Flexible Spending Account

FSA/BENNY CARD

Available Programs:

Unreimbursed Medical
Dependent Care

Flexible Spending Account Info

County Authorized Benny Card

- Funds available after 1st payroll date of new election effective date _____ for unreimbursed medical expenses
- Minimum of $10.00 per pay period or up to a maximum $2,750 annual contribution limit
- All benefits opted by employee are withheld pre-tax to provide substantial tax savings to participants
- Cover medical, dental and vision out of pocket expenses on your dependents!
- Complete 125 Cafeteria Plan form/Online enrollment
- $570 Roll-over! 90 days to claim expenses from rollover funds after year end.

Examples of annual savings

$500 Annual Expenses at 22% Tax Rate – Save $110 Annually

Calculate how much more money you could take home when you use a pre-tax benefit.

Save $9 monthly/$110 annually with a Healthcare FSA

These figures represent potential savings only and should be used only for estimating your annual Healthcare FSA contribution.

YOUR ESTIMATED...	
Estimated Tax Rate	22%
Estimated Monthly Eligible Expenses:	$42

$2500 Annual Expenses at 28% Tax Rate – Save $698 Annually

Calculate how much more money you could take home when you use a pre-tax benefit.

Save $58 monthly/$698 annually with a Healthcare FSA

These figures represent potential savings only and should be used only for estimating your annual Healthcare FSA contribution.

YOUR ESTIMATED...	
Estimated Tax Rate	28%
Estimated Monthly Eligible Expenses:	$208

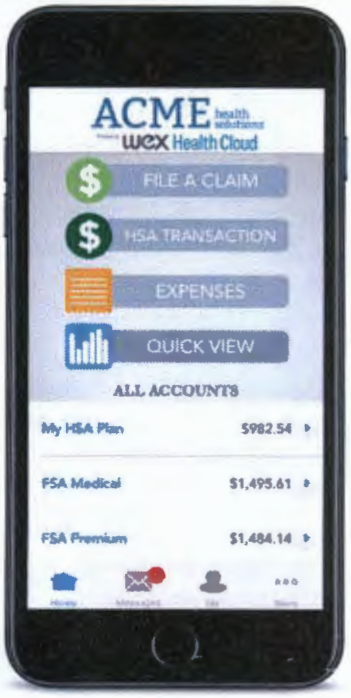
How to use your FSA

- While you can't use your FSA for insurance premiums, you can use it for copayments, coinsurance, deductibles, prescription medications, and dental and vision care, according to the IRS.
- List of eligible expenses available.

Easy Access to FSA Balance

Quick access to your balance, claim notices and file required receipts.

Go to your App store for iPhone or Android, search BC Flex



Keep and submit your receipts to Boon Chapman flex department

- **You are required to submit receipts for Benny Card transactions that are not regular co-pays. Basically submit receipts for every purchase that is not a co-pay.**
- **Receipts are used to verify a qualified expense and should contain following information:**
  - **VENDOR**
  - **PATIENT NAME**
  - **DATE OF SERVICE**
  - **SERVICE DESCRIPTION OR DIAGNOSTIC CODE**
  - **SERVICE CHARGE**

Your card could be suspended until expense is resolved.

FSA – DEPENDENT CARE EXPENSE AVAILABLE

- The dependent care FSA limit is $5,000 Annually.
- Benefits of a **Dependent Care FSA**. The IRS limits the total amount of money you can contribute to a **dependent care** to $5,000 each year for married couples filing jointly, unmarried couples, and single individuals, and $2,500 if you are married and filing separately.
- **Dependent Care** Flexible Spending Accounts have a **use it or lose it** rule. You may be able to be reimbursed for expenses incurred up until December 31.
- Dependent Day Care Reimbursement Request Form must be completed along with Affidavit by provider

FSA – DEPENDENT CARE EXPENSE

- Expenses will be reimbursed only **after** the care has been provided, and not when you, the participant, are formally billed, charged for, or pay for the dependent care.
- The expenses must be incurred by you during a period when you have a dependent or spouse who is a qualifying individual which is either:
  - * A dependent under age 13 for which you are entitled to an income tax deduction; or
  - * A dependent or spouse, regardless of age, who is incapable of caring for him/herself, spends 8 hours a day in your household.
- The expense must be for the care of the 'qualifying individual', which you incur to enable you (and, if applicable, your spouse) to be gainfully employed.
- If the expenses are for services provided outside your household, at a Dependent Day Care Center that provides care for at least 6 non-residents, it must:
  - * Comply with all state and local laws;
  - * Charge a fee for providing the services.

Enroll online or Cafeteria Plan form.

BOON-CHAPMAN

Manage your healthcare accounts from the palm of your hand.

Want to check your healthcare account balances and submit receipts from anywhere? There's an app for that! Boon-Chapman lets you easily and securely access your health benefit accounts, submit claims and upload receipts at any time. You have quick access to common tasks[1] with an easy-to-use design that helps make sense of your health and financial information.

