Village of Bayside

Flexible Spending Account (FSA) Important Plan Information

Please review the following information in preparation for your FSA enrollment!

Upcoming FSA Plan Year: 01/01/2020 - 12/31/2020

Run-Out Period: You have until 02/29/2020 to **submit** claims for expenses incurred during the ***current*** Plan Year.

FSA Carry Over Your FSA Plan allows you to carry over up to $500.00 of unused funds from your current Plan Year Health Care FSA to be spent in the new Plan Year.

Maximum Election Amount: Health Care FSA: $2,750
Dependent Care FSA: $5,000

(Note: Group insurance premiums are deducted pre-tax automatically. Contact your employer's benefits representative if you have questions.)

FSA Deductions: 27 FSA Deductions
(Your plan year election will be divided by the number shown above.)

Reimbursement Schedule: Eligible claims received Friday by noon will have reimbursements released the following Friday.

Reimbursement Method: **Mandatory Direct Deposit** New participants – If enrolling online, please have your bank account and routing numbers available when enrolling. If you are enrolling via paper, complete a direct deposit form and attach a voided check with your FSA Enrollment Form.

Email Claim Notifications: Email notifications will be sent to inform you of claims received, reimbursements issued or requests for additional information needed to process your claims. By providing your email address when you enroll, you will automatically receive these notifications.

Online Account Access: You may view account details including balance, claims and reimbursements and also access claim forms via the DBS website at **www.dbsbenefits.com.**

You will need the following PIN # to create an online account if you have not done so already: **VOB**

Enrollment Method:

Enroll online	See attached enrollment instructions.
or	
Paper enrollment	Please return the completed enrollment form to your benefits representative by the deadline date below.

Deadline to Enroll: 12/6/2019

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Flexible Benefit Plan Online Enrollment Instructions

To enroll online you will need an A.S.A.P.® (Advanced Strategic Administration Program) account. If you already have an account please skip to the 'How to Enroll' section below.

How to Create an A.S.A.P.® Account:

1. Logon to the DBS website at DBSbenefits.com
2. Select '**User Login**' located at the top right of your screen.
3. Select '**Create New Account**' and enter the employer PIN: **VOB**
4. Enter the required account information and select 'Submit'. Your online account will be created and you may now complete the online enrollment.

How to Enroll:

1. Enter the **Login Name** and **Password** you created when setting up your online A.S.A.P.® account and click **'Login'**.
2. Select the **1/1/2020 – 12/31/2020** plan year on the top of the screen and then select **'Enrollment'** from the menu bar.
3. Complete the enrollment information as asked for on the online enrollment form.
4. Direct Deposit of claim reimbursements is a requirement of your plan. You will need to complete the bank account information section of the online enrollment form in order to submit your enrollment. If you are a current FSA participant, your current bank information will auto-fill on the screen. You can update banking information or proceed with the current information.
5. Review the '**Legal Terms**' and check the box if you agree to the stated terms (required in order to enroll).
6. Next click on the red **'Click Here to Submit Enrollment'** button. A window will pop up confirming you have successfully enrolled and providing the details of your enrollment.
7. You will have an option to print the enrollment form by clicking on the **'Print Your Enrollment'** box.
8. When finished click on the **'Logout'** link at the top of the page.

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Flexible Benefit Plan Enrollment Form

Please Print

Employee Name _____ Social Security # _____-_____-_____

Home Address _____

City _____ State_____ Zip _____

Daytime Telephone _____ Email _____

Employer Name _____ Branch/Location _____

Benefit Plan Year: _____/_____/_____ to _____/_____/_____ Number of Payroll Deductions: _____

Date of First Deduction: _____/_____/_____ Effective Date: _____/_____/_____

Health Care FSA (HCFSA)

I elect $ _____ x _____ = $ _____ for reimbursable medical expenses for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

Dependent Care FSA (DCFSA)

I elect $ _____ x _____ = $ _____ for reimbursable dependent care expenses for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

Waiver

☐ I do not want to participate in the Flexible Benefit Plan (areas listed above). My employer has offered me the opportunity to enroll and I am declining to participate for the above plan year.

I understand that my employer will deduct my election in equal amounts from my paycheck throughout the plan year. If at the end of the plan year the total declared reduction in my compensation exceeds the substantiated expenses, I understand that unused funds may become the property of my employer depending on the provisions of the plan. I also understand that I will have an opportunity to make a new election, if I so desire, prior to the beginning of each subsequent plan year, in accordance with the procedures described in the Plan Document. By affixing my signature below, I certify that I have examined this Agreement and understand and agree to comply with the terms of the plan and applicable code sections of the Flexible Benefit Plan. All amounts listed will be incurred (meaning having a date of service) within the Flexible Benefit Plan Year. I also understand that Diversified Benefit Services, Inc. is not engaged in giving tax or legal advice and that I have consulted with my tax accountant on the appropriateness of the plan for me. I also understand that my monthly Social Security retirement benefit, if I receive one, may be reduced slightly by contributing pre-tax dollars to a Flexible Benefit Plan. Also, by providing an electronic mail address (email), consent is given to receive unencrypted information regarding my FSA reimbursement account, including claims and personal health information, in electronic form at the e-mail address provided.

