2019 Flexible Benefit Plan

Your plan year will run from your date of eligibility to December 31, 2019. If you have any questions regarding your enrollment, we encourage you to call P.R.I.M.E. Benefit Systems at 319-294-4046 or 800-473-8970 ext 4046. Please complete and return the Flex Election form to the Human Resources Department as soon as possible.

2019 HIGHLIGHTS

- **WHY ENROLL?** If you have never participated in a Flexible Spending Plan now is the time to enroll. Why not save taxes on certain expenses you already have to pay for? Your existing health plan may already cover most of your expenses, but there are unavoidable expenses you must pay out of your pocket (deductibles, coinsurance, co-payments, dental expenses, vision expenses, and over-the-counter medication expenses). By participating in a Medical Flexible Spending Plan, those eligible expenses can be reimbursed to you with tax-free dollars. Not only will you save income taxes, you are also likely to have eligible medical expenses reimbursed BEFORE you have had the County withhold money from your paycheck. In other words, you will get money back before you have the same amount withheld from you. If you have dependent care expenses for day care, home care, or nursery care expenses for your eligible dependents, those eligible expenses can also be reimbursed to you with tax-free dollars.

- **MORE NEWS REGARDING OVER-THE-COUNTER MEDICINES** – The IRS has issued new rules regarding Over-The-Counter (OTC) drugs and medicines. You must now provide P.R.I.M.E. with an **actual prescription** from your doctor. For most OTC items, you will probably decide that obtaining an actual prescription is more trouble than it is worth. Over the Counter SUPPLIES are still eligible without a prescription.

- **PREVENTING IDENTITY THEFT** - P.R.I.M.E. takes identity theft seriously. Therefore, when you submit a claim for reimbursement, we are giving you the choice of identifying yourself using your (1) social security number or (2) using your "BDID." Your "BDID" is your MMDDYYYY (date of birth, using all 8 characters, with no dashes PLUS the last 4 digits of your social security number. So, if your date of birth is 02/09/1973 and your SSN is 481-60-5396, your BDID would be 020919735396.

- **E-MAIL ADDRESS** - The best way of communicating with you is through e-mail. On the Election Form, please list an e-mail address that we may use to contact you. If you prefer a phone call, let us know the best number to use to contact you.

- **CHANGE IN STATUS** - If you have a change in your family status (birth of baby, divorce, etc.) during the plan year and wish to make a change to your annual flexible spending election amount, you will have 30 days to notify the County. Report in person to the Linn County Human Resources office to complete the required paperwork.

- **2 ½ MONTH GRACE PERIOD** - Anyone who has a positive balance in their **medical and/or dependent care** flexible spending account on December 31, 2019, will have a 2 ½ month grace period to submit claims with dates of service to March 15, 2020. Claims will be applied towards your OLD plan year balance first. The grace period makes it much easier to ensure that you are able to claim 100% of your annual election. You will have until April 30, 2020 to file a 2019 claim. Keep in mind, the OLD plan year will then be closed out on the next regularly scheduled disbursement date following April 30, 2020.

- **REMINDER** – Flexible spending plans are designed to pay last. On the pink Election Form, please pay attention to the questions asking whether **you or any other member of your family** are 1) covered under a High-Deductible Health Savings Account (HSA); 2) "double covered" where one or more members of your family have more than one health, dental or vision insurance policy or another flexible spending plan covering them; or 3) covered (or soon to be covered) under another flexible spending plan? If any of these circumstances apply to you, then mark "YES" and call P.R.I.M.E. to ask how this may affect your reimbursements.

- **RECEIPTS** – An Explanation of Benefits (EOB) from Wellmark Blue Cross Blue Shield is required for reimbursement of provider services and pharmacy expenses. Eye exam reimbursement claims also require an EOB from Wellmark. Other eligible expenses should be accompanied by a receipt listing the date, item, retailer and amount.

HOW THE PLAN BENEFITS YOU

By participating, you will increase your annual take-home pay. Why? Because the plan gives you the right to pay less Federal, State, and Social Security taxes. The taxes saved are yours to spend or invest. The savings is based on a 1978 tax law allowing you to designate a portion of your taxable wages for the year which may be legally converted into tax-free benefits from your employer. Eligible benefits include: a) medical expenses; b) dependent care expenses; and c) employee portion of insurance premiums for group coverage with the County.

