TO: Southington Public Schools FSA Plan Participants

FROM: Crosby Benefit Systems

DATE: June 3, 2015

SUBJECT: Flexible Reimbursement Account Enrollment for the New Plan Year

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The new plan year for the Flexible Reimbursement Account Plan will begin July 1, 2015. To participate, ***it is necessary to re-enroll every year*** during open enrollment. **This year's open enrollment is from 06/01/2015 to 06/30/2015.**

Enrollment Information

Please complete the Enrollment Form and forward it to your Human Resources or Benefits Office before the open enrollment period ends. Indicate the amount you wish to contribute for the *upcoming plan year* using the key points listed below when making your decision.

- The plan year is July 1, 2015 through June 30, 2016.
- Maximum Medical Care Reimbursement Account Election is: $2,550
- Minimum Medical Care Reimbursement Account Election is: $150
- Maximum Dependent Care Reimbursement Account Election is: $5,000
- Minimum Dependent Care Reimbursement Account Election is: $150

The current plan year will be ending soon. Please note that:

- Current plan year ends: June 30, 2015
- Current plan year grace period ends: September 15, 2015.
- Current plan year run out ends September 30, 2015. ***Balances remaining after this date will be forfeited.*** Only eligible expenses incurred by the last day of the plan year and postmarked by the last day of the run out period will be reimbursed.

FSA Brochure

Review the enclosed brochure to estimate your expenses for the upcoming plan year. Review the information carefully and include only allowable expenses.

FSA Video

To view a video FSA presentation, go to CrosbyBenefits.com and click "Participant Area" and then click "FSA Videos".

Go Paperless

Choose to receive communications via email rather than US Mail. This helps protect our environment and reduces the amount of printed material we generate. To sign up for paperless, log into your MyCrosbyBenefits.com account and click "Sign up for E-Communications" in the Lobby section after the plan year begins.

Is Direct Deposit Easier For You?

You have the option to have your FSA reimbursement directly deposited into your bank account. In order to participate please go to:

- Mycrosbybenefits.com and login with user name and password (if you have not previously logged in – sign in as new user and complete the prompted fields). You will be emailed login information shortly.
- Once logged in - please click on the "reimbursement accounts" button in the lobby screen.
- Click on profile tab in upper right hand section - scroll to bottom of page and click on edit in the Direct Deposit box then complete the Direct Deposit information.

Carryover Feature – Effective with 2015 -- 2016 Plan Year

The Carryover Feature allows Medical Care Reimbursement Account plans to carryover up to $500 of unused FSA balance from one year to the next. Your employer has chosen to offer this added feature. This means you won't need to precisely predict your healthcare expenses months in advance or rush to spend every last dollar before the end of the year. The balance carried over will be automatically added to your election amount for the new plan year and will be available on the first day of the new plan year.

Dependent Care Grace Period Feature – Effective with 2015 -- 2016 Plan Year

Your employer has chosen to offer the Dependent Care grace period feature. This feature allows Dependent Care Reimbursement Account plans to reimburse participants for claims incurred up to 2-1/2 months after the close of a plan year. The grace period does not apply to Medical Care expenses because your employer offers the Carryover feature (see above).

- The run-out period will still end on September 30, but you now have through September 15 to incur Dependent Care expenses for the prior plan year's account balance.
- Expenses submitted prior to September 15 will automatically be withdrawn from the balance of the previous plan year, as long as there is a balance remaining.
- Once the previous year's balance is gone, expenses will be automatically withdrawn from the new plan year's balance.

This feature allows you more time to incur expenses and benefit from the tax savings associated with participating in a reimbursement account.

If you need assistance or have questions, please contact your Human Resources or Benefits Office or call Crosby Benefit Systems at 866-918-9711.

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Southington Public Schools
Client FSA Carryover FAQ

The new Health Care FSA Carryover feature will allow the carryover of any remaining balance up to $500 from your 2015-16 Health Care FSA to your 2016-17 Health Care FSA. The information below describes how this change may affect you.

- Effective July 1, 2016, if you have $500 or less in unused 2015-16 Health Care FSA funds, those funds will automatically roll over into your Health Care FSA for 2016-17, effective July 1, 2016.

