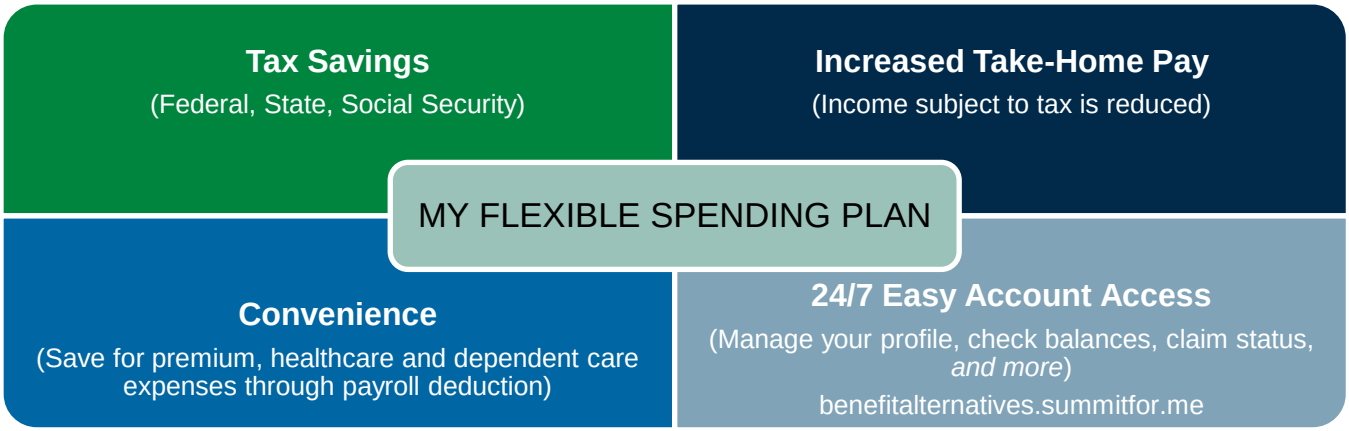
FLEXIBLE SPENDING ACCOUNT
2023-2024

What is a Flexible Spending Plan?

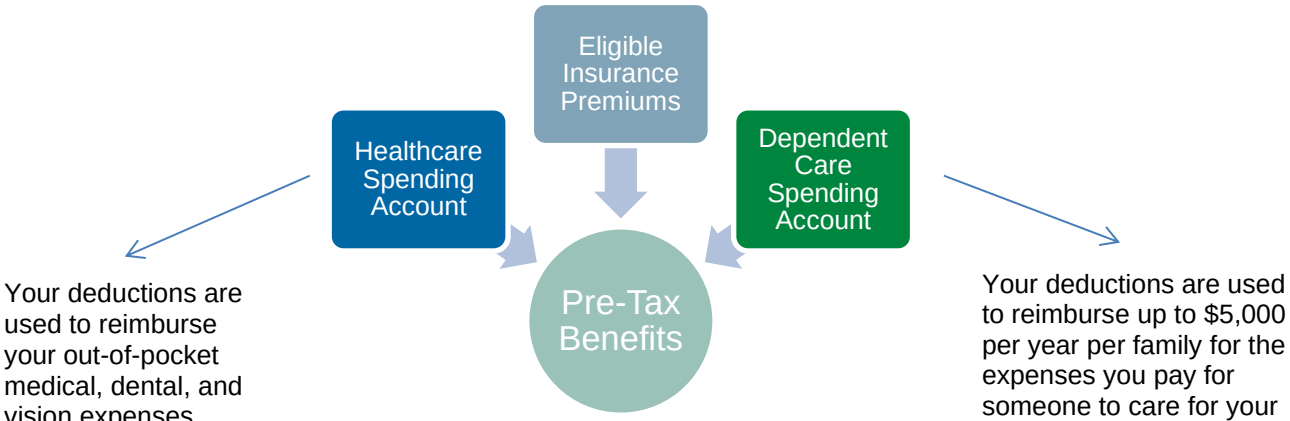
A Flexible Spending Plan is a benefit you elect during Open Enrollment each year. Your plan allows you to deduct certain amounts you select from your paycheck before any taxes are calculated. Your deductions can then be used to pay for certain medical and daycare expenses income tax free. Because your deductions are set aside are pre-tax, you are able to save 30% - 40% (*depending on your tax bracket*) of every dollar you deposit.

