Auxiant®
Your Integrated Benefits Partner

Dear Employee,

Welcome to your 2020-2021 Flexible Spending Plan administered through Auxiant. Your employer has made this benefit available to you as a way to increase your take-home pay and reduce your taxes.

The money that you elect to set aside for your Flexible Spending Plan is automatically deducted from your salary on a pre-tax basis and deposited into your flexible spending account before federal, state and FICA taxes are withheld. ***Total Annual Maximum Election amount allowed for Unreimbursed Medical Expenses is $2,750.00.***

After you incur your medical or dependent care expenses, you simply submit a completed claim form to Auxiant along with any required documentation (such as receipt or explanation of benefits) for reimbursement of your eligible expenses. A claim form is included in this packet. You will receive a check once your claim is processed by Auxiant.

Included with this letter is the following information:

- Frequently Asked Questions
- Eligible Expenses for Reimbursement under Flexible Spending
- Flexible Spending Enrollment Form
- Flexible Spending Claim form
- Dependent Childcare Annual Request Form
- How Flexible Spending Compensation Can Work
- Flexible Spending Employee Worksheet
- Direct Deposit Form

Should you have any questions, please feel free to contact Auxiant at

P.O. Box 75008
Cedar Rapids, IA 52407-5008
Attention: Flex Department
Phone: (319) 398-3283 or (800) 475-2232
Fax (319) 739-1109

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Frequently Asked Questions & Answers Regarding Flexible Benefits

Q. How do I submit my expenses for reimbursement?

A. You can file the claim via the consumer accounts page on Auxiant.com or submit a claim form. Enclosed with this packet is an Auxiant Flexible Spending Claim form. Please complete the claim form and attached any necessary document to the form. You may either mail or fax the completed form with documentation to Auxiant.

Q. Can checks from the Flexible Spending Account be made payable to the provider of service?

A. No, you must incur the expense for health or dependent care before reimbursement can be made. The checks for reimbursement can only be made payable to the individual employee.

Q. What happens to money left in the account at the end of the year?

A. If you are enrolled in the Health Care and Dependent Care Spending Accounts as of the end of the plan year, you are eligible for a 75 day (two-and-a-half month) grace period. The grace period allows you and your dependents (if applicable) to continue incurring Medical Care and Dependent Care Expenses for up to 75 days (two-and-a-half months) following the end of the plan year and to be reimbursed for those expenses with any remaining account balance from the prior plan year. The Medical Care and Dependent Care Expenses that you and your dependents (if applicable) incur during the grace period (as well as those incurred during the plan year) are subject to your Health Care and Dependent Care Spending Accounts timely filing provision. If, at the end of **the timely** filing deadline there is a balance left in your account from the previous plan year that amount will be forfeited.

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Frequently Asked Questions & Answers Regarding Flexible Benefits

Q. How can I change my salary reduction or benefit levels?

A. You may change your salary reduction on a yearly basis. You may elect new benefit coverage's on a yearly basis during the enrollment period. Changes to your salary reduction are not allowed during the year except when one of the following IRS approved status changes occurs:

- Marriage or Divorce
- Birth or Death of a family member
- Loss of employment
- Loss of spouse's employment
- Spouse changes from part-time to full-time employment or from full-time to part-time or takes and unpaid leave of absence
- Significant change in the coverage offered by the spouse's employer that affects the spouse and / or employee

Q. What expenses will the flexible reimbursement accounts cover?

A. Each account (dependent care and unreimbursed medical care) has its own list of eligible expenses. The unreimbursed medical care portion can be viewed as an extension of your health care plan. A sample list of eligible expenses is included in this packet. The dependent care portion covers expenses that are necessary so that you (and your spouse, if you are married) can work. The category of eligible dependents includes children, disabled spouse, and disabled adult dependents. A child must be under age 13 or be disabled to be considered a dependent for tax purposes.

It is important to remember that any expenses you submit to your flexible spending accounts cannot be itemized on your tax return. You can do one or the other but not both.