HOW THE PLAN WORKS

The open enrollment period allows you to declare the amount you want to convert into tax-free dollars. First, you need to make a reasonable estimate of the amount of medical and/or dependent care services you will incur in 2019. Then simply transfer your estimate onto the P.R.I.M.E. Election Form. This constitutes your permission to convert taxable wages into tax-free benefits. Your election will be divided by the number of pay periods during the 2019 Plan Year. An equal amount of money will be set aside each pay period throughout the year.

P.R.I.M.E. will send you a confirmation packet which will include a complete description of the claims process, along with forms necessary to claim your tax-free reimbursement. When we receive your claim requests, we will review them and will determine if the expense is eligible for reimbursement, given the rules established by Congress and the IRS. Once your claim is approved, you will be paid on disbursement dates agreed to by P.R.I.M.E. and the County via check or Electronic Funds Transfer (EFT).

Weekly Disbursements – Claims submitted by Wednesday will be paid on Friday.

ELIGIBLE EXPENSES

EMPLOYER SPONSORED PRE-TAX INSURANCE PREMIUMS – Insurance premiums that the County may ask you to contribute towards your group coverage. This level of benefit should NOT be included in your Medical Flexible election amount.

MEDICAL FLEXIBLE SPENDING – Eligible medical expenses are any out-of-pocket expenses incurred by you or a family member, and NOT REIMBURSED by your insurance carrier or any other source. These expenses would include the annual deductible for your insurance (medical, dental, prescription drug, etc.) and all co-insurance or co-payments. Please refer to the listing of eligible and non-eligible expenses for further detail.

If you participate in a Medical Flexible Spending Account, you are entitled by law to be reimbursed for the amount of your claim, not to exceed your annual election, without regard to the current balance in your account.

DEPENDENT CARE FLEXIBLE SPENDING - Any expense that you incur for a babysitter, daycare, preschool or adult daycare that makes it possible for you and/or your spouse to work. These would be the same expenses you may be taking as a tax credit on IRS Form 2441. Generally, taking these expenses through your employer's flexible spending plan is better for you because there are no declining tax credit percentages as you make more money**. The federally mandated limit under this plan is $5,000 regardless of the number of children.**

IMPORTANT - RECENT LEGISLATION NOW ALLOWS YOU TO PARTICIPATE IN THE DEPENDENT CARE FLEX ACCOUNT EVEN IF YOU EXPECT TO RECEIVE AN EARNED INCOME CREDIT (EIC).

Your Plan Year will run from your date of eligibility through December 31, 2018. Be reminded of the new 2 ½ month grace period for medical and dependent care flexible spending accounts.

HOW DO I ENROLL?

Estimate your annual medical and dependent care expenses. Fill in the amounts on the Election Form. Sign and date the form and return it to Linn County Human Resources Department **as soon as possible**. A Summary Plan Description will be provided to each Flexible Spending Plan participant. Please refer to this document for complete details regarding your plan.

FLEXIBLE SPENDING ACCOUNTS BENEFIT EVERYONE—ESPECIALLY YOU!!

A Flexible Spending Account, or FSA, is a smart, simple way for you to put aside money, tax-free, to cover the everyday expenses you know you'll have in the coming year. You can use it to pay for non-covered medical or dental expenses, child care, and even dependent adult care costs.

Contributions to an FSA are made before taxes are taken out of your pay, you reduce your total taxable income and get to keep more of every dollar you earn. ***It's like giving yourself a raise while you take care of important health and dependent care expenses at the same time.*** And FSA's aren't just for people with major expenses. Think of all those routine everyday expenses you might overlook—co-pays, deductibles, vision and dental expenses, they all add up. And they could all be reimbursed to you through your own FSA.

Flexible Spending Accounts are authorized by the IRS and available through your employer. This type of account allows you to set aside money for non-reimbursed health care and/or dependent day care expenses throughout the year. You submit a claim for those expenses, and you are reimbursed with ***tax-free dollars*** from your account.

Health Care Accounts reimburse you for out-of-pocket medical, dental, vision, hearing and prescription drug expenses such as co-pays, co-insurance, certain over-the-counter medications, eyeglasses, contacts, and more.

Dependent Care Accounts reimburse you for dependent day care expenses you incur to allow you and, if married, your spouse to work. These expenses include day care, before-and-after school programs, nursery school or preschool, summer day camp and even adult day care.

When you elect to use these types of accounts, you reduce your taxable income—so you ***pay less in income taxes***.

HOW DOES AN FSA WORK?