► The advantages of your plan include:



What Things Can I Pay For Tax-Free?

There are three different pre-tax benefits you can take advantage of in your plan.



Illustrating Your Tax Advantages:

	Traditional Method of Payment	Pre-Tax Health Premium and Reimbursement Accounts
Family's Annual Income	$42,000	$42,000
Election – Premium	-0-	-1,500
Election – Health Care	-0-	-1,200
Election - Dependent Care	-0-	-3,000
Taxable Income (*before exemption/ standard deduction*)	**$42,000**	**$36,300**
Less Tax: Federal Tax	-2,100 (15%)	-1,395 (10%)
State Tax (6%)	-2,406	-2,064
FICA (7.65%)	-1,503	-1,067
Net Income	**$35,991**	**$31,774**
Health & Dependent Care Costs (*AFTER TAX*)	-1,500 -1,200 -3,000	-0- -0- -0-
Net Spendable Income	**$30,291**	**$31,774**
Estimated Tax Savings		**$1,483**

THE ABOVE EXAMPLE ASSUMES THE FOLLOWING:

- Married, filing jointly, with one dependent (tax exemptions and standard deductions of $22,350)
- State tax of 6% on federal taxable income. Rate and application will vary by state and/or city.

Who Can Participate in the Plan?

- Existing employees who work at least 0 hours per week are eligible to participate.
- New employees may participate the first of the month following date of hire days.

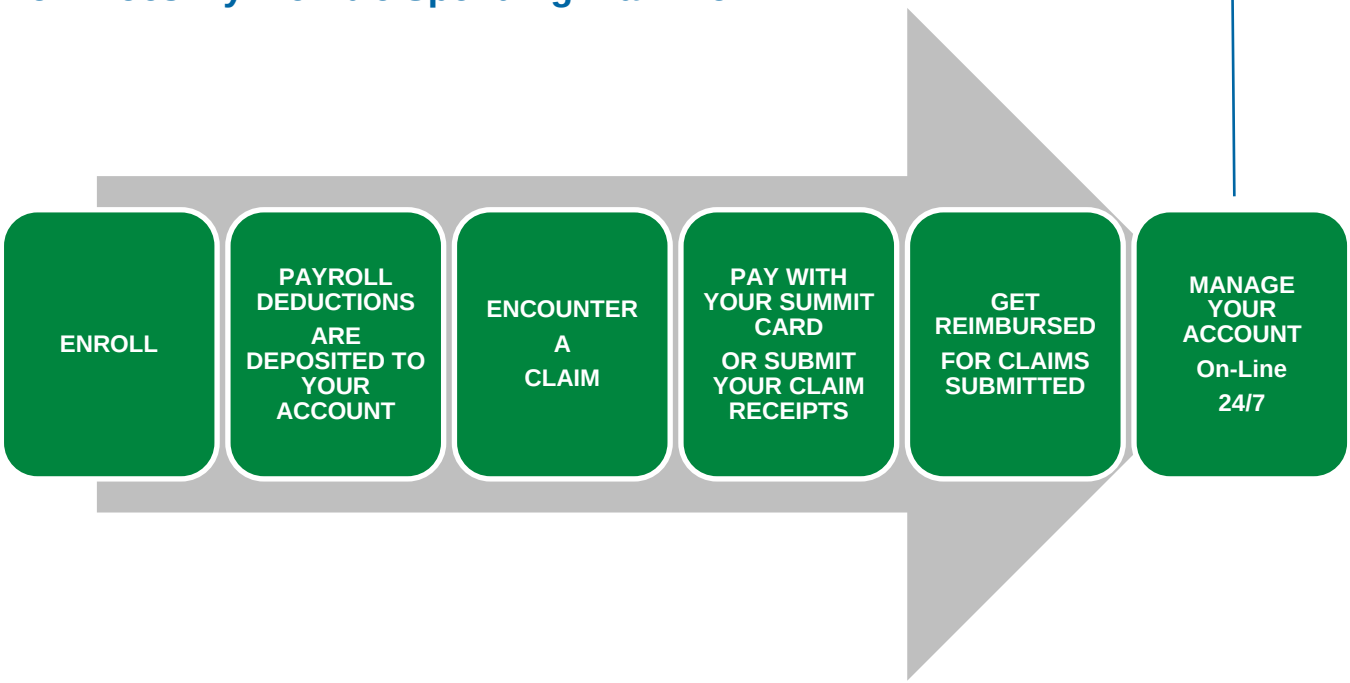
Your Employer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

