

**FLEXIBLE SPENDING PLAN**

**SECTION 125**

**A GUIDE FOR EMPLOYEES**

**JACKSON COUNTY, BLACK RIVER FALLS, WI 54615**

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## **SECTION 125 – THE ADVANTAGES**

*Section 125 is a section of the IRS code that allows employers to offer a unique benefit to their employees. This benefit allows certain expenses deducted from the employee's paycheck before taxes. These expenses include: employee portion of the group insurance premium, deductible and coinsurance amounts and some procedures not covered by insurance such as routine physicals, immunizations, vision care, etc., and dependent care.*

*You may also elect to participate in only one plan; the pre-tax for the employee portion of the health and dental insurance premiums. Please review the following information for details regarding the other Flexible Spending Accounts that are available.*

### **1. How much money will come out of my paycheck if I decide to participate?**

*You estimate your total expenses for each of the accounts you decide to participate in. This amount is then divided by the number of times the deduction will be taken during the plan year. (For example: \$360.00 plan year election divided by 24 pay periods = \$15.00 per pay period.) The maximum amount allowed for the Unreimbursed Medical account per year is \$2,000.00.*

### **2. How long do I have to decide which benefits I would like to include in my benefit plan?**

*You must determine your choice of benefits and the amounts prior to the effective date of the plan. The coverage year runs from January through December. A new enrollment form must be signed and submitted prior to the end of each year for Unreimbursed Medical or Dependent Care benefit plan electives. If you are requesting health or dental insurance premiums only as a pretax account you do not have to fill out a new enrollment form each year.*

### **3. Does the plan cover my family?**

*Yes. The program is designed for the benefit of you, your spouse, and your dependent children. Even if you are covered by an insurance plan other than with Jackson County you may still set aside money for out-of-pocket medical, dental, optical, and dependent care expenses.*

### **4. Do I have to use all of the available accounts to be able to participate in the plan?**

*No. You design the Flexible Spending Plan to fit your specific needs. You may use any combination of the available accounts or none at all. Participation in the plan is voluntary.*

**5. *If I put pre-tax dollars in a FSA, won't I have less money?***

*No, you will actually save money because you will not be paying taxes on the money you elect to set aside in the Flexible Spending Accounts. You will also receive up to 100% reimbursement of the amounts elected by filing eligible claims against your account balance. In most cases the savings in payroll taxes actually offsets the additional amounts the employee was able to set aside for the FSA each pay period.*

**6. *Can I change my elections at any time?***

*Once the plan year begins, you cannot adjust your elections until the following plan year unless you experience a qualified change in family status. Situations may include, but are not limited to: marriage, legal separation, divorce, birth or adoption of a child, death of a spouse or child, change of employment status of employee or spouse, or a third party-initiated change, such as a change in the cost of insurance or daycare. You will have 60 days to report such a situation, and change your elections consistent with that change. Special instructions available if you terminate employment in mid year.*

**7. *If I have money left in one Flexible Spending Account and have run out of money in another, can I use the leftover money for another account?***

*Under IRS regulations, each FSA is separate and is not interchangeable. Dependent Care may only be reimbursed under the Dependent Care FSA and Unreimbursed Medical expenses may only be reimbursed through the Unreimbursed Medical FSA.*

**8. *What happens if I don't use all of the money I have set aside in the Flexible Spending Accounts?***

*You have 60 days after the end of the year to submit claims for that previous year plan. Any amounts remaining in the Dependent Care FSA at the end of the year will be subject to the **"USE IT OR LOSE IT"** provisions of the regulations governing the benefit. Unused amounts of up to \$500 remaining at the end of the plan year in the Unreimbursed Medical FSA will be allowed to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year. This carryover of up to \$500 does not affect the maximum amount of salary reduction contributions that the participant is permitted to make.*

**9. *If I participate in this plan, can I still receive tax credits and itemize medical deductions on my tax return?***

*By participating in the Unreimbursed Medical FSA and the Premium Only portion of the plan, you are already receiving the tax savings on the expenses and are unable to claim them again on your tax return. In order to itemize deductions on your tax return, your medical*