Employee Signature _____ Date _____

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Direct Deposit Application

Participant Information (please print):

Employer Name: _____

Participant Name: _____ Last Four Digits of SS#: ☐☐☐☐

Participant Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

Check Box for New Account/Change/Cancel (please select one):

☐ New Account ☐ Change Account ☐ Cancel Direct Deposit

Participant Banking Information:

I would like my Flexible Spending Account (FSA) reimbursements to be deposited to the account listed below:

Financial Institution: _____

Routing # (nine digits): _____ (is usually between the ⑆ symbols on your check)

Account #: _____ (is usually between the ⑈ symbols on your check)

Account Type:

☐ Checking (attach a voided or cancelled check)

☐ Savings (Please DO NOT attach a deposit slip. Most deposit slips have the bank's *internal* routing number. Please obtain the proper routing number from your financial institution.)

Please Read the Terms and Sign Below

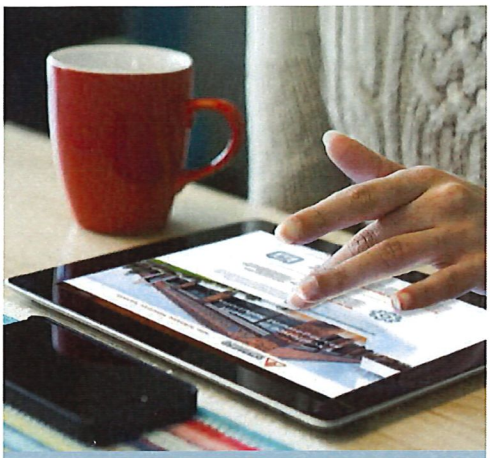
I hereby authorize Diversified Benefit Services, Inc. (DBS) to reimburse amounts owed to me by initiating credit entries to my account at the financial institution listed above. Additionally, I hereby authorize the financial institution to accept and to credit any credit entries initiated by DBS to my account. I acknowledge and agree that in the event DBS deposits or credits funds incorrectly to my account, and/or in the case of an overpayment (fraudulent, inadvertent, or otherwise), I authorize my employer to debit my account for an amount not to exceed the original amount of the incorrect credit. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor. I understand that DBS is responsible for the successful transaction of funds into my account. I agree to hold DBS harmless from loss and to indemnify DBS, limited to the amount of the deposit.

Any dispute arising out of or in connection with this agreement, if not resolved through other methods, shall be determined in accordance with the laws of the State of Wisconsin.

This authorization is to remain in full force and effect until my employer and financial institution have received written notice from me of its termination. The written notice shall be delivered in such a manner as to afford my employer and financial institution reasonable time to implement the change.

Participant Signature: _____ **Date:** _____

Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
(262) 367-3300, (800) 234-1229
Fax (262) 367-5938
DBSbenefits.com



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Claims Filing
Options that meet your needs.

Why file online?

- **Fast**
  There's no quicker way to get reimbursed for your FSA or HRA claims.
- **Convenient**
  Day or night, on your favorite device, go online and get account information.
- **Safe**
  You have encrypted Internet access to the site, which is protected and Verisign secured.
- **Comprehensive**
  View account balance and activity.

DBSbenefits.com

File Online—it's fast, convenient and secure

Using your laptop or PC, you can submit your claims online 24/7. DBS's exclusive A.S.A.P.® (Advanced Strategic Administration Program) is a safe and quick way to see claim information and get reimbursed from your Health Care FSA (HCFSA), Dependent Care FSA (DCFSA), Limited Purpose FSA (LPFSA), or Health Reimbursement Arrangement (HRA).

1. Login to your online account at DBSbenefits.com
2. Select the Benefit Plan Type (FSA, HRA)
3. Select "Claims > Claims View/Submit > Submit"
4. Complete the required information
5. Attach an image with supporting documentation (.pdf or .jpg)
6. Submit

File on the go—use our Mobile Phone App

Filing using your smartphone or tablet is simple.

1. Login using your A.S.A.P.® name and password, click "File a Claim"
2. Take a picture or use an existing photo, click "Attach Image"
3. Select the Benefit Plan Type
4. Enter dollar amount, answer questions, click "Submit"

Visit your favorite app store to download.

ANDROID APP ON Google play Available on the App Store

File via mail or fax

More traditional filing is available, too.