What is the Plan Year?

The Plan Year for AGNES SCOTT COLLEGE starts every July 1st, and ends on June 30th.

benefitalternatives.summitfor.me

How Does My Flexible Spending Plan Work?



Important Differences to Note:

Healthcare Spending Account	Dependent Care Spending Account
▶ **You may be reimbursed for your entire annual election at any time during the Plan Year.** The reimbursement amount is not based on how much you have contributed to the plan to that point. For example, you have an annual election of $500, and you have contributed $250 so far in the Plan Year. You submit your first receipt for $300. You will be sent a check for the full $300 even though you have only contributed $250. Of course, you can never be paid more than your annual election.	▶ **You are only paid up to the amount you have in your account at the time of service.**
If you are not using your SUMMIT Card, all receipts must be received by Benefit Alternatives, Inc. seven WORKING (not calendar) days before your payday (or when you normally would receive your reimbursement check) to ensure that you will receive a check in that reimbursement period.	

What Health Expenses Are Eligible for Reimbursement?

Eligible Expenses

- Health, Dental, or Vision Expenses That Are Not for "General Well Being" or Cosmetic Reasons
- Office Visit Copays
  Prescription Copays
  Deductibles
  Coinsurance
- Expenses for You
  Expenses for Your Spouse
  Expenses for Your Qualified Dependents

Ineligible Expenses

- Expenses That Will Be or Can Be Reimbursed Elsewhere
- Expenses for Dates of Service That Fall Outside of the Plan Year
- Insurance or COBRA Premiums

Potentially Eligible Expenses

- CPR Classes
  Doula (birthing coach)
  Exercise Equipment/Programs
  Genetic Testing
  Hormone Replacement Therapy
  Home/Auto Modifications
- Massage Therapy
  Nutritionist Services
  Sleep Deprivation Treatment
  Weight-loss Drugs or Programs
  Lactation Consultant

►YOU OR YOUR DEPENDENTS DO NOT HAVE TO BE COVERED UNDER THE AGNES SCOTT COLLEGE INSURANCE PLAN in order to participate in the advantages of the Flexible Spending Plan.

► A comprehensive list may be found in the Summary Plan Description available from AGNES SCOTT COLLEGE.

►There is a $3,050.00 maximum election per Plan Year.

Documentation You Will Need To Keep:

- ► Original Itemized Receipts
- ► Insurance Company EOB's
  (Explanation of Benefits forms)
- ► Supporting Documentation
  (i.e. – Claim and Reimbursement Forms)

What Dependent Care Expenses Are Eligible for Reimbursement?

► Definition of an Eligible Dependent:

- ► Child under the age of 13 who lives with you more than half the year. Special rules apply if you are divorced and are also the custodial parent. Please see your Summary Plan Description.
- ► Spouse or other qualifying dependent who is physically or mentally incapable of self-care and lives with you more than half the year.

► Eligible Expenses:

- ► Eligible expenses are costs incurred to pay someone to care for your dependents so that you (single parent) or you and your spouse can work.
- ► The following is a sample list of covered expenses. Please see your Summary Plan Description for a comprehensive listing.