Q. Are Insurance Premiums eligible for reimbursement under my unreimbursed medical flex account?

A. No. While your premium/employee contributions for your employer sponsored health plan may be available on a pre-tax basis through your employers cafeteria plan, insurance premiums (including Medicare premiums) are NOT an eligible expense for you to submit against your unreimbursed medical flex election.

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Frequently Asked Questions & Answers Regarding Flexible Benefits

Q. Can the money designated for Health Care Reimbursement be transferred to Dependent Care Reimbursement (or vice versa)?

A. No, the dollars you designate for each account are not transferable; they must be spent on expenses for the coverage they were designated for originally.

Q. How do I know what my Flexible Spending Account balance is?

A. Each time you use your plan, you will receive an Explanation of Benefits from Auxiant which shows the election (annual pledge), contributions to date, expenses to date, available contributions, unreimbursed expenses and payments to date. A sample claim form is included in this packet. In addition, all of this information is available on the Auxiant.com website under the AuxiantHealth link.

Q. What happens if I terminate employment during the plan year?

A. You will have an additional period of time (a run out period) after termination to submit claims for reimbursement but all claims must be incurred prior to your termination date. Please see your plan document or contact Auxiant with further questions.

Q. Can I be reimbursed for Orthodontia fees all at once if I pay the entire amount to the orthodontist up front?

A. No. The expense must be reimbursed as the expense is incurred. The down payment can be submitted up front, but the monthly payments must be submitted as each month's adjustment is incurred.

Q. Are expenses for before-school and/or after-school care eligible under the dependent care account?

A. Yes. If a child under the age of 13 receives before and/or after school care at school, you must separate the cost of the before and/or after school care from the cost of the school.

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Flexible Spending-Unreimbursed Medical Plan

Eligible Qualified Medical Expenses

"Qualified Medical Expenses" under your Flexible Spending Unreimbursed Medical plan are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners; they include the costs of equipment, supplies, and diagnostic devices needed for these purposes; they also include the amounts you pay for transportation to get medical care. They do not include expenses that are merely beneficial to general health, such as vitamins, gym memberships or a vacation. The complete detail can be found at: http://www.irs.gov/pub/irs-pdf/p502.pdf and http://www.irs.gov/pub/irs-pdf/p969.pdf. *Expenses for you, your spouse, or any tax dependent (claimed on your tax return) are eligible for reimbursement.*

Below is a list of examples of **Eligible Expenses** to provide some general guidance:

- Acupuncture
- Alcoholism Treatment
- Ambulance Hire
- Artificial Limbs
- Artificial Teeth
- Birth Control Pills
- Braces – can be reimbursed on a monthly basis or as payment amount made***
- Braille - Books & Magazines
- Car Controls for the Handicapped
- Care for Mentally Handicapped Child
- Chiropractors
- Christian Science Practitioners' Fees
- Co-Insurance amounts you pay
- Contact Lenses
- Cost of Operations & Related Treatments
- Crutches
- Deductible Medical Coverage Amounts You Pay
- Dental Fees
- Dentures
- Diagnostic Fees
- Drug and Medical Supplies
- Eyeglasses, Including Examination Fee
- Fee of Practical Nurse
- Fees for Healing Services
- Handicapped Person's Special Schools
- Hearing Devices & Batteries
- Home Improvements Motivated by Medical Considerations
- Hospital Bills
- Hypnosis for Treatment of an Illness
- Insulin
- Laboratory Fees
- Laetrile by Prescription
- Lasik Eye Surgery
- Life Fee to Retirement Home for Medical Care
- Medical Information Plan
- Medically Necessary Expenses that are not covered under your medical plan
- Membership Fees in Association with furnishing Medical Services, Hospitalization & Clinical Care
- Nurses' Fees (Including Nurses' Board & Social Security Tax Where Paid by Taxpayer)
- Obstetrical Expenses
- Operations
- Orthodontic Services (on a monthly basis or actual amount paid)***
- Orthopedic Shoes by Prescription
- Oxygen and Oxygen Equipment
- Physician Fees
- Physician-Recommended Swimming Pool or Spa Equipment Costs & Maintenance
- Psychiatric Care
- Psychologist Fees
- Mentally Handicapped Persons' Cost for Special Home
- Routine Physicals & Other Non-Diagnostic Services or Treatments
- Seeing-Eye Dog & Its Upkeep
- Special Diets
- Special Education for the Blind
- Special Plumbing for the Handicapped
- Sterilization Fees
- Surgical Fees
- Telephone, Special for Deaf
- Television Audio Display Equipment for the Deaf
- Therapeutic Care for Drug and Alcohol Addiction
- Therapy Treatments
- Transportation Expenses Primarily in the Rendering of Medical Service, *i.e.* Mileage to Hospital ($0.16.5 per mile) or Cab fare in Obstetrical Cases
- Vitamins by Prescription
- Wheelchair
- Wigs
- X-ray