- This new Carryover provision replaces the 2 ½ month grace period provision.

Questions and Answers:

1. **Who is eligible for the Carryover?** Active employees with a Health Care FSA who have unused funds in their account as of June 30, 2016 will be eligible to roll over funds.

2. **How much can/will be rolled over?** Any remaining balance up to $500 will be rolled over into the 2016-17 Health FSA.

3. **Why are we replacing the 2 ½ month grace period currently in use with a Health Care FSA?**
   This new Carryover provision offers greater flexibility that was not available under the law in prior years. In order to provide this more flexible feature, the IRS requires that we eliminate the 2 ½ month grace period for our Health Care FSA participants.

4. **When will the rolled over Health Care FSA funds be available for use?** Carried over funds will be available to use as of July 1, 2016. For expenses incurred in 2016-17, any current plan year funds will be drawn down first, and then 2015-16 carried over amounts will be used.

5. **Does the Carryover apply to the Dependent Care FSA?** No, the Carryover only applies to the Health Care FSA. It does not apply to the Dependent Care FSA.

6. **If I do not elect a Health Care FSA for 2016-17, but I have leftover Health Care FSA funds from 2015-16, will those funds be carried over into a 2016-17 FSA?** Yes, for active employees, even if you do not elect a Health Care FSA for 2016-17, any unused available balance from 2015-16, up to a limit of $500, will be rolled over for you to use during 2016-17.

7. **I may want to elect to contribute $2,500 (the maximum allowed amount) into the Health Care FSA for the 2016-17 plan year. If I have funds from my 2015-16 Health Care FSA to roll over, won't my Health Care FSA exceed the $2,500 maximum?** Yes, but it is allowable for your Health Care FSA account to exceed the $2,500 maximum annual deferral as long as no more than $2,500 is *deducted* from your pay on an annual basis.

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Reimbursement Account Enrollment Form

Please print clearly and return completed form to your Employer

Employee Information

Employee Name _____
Last Name First Name MI

Employer _____ Div/Loc/Dept#_____

SSN / Employee ID _____ Please enter your SSN or Employee ID. Many employers use an ID other than SSN with Crosby Benefit Systems. If you are unsure which number to use, please contact us or your HR/Benefits department.

Home Address _____

_____
City State Zip

Date of Hire _____ Date of Birth (required) _____ Phone (_____)_____

Payroll Mode: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other

Go Paperless!

Enter email address to receive communications by email rather than USPS: _____

You may cancel this request at any time by emailing Crosby at servicecenter@crosbybenefits.com.

☐ Store my email address but opt me out of receiving all electronic email communications.

Direct Deposit

I authorize Crosby Benefit Systems to deposit my full reimbursement into my:

___**CHECKING** account or ___**SAVINGS** account *(please choose one)*

Routing/Transit Num: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account Num: _____

For Direct Deposit: 1. Complete Checking or Savings. 2. Complete Routing/Transit Number AND Account Number. If you are already enrolled in Dir Dep, please do not complete above. For new Dir Dep, if any information is missing, request will not be processed.

Medical Care FSA

☐ **I elect to participate in the MEDICAL CARE Reimbursement Account** sponsored by my employer.

I elect to contribute $_____ Annually.

For HR Use Only: Effective Date: _____

Dependent Care FSA

☐ **I elect to participate in the DEPENDENT CARE Reimbursement Account** sponsored by my employer.

I elect to contribute $_____ Annually.

For HR Use Only: Effective Date: _____

Employee Certification

I understand that my annual Flexible Spending Account election may require adjustment to comply with IRS Section 125, 129 and 105 nondiscrimination guidelines. I also understand that I may not change or stop deposits to the account(s) indicated above until the end of the plan year unless I have a change in status, as defined by IRS regulations and my employer's plan. ***If I do not use all the money in my account(s) during my dates of participation, I understand that any balance will be forfeited.*** I understand that there will be no interest build-up in the account(s). I have read and understand the rules and regulations on the reverse side of this form.