First, you will need to decide how much money to allot on an annual basis and make your election with P.R.I.M.E.

Second, P.R.I.M.E. requests your employer to deduct equal installments of the annual allotment you elect. P.R.I.M.E. receives your elected amount for deposit into your appropriate account (s).

Third, when you incur an eligible expense, you'll generally pay for it out of pocket, and then submit a claim for reimbursement to P.R.I.M.E. All claims must be accompanied by the appropriate documentation, such as an itemized receipt or an explanation of benefits.

Finally, P.R.I.M.E. processes claims and issues reimbursement to you. You have the option for direct deposit of reimbursement funds into a checking or savings account through Electronic Funds Transfer (EFT) or a paper check will be mailed to you.

EXAMPLE OF SEMI-MONTHLY EMPLOYEE SAVINGS:

	BEFORE FSA	WITH FSA
Gross Pay:	**$1,000.00**	$1,000.00
Pre-tax Deduction:	- .00	- 50.00
Taxable Income:	$1,000.00	950.00
Taxes at 27.65%:**	276.50	262.68

Per Pay Tax Savings: $ 13.82
Annual Tax Savings: $ 331.68

** 15% federal income tax, 5% state income tax, and 7.65% FICA taxes
Employees' W-2s will show reduced taxable wages and lower FICA taxes

Medical FSA Election Worksheet

Use this worksheet to help you estimate your eligible medical expenses. In making your enrollment decision for next year, some of the questions to consider include the following:

- Do you expect to have medical, dental or vision expenses that are not fully covered by insurance?
- Do you, your spouse, or your tax dependents (as defined by Code 152) have a chronic illness that requires expensive medication or frequent visits to a physician?
- Do you, your spouse, or your eligible dependents need prescription eyeglasses, prescription sunglasses, contact lenses, and/or contact lens solutions?

Medical Expenses **These include, but are not limited to, the following types of medical care expenses incurred by you and/or your eligible dependents:**	**Past 12 Months $**	**Next Year's Projected Expenses $**
I. Medical care expenses not covered by your insurance or your spouse's insurance		
Physician office visit co-pays		
Chiropractor office visit co-pays		
Deductibles amounts that are your responsibility to pay		
Coinsurance that you must pay after your deductible is met		
Drug and chemical dependency treatment (including smoking cessation program)		
Counseling component of weight loss program		
Mileage (currently 23 cents per mile as of 01/01/15)		
Over-the-counter drugs and medicines with valid prescription		
Routine physical exams, including mammograms, and lab fees		
Prescription drug co-pays or prescription drug deductibles		
Well-child care, including immunizations		
Surgeries (inpatient, outpatient, surgeon, anesthesiologist)		
II. Dental care expenses not covered by insurance		
Dental exams		
Fillings/bridges/restoration		
Braces		
X-rays		
Deductibles		
Coinsurance		
Fees for Cosmetic services are not eligible		
III. Vision care expenses not covered by your insurance		
Eye Exams		
Contact lens solutions and cleaners		
Frames, prescribed lenses, contact lenses and/or prescription sunglasses		
Corrective eye surgery		
Deductibles		
Coinsurance		
TOTALS		

Federal Restrictions on Reimbursement of Over-The-Counter Drugs and Medicines

In October of 2011, the IRS issued a guidance stating Over-The-Counter (OTC) drugs and medicines are eligible for reimbursement only if a prescription from a medical doctor is provided. This means that you might want to alter your thinking in terms of how much to withhold for OTC expenses.

1) Without a prescription from your physician you will no longer be able to use your Medical Flex Spending Accounts to purchase OTC drugs and medicines (Advil, ibuprofen, cough syrup, etc).

2) However, if you obtain a prescription from your physician, then the OTC drug or medicine IS an eligible expense.

3) OTC supplies that are NOT "medicines" (such as bandages, contact lens solution, etc.) will continue to be eligible as usual.

4) In order to meet Federal requirements for reimbursement, a receipt identifying the patient, the date and amount of purchase and an Rx number must be submitted. Alternatively, a copy of the prescription, which includes dosage (amount and interval), duration and patient's name, may be submitted with a receipt of purchase. The prescription **must** include the prescribing physician's name and license number.