*expenses have to be a minimum of 7.5% of your gross earnings. Most people are unable to qualify for the deduction unless they experience a catastrophic loss. For certain expenses, such as childcare, we recommend you consult with your tax advisor to determine which option best fits your personal situation.*

**10. How will my participation in this plan affect my taxes at the end of the year? Will I have to do anything differently when filing my tax return?**

*The amount of taxable wages reported on your W-2 will be automatically reduced to reflect the amounts you elected to pre-tax under the plan. You simply use the amount shown on the W-2 as taxable income and complete your return as you always have done. Dependent Care participants, however, must also attach Schedule 2441 to the tax return. The amount pre-taxed for Dependent Care will appear in a special box on the W-2 form.*

**11. Will participation in the plan affect my social security retirement/disability benefits later on?**

*Since your wage base is reduced by the amount you elect to deduct pre-tax, the contribution to Social Security is less, and may affect your benefits if you become disabled or retire. The reduction is generally minimal, but if necessary you can offset the reduction with other options. Participation in the Flexible Spending Plan does not affect the Wisconsin Retirement System.*

**12. What is involved in obtaining reimbursement for expenses under the Flexible Spending Accounts?**

*To receive reimbursement for your expenses under the Flexible Spending Accounts, simply complete a reimbursement form and submit it to the County Clerk's Office, (Payroll Department) along with a copy of your bills, explanations of benefits, or receipts. The expense must be incurred during the plan year; in other words, the service must have happened during the plan year. If an expense is subject to insurance billing, you must submit the Explanation of Benefits from the insurance carrier showing the amount for which you are responsible. Canceled checks and balance due statements are not acceptable forms of proof of service. Canceled checks may be used, however, for Dependent Care expenses.*

**13. How soon can I expect to receive my reimbursement check?**

*Claim forms are processed on a daily basis. Reimbursement checks are generated each week and will be paid out on Friday but must be received with sufficient time to process for the weekly run. The checks are always issued to you, and cannot be issued to pay your providers directly. A breakdown of the account activity will be included with each payment. Participants will also receive periodic account statements that would summarize year to date activity.*

## **UNREIMBURSED MEDICAL FLEXIBLE SPENDING ACCOUNT**

***The unreimbursed medical FSA covers out-of-pocket medical, dental and optical expenses not covered under an insurance program. The maximum amount allowed is \$2,000.00 per year.***

*Under the unreimbursed medical FSA, you are able to withdraw up to your annual election at any time during the plan year, upon presentation of proof of eligible expenses. You are responsible for reimbursements above the contributed amount if employment ceases.*

*Although not all expenses are listed below, the more commonly reimbursed items are listed to assist you in determining whether or not this account would fit your family situation. If you have a question about an expense not listed, please contact the County Clerk's Office (Payroll Department). Some expenses do require a doctor's letter stating that the treatment is medically necessary.*