I certify that the Flex Debit Card, if applicable, will only be used for expenses considered eligible as defined under the Flexible Spending Account Summary Plan Description. I certify that these expenses have not been and will not be reimbursed through any other means, including my or my dependent's insurance plans. I will repay funds in the event that I misuse the Flex Debit Card to authorize payment of any non-eligible expenses, or fail to provide sufficient documentation within the stated time frame, as explained in the *Supporting Documentation* section on the reverse side of this form.

My signature authorizes reductions from my pay checks for the purpose of funding my tax-free reimbursement account(s).

X Employee Signature _____ Date _____

For HR Use Only:

Authorized by _____ **Date** _____

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

MEDICAL

ELIGIBLE EXPENSES:

In general, an employee may be reimbursed for a health care expense which is deductible for federal income tax purposes, but which has not and/or will not be reimbursed by any other source, and which has not been nor will not be deducted on the employee's income tax return. Some examples of eligible expenses include co-insurance and deductible amounts; vision, hearing, dental, over-the-counter medical supplies; and prescription drug expenses not covered by your health insurance.

INELIGIBLE EXPENSES:

Examples of ineligible expenses include insurance premiums; vitamins/supplements for general good health; cosmetic procedures, products and prescriptions; and counseling not related to a medical condition.

SUPPORTING DOCUMENTATION:

The following forms of supporting documentation may be attached to the reimbursement request form:

Expenses covered by your health care plan:

Medical and dental expenses covered by your health care plan must be submitted to that plan. You may submit an Explanation of Benefits Statement with a reimbursement request for the portion of your claim not paid by your health care plan.

For all expenses, you must attach bills or evidence of payment that clearly state all of the following:

1. Name of person receiving the service
2. Nature of service or supplies (includes medication name)
3. Name of service provider
4. Amount reimbursable under the plan
5. Date(s) service was rendered

DEPENDENT**

ELIGIBLE EXPENSES:

The annual amount reimbursed cannot exceed the earned income of the lower-paid spouse or $5,000, whichever is less. If you are married, filing separately, your annual reimbursement cannot exceed $2,500.

The expenses must be employment-related and incurred for the care of a dependent of the employee who is under age 13 and for whom the taxpayer is entitled to a dependent deduction under Internal Revenue Code Section 151(c), or is a dependent of the employee who is physically or mentally incapable of caring for himself or herself, resides with the employee for more than half of the year, earns below $3,200 and will not be deducted or taken as tax credits on the employee's federal and/or state income tax return for any year.

The payments cannot be made to a person who is claimed as a dependent by the employee.

Expenses for DAY camp programs are allowable; however, if camp hours exceed the employee's working hours, submit ONLY that portion of expenses incurred for work-related hours. **OVERNIGHT CAMP is NOT an allowable expense**, even on a prorated basis.

SUPPORTING DOCUMENTATION:

For all expenses, you must submit bills or evidence of payment that clearly state all of the following:

1. Name of person receiving the service
2. Name of service provider
3. Nature of service
4. Amount reimbursable under the plan
5. Date service was rendered
6. Provider's Tax ID Number

****QUALIFICATION GUIDELINES FOR A DEPENDENT CARE ACCOUNT**

To qualify, both the employee and spouse must be working, or one working and the other enrolled as a full-time student, or actively looking for work. If the employee is single, divorced or legally separated, the employee's need for dependent care assistance must be work related.

PLEASE NOTE

Service dates for reimbursable expenses must fall within the plan year. Reimbursement requests not submitted during the plan year must be submitted prior to the end of the run out period. Please contact your Human Resources Department or Crosby Benefit Systems for more information.

Over-the-counter medicines and drugs can only be reimbursed if prescribed by a physician. This change does not apply to medical supplies such as insulin even if purchased without a prescription, or other health care expenses such as medical devices, eyeglasses, contact lenses, bandages, co-pays and deductibles.

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D *Flexible Benefits Plan*
DEPENDENT CARE Reimbursement Request

PLEASE PRINT CLEARLY **CROSBY BENEFIT SYSTEMS**

Employee Information

To update your address or email, please login to MyCrosbyBenefits.com

Please also notify employer of any address changes.