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Examples of over-the-counter (OTC) items that are eligible for unreimbursed medical reimbursement as part of a flexible benefit cafeteria plan:

- Bandages
- Contact lens solution
- Physical Contraception (i.e. condoms)
- Incontinence Supplies
- First Aid Supplies
- Medications
- Menstrual Supplies

Examples of over-the-counter items that **are not eligible** for reimbursement as part of a flexible benefit cafeteria plan without a physician's prescription to treat a specific medical condition include:

- Chapstick or Lip Balm
- Cosmetics
- Cotton Balls
- Deodorant
- Dietary Supplements
- Face Cream or Moisturizers
- Fiber Supplements
- Food Items (Slimfast)
- Hair Removal Treatment and Waxes
- Herbs
- Shaving Creams and Razors
- Suntan Lotion
- Teeth Whitening Kits and Powders
- Toothpaste
- Vitamins (taken to improve overall-health)
- Weight Loss drugs for general well being

**ORTHODONTIC EXPENSES:

Orthodontia - Unlike other HCFSA expenses which are deemed incurred when the services are rendered, orthodontia expenses are deemed incurred when paid. Therefore, only payments made during your eligibility period and plan year may be reimbursed. Proof of payment to an orthodontic provider is required for reimbursement. Payments made toward orthodontia in a previous plan year or before your eligibility period are not reimbursable. This rule provides for two options for reimbursement. If a participant pays a lump sum up front then that payment can be reimbursed in full (provided the lump sum is paid during the same plan year from which reimbursement is requested and while the participant was covered under the plan). Second, participants that do not pay up front and opt for monthly payments can be reimbursed as those monthly payments are made (provided the monthly payment is paid during the same plan year from which reimbursement is requested and while the participant was covered under the plan). Again, **proof of payment is required.**

How Flexible Spending Works - Sample Cases

The Working Couple Raising Children

Pat, 30 and his wife, Nancy, 28, both have jobs outside the home. They have two small children. Pat and Nancy have an annual income of $48,000. This couple chose to use flexible spending to help pay both their unreimbursed medical/Dental expenses and their child care expenses. The couple saves $2536.05 annually with flexible spending.

The Couple with Grown Children

Steve, 45 and Laura, 42, have two children in college. The couple earns $54,000 per year. Steve and Laura chose to use flexible spending to pay for both of their unreimbursed medical and dental expenses. With Flexible spending, their take-home pay increased by $1136.85.

The Single Parent

Sarah, 27, is divorced and has two children. She earns $24000 per year. Her children attend a certified day-care center. Sarah uses Flexible Spending to pay for unreimbursed medical/dental expenses and childcare. Flexible spending increased her take-home pay by $1958.88.