Eligible Expenses

- ► Day Care
- ► In-Home Care
- ► Nursery or Pre-School
- ► Au Pair (Nanny) Services
- ► After School Care
- ► Day Camp
- ► Certain Elder Care Services

Ineligible Expenses

- ► Overnight Camp
- ► Babysitting (Non-Work-Related)
- ► Kindergarten
- ► School Tuition
- ► Long Term Care Services

- ► If you have used your Dependent Care Spending Account, you cannot claim Day Care expenses for the end of the year tax credit. Please see your Summary Plan Description for all details.

Documentation You Will Need to Keep:

Original Provider Itemization of Services Including:

- ► Provider Name, Address, Tax ID/SS #
- ► Date(s) of Service
- ► Name and Date of Birth of the Dependent
- ► Completed Claim Form

Understanding the Rules

Changing Elections

Once you have made an election, you may not change that election unless you have a "change in status".

For the Dependent Care Spending Account only, you may make a change in your deduction only if the provider changes what they charge. If the provider is a family member, this does NOT apply.

Qualified Expenses

If you are not using your SUMMIT Card, you must have a receipt to be reimbursed.

Be familiar with the list of eligible and ineligible expenses in order to maximize the value of your account.

Use-It-Or-Lose-It

If you do not use your SUMMIT Card or you do not submit receipts, you may not get your money.

The IRS now allows you to carry over up to $610 of unused Health Care Account funds to the next Plan Year.

Helpful advice for managing the "use-it-or-lose-it" rule:

- Only set aside money for expenses you know you will spend.
- Review your family expenses over the last year or two as a guide for finding commonly recurring expenses (routine medications, glasses, chiropractic visits, etc.).
- Do not set aside money for non-recurring expenses (root canal, broken foot, etc.).
- Remember your tax savings may serve as a cushion if you have over-estimated your expenses.

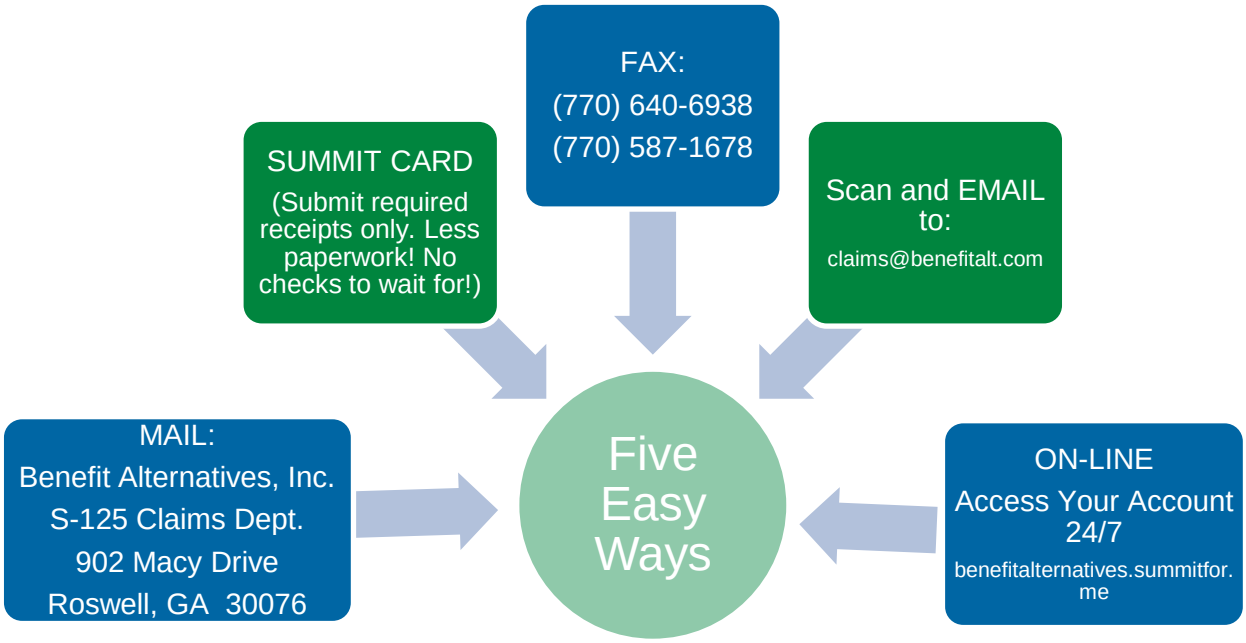
Example: let's assume you are in a 30% tax bracket and you set aside $1,000 in your account. You saved $300 in taxes from your savings election. If you made a mistake in your estimates and you only had $400 in receipts for the year, you can carry forward $500 to the next Plan Year and you will lose $100. But, you are still ahead by $200 because of your tax