Employee Name _____
Last First MI

Employer _____

SSN / Employee ID _____

Please enter your SSN or Employee ID. Many employers use an ID other than SSN with Crosby Benefit Systems. If you are unsure which number to use, please contact us or your HR/Benefits department. If you do not enter an SSN/Employee ID, Crosby will attempt to identify you based on other information but this could delay or prevent processing of your request.

Home Address _____
Street City State Zip

Email Address _____

Home Phone (_____)_____ Work Phone (_____)_____
area code area code ext.

Expenses

Supporting documentation should include:
1. Name of person receiving service
2. Name of service provider
3. Nature of service
4. Amount of expense
5. Date(s) of service (not paid date)

Please list all out-of-pocket dependent care expenses for which you are requesting reimbursement.

Dependent Name & Description of Expense	Dates of Service (not paid date) Start Date	End Date	Amount
	___/___/___	___/___/___	
	___/___/___	___/___/___	
	___/___/___	___/___/___	
	___/___/___	___/___/___	

TOTAL EXPENSES $_____

Provider Signature

Provider may complete and sign here instead of providing bill or receipt.

To be completed by Provider unless third party bill or other evidence is attached.
I certify that the services listed above have been provided.

Provider Name & Address: _____

Provider Signature: _____ Date: _____

Be sure all Supporting Documentation, as defined in Important Information section on reverse side of form, is included in the section above or is otherwise attached. Retain a copy for your records. Canceled checks are not acceptable. Failure to submit required information will delay (or prevent) claims processing.

Employee Certification

By submitting this form, I hereby certify the following:

- The expenses listed above are "Eligible Employment Related Expenses" as defined in the Summary Plan Description ("SPD"). See reverse side for general information regarding Eligible Employment Related expenses.
- The expenses are for the custodial care of one or more "Qualifying Individuals" as defined in your SPD. (Note: See reverse side for general information regarding "Qualifying Individuals".)
- I have not been reimbursed nor will I seek reimbursement of the expenses listed above from any other source (e.g. under a spouse's employer's plan).
- I have obtained or made reasonable efforts to obtain the provider's taxpayer identification number ("TIN") and I will include that TIN on the Form 2441 that I attach to my federal income tax return.
- If the provider is a dependent care center which provides care for six (6) or more individuals, the center complies with all applicable state laws.

Please SIGN

I have read and understand both the information on the reverse side (or page 2) of this form and the fact that I can request a copy of the SPD from the Employer if I do not currently have a copy.

Employee Signature _____ **Date** _____

IMPORTANT INFORMATION

Please note: Nothing in this section is intended to supersede or replace the provisions of the Summary Plan Description (SPD). If there is a conflict between this section of the Form and the SPD, the SPD controls.

Dependent Care Eligible Expenses - The annual amount reimbursed cannot exceed the amount set forth in the SPD. The expenses must be "Eligible Employment Related Expenses" as defined in your SPD. Generally, Eligible Employment Related Expenses are expenses for the custodial care of one or more Qualifying Individuals that enable you (and your spouse, if applicable) to work or to look for work.

A "Qualifying Individual" is defined in more detail in your SPD. Generally, a Qualifying Individual is any one of the following:

- A "qualifying child" (as defined in Code Section 152(c)) for whom you are entitled to an exemption under 151 who is under the age of 13 and who resides with you for more than half of the year;
- A dependent (as defined below) that is incapacitated and resides with you for more than half of the year; or
- A legal spouse who is incapacitated and resides with you for more than half of the year.

A "dependent" for purposes of identifying certain Qualifying Individuals is any individual who meets the requirements described in Code Section 152 without regard to subsections (b)(1), (b)(2) and (d)(1)(B). Generally, this will be anyone whom you could claim as a dependent on your tax return (as defined by Section 152) and anyone that you could otherwise claim as a dependent on your federal tax return but for the fact that:

- The individual has income in excess of the income threshold established for "qualifying relatives" defined under Code Section 152(d)
- You are a dependent of another person, or
- The individual is a child of yours who is married and files a joint tax return with his/her spouse.

