care Tax Credit vs. Dependent Care Flexible Spending Account.

If you have qualifying dependent care expenses, you may be able to choose one or both of two ways to reduce your taxes. You may be able to obtain a tax credit (which is a direct reduction in the amount of taxes you otherwise would owe) or you may be able to reduce your taxable income. This worksheet will help you decide which is better for you.

If you qualify for the tax credit, you are allowed to deduct from the taxes you owe a percentage of the lesser of (1) your actual qualifying dependent care expense or (2) $2,400 if you have one dependent or $4,800 if you have two or more dependents. The percentage is based on your adjusted gross income for the year. The chart to the right will help you determine your percentage.

IF YOUR ADJUSTED GROSS INCOME IS:		% of Dep. Care You Can Deduct from Your Taxes:
OVER	TO	
$0	$15,000	35%
$15,000	$17,000	34%
$17,000	$19,000	33%
$19,000	$21,000	32%
$21,000	$23,000	31%
$23,000	$25,000	30%
$25,000	$27,000	29%
$27,000	$29,000	28%
$29,000	$31,000	27%
$31,000	$33,000	26%
$33,000	$35,000	25%
$35,000	$37,000	24%
$37,000	$39,000	23%
$39,000	$41,000	22%
$41,000	$43,000	21%
$43,000		20%

In lieu of the Dependent Care Tax Credit, each year you may elect to have an amount deducted from your paycheck before taxes and put in your Dependent Care FSA. This amount must be used during the year for qualifying dependent care expenses. In other words, you will not have to pay taxes on the amount you contribute to the Dependent Care FSA that is used to pay your qualifying dependent care expenses. If, however, either you or your spouse has Earned Income (as defined in the plan) of less than $5,000, your income exclusion will be limited to the amount of that Earned Income.

Use the following worksheet to determine whether you should use the Dependent Care Tax Credit or the Dependent Care Flexible Spending Account. Remember to compare your actual dependent care expenses to $2,400 (for one dependent) or $4,800 (for two or more dependents). Take the lesser amount from this comparison and multiply it by your adjusted gross income percentage from the chart. This will be your tax credit.

WORKSHEET

	Using the Tax Credit	Using the Dependent Care FSA
Adjusted Yearly Gross Income	$__________.___	$__________.___
Subtract: Dependent Care Account		(__________.___) –
Taxable Yearly Income	$__________.___	$__________.___
Taxes		
Federal* (___%)	$__________.___	$__________.___
State* (___%)	__________.___	__________.___
Social Security (generally 7.65%)	__________.___ +	__________.___ +
Total	$__________.___	
Subtract: Tax Credit	(__________.___) –**Total Taxes**	**$__________.___**

* The actual tax rate will vary depending upon your annual income. Estimate your own tax liability or check with your tax consultant.

Eligible Expenses:

- Fees paid to a childcare center or to a day care camp that, if providing care for more than six children, complies with all state and local regulations.
- Fees paid to a babysitter inside or outside of the home.
- Fees paid to a relative who provides dependent care services, other than your spouse, to your child (on the last day of the calendar year) or to a dependent you claim for federal income tax purposes.
- Legally mandated taxes paid on behalf of the provider.

Ineligible Expenses:

- Transportation to and from the place where dependent care services are provided.
- Food, clothing and education.
- Expenses for which federal child care tax credits are taken, or are claimed under Healthcare FSA.
- Overnight camps.
- Tuition.

See www.irs.gov for a complete listing.

Kellogg Community College

FSA Enrollment Form

EMPLOYEE INFORMATION			BENEFIT ADMINISTRATOR SECTION	
LAST NAME	FIRST NAME	MI	PLAN YEAR **January - December**	GROUP # **140264**
EMPLOYEE ID NUMBER	SEX ❑ M ❑ F	DATE OF BIRTH	EFFECTIVE DATE	DIVISION #
HOME ADDRESS	EMAIL ADDRESS		DATE OF HIRE	
CITY	STATE	ZIP CODE	PAY CYCLE ❑ WEEKLY ❑ MONTHLY ❑ BI-WEEKLY ❑ SEMI-MONTHLY ❑ OTHER: ___________________	
HOME TELEPHONE	WORK TELEPHONE	**I GIVE THE FSA TEAM PERMISSION TO RELEASE INFORMATION ABOUT MY FSA TO MY SPOUSE.** ❑ **YES** ❑ **NO**		

Please check all that apply:

❑ HEALTH CARE ACCOUNT

I would like to contribute $_________ per pay period ($__________ annually) to my Health Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by your employer is $2,500 per plan year.