While you need to pay careful attention to the use-it-or-lose-it concept, any risk should be lessened by good planning.

Where Do I Get Additional Information About the Plan?

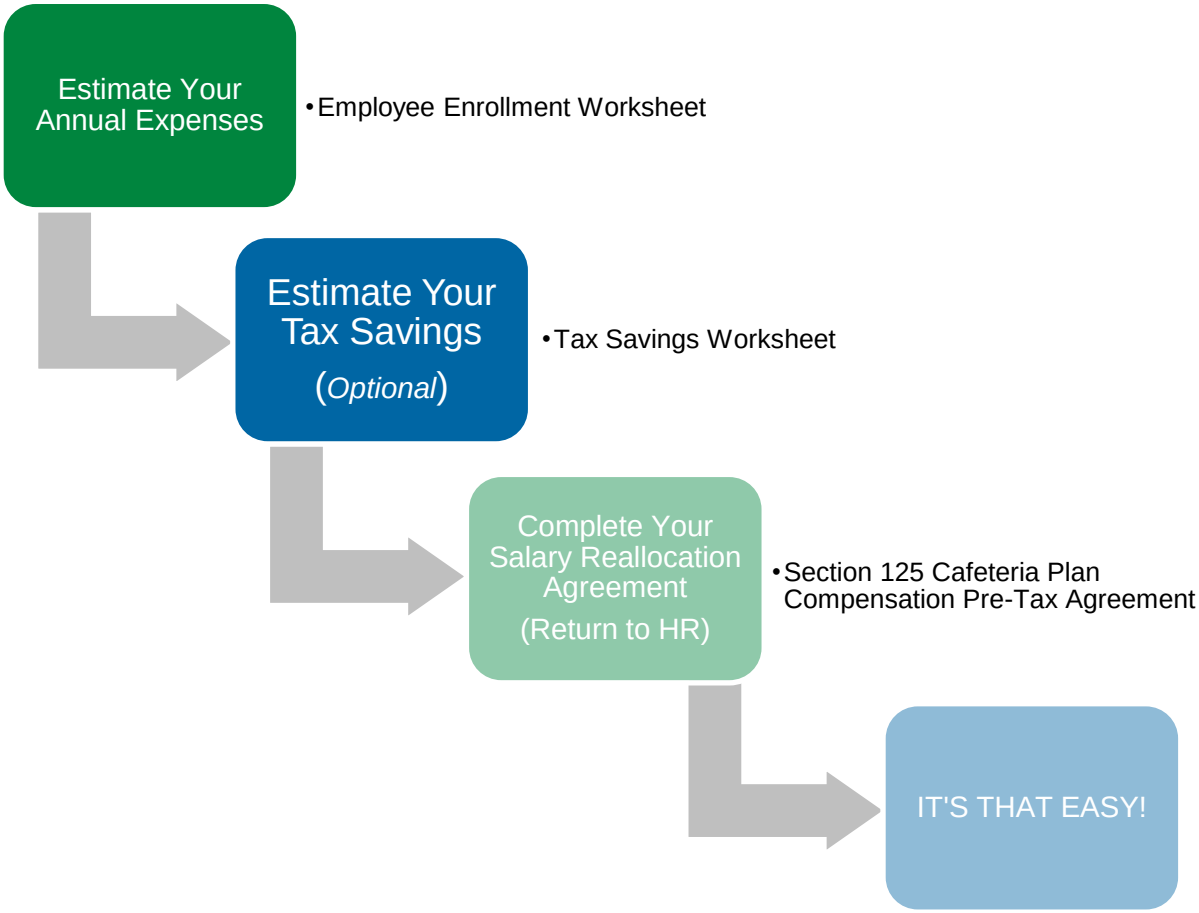
- Informational Meetings are conducted each year prior to the end of the Plan Year by our Plan Supervisor. A representative will be in attendance to give you detailed information and answer any questions you may have about the Plan.

