General Information

Employer-sponsored flexible spending accounts (FSAs) are benefit plan arrangements that allow employees to pay for certain health care or dependent care expenses on a pre-tax basis.

The maximum amount of expenses an employee may be reimbursed for under a dependent care FSA is $5,000 annually ($2,500 for a married taxpayer filing separately). The IRS statutory limit set for Health FSA is a maximum of $2500.00 Employer can set any limit up to the $2500 maximum.

To maintain a tax-qualified status, flexible spending account plans must comply with special requirements under Internal Revenue Code Section 125. They must also meet some general rules that apply to all cafeteria plans, including written plan, reporting, and record keeping requirements. FSAs also are subject to those portions of the federal tax code that apply to the type of benefit offered such as Section 213 for health care FSAs, and Section 129 for dependent care FSAs. Health care FSAs must conform to the rules under tax code Sections 105 and 106 for the coverage and reimbursements to qualify for tax-favored treatment.

FSA Advantages

Flexible spending accounts offer significant tax advantages. Employees generally do not pay federal income, state income, or FICA taxes on the salary they contribute to a FSA plan. Employers, in turn, do not pay matching FICA (7.65%) and FUTA taxes because employees' gross incomes are marginally reduced. FSAs also allow employers to offer a low-cost benefit that is targeted to meet employee needs in critical benefit areas. Childcare costs are of vital concern to both single parents and married employees with young children who must work. Moreover, employees of all ages and in all industries are experiencing increased medical care costs, as employers are working to reduce those benefit costs through cost-sharing arrangements. A health care FSA, which allows employees to pay co-payments and deductibles with tax-free dollars, can go a long way to helping employees shoulder their share of the burden.

General Requirements under Section 125

To maintain tax-qualified status and offer tax advantages to both employees and employers, flexible spending accounts must comply with final and proposed regulations under tax code Section 125. These regulations apply to both dependent care and health care FSAs, such as the "use-it-or- lose-it" rule, periods of coverage, incurred expenses, and benefit elections.

How Does an FSA Operate?

Flexible spending accounts operate by reimbursing employees for qualified expenses that are incurred during the plan year. For this reason, they are often referred to as "reimbursement accounts."

Flexible spending accounts are usually funded through voluntary pre-tax salary reduction agreements with employees. However, they may be funded with employer contributions, as long as the employer specifies the amounts available to employees in the written plan document. Similarly, the amounts employees may elect to contribute on a salary reduction basis should be specified in the plan document. (NOTE: If an employer contributes dollars to the plan for the employee, the plan may be required to meet regulations and pay fees associated with the Affordable Care Act. Caution is advised when considering employer plan dollars.

At the beginning of each plan year, employees make their "benefit elections," i.e., stating whether they will participate in the FSA and how much pre-tax salary they agree to contribute. Once made, benefit elections may not be changed during the plan year, unless the change is due to and consistent with a change in status. Moreover, since amounts that remain in employees' accounts at the end of the plan year are forfeited under the "use-it-or-lose-it" rule, unless the Employer has implemented the IRS carryover rule that went in to effect 1/1/2014, employees should plan conservatively so to not fund their accounts with amounts greater than the expenses they expect to incur.

To receive funds from their accounts, employees are required to submit written proof that they have incurred an expense that is qualified for reimbursement under the plan (i.e., a copy of their insurance Explanation of Benefits or an itemized statement from the provider). The participant must also sign a written statement that the expense has not been reimbursed, or is not reimbursable, under any other health plan coverage.

Employees are required to make binding benefit elections prior to the beginning of each plan year -before benefits become currently available - under Section 125. When making an election to participate in a FSA, employees specify how much, if any, pre-tax salary they wish to contribute to the plan. The maximum amounts that employers allow employees to contribute should be specified in the written plan document, as should any amounts that are employer-provided.