<i>Acupuncture</i>	<i>Guide dog and upkeep</i>	<i>Routine physicals</i>
<i>Ambulance hire</i>	<i>Hearing devices and batteries</i>	<i>Smoking Cessation</i>
<i>Artificial limbs</i>	<i>Home improvements motivated</i>	<i>Prescribed Special diets</i>
<i>Braces</i>	<i>by medical considerations</i>	<i>Surgical fees</i>
<i>Birth Control</i>	<i>Hospital bills</i>	<i>Telephone/Television</i>
<i>Braille books and magazines</i>	<i>Hypnosis for treatment of illness</i>	<i>audio equip for deaf</i>
<i>Car controls for</i>	<i>Laboratory fees</i>	<i>Therapeutic care for</i>
<i>handicapped</i>	<i>Medical Information Plan</i>	<i>drug/alcohol</i>
<i>Chiropractors</i>	<i>Nursing Fees (including room,</i>	<i>Therapy treatments</i>
<i>Co-insurance</i>	<i>board and SS tax where paid</i>	<i>related to medical</i>
<i>Contact Lenses and Supply</i>	<i>by taxpayer</i>	<i>conditions</i>
<i>Crutches</i>	<i>Obstetrical expenses</i>	<i>Transport expenses</i>
<i>Deductibles</i>	<i>Orthodontia</i>	<i>to medical services</i>
<i>Dental Fees</i>	<i>Orthopedic Shoes</i>	<i>Tuition fee(part), if</i>
<i>Dentures</i>	<i>Oxygen</i>	<i>college furnishes</i>
<i>Diagnostic Fees</i>	<i>Physician Fees</i>	<i>breakdown of medical</i>
<i>Drug &amp; medical supplies</i>	<i>Physician – prescribed</i>	<i>Vision correction</i>
<i>Eyeglasses, including exam</i>	<i>pool/spa equip costs</i>	<i>procedures</i>
<i>Fee associated with the</i>	<i>and maintenance motivated</i>	<i>Vitamins by prescription</i>
<i>education and medical</i>	<i>by medical considerations</i>	<i>Wheelchair</i>
<i>care of individuals with</i>	<i>Psychiatric care</i>	<i>X-rays</i>
<i>development disabilities</i>	<i>Psychologist Fees</i>	

### **YOU CANNOT OBTAIN REIMBURSEMENT FOR:**

- \*Premiums incurred by a spouse through his/her employer or other insurance individually owned*
- \*Non-Prescription medication or dietary supplements*
- \*Childcare expenses through a medical FSA*
- \*Cosmetic procedures (i.e: teeth bleaching, elective plastic surgery, etc.)*
- \*Uniforms*                      *\*Maternity Clothes*                      *\*Marriage Counseling*

## **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

*Under the Dependent Care account, you are able to deduct pre-tax dollars for work-related child care or adult day care expenses. The expenses must be incurred during the plan year. Both you and your spouse (if married) must be working, or be a full-time student, to have expenses eligible for payment through the FSA. Estimate only those expenses you are reasonably certain you will incur during the plan year. Be careful to allow for sick days, vacation time, and other times of the year when you may not be paying the same amount per week for dependent care.*

<b>ELIGIBLE</b>	<b>INELIGIBLE</b>
<i>Care for dependents (under age 13) of gainfully employed guardians</i>	<i>Educational programs for post-kindergarten dependents</i>
<i>Care for dependents who are mentally or physically incapable of self care</i>	<i>Care provided by person(s) claimed as a dependent on your, or your spouse(s) tax return</i>
<i>Baby-sitter, daycare provider, home care provider</i>	<i>Care provided by child/stepchild under age 19 at end of plan year</i>
<i>Licensed daycare centers, caring for more than six (6) non-resident people</i>	<i>Cost of food, clothing, entertainment unless costs are incidental to care</i>
<i>Daytime camps or training programs</i>	<i>Care provided by someone not reporting their daycare income</i>
<i>Pre-Kindergarten educational program</i>	<i>Overnight camps and transportation</i>
<i>All Latch Key Programs</i>	<i>Field trips</i>

*The employee must fill out and attach Schedule 2441 to his/her federal tax return.*

### **LIMITATIONS:**

1. *Contribution Limits*
  - \* *Married filing separately*                      \$2,500.00\*
  - \* *All Others*    \$5,000.00\*

*\*Contribution cannot exceed the lesser of the participant's income as reduced by the dependent care salary reduction amount of the spouse's income.*

2. *Both you and your spouse (unless spouse is disabled or a full-time student) must work. If spouse is a full-time student or disabled, the spouse is deemed to have earned an income of \$2,400 (if dependent care expenses apply to one dependent) or \$4,800 (if dependent care expenses apply to two or more dependents).*
3. *You CANNOT use any FSA funds allocated for Dependent Care expenses for any other purpose. Any account balance remaining at the end of the year that cannot be substantiated for Dependent Care services rendered within the plan year will be forfeited by law.*
4. *Dependent Care expenses are reimbursed up to the cash balance in your account.*

**HOW DO I SAVE MONEY AND INCREASE MY SPENDABLE INCOME**

The following illustrations give an example of how you can increase your spendable income through participation in a pre-tax program. The example is for someone who requested 0 exemptions, and married status for withholding.