Eligible Expenses under the Medical Flexible Spending Account

Acupuncture
Ambulance

Birth control (prescription)
Braille books

Capital expenses to your home
(physician prescribed)
Chiropractic care
Contact lenses
Contact solutions

Deductible and co-payments
Dental fees - exams, fillings, x-rays
Dentures

Eyeglasses
Guide dogs

Hearing aids & batteries
Hospital charges

Lab Fees
Laser eye surgery

Medical services
Mileage ($.18 per mile)
(effective 1/1/18)

Occlusal guards to
prevent teeth grinding

Occupational therapy
Osteopathy
Optometrist fees

Orthodontic treatment

Over-the-counter supplies
OTC drugs and medicines
require a prescription
(see reverse side for examples)

Physicians fees
Physicals (Routine)
Physical therapy
Prescription drugs
Prosthetics
Psychiatric care
Psychologists (PhD)

Reading glasses

Special schools for the disabled

Sterilization

Transplants
Treatment for chemical dependency

Vaccinations
Vision care

Weight loss programs
for **counseling** only
(physician verification required)

Wheelchairs-includes rental
or purchase

X-ray fees

Non-Eligible Expenses Under the Medical Flexible Spending Account

Breast pumps

Counseling (MSW)
Cosmetic Surgery/Procedures/Drugs
Diaper service

Electrolysis
Extended Warranties - i.e. contact
lenses and glasses etc.)

Funeral expenses

Group insurance premiums
at your spouse's employer

Health club dues

Massage therapy - will NOT be an allowable expense unless for the treatment of an injury or trauma (must include note from medical physician)

Maternity clothes
Meals that are not part of in-patient care
Non-prescription sun glasses
Personal use items (face creams, Q-tips, etc.)

Teeth bleaching or whitening

Vitamins or dietary supplements which do not require a prescription.
Weight loss programs
-food
-exercise
-non prescription weight loss drugs

Over-The-Counter Items That Do NOT Require A Prescription

Bandages and First Aid items
Birth Control (Over The Counter)
Blood Pressure Kits
Canes and Walkers
Contact Lens Solution
"Clear Eyes" types of Solution
Denture Products
Diabetes Testing Supplies
Durable Medical Equipment
Heating Pads
Hot, Cold and Steam Packs
Incontinence Products
Insulin, needles, alcohol swabs
Orthopedic Aids
Pregnancy and Fertility Testing Kits
Splints, Support, Braces
Thermometers

Over-The-Counter Drugs and Medicines That DO Require A Prescription

The following are examples, and do not represent an exhaustive list. In general, any Over-The-Counter drug or medicine, which must be applied, swallowed, inserted, or inhaled requires a prescription.

Acid Controllers
Allergy and Sinus Medication
Antibiotic Products
Anti-gas and Diarrhea Medication
Anti-Itch/Insect Bites
Antiparasite Treatments
Baby Rash Ointments and Creams
Cold, Cough and Flu Medicine
Digestive Aids
Feminine Anti-Fungal/Anti-Itch
Hemorrhoid Medication
Laxatives
Pain Relief (aspirin, Tylenol, etc)
Respiratory Treatments
Sleep Aids/Sedatives
Stomach Remedies

Linn County, Iowa

2019 FLEXIBLE BENEFITS ELECTION FORM

FOR OFFICE USE ONLY: 161

HSA: Yes___ No___ | **Med PRO Rate $**_____
PBSID#_____ Pay Periods Remaining:_____ | **Dep PRO Rate $**_____
2019 Plan Year Begin Date: Date of Eligibility | EEdata1_____ | Confirm_____ | Erlist_____
2019 Plan Year End Date: December 31, 2019 | Approach_____ | Calcfile_____ | ACH_____

*Please complete the following Medical and Dependent Care Election form for the 2019 Plan Year and deliver to the HR office **as soon as possible**. If you decide not to participate in the 2019 Plan Year you must complete the name and address section and mark "No" in both medical and dependent care boxes.* **Please complete both sides.**

Name:_____ Date of Hire:_____ Department:_____

Social Security Number:_____ Date of Birth:_____ Employee #:_____

Current Address:_____
Street Address City State Zip

Email Address:_____ Phone Number:(_____)_____-_____

MEDICAL FLEXIBLE SPENDING ACCOUNT - MUST BE COMPLETED BY EVERYONE

☐ Yes, I would like to allocate a portion of my salary, or gross wage to be deposited into my own Medical Flexible Spending Account.
$_____, Please enter the TOTAL Annual Plan Year amount, not to exceed $2,650. This Plan Year amount should be deducted from my pay on a pro rata basis each pay period.

☐ No, I do not want to take advantage of this tax-saving Medical Flexible Spending Account.