Plan sponsors may permit employees to make changes in benefit elections only under the following conditions (each of these conditions may or may not allow a change in the reimbursement portion of the FSA):

- The cost of dependent care increases or decreases
- A change made under the plan of the spouse's or dependent's employer
- The participant has a change in eligibility for Medicare or Medicaid
- The participant has a change in status

Change in Status

If one of the following "Change in Status" events occur, and the requested election change is consistent with the event, the participant is permitted to change his or her election during the plan year.

- **Change in employee's legal marital status** - including marriage, divorce, death of spouse, legal separation and annulment.
- **Change in number of dependents** - including birth, adoption, placement for adoption, and death.
- **Change in employment status of the employee, the employee's spouse or the employee's dependent** - such as termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite.
- **Dependent satisfies (or ceases to satisfy) dependent eligibility requirements** - an event that causes the dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, gain or loss of student status, marriage or any similar circumstances.
- **Residence change** - a change in the place of residence of an employee, spouse or dependent, as long as the residence change affects the employee's eligibility for coverage.

Period of Coverage (Plan Year) / Incurred Expense

Flexible spending accounts may reimburse employees only for qualified expenses that are "incurred" during the plan's "period of coverage." These terms are defined as follows:

- The period of coverage for a health care or a dependent care FSA is 12 months. In practical terms, the period of coverage is the plan year. In cases where an employer has a short first plan year or where the plan year is being changed, the period of coverage must be the entire short plan year. An FSA program may not allow employees to participate only for periods during which they expect to incur health care or dependent care expenses, such as on a month- by-month or an expense-by-expense basis.

Expenses are "incurred," IRS rules say, only after the service or item has been provided, **not when the employee is formally billed or pays for the service**. Thus, employers may not reimburse employees in advance for services not yet rendered. Actual reimbursements, however, may be made after the period of coverage has ended (usually 90 days after the end of the plan year).

Terminating Employees

Employees who terminate their employment before the end of the plan year:

- May forfeit their account balances, by failing to request reimbursement in the run-out period established by the employer.
- If the participant has a positive health care FSA balance, they may elect COBRA continuation coverage, paying 102 percent of the premium and extending the coverage period until COBRA eligibility expires.

Reimbursable Expenses for Health Care FSAs

Health care expenses that may be reimbursed through a health care FSA are those that are excludable from gross income under tax code Section 213, and are not reimbursable under any other health plan coverage. This could include expenses for:

- Deductibles
- Co-insurance payments
- Dental expenses not covered by insurance
- Prescription drugs
- Chiropractic services
- Vision expenses
- Hearing devices
- Psychiatric/psychologist's fees

Cosmetic procedures are not eligible for reimbursement. In addition, a health care FSA may not reimburse employees for expenses that are covered under another health plan or for health insurance premiums, whether for the employee, the employee's spouse, or the employee's dependents. (Note: Premium payments may be paid on a salary reduction basis as part of a normal cafeteria plan arrangement or through a premium- conversion plan.)

Over-the Counter Items (OTC)

The medical flexible spending account (FSA) allows for reimbursement of over-the-counter items purchased on a non-prescription basis such as bandaids, contraceptives, hot/cold packs, etc. Over-counter-drugs and medicines are not reimbursable without a doctors prescribtion. Examples of OTC items requiring a doctor's prescription include: antacids, allergy medicine, pain relievers and cold medicine. Non-prescription dietary supplements (such as Ensure) and vitamins that are purchased to maintain good health are not eligible for reimbursement under a medical FSA. General hygiene products such as toothpaste or cosmetics also are not eligible for medical FSA reimbursement. If your employer offers the flex debit card as a form of reimbursement, please note that OTC drugs and medicines will not be approved at the point-of-sale. A paper claim must be filed and the doctor's Rx included to be reimbursed.

Claim Submission for Health Care FSAs

An employer may reimburse an employee's health care FSA claim only if the employee provides:

- A written statement from an independent third party stating that the expense has been incurred and stating the amount of the expense, and;
- A statement that the health care expense has not been reimbursed and is not reimbursable under any other health plan coverage.