1. Download a claim form at DBSbenefits.com
2. Select the "Participant Resources Tab > Forms"
3. Complete the form and attach copies of your documentation
4. Mail to Diversified Benefit Services, P.O. Box 260, Hartland, WI 53029
5. Or fax to 262-367-5938

For assistance, please call DBS at **(800) 234-1229**
or visit **DBSbenefits.com**

Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
(800) 234-1229

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Flexible Benefit Plan Expense Worksheet

Use this worksheet to estimate your expenses. Plan Year: _____/_____/_____ to _____/_____/_____

Dependent Care FSA

Consider what expenses you will have in the next plan year for dependent care such as day care, adult care, etc. to allow you or your spouse to work or attend school full time. This is for dependents under the age of 13, adult dependents or other legal dependents.

Total Annual Amount $_____

Health Care FSA

Consider what expenses you and/or your spouse and legal dependents will have during the upcoming plan year that will not be paid for by insurance. Also look at what expenses you had during the past year or two and give a conservative estimate for what they might be for the upcoming plan year.
(Expenses must be incurred, this means having a date of service—not paid for—during the plan year.)

Health insurance deductible (not including premiums) $_____

Co-pays for medical expenses $_____

Dental insurance deductible $_____

Dental expenses such as exams, cleanings, fillings, caps, crowns, braces, bridges, x-rays, etc. $_____

Vision expenses such as exams, glasses, frames, contact lenses, supplies or LASIK surgery $_____

Hearing aids (including batteries) $_____

Prescription drugs $_____

Over-the-counter (OTC) drugs such as allergy and anti-inflammatory drugs, cold and flu medications, muscle relaxants, pain relievers, cough suppressants and acid reflux medications (OTC drugs require a prescription number) $_____

Other expenses (see additional expenses below) $_____

Total Annual Amount $_____

Additional Eligible Expenses for the Health Care FSA

- Acupuncture
- Alcoholism treatment
- Ambulance service fee
- AODA assessment
- Artificial teeth—medically necessary
- Artificial limbs
- Bandages
- Birth Control by prescription (and/or over-the-counter contraceptives)
- Braces
- Braille—books and magazines
- Breast pump and supplies
- Car controls for the disabled
- Care for mentally handicapped child
- Chiropractic expense
- Co-insurance amounts you pay
- Contact lenses
- Contact lens solutions and enzyme cleaners
- Cost and repair of special telephone equipment for the hearing-impaired
- Cost of medically necessary operations and related treatments
- Crutches
- Dental fees such as X-rays, cleanings, exams or crowns
- Dentures
- Diabetic supplies
- Diagnostic fees
- Disposable contact lenses
- Eye examinations
- Eyeglasses
- Fee for in-home practical nurse
- Hearing aid devices and batteries
- Hospital services
- In-patient treatment expense for drug and alcohol addiction
- Insulin
- Kera Vision Intacs surgery
- Laboratory fees as prescribed by a physician
- LASIK surgery
- Mammograms
- Medical deductibles
- Medical services
- Medical supplies (medically necessary)
- Mentally handicapped person's cost for special home nursing services for in-home care (including nurses' meals and Social Security tax)
- Mileage for medical care
- Obstetrical expenses
- Organ donor transplant medical expense payments for surgical, hospital, laboratory and transportation expenses
- Orthopedic inserts
- Osteopath fees
- Oxygen and medically necessary oxygen equipment
- Physician fees
- Physician-prescribed swimming pool or spa equipment costs and maintenance due to medically necessary reasons
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Radial keratotomy
- Routine physicals
- Seeing eye dog and its upkeep
- Smoking cessation programs (by prescription only)
- Special education for the blind
- Special plumbing for the handicapped
- Special school for mentally impaired or physically disabled person
- Sterilization fees
- Surgical fees
- Television audio display equipment for the hearing-impaired
- Therapy treatments for medically necessary reasons
- Transportation expenses primarily for and essential to rendering special medical services as prescribed by a physician
- Vitamins and nutritional supplements (with pre-approved letter of medical necessity from physician)
- Weight loss program fees (with pre-approved letter of medical necessity from physician)
- Wheelchair
- X-rays

Expenses NOT Eligible for Reimbursement

Surgery for cosmetic reasons

Medical supplies that are not medically necessary

Teeth bleaching/bonding/whitening

Health club membership dues

Over-the-counter vitamins and other dietary supplements for general health purposes

Cosmetic drugs

Marriage counseling

Group insurance premiums deducted from your paycheck

Your Estimated Plan Year Savings

Total plan year elections for the above categories: $_____

Multiply by approximately 30% (estimated tax savings): x 30%

This is your estimated tax savings for the plan year: $_____

(Your savings may be different due to your effective income tax rate)

Note: If further verification is needed regarding whether an expense qualifies, please call our office at (800) 234-1229. Consult your tax advisor for maximum benefit. It is understood that Diversified Benefit Services, Inc. is not engaged in the practice of law or giving tax advice.