How Do I Submit My Expenses?



How Do I Sign Up for the Plan?

- Each year, you must complete the Salary Reallocation Agreement in your packet and return it to your Human Resources Department prior to the cut-off date.



PLEASE NOTE THAT ALL EXISTING EMPLOYEES AND NEW HIRES MUST COMPLETE THE ENROLLMENT FORM ON THE NEXT PAGE, EVEN IF YOU ARE DECLINING TO PARTICIPATE. WE MUST HAVE RECORD OF YOUR ENROLLMENT OR YOUR DECLINATION.

SMART·ER·START HEALTHCARE SAVINGS TOOLS

(*if you are enrolling*)

- Healthcare Expense Estimator
- Dependent Care Expense Estimator
- Tax Savings Estimator

Healthcare Expense Worksheet

(*For Your Records Only. Do Not Turn In.*)

Instructions:
Using this form, you can identify an estimate of the amount of annual medical, dental, vision, and childcare expenses you pay out-of-pocket. You may find it helpful to review your expenses last year and adjust that amount by any new information you may have.

Eligible Expenses	Copayments	Deductible	Coinsurance	Other	Total
Baby/Child					
Lactation Consultant*					
Lead Paint Removal					
Special Formula*					
Special School Tuition (Disability or Learning Disability)					
Well Baby/Well Childcare					
Dental					
X-Rays					
Dentures/Bridges					
Exams/Teeth Cleaning					
Extractions/Fillings					
Oral Surgery					
Orthodontia					
Periodontal Services					
Vision					
Eye Exams					
Eyeglasses and Contacts					
Laser Eye Surgeries					
Prescription Sunglasses					
Radial Keratotomy					
Hearing					
Hearing Aids / Batteries					
Hearing Exams					
Diagnostic Lab/X-Ray					
Blood Tests					
Metabolism Tests					
Body Scans					
Cardiograms					
Laboratory Fees					
X-Rays					
Medical Equip / Supplies					
Air Purification Equip.*					
Arches/Orthotic Inserts					

*=Potentially eligible expenses requiring proof of medical necessity to qualify for reimbursement.

Eligible Expenses	Copayments	Deductible	Coinsurance	Other	Total
Medical Equip / Supplies					
Contraceptive Devices					
Crutches and Walkers					
Wheelchairs					
Exercise Equipment*					
Hospital Beds*					
Mattresses*					
Medic Alert Bracelet, Etc.					
Nebulizers					
Orthopedic Shoes*					
Oxygen*					
Post-Mastectomy Clothing					
Prosthetics					
Syringes					
Wigs*					
Medical Services					
Acupuncture					
Inpatient/Outpatient Alcohol/Drug Treatment					
Ambulance					
Fertility Treatment					
Hair Loss Treatment*					
Hospital Services					
Immunizations					
In Vitro Fertilization					
Physical Examination					
Reconstructive Surgery (congenital defect or accident or medical treatment)					
Service Animals					
Sterilization / Reversal					
Transplants (including donor)					
Transportation*					
Medications					
Insulin					
Prescription Drugs					
Obstetrics					
Doulas*					
Lamaze Class					
OB/GYN Exams					
Pre- and Postnatal Svcs.					