❑ DEPENDENT CARE ACCOUNT

I would like to contribute $_________ per pay period ($__________ annually) to my Dependent Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by the IRS is $5,000 per family or $2,500 per individual (or spouse when married and filing separate tax returns)

ELIGIBLE DEPENDENTS:

Dependent's Name (Last, First, MI)	Sex	Relationship	Birth Date	Social Security Number
		Spouse		
		Child		
		Child		
		Child		

EMPLOYEE SIGNATURE REQUIRED

I understand that the above elections will remain in effect until the last day of the calendar year indicated on this Form. I understand that I may change my elections during the calendar year only if (1) I experience a "status change," as defined under the Plan and my change in elections is consistent with that "status change," or (2) I exercise a Special Enrollment Right as described in the Notice of Special Enrollment Periods that accompanies this Election Form. I also understand that if I do not submit a new Election Form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. I understand that the Employer may modify my benefit elections if appropriate to insure that the Plan complies with the requirements of the Plan and applicable law and that, subject to the requirements of applicable law, the Employer has the right to amend or terminate the Plan. I understand that if I fail to request Plan enrollment within 30 days after my (and/or my dependent's) other coverage ends, I will not be eligible to enroll myself or my dependent(s), as applicable, during the special enrollment period.

EMPLOYEE SIGNATURE	DATE

Mail completed form to: Meritain Health, P.O. Box 30111, Lansing, MI 48909

Fax to: 888.837.3725
Customer Service: 800.748.0003

REIMBURSEMENT REQUEST FORM

Employer Name: Kellogg Community College

Employee Name:________________________ **SS# or ID#:**____________

Address:________________________ **Telephone #:**____________

City:____________ **State:**______ **Zip:**______ **Is this a change of address?** ❑ Y or ❑ N

Select account from which you are requesting reimbursement, and fill out all requested information completely.
For further instructions, see Guidelines for Reimbursement *on back of this form.*

❑ Flexible Spending Account (FSA)

Date of Service	Name of Provider (Ex: physician, hospital, dentist, pharmacy)	Type of Service (Ex. copay, Rx, ortho)	Name of Patient	Amount of Expense	Was this service covered by any insurance plan?
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
			Total amount requested from your **FSA:**	$	

If more space is needed, list additional requests on a separate page. Please include all requests in the total.
A minimum request amount (as established in your plan document) may need to be met before a claim can be paid.

❑ Dependent Care Account (DCA)

Name of Day Care Provider	Dates of Service		Dependent's Name	Date of Birth	Amount of Expense
	From	To			
					$
					$
					$
				Total amount requested from your **DCA**:	$

Provider Signature:____________________ **Provider SSN# or Tax ID:**____________

Signature not required if signed receipt or Day Care Center statement is attached. Altered receipts cannot be accepted.

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provision.

Employee Signature:________________________ **Date**:____________

Guidelines for Reimbursement

NOTE: Incomplete or illegible submission may result in processing delays. Be sure to include all necessary information, sign and date form. Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.

Health Flexible Spending Account

- Attach a copy of the Explanation of Benefits (EOB) for each submission. All claims **MUST** be submitted to your insurance company prior to request for reimbursement. **Estimates for services that have not yet been incurred cannot be accepted.**

  OR

  Submit a paid receipt for your co-payments. **Credit card receipts, canceled checks, or cash register receipts cannot be accepted for copayments. Itemized cash register receipts are acceptable for over-the-counter (OTC) items/supplies that do not contain a medicine or drug. If the OTC item does contain a medicine or drug, you will need to submit a cash register receipt as well as a doctor's prescription.**

  OR

  If you do not have insurance coverage, submit an itemized statement from the provider showing the provider's name and address, patient name, date and description of service and amount charged. Additionally, prescription expenses must include the drug name or number. **Balance forward or paid on account statements cannot be accepted.**

- Orthodontic reimbursement: For first request, submit a copy of the Service Agreement or contract itemizing the treatment period, down payment, monthly payment, banding date and amount covered by insurance, if any. For subsequent claims, submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement.

Dependent Care Reimbursement Account

- Expenses submitted must have been incurred for the care of a "qualifying individual" for the purpose to be gainfully employed.
- A qualifying individual is (i) a dependent of yours under age 13, (ii) a dependent of yours (or your spouse) who is incapable of caring for himself/herself.

Medical and Dental Expenses Generally Eligible for Reimbursement

(Source: IRS Tax Publication 502)

You *Should* Claim

- Fees for health services or supplies provided by physicians, surgeons, dentists, ophthalmologist, optometrists, chiropractors, podiatrists, psychiatrists, psychologists, or Christian Science practitioners
- Acupuncture
- Fees for hospital, ambulance, laboratory, surgical, obstetrical, diagnostic, dental and X-ray services
- Costs incurred, including room and board, during treatment for alcohol or drug addiction at a hospital or treatment center
- Special equipment, such as wheelchairs, special handicapped automotive controls, and special phone equipment for the deaf
- Special items, such as dentures, contact lenses, eyeglasses, hearing aids, crutches, artificial limbs and guide dogs for the vision or hearing impaired
- Transportation for needed medical therapy
- Nursing services
- Rehabilitation expenses

You Should *NOT* Claim

- Any items which will be paid for by insurance or for which you are reimbursed by insurance or any other health plan
- Bottled water
- Health club dues
- Any illegal operation or treatment
- Programs to control weight (unless the program is undertaken at a physician's direction to treat an existing illness, including obesity)
- Elective cosmetic surgery
- Medical insurance premiums paid outside of your company by you or your spouse at his or her place of employment
- Nursing care for a normal, healthy baby
- Maternity clothes
- Burial expenses

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