	Working Couple Raising Children		Working Couple Grown Children		Single Parent	
	Without Flexible Spending	With Flexible Spending	Without Flexible Spending	With Flexible Spending	Without Flexible Spending	With Flexible Spending
Monthly Pay	$4,000.00		$4,500.00		$2,000.00	
Salary Reductions						
Medical/Dental Prem.	$0.00	$125.00	$0.00	$125.00	$0.00	$60.00
Medical/Dental OOP Exp.	$0.00	$200.00	$0.00	$200.00	$0.00	$100.00
Child Care Expenses	$0.00	$400.00	$0.00	$0.00	$0.00	$400.00
Adjusted Gross Pay	$4,000.00	$3,275.00	$4,500.00	$4,175.00	$2,000.00	$1,440.00
Payroll Taxes						
Federal & State	$860.00	$704.13	$967.50	$897.63	$430.00	$309.60
Social Security	$306.00	$250.54	$344.25	$319.39	$153.00	$110.16
Total Taxes	$1,166.00	$954.66	$1,311.75	$1,217.01	$583.00	$419.76
After Tax Pay	$2,834.00	$2,320.34	$3,188.25	$2,957.99	$1,417.00	$1,020.24
After Tax Expenses						
Medical/Dental Prem.	$125.00	$0.00	$125.00	$0.00	$60.00	$0.00
Medical/Dental OOP Exp.	$200.00	$0.00	$200.00	$0.00	$100.00	$0.00
Child Care Expenses	$400.00	$0.00	$0.00	$0.00	$400.00	$0.00
Total Post-Tax Expenses	$725.00	$0.00	$325.00	$0.00	$560.00	$0.00
Net Spendable Income	$2,109.00	$2,320.34	$2,863.25	$2,957.99	$857.00	$1,020.24
ANNUAL DIFFERENCE	**$2,536.05**		**$1,136.85**		**$1,958.88**	

Note: The above is for illustrative purposes only. Projections are based on current laws, using assumed wage amounts and benefit costs. Actual amounts will vary. Costs reimbursed may not be applied toward federal income tax credits or deductions. If legal or accounting advice is required, consult your personal tax advisor.

REMEMBER: BE CONSERVATIVE

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Expense Planning Worksheet

This worksheet will help in determining how much money to put into your Flex Account each pay period.

1. Estimate your un-reimbursed medical costs for:

Health insurance deductibles	$ _____	Per _____
Co-insurance	$ _____	per _____
Vision care (eye exams, contacts, glasses)	$ _____	per _____
Routine exams (OB-GYN, physicals, etc.)	$ _____	per _____
Travel costs related to medical care	$ _____	per _____
Prescription drugs (including birth control)	$ _____	per _____
Wheelchair, crutches, medical appliances	$ _____	per _____
Other	$ _____	per _____

2. Estimate your un-reimbursed dental costs for:

Examinations and cleanings	$ _____	per _____
Braces and retainers*	$ _____	per _____
Fillings, crowns, and bridges	$ _____	per _____
Dentures, including replacements	$ _____	per _____
Implants, inlays, S-rays	$ _____	per _____
Fluoride treatments	$ _____	per _____
Other	$ _____	per _____

*Ortho in a calendar year=Initial down pymt + monthly adjustments in that year.

3. Estimate your Dependent Care Expenses:
If you are a single parent, or your spouse also works outside the home, how much do you pay for childcare? (Including before and after school care for school-age children). This amount cannot be more than the smallest of:

$ _____ per _____

1. Your earned income*
2. Your spouse's earned income*
3. $5,000 ($2,500 if married filing separately)

Earned income includes wages, salaries tips, other employee compensation and net earnings from self-employment. Earned income also includes strike benefits and any disability pay you report as wages. Earned income does not include pensions or annuities, social security payments, workers' compensation, interest, dividends, or unemployment compensation.

