

Fairfield Public School Announces Open Enrollment of Flexible Spending Account Plan Year 2016-2017



Fairfield Public Schools in conjunction with **Wage Works** is offering a Flexible Spending Account (FSA) open enrollment period from **May 12 through May 26, 2016**. Once a year you have the opportunity to elect coverage for medical and prescription drug expenses not covered by insurance, and for dependent care costs. The money you contribute is not subject to payroll taxes, which can result in substantial tax savings.

OVERVIEW

2016-2017 Limits (July 1, 2016 – June 30, 2017)

Health Reimbursement Account contributions are limited to **\$2,500**.

Dependent Care Reimbursement Account contributions are limited to **\$5,000**.

Minimum contribution for the Health Care and Dependent Care Accounts is \$500.00 per account.

Open Enrollment Period

Enrollment for Flexible Spending Account (FSA) for the plan year 2016-2017 will begin on **May 12 and end on May 26, 2016**.

How to Enroll

The attached enrollment form **must be completed and submitted to the Insurance Office via interoffice mail no later than May 26, 2016**. Your participation in the FSA is completely voluntary, and it's important to remember that unlike other Federal benefits, your FSA election is only effective for one Plan Year.

Forms can also be found in **U:\AllStaff\Insurance\FLEXIBLE SPENDING 2016-2017 Wage Works**.

You must enroll each year that you choose to participate.

If you have any questions about the FSA Programs contact Andrea DeAlmeida or Gina Reynolds at extension **8381**.

FSA Program Features

- Once you enroll in an account, you cannot stop or change your deductions unless you experience a qualifying event.
- Health Care FSA (HCFSA) funds and Dependent Care FSA (DCFSA) funds must remain separate. Contributions made to one account cannot be used to reimburse expenses for the other account.
- You can incur eligible expenses for your 2016-2017 accounts until **September 15, 2017. (Grace Period)**
- You can file claims for reimbursement of 2016-2017 expenses through **September 30, 2017. (Submission date)**
- You can claim amounts equal to your entire annual health care contribution from your **Health Care** FSA at any time during the year.
- To receive a reimbursement from your **Dependent Care** FSA, you must have accumulated sufficient contributions to cover the claim being made.

Applicable Administrative Fee

Employees participating in the Flexible Spending Account for the plan year 2016-2017 will pay a post-tax administrative fee of \$3.57 per month. This fee will be charged through post-tax payroll deductions.

Wage Works is pleased to offer a debit card. Your new card can be used for health care expenses only. The debit card cannot be used for Dependent Care; you must submit a dependent claim form to Wage Works.

Cards will be issued on or about July 1st.

If you currently have a card, it is good for 3 years.

No claims or reimbursements can be made until enrollment is complete which is on or about July 15th.

Open Enrollment of Flexible Spending Account

Plan Year 2016-2017

Receipts

Remember to save your receipts! When you incur an eligible expense, just use your card for Health Care expenses or send in your eligible expense receipt for Dependent Care with the necessary form. You can complete a claim form on line at www.wageworks.com Claims forms are also located in the U:\AllStaff\Insurance\FLEXIBLE SPENDING 2016-2017 Wage Works.

Dependent Care Provider Requirements

Your dependent care provider must sign the claim form for verifying charges incurred or you must submit a receipt from the provider for services rendered. You are required to provide the name, address, and tax id # of your dependent care provider when you file your income tax return.

Newly Hired Employees (after this open enrollment period)

If you are a new employee with FPS, you will have **30 days** from date of hire to apply for FSA program. You will be receiving in your new hire kit all relevant paper forms for the FSA program. Please make sure that these forms are submitted to the Insurance Office for processing.

Qualifying Event/Mid-Year Change

In order to process an HCFSAs/DCFSAs mid-year change, you must notify the **Insurance Office** by submitting an Enrollment/Change Form and a Qualifying Event Mid-Year Change Form with proper documentation. Please see the forms in the U:\AllStaff\Insurance\FLEXIBLE SPENDING 2016-2017 Wage Works.

- **HEALTH CARE FSA** - You will be permitted to increase your annual contribution if you are adding new dependents. You cannot, however, decrease or discontinue your HCFSAs contribution for any reason during the Plan Year. In addition, under HCFSAs, you must participate for the entire Plan Year.
- **DEPENDENT CARE FSA** - You may increase, decrease, or terminate your annual allocation if you experience a mid-year qualifying event.

Termination of Employment/Unpaid Leave of Absence

Health Care Flexible Spending Account

If your employment is terminated, or you take an unpaid leave of absence, you can have the remainder of your deductions taken on a pre-tax basis from your last paycheck or prorated for the remaining paychecks. In order for the payroll deductions to be made, you must notify the **Insurance Office** in writing **30 days** prior to your termination or unpaid leave of absence or prior to the cut-off date of your last paycheck.

If you fail to provide the required written notification, you must fully fund the remainder of your account with after-tax payments up to your annual contribution.

Dependent Care Flexible Spending Account

If you terminate employment or are on an unpaid leave of absence, your participation in DCFSAs will cease. You must notify the Insurance Office in writing to terminate your payroll contributions.

Important

Failure to incur expenses within the plan year or grace period and submitting reimbursement to Wage Works by September 30, 2017 will result in a forfeiture of the balance of the account(s) per IRS regulations.



Enrollment Form – Flexible Spending Accounts

July 1, 2016 – June 30, 2017

GENERAL INFORMATION:

Employee Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____

Date of Hire (MM/DD/YYYY): _____

FLEXIBLE SPENDING ACCOUNTS:

I hereby elect to participate in the Flexible Spending Accounts

I hereby elect NOT to participate in the Flexible Spending Accounts

	Per Pay Period	# Pay Periods	Annual Election
Health Care FSA	\$ _____	x _____	= \$ _____
Dependent Care FSA (Day care expenses incurred during employment hours)	\$ _____	x _____	= \$ _____

Effective date of coverage: _____ The first payroll deduction will be on _____, 20____

My pay schedule is: weekly bi-weekly semi-monthly monthly

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Employee Signature

Date

WageWorks is the administrator of your Plan.
Please return this form to your Employer.