<u>Premium, Unreimbursed Medical and Dependent Care</u>	<u>Without Flex Plan</u>	<u>With Flex Plan</u>
Gross pay per paycheck	\$1,000.00	\$1,000.00
Pre-tax deductions:		
Group Medical Premiums		50.00
Unreimbursed Medical		12.50
Dependent Care		75.00
Wages Subject to Tax	\$1,000.00	\$ 862.50
Federal Tax Withheld	91.00	70.00
Social Security Tax	74.50	64.26
State Tax Withheld	50.50	39.49
Group Medical Premiums	50.00	
Unreimbursed Medical	12.50	
Dependent Care	75.00	
Net Spendable Income	\$ 636.70	\$ 688.84
Net INCREASE in Spendable income per pay check		<b>\$ 42.14</b>

<u>Premium Only Pre-tax</u>	<u>Without Flex Plan</u>	<u>With Flex Plan</u>
Gross pay per paycheck	\$1000.00	\$1000.00
Pre-tax deductions:		
Group Medical Premiums		50.00
Wages Subject to Tax	\$1000.00	\$ 950.00
Federal Tax Withheld	91.00	82.00
Social Security Tax	74.50	70.78
State Tax Withheld	50.30	46.40
Group Medical Premiums	50.00	
Net Spendable Income	\$734.20	\$750.82
Net INCREASE in spendable income per pay check		<b>\$ 16.62</b>



**REQUEST FOR REIMBURSEMENT**

**INSTRUCTIONS: FAILURE TO COMPLETE ALL SECTIONS OF THE FORM MAY DELAY THE PROCESSING OF YOUR CLAIM.** Complete **PART I** of the form. Complete **PART II** of the form indicating the type of expense (Medical or Daycare), the incurred date(s) of the expense, a brief description (for example, Orthodontia, Prescription, Office visit, Dental, etc.), and the amount of the incurred expense. Attach **COPIES** (do not send originals) of the receipts for each expense showing the **incurred date** (not the paid date) and the amount. **If you are submitting more than one expense, number the copies to correspond to the number of the line on which the expense is listed.** Total the amount of your claim. You have 60 days after plan year to submit claims for that year. Please read and complete **PART III** of the form and send to the County Clerk's Office, Payroll Department, at 307 Main Street, Black River Falls, WI 54615

**EMPLOYEE INFORMATION**

**PART I** \_\_\_\_\_

**PLEASE PRINT**

Social Security Number (last 4) # \_\_\_\_\_

Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_

**REIMBURSEMENT INFORMATION**

**PART II** \_\_\_\_\_

**TYPE CODES:** M = Unreimbursed medical/dental/optical D = Daycare

<b>TYPE CODE</b>	<b>SERVICE DATE(S) FROM - TO</b>	<b>PROVIDER NAME</b>	<b>DEPENDENT NAME</b>	<b>AMOUNT</b>	<b>OFFICE USE</b>
1. _____	_____ - _____	_____	_____	_____	_____
2. _____	_____ - _____	_____	_____	_____	_____
3. _____	_____ - _____	_____	_____	_____	_____
4. _____	_____ - _____	_____	_____	_____	_____
5. _____	_____ - _____	_____	_____	_____	_____

(For additional claims, use another reimbursement application) **TOTAL** \_\_\_\_\_

**EMPLOYEE AUTHORIZATION**

**PART III** \_\_\_\_\_

*I certify that the above information is correct and that the expenses claimed were incurred by me or by my eligible dependents after my effective date of coverage in the Jackson County Flexible Spending Plan but prior to the end of the plan year. I further declare that these expenses have not been and will not be paid under insurance or any other benefit program and that I have not and will not claim these expenses on my personal income tax return.*

**EMPLOYEE SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_