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Flex Spending Account Claim Form

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This request is for reimbursement of:

☐ Medical Care Expenses (Complete parts A, B, and D)
☐ Dependent Care Expenses (Complete C and D)

☐ **MARK IF CHANGE OF ADDRESS**

Name		Member ID	
Address		City, State Zip	
Employer	**Independence Community School District**	Date Submitted	
E-mail		Phone	

A. MEDICAL EXPENSE INFORMATION

1. EXPENSES (attach bills, statements, or other evidence of these expenses) *

DATE OF SERVICE	VENDOR NAME:	PATIENT NAME:	TYPE OF SERVICE PROVIDED	AMOUNT
**** Canceled check is not sufficient evidence***			Total expenses	

2. TOTAL EXPENSES = _____

B. SPOUSE AND DEPENDENT INFORMATION * (If expenses were for your spouse or dependent)

Name	*Date of Birth*	*Relationship*

* Your spouse is the person to whom you were married at the end of the Calendar year. Your dependents are your child, Step child, parent, other close relative, or a person who lives in your home, if you provide over half of his/her support, and they are claimed as a dependent on your Federal Tax Return.

C. DEPENDENT CARE (CHILD CARE) INFORMATION (*Required unless provider is non-profit organization)*

DEPENDENT NAME**	AGE	DATES OF SERVICE	PROVIDER NAME and ADDRESS	PROVIDER'S TIN or SSN	REQUESTED AMOUNT

Signature of Daycare Provider _____

**Care for Dependent Children under the age of 13 are eligible for Dependent Care reimbursement, unless *Special Rules* apply.

D. MEMBER SIGNATURE REQUIRED

I certify that the expenses listed above qualify for reimbursement and have been incurred by eligible members of my family. These expenses have not been reimbursed by my health care plan or any other health care plan such as my spouse's. Bills, statements or other evidence of these expenses are attached. In claiming reimbursement for dependent care expense, I understand the reimbursements may not exceed the lesser of:(a) $5,000 if married filing joint return or head of household or $2,500 if single or married filing separate returns; or (b) your taxable compensation; or (c) your spouse's actual or deemed earned income. I certify that if single or married, (my spouse and I) will not receive reimbursements in excess of allowable limit.

Signature _____ Date _____

Send Claims to: ATTN: Flex Department
AUXIANT, P.O. Box 75008, Cedar Rapids, IA 52407-5008
PHONE: (319) 398-3283 or (800) 475-2232 Fax (319) 739-1109

Dependent Childcare Annual Request Form 2020-2021
For "Standing Request Reimbursement"

Employee Information:

Employer _____

Employee _____ SSN _____
Last First Middle

Address: _____
Street City State Zip Code

Phone Number (____) _____

Eligible Dependents: _____

_____

Daycare Provider Information:

Name _____ Tax ID _____

Address _____
Street City State Zip Code

Phone Number (___) _____

Standard Fee $_____ per [] Week [] Month
[] Other* _____
*(may require additional information)

Service Effective Date: _____ thru _____

(Only service dates between **07/01/2020 and 09/14/2021** are eligible for reimbursement during the **2020-2021** plan year. This form must be filled out every plan year in order to receive standing reimbursement.)

Daycare Provider's Signature _____ Date _____

I certify that the above information is correct. In the event that there are any changes and/or reductions in the above fees, I will notifyAuxiant immediately to discontinue automatic reimbursement until such time that I deliver new documentation for my amended Annual Request.

Employee's Signature _____ Date _____

Note: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. If your spouse is either a full-time student or is incapable of taking care of themselves, then they are deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes or is your child or stepchild and is under age 19.

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Direct Deposit Form:

Employer: _____

Employee: _____

Social Security#: _____

Address: _____

City: _____

State: _____ Zip: _____

I wish to receive my flexible spending reimbursements by Direct Deposit. I hereby authorize Auxiant to originate electronic credit transactions to my bank, credit union, or savings and loan account indicated below and to credit the same to such account. If necessary, Auxiant may make deductions from my account for any payments credited to my account in error. This authority is to remain in full force and effect until Auxiant has received written notification from me of its termination in such time as to afford Auxiant and my bank a reasonable opportunity to act on it.