In more practical terms, employers may require employees who seek reimbursement to submit items such as a physician's bill or sales receipt to prove they have incurred a covered expense. To satisfy the second requirement above, employers may require employees to sign a statement on their claims submission form that the expense is not reimbursable under any other health care plan coverage.

Risk-of-Lose Rule or "Uniform Coverage Rule" for Health Care FSAs

The uniform coverage requirement, sometimes called the risk-of-loss rule, requires health care expense FSAs to operate like insurance plans and demonstrate risk, rather than mere reimbursement accounts. This essentially means that employers must make the full amount of coverage elected by a plan participant available to the employee from the start of the plan year, regardless of how much has been paid into the account. Employer can limit their liability by setting a maximum in the health care FSA - up to $2500.

2½ Month Extension

In May of 2005 the Treasury Department and the IRS issued Notice 2005-42, which will allow employers to modify Flexible Spending Arrangements (FSAs) to extend the deadline for reimbursement of health expenses up to 2½ months after the end of the plan year. Previously, employees were required to "use-or-lose" FSA funds by the end of the year. Under the old rules, any unspent funds at year's end would be forfeited. This rule will give employees more time to pay for medical expenses and will ease the year-end spending rush prompted by the prior rule. Please keep in mind that the new rule is not law and is an employer’s choice to implement.

Carry Over rule

The IRS has provided an alternative to the "use it or lose it" rule in that employers can decide to amend is Health FSA starting as early as the 2013 plan year to permit the rollover of up to $500 from one year to the next. This rule is not automatic and the employer must amend their plan to allow the carryover dollars and to set the limit, of which can be any amount up to $500.

FSA Forfeitures

Because of the tax advantages of the Flex Spending Account, the Internal Revenue Service (IRS) has strict guidelines for its use. One of these guidelines is commonly known as the "use it or lose it" rule. Put simply, if you contribute pre-tax dollars into your Health Care FSA or Dependent Care FSA and then do not have enough eligible expenses during the Plan Year to equal the amount you contributed, you will lose the balance remaining in your account when the Plan Year ends, unless the employer has implemented the 2 1/2 month extension or the carry over rule. That is why it is important to plan carefully before deciding how much to contribute. With careful planning, you can minimize the risk of losing any of your contributions. According to the IRS, after all submitted reimbursement claims have been processed, any funds remaining must be returned to the employer.

The IRS allows employers to use the forfeiture money in any of the following ways:

- Employers may use forfeitures by applying them toward "reasonable" administrative costs incurred during the plan year
- Employers may use forfeitures by donating them to a charity of their choice
- Employers also may credit experience gains to employees' FSAs in the following plan year, as long as the funds are allocated on a "reasonable and uniform" basis to all of the FSA plan participants
- Employers may leave the forfeitures in their checking account to fund the plan

In no case may the funds be allocated to employees in a way that is directly or indirectly based on their claims experience.

Obligations under COBRA for Health Care

Employees have a right to elect continued participation in a health care expense flexible spending account as part of their continuation in health coverage under COBRA.

A health care FSA is considered to be a "group health plan" with respect to the health care continuation rules of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This means that employees who have terminated their employment and have a positive FSA balance have the right to elect to continue their participation in the health care FSA.

Reimbursable Expenses for Dependent Care FSAs

A dependent care FSA may reimburse an employee for up to $5,000 ($2,500 for a married employee filing separate tax returns) of dependent care expenses each plan year.

Reimbursable expenses are non-health care expenses that:

- Enable the employee, or the employee's spouse, to be gainfully employed or to attend school full- time. Gainful employment may be full or part-time, inside or outside of the home. Volunteer work does not meet the definition of gainful employment.
- Ensure a qualified dependent's well being and protection. Qualified dependents are children under age 13. Also considered to be qualified dependents are disabled spouses and other dependents who are physically or mentally incapable of selfcare, and who regularly spend at least eight hours each day in the taxpayer's household.