Dependent Care expenses are not eligible if paid to a person who is claimed as a dependent by the employee. Every dollar that you are reimbursed tax free under this plan for Eligible Employment Related Expenses reduces the base amount for which you may be eligible for the Dependent Care Credit under Code Section 21. If you plan to also take a credit for Eligible Employment Related Expenses, you should consult with a qualified tax or legal advisor.

You are required to include the name, address, and TIN of the service provider on the Form 2441 that you must attach to your federal income tax return. Overnight camp is not an allowable expense, even on a prorated basis. Kindergarten is not an allowable expense.

Dependent care expenses submitted before the service is provided are not reimbursable. If a claim is submitted in advance of the actual service date, it may be denied. For example, expenses for a particular month should not be submitted until the last day of that month. If services are provided by a dependent care center, which provides care for more than six individuals (other than a resident of the facility), the center must comply with all state and local laws.

Supporting Documentation - All expenses require the information noted below for approval. These may be provided by completing the Provider Signature section on the reverse of this form, or by attaching third party bills or other evidence that includes:

1. Name of person receiving the service
2. Name and address of service provider
3. Nature of service
4. Amount of expense
5. Date(s) of service (not paid date)

Submission of Reimbursement Requests - Fax (preferred), email or mail reimbursement requests. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable.

Please Note - Service dates for reimbursable expenses must fall within the plan year (or grace period, if adopted by the employer). Expenses must be incurred on or after the participant's effective date and before the end of the plan year (or grace period, if adopted by the employer). After enrollment, changes to a reimbursement account may only occur when there has been a qualified change in status or cost or coverage change.

Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Contact your Human Resources Department or Crosby Benefit Systems for more information.

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M *Flexible Benefits Plan*
MEDICAL CARE Reimbursement Request

PLEASE PRINT CLEARLY **CROSBY BENEFIT SYSTEMS**

Employee Information

To update your address or email, please login to MyCrosbyBenefits.com

Please also notify employer of any address changes.

Employee Name _____
Last First MI

Employer _____

SSN / Employee ID _____

Please enter your SSN or Employee ID. Many employers use an ID other than SSN with Crosby Benefit Systems. If you are unsure which number to use, please contact us or your HR/Benefits department. If you do not enter an SSN/Employee ID, Crosby will attempt to identify you based on other information but this could delay or prevent processing of your request.

Home Address _____
Street City State Zip

Email Address _____

Home Phone (_____)_____ Work Phone (_____)_____
area code area code ext.

Expenses

Please ensure your supporting documentation includes:
1. Name of person receiving service (except for retail purchases)
2. Name of service provider
3. Nature of service or supplies (for example, eye exam or dental implant)
4. Amount of reimbursable expense
5. Date(s) of service

Please list all out-of-pocket unreimbursed eligible medical expenses, as defined in the Summary Plan Description (SPD), for which you are requesting reimbursement.

Description of Expense	Date of Service	Amount*

*Do not include amounts paid or eligible for payment under any other health care plan or program, federal, state or governmental program, Workers' Compensation, or any other policy of health insurance.

TOTAL EXPENSES $_____

Include with this form all "Supporting Documentation" as defined in the Important Information section on the reverse side of this form. Retain a copy for your records. Canceled checks are not acceptable. Failing to submit Supporting Documentation will delay (or prevent) claims processing.

Employee Certification

By submitting this form, I hereby certify the following:

- All expenses identified above are "Eligible Medical Expenses" as defined in the SPD (Note: You can find general information regarding Eligible Medical Expenses in the Important Information section on the reverse side).
- All expenses were incurred by me (the employee), my legal spouse, or an eligible dependent as defined in the SPD (Note: You can find general information regarding the definition of legal spouse and eligible dependents in the Important Information section on the reverse side).
- I have not been reimbursed nor will I seek reimbursement of the expenses listed above from any other source (e.g. under a spouse's employer's plan).
- I will not deduct the above listed expenses on my personal federal and/or state income tax return for any year. My employer does not accept responsibility for direct payment to any individuals other than the employee.

I have read and understand both the information on the reverse side (or page 2) of this form and the fact that I can request a copy of the SPD from the Employer if I do not currently have a copy.