DEPENDENT CARE (Day Care/Preschool) FLEXIBLE SPENDING ACCOUNT - MUST BE COMPLETED BY EVERYONE

☐ Yes, I would like to allocate a portion of my salary, or gross wage to be deposited into my own Dependent Care Flexible Spending Account.
$_____, Please enter the TOTAL Annual Plan Year amount, not to exceed $5,000. This Plan Year amount should be deducted from my pay on a pro rata basis each pay period.

☐ No, I do not want to take advantage of this tax-saving Dependent Care Flexible Spending Account.

INSURANCE PREMIUMS THROUGH THE COUNTY'S GROUP HEALTH OR DENTAL PLANS

Linn County offers a choice between having your County group health/dental plan premiums deducted from your pay before or after federal and state income tax. By choosing 'Yes' your health/dental premiums will be deducted before tax and your take-home pay will increase because you will be paying less federal and state income taxes. By electing this option there is never any risk of loss like there is on the other two cafeteria flexible spending accounts. By choosing 'No' your take-home pay will decrease because you will be paying more in taxes. Your election will remain in effect until we receive a timely notice because of an Eligible Change in Status, or you elect NO during any annual open enrollment period in December of each year. You are taking advantage of the County's "Evergreen" provision as stated in the County's legal written plan.

☐ Yes, I want to begin paying for my health/dental premiums on a pre-tax basis.

☐ No, I want to pay for my health/dental premiums without saving federal and state income taxes.

Signature:_____ Date:_____

LIST ELIGIBLE FAMILY MEMBERS:
Complete this section if you have elected "Yes" to participate in the Medical or Dependent Care Plans, and you have eligible dependents (spouse, children, parents) for whom you may be submitting claims for reimbursement.

NOTE: Administratively, we define "eligible dependent" to be any legal relative regardless of whether that person is living with you in your home for whom you provide half of their support. Further, an eligible dependent may be any child of minority age not related to, but living with you under a custodial care arrangement. An eligible dependent does not have to be claimed on your personal tax return.

Please list spouse if applicable, then dependents in birth order.

Relationship	Name (Last Name if Different from Yours)	Birth Date Mo/Day/Yr		
Spouse				

Please answer the following questions in their entirety:

1. Are you or any member of your family covered by a High-Deductible Health Savings Account (HSA)? Yes_____ No_____
2. Are you or any member of your family "double covered" where there is more than one health, dental or vision policy covering them? If yes please indicate who is double covered and how? _____. Yes_____ No_____
3. Are you currently covered under another flexible spending plan with your spouse's employer? Yes_____ No_____

REIMBURSEMENT OPTIONS

How would you like to be reimbursed?

☐ Check delivered by mail
☐ Electronic Fund Transfer (COMPLETE THE AUTHORIZATION BELOW IF YOU HAVE NOT ALREADY DONE SO)

If you choose EFT, how would you like to be notified of reimbursement?

☐ Benefit Statement delivered by mail
☐ PDF Benefit Statement delivered by email

Email Address:_____

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS

Any reimbursements for your flexible spending account will be directly deposited into your savings/checking account. To guarantee the reimbursement will be made to the correct checking/savings account it is **VERY IMPORTANT** you attach a voided check with the word "VOID" written across the face of the check, to this form.

I (we) hereby authorize P.R.I.M.E. Benefit Systems, Inc., to initiate credit entries to my (our) bank account named below, and to initiate debit entries solely to correct any errors. Written notification will be made. (Please note that the employee must be an owner on the account).

Bank Name:_____
Bank Address:_____
City:_____ State:_____ Zip:_____
Routing Number:_____ Account Number:_____
Type of Account: ☐ Savings or ☐ Checking

This authority is to remain in full force and effect until P.R.I.M.E. Benefit Systems, Inc. and my bank have received written notification from me (or either of us) of its termination in such time and in such manner as to afford P.R.I.M.E. Benefit Systems, Inc. and Depository a reasonable opportunity to act on it.

By my signature below, I agree that if my bank information changes during the course of the plan year, I will immediately submit the most recent "voided" check to P.R.I.M.E. Benefit Systems, Inc. so the proper changes can be made. I acknowledge that failure to submit current bank information will cause a delay in my claim reimbursement.

_____ _____
Signature Date

REMEMBER YOU MUST RETURN THIS FORM EVEN IF YOU DECIDED NOT TO PARTICIPATE