Dependent care FSAs may not reimburse employees for amounts paid to persons whom they claim as their own dependents for income tax purposes or for amounts paid to a child of their own who is under age 19 at the close of the tax year. Additionally, employees may not be reimbursed for amounts paid to camps where their dependents stay overnight -e.g., summer camp for children.

No Advance Payment for Dependent Care FSAs

Dependent care expenses may not be reimbursed until they are actually incurred - i.e., after the care has been provided, and not when the participant is formally billed, charged for, or pays for the dependent care. Thus, even though some day care centers require advance payment for services, employers may not reimburse employees for the expense until after the care has been provided - a situation that may in some cases cause some financial hardship for employees.

The dependent care account can only reimburse with funds deposited into the account (deductions withheld from your paycheck). If there are not funds available when you submit a claim, we will enter it into our system. As soon as additional funds are deposited, a check will be issued. If the amount of your expense was more than your account balance, the excess part of your claim will be carried over to the next pay period, to be paid out, as your account balance becomes adequate.

Claim Submission for Dependent Care FSAs

To receive reimbursement for qualified expenses through a dependent care FSA; IRS rules require that employees submit to the employer:

- A written statement from an independent third party stating that the expense has been incurred and the amount of the expense, and;
- A statement that the expense has not been reimbursed and is not reimbursable under any other dependent care plans.

In practical terms, employers generally require employees to submit a bill or receipt from their day care provider. Whether the bill is a printed invoice from a day care center or a hand-written notice from an in-home provider, it should indicate the amount charged for the service and the dates of service covered. To satisfy the second requirement listed above, employers may require employees to sign a statement on their claims submission form stating that the claim is not payable under any other dependent care plan

Private Premium Accounts

This program saves employees money if they are paying for a health-related* insurance plan personally (a non-group plan). With a Private Premium Reimbursement Account employees may be able to put money aside for certain premiums on a pre-tax basis.

In order to participate in a Private Premium Reimbursement Account, the employee has to be the owner of the policy or the policy can cover a qualified dependent. Group policies offered by an employer (or your spouse's employer) are not "individually owned" and cannot be paid for through this account.

The following can be reimbursed from a Private Premium Reimbursement Account for premiums that pay for:
• Dental Insurance
• Vision Insurance
• Cancer Insurance
• Intensive Care Insurance
• Hospitalization Insurance
• Partner MD and annual doctor service fees

* **Long-term care policies, Medicare Part D and Advantage plans, and life insurance are NOT reimbursable. Effective 1/1/14 INDIVIDUAL PRIVATE HEALTH INSURANCE (Major Medical) plan are also NOT reimbursable.**

***NOTE:** for taxable years beginning after 2013, Individual health policies that are Exchange related coverage **CANNOT** be reimbursed or paid for under a cafeteria plan.

Partner MD and any annual doctor service fees are reimbursable only from this account and are not reimbursable through a Medical Reimbursement Account.

The basic rules of your flex Private Premium Account

Proof of payment can include a copy of the check you are sending for payment or a copy of your charge card bill or bank statement showing payment.

The first time you file for reimbursement, please include a copy of the statement or invoice from the insurance company showing the amount due for the policy and proof of payment. For the rest of the plan year, only proof of payment is required to accompany each Request for Reimbursement. However, if the amount of your premium changes, you will need to provide a new invoice or statement.

For Private Premium Reimbursement Accounts, reimbursement is limited to the funds available in your account at all times. Flexible spending account rules apply.

Remember, just like any other Flexible Spending Account, once the plan year begins, you cannot change the amount you contribute to this account unless there is a Change of Family Status.

In addition, any amounts left in your account after the plan grace period will be lost. This is sometimes referred to as the Use It or Lose It Rule.

You also cannot terminate from the plan unless there is an appropriate Change of Family Status or you are no longer eligible for this benefit. If that occurs, you are allowed 90 days after the end of the plan year to submit receipts for premiums paid during the plan year for coverage during the plan year.