Please SIGN

Employee Signature _____ **Date** _____

IMPORTANT INFORMATION

Please note: Nothing in this section is intended to supersede or replace the provisions of the Summary Plan Description (SPD). If there is a conflict between this section of the Form and the SPD, the SPD controls.

Eligible Medical Expenses - In general, only expenses for "medical care" as defined in your SPD are eligible for reimbursement under the Medical Care Reimbursement Account (as defined in Code Section 213(d) with notable exceptions). IRS Publication 502 (available at www.irs.gov) summarizes medical expenses allowable as deductions for tax purposes. Publication 502 states as allowable some expenses which ARE NOT reimbursable under a Medical Care Reimbursement Account (for example, insurance premiums). In all situations, only medical care expenses not reimbursed from any other source are reimbursable.

Examples of eligible expenses include co-payments/deductibles, vision, hearing, dental, and most uncovered prescription drug expenses. Examples of ineligible expenses include insurance premiums, vitamins/supplements for general good health, cosmetic procedures and products, and counseling not related to a medical condition.

Please note: Over-the-counter medicines and drugs can be reimbursed only if prescribed by a physician. This does not apply to medical supplies such as insulin (even if purchased without a prescription), or other health care expenses such as medical devices, eye glasses, contact lenses, bandages, co-pays and deductibles.

Legal Spouse and Eligible Dependents - Only eligible medical expenses incurred by you, your "legal spouse" or "eligible dependents" (as defined in the SPD) are eligible for reimbursement. Generally, your legal spouse is your spouse as recognized by federal law. Your eligible dependents include any individual who would qualify as an eligible dependent as defined in Code Section 105. Consult with a qualified tax or legal counsel to determine if expenses incurred by individuals for whom you request a reimbursement qualify as your legal spouse or eligible dependents.

Supporting Documentation - For all expenses, attach bills or evidence of charges that clearly state all of the following:

1. Name of person receiving service (except for retail purchases)
2. Name of service provider
3. Nature of service or supplies (for example, eye exam or dental implant)
4. Amount of reimbursable expense
5. Date(s) of service

Medical and dental expenses covered partially by your health care plan(s) are generally allowable. Explanation of Benefits statements which contain the above information may be submitted as supporting documentation. For over-the-counter products, provide a cash register receipt with product information or include a copy of the box/bottle with cash register receipt. In many instances, you may be required to provide additional substantiation as determined by the claims administrator. For example, a doctor's note or physician's prescription may be required for some expenses to verify that the expense qualifies as medical care.

Medical Practitioner's (Doctor's) Notes - For some expenses, a medical practitioner note is required to verify that the expense qualifies as medical care. To be allowable, a medical practitioner note may be written by a doctor of medicine, dentistry, podiatry or optometry; an authorized chiropractor, an alternative healer; or other qualified medical practitioner. A medical practitioner note must contain all of the following items: 1. date; 2. patient's name; 3. medical practitioner's name; 4. statement of medical necessity; 5. the prescribed treatment; and 6. the duration of treatment required.

Cosmetic procedures (for example, teeth bleaching) and drugs (prescription and nonprescription) to be used for a cosmetic purpose are not reimbursable. Under the plan, medical care "does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease." Expenses for transportation primarily for, and essential to, medical care are reimbursable. For such expenses, information must be provided that states the nature of medical care (for example, "doctor's appointment") and the date service was provided.

Orthodontia expenses can be reimbursed in one full sum or in monthly installments. Proper documentation of procedure and payment plan must accompany each claim form. For orthodontia expenses to be eligible, payment must have been made within the current plan year.

Submission of Reimbursement Requests – Upload (at MyCrosbyBenefits.com), fax or mail reimbursement requests. If your reimbursement request is denied, written notification will be mailed to you or emailed if you have selected electronic communications delivery. You may resubmit expenses with proper documentation, if applicable.

Please note - Service dates for reimbursable expenses must fall within the plan year (or during the grace period if adopted by the employer). Expenses incurred before participation began or after participation has terminated will not be reimbursed. After enrollment, changes to a reimbursement account may only occur when there has been a qualified change in status.

Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Contact your Human Resources Department or Crosby Benefit Systems for more information.

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