*=Potentially eligible expenses requiring proof of medical necessity to qualify for reimbursement.

Eligible Expenses	Copayments	Deductibles	Coinsurance	Other	Total
Practitioners					
Allergist					
Chiropractor					
Christian Science Practitioner					
Dermatologist					
Homeopath					
Naturopath*					
Optometrist					
Physician					
Psychiatrist/Psychologist					
Outpatient Therapies					
Alcohol & Drug Addiction					
Counseling (not marital or career)					
Exercise Programs*					
Hypnosis					
Massage*					
Occupational					
Physical					
Smoking Cessation Programs					
Speech					
Weight Loss Programs*					
Over-The-Counter Items *(prescription not required)*					
Antiseptics, Wound Cleaners					
Baby Electrolytes					
Denture Adhesives, Repair, Cleansers					
Diabetes Testing and Aids					
Diagnostic Products *(thermometers, blood pressure monitors, cholesterol testing)*					
Elastic Bandages, Athletic Treatments *(ACE, braces, hot/cold therapy, orthopedic supports)*					
Contact Lens Care					

*=Potentially eligible expenses requiring proof of medical necessity to qualify for reimbursement.

Eligible Expenses	Copayments	Deductibles	Coinsurance	Other	Total
Over-The-Counter Items *(prescription not required)*					
Family Planning *(pregnancy and ovulation kits)*					
Menstruation products					
Over-The-Counter Medicines					
First Aid Dressing and Supplies					
Hearing Aid/Batteries					
Incontinence Products					
Reading Glasses and Maintenance Accessories					
Total Healthcare Expenses **(enter on line #1-next page)**	**$**	**$**	**$**	**$**	**$**

*=Potentially eligible expenses requiring proof of medical necessity to qualify for reimbursement.

Dependent Care Expense Worksheet

(*For Your Records Only. Do Not Turn In.*)

Eligible Expenses	Amount
Day Care Expenses	
Before and After School Care	
Preschool	
Day Camp	
Day Care Center	
Au Pair (Nanny)	
Transportation (*if provided by Day Care Center*)	
Sick Child Facility	
FICA/FUTA Taxes of Provider	
Elder Day Care (*parent claimed as dependent on tax return*)	
Total Dependent Care Expenses ***(enter on line #2 – next page)***	**$**

My Tax Savings (*Optional Calculation*)

Line #	My Data	My Results
1	My Total Healthcare Expense Estimate (page 13)	
2	My Total Dependent Care Expense Estimate (above)	**+**
3	Total Annual Estimated Expenses:	**=**

4	My Federal Tax Bracket	%
5	My State Tax Bracket	+ 6.00%
6	My FICA Tax Bracket	+ 7.65%
7	Total Tax Percentage:	= %
8	Multiply Line 7 x Line 3	=
9	Less: Estimated Child Care Credit from Federal Income Tax Form (if itemized)	-
10	**My Tax Dollars Saved by Using the Cafeteria Plan**	**=**

** This is a quick estimation tool. Please consult your financial advisor for specific questions or amounts as they relate to your personal situation.**

SECTION 125 CAFETERIA PLAN
CLAIM FORM
INSTRUCTION GUIDE

If you are missing information, your request for reimbursement will be denied or delayed. Please keep all of your original receipts and only send in copies of your receipts with your completed Claim Form. You are responsible for maintaining all original receipts and copies of your submitted Claim Forms in the event you are audited by the IRS. If you are claiming mileage expenses, please attach the "Mileage Claim Form" and include the amount claimed on THIS form.