Bank: _____

Routing #: _____

Account #: _____

Type: ☐ Checking ☐ Savings

Signature: _____ Date: _____

Is this a change to a current authorization? ☐ Yes ☐ No

Please attach a voided check to this form for verification of routing and account numbers.

Send completed forms to:
Auxiant
Attn: Flexible Spending Department
P.O. Box 75008
Cedar Rapids, IA 52407-5008

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Independence Community School District

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FLEXIBLE BENEFIT CAFETERIA PLAN (SECTION 125)
Enrollment Agreement/Affidavit

ENROLLMENT INFORMATION: Expense Period – July 1, 2020 through June 30, 2021

Name_____ Member ID_____ Date of Birth_____

Address_____City_____State_____Zip_____

Date of Hire_____ Date of Eligibility _____Pay Cycle: **M (monthly)**

By enrolling, I understand that:

1. If at the end of the expense period, the total declared reduction in compensation exceeds the substantiated expenses, the IRS requires that any unused amount become the property of the employer and may not be paid to me in cash or used to provide benefits in a later plan year.
2. I can no longer deduct these expenses from my individual State and Federal income tax returns since they will be paid with non-taxed income.
3. I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse or such other events as the Plan Administrator determines will permit a change or revocation of an election).
4. The Plan Administrator will deduct any additional premium during the plan year if my fixed premium amounts increase.
5. The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event it is believed advisable in order to satisfy certain provisions of the Internal Revenue Service Code.
6. This reduction in my taxable wage base will reduce my wages for Social Security purposes and may reduce Social Security benefits to be paid at death, retirement, or disability. I agree to hold harmless the Administrator and its representatives for any loss of Social Security Benefits, which is a result of participation in the Section 125 Plan.
7. ***Total Annual Maximum Election amount allowed for the Unreimbursed Medical Expense Plan is $2,750.00.***

Yes, I want to enroll. This agreement is subject to the terms of the Plan Document for the above named Flexible Benefit Cafeteria Plan, in effect and as amended from time to time, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation redirection agreement relating to such plan(s). Under penalties or perjury, I certify that I have examined this affidavit and to the best of my knowledge and belief, it is true, correct and complete.

Employee's Signature: _____Date: _____

PARTICIPATION/REDUCTION AMOUNTS: I hereby authorize **Independence Community School District**, hereinafter referred to as the Plan Administrator, to reduce my gross monthly wages on a pre-tax basis by the amounts stated below for the above expense period. Each of the amounts indicated are reimbursable and satisfy the requirements of the Section 125 Flexible Benefit Plan.

Annual Election Amounts

A. Unreimbursed Medical $_____ (Maximum $2750) *Divide by 12: $_____per pay period*

C. Dependent Care $_____ (Maximum $5000) *Divide by 12: $_____per pay period*

Annual amounts will be broken down by pay period and may be rounded to not exceed the maximum listed, if necessary.

Automatic Claims Rollover Election: *This option may be elected if Auxiant is providing administration for your Medical and/or Dental plan though this employer. If you elect Automatic Claims Rollover, the claims that go to the medical/dental plan that are subject to deductible and coinsurance can automatically be "rolled over" into your Flex plan for reimbursement.* ***If you are not enrolled in Auxiant insurance or have additional insurance coverage outside of this employer's plan, automatic claims rollover CANNOT be elected.*** *Drug copays and office visit copays do not automatically roll over.*

If you have Auxiant insurance though this employer and *do not* have additional insurance coverage outside this employer's plan, you have the option to mark "Yes" to Automatic Claims Rollover.

Do I want Automatic Claims Rollover (If left blank it is an automatic No) (circle one): Yes No

No, I don't want to enroll in Flex. I acknowledge that I have been informed of the above referenced plan. I hereby elect not to participate. I understand that this waiver will remain in effect for the remainder of this plan year, but that I may decide to participate in later plan years by making an election to participate during the election period prior to each plan year.

Employee's Signature: _____Date: _____