Proper Documentation and Receipts

Medical Expense Receipts	Dependent Care Receipts	Unacceptable Documentation
•Date of service or purchase	•Date(s) of service	•Balance forward statements
•Description of service or item	•Dollar Amount of Service	•Statements only showing amount paid
•Insurance company EOB	•Name of Provider	•Credit card receipts or cancelled checks
•Dollar Amount (after insurance)	•Tax ID number for Provider	•Bills for pre-paid expenses that have not occurred

Important Submission Dates You Must Meet

Failure to meet these Plan Year submission dates can cause forfeiture of reimbursement or spending account values (use-it-or-lose-it rule).

►Routine Plan Year Submissions

If you are submitting paper claims, the claim must be received by Benefit Alternatives, Inc. no later than seven (7) business days before your pay day. Any submissions received after that time will be paid on the next pay period.

►Understanding the Plan Run-Out Period

The run-out period is a specified period of time after the end of the Plan Year during which you may continue to SUBMIT claims incurred during the Plan Year Period. This is not a time period where you can continue to incur new expenses, but rather, the run-out period allows you to gather and submit expenses before forfeitures are applied. You have a ninety (90) day run off period. Any claims incurred on or before the last day of the Plan Year must be received by Benefit Alternatives, Inc. on or before the ninetieth day. If we receive any claims past the ninety (90) day run-out period, they will not be paid.

What To Do If A Claim is Denied or Rejected

If you do have a claim rejected, you will receive the rejection notice at the home address you list on your claim form. Your notice will provide you the reasons for the denial or rejection.

- ► A **denia**l typically results from expenses that are not qualified under the Plan or which have not been submitted within the time frames established by the Plan.
- ► A **rejection** typically occurs when information is missing, difficult to read, or improperly documented.

Questions?

Our office is open from 9am – 5pm eastern standard time. We have listed your day-to-day contact in our office below. Please contact us with any questions you may have.

Shirley Schmuhl, Plan Analyst, (770) 993-8683 (voice) • (866) 323-2363 toll free • shirley@benefitalt.com (email)

SECTION 125 CAFETERIA PLAN
CLAIM FORM (2023-2024)
AGNES SCOTT COLLEGE

Plan Year = 7/1/2023 - 6/30/2024

Please carefully read *all* instructions before filing your claim for reimbursement. *=Required field.

*Employee Name (First, MI, Last) (PRINT)

*Social Security Number

*Mailing Address

Email Address

*City

*State

*Zip

( ) -

*Daytime Phone

Extension

Reimbursement Account Type	List First Date of Service (From)	List Last Date of Service (To)	Total Expenses Submitted
Health Care Expenses	____/____/____	____/____/____	$
Dependent Care Expenses Day Care Provider Tax ID #:_____	____/____/____	____/____/____	$
Have you previously filed for any of these same expenses with us using any other method? (ex - fax, mail, email) ❍Yes ❍No **Note: Receipts must be received 7 business days prior to your pay day. Any receipts received after that time will go on the next check run. We do not return receipts.**		**Total Submitted:**	$

READ THE FOLLOWING VERY CAREFULLY:

I certify by signing below that all expenses for which reimbursement is requested were incurred during the Plan Year in which I am applying for reimbursement and have not been reimbursed or are not reimbursable under any other health plan coverage. I understand that I alone am responsible for the accuracy and veracity of all information relating to this claim and unless an expense for which reimbursement is made is a proper expense under the Plan, I may be liable for payment for all related taxes and penalties including Federal, State, and FICA on amounts paid from the Plan which relates to such expense or expenses. If I have submitted a claim by fax, I will NOT mail the same claim. I also give Benefit Alternatives, Inc. permission to use any information submitted to process my claim.

Employee Signature

Date

INCLUDE COPIES OF THIS CLAIM FORM AND ALL RECEIPTS IN YOUR SUBMISSION

MAIL to: Benefit Alternatives, Inc. • S-125 Claims Department • 902 Macy Drive • Roswell, GA 30076

FAX to: (770) 587-1678 or (770) 640-6938 • Email to: claims@benefitalt.com

On-Line Account Access: benefitalternatives.summitfor.me

Need Help? Just call: VOICE: (770) 993-8683 local • (866) 323-2363 toll free