Stay up to speed

With **Boon-Chapman**, you can get to the healthcare account information you need—fast. Wondering whether you have enough money to pay a bill or make a purchase? The **BC Flex** Mobile Application puts the answers at your fingertips.

- Quickly check available balances and account details for medical and dependent care FSA, HSA, HRA, VEBA, transportation and premium reimbursement plans
- View charts summarizing account information
- Set account alerts and get notifications via text message
- View claims requiring receipts
- Link to an external web page to obtain helpful information such as a list of eligible expenses
- Retrieve a lost username or password
- Use your device of choice – including iPhone®, iPad®, iPod touch® and Android™ smartphones and tablet devices

Tap and take action

Make a payment, capture a receipt or take any number of actions – whether you're on the couch or waiting in line. With The **BC Flex** Mobile Application you can get it done fast and enjoy the rest of your day:

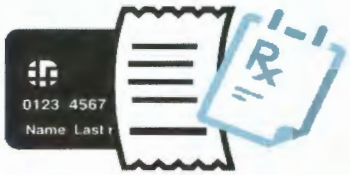
- Submit claims for medical and dependent care FSA, HRA, VEBA, transportation and premium reimbursement plans
- Snap a photo of a receipt and submit with a new or existing claim, or store in your camera roll for later use in claim filing
- Request a distribution from an HSA account
- Contribute funds to an HSA account
- Access your account funds to pay yourself or someone such as doctor
- Add and store information on new payees
- Enter and view expense information and receipts
- Report a debit card as lost or stolen

[1] Some functionality listed may require additional products or services.

Imagine what you could do with BC-Flex Mobile Application

Get Reimbursed Quickly

Let's face it – no one *really* likes to visit the doctor, dentists, pharmacy or other healthcare provider. But sometimes you do and you may forget to use your health benefits card. So, when you pay for a qualified medical expense using your own money, you want to maximize your dollars and be reimbursed from your pre-tax account. File a claim with a receipt or request a distribution from your HSA soon after it happens. Right



Track Receipts

Why is it that the one receipt you need is always the one you can't find? With The **BC Flex** Mobile Application, you can record a health expense and capture the receipt the moment the transaction happens. That's peace of mind with a touch of a button.

Check Balances

Wondering whether you can pay for an elective procedure or a mounting bill? Do a quick account check to see your current balance. No need to wait for an answer – it's right at your fingertips.

Get started with The BC Flex Mobile Application in minutes.

Download on the App Store

ANDROID APP ON Google Play

Download the BC Flex app for your chosen device from the Apple App Store or Google Play and log in using the password you use to access the Boon-Chapman consumer portal.

(Initial login must be done via Flex consumer portal to access app.)

Look for this in your APP Store

BOON-CHAPMAN

SECTION 125 FLEX

HEALTH CARE REIMBURSEMENT REQUEST FORM

Mail, Fax or e-mail claim forms to:
Boon-Chapman
P.O. Box 9201
Austin, TX 78766
(800) 252-9653 Phone
(512) 459-1552Fax
flex@boonchapman.com

A. INSTRUCTIONS

- COMPLETE ALL SECTIONS (B,C, AND D) FOR CHARGES TO BE CONSIDERED FOR REIMBURSEMENT.
- IF EXPENSE IS COVERED BY INSURANCE, SUBMIT TO APPROPRIATE CARRIER.
- ATTACH EXPLANATION OF BENEFITS (EOB) FROM THE INSURANCE CARRIER OR CO-PAY RECEIPTS.
- IF YOU ARE SUBMITTING AN ITEMIZED BILL ONLY, INDICATE WHY THIS BILL HAS NOT BEEN PAID BY YOUR INSURANCE PLAN
- ITEMIZED BILLS SHOULD INCLUDE THE FOLLOWING:
  * PROVIDER NAME & ADDRESS * PATIENT NAME * ITEMIZED CHARGES * DATE OF SERVICE * TYPE OF SERVICE
- CANCELLED CHECKS, NON-ITEMIZED RECEIPTS AND BALANCE DUES ARE **NOT ACCEPTABLE** PROOF OF EXPENSES.

B. EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY #	COMPANY NAME	NEW ADDRESS **(CIRCLE ONE)** YES NO	**PLAN YEAR**
LAST NAME	FIRST NAME	EMAIL ADDRESS	
ADDRESS	CITY	STATE	ZIP CODE

C. HEALTH CARE EXPENSES

PLEASE INDICATE IF YOU HAVE THE FOLLOWING TYPES OF COVERAGE: **(CIRCLE ONE)** DENTAL COVERAGE? YES NO
MEDICAL COVERAGE? YES NO
VISION COVERAGE? YES NO

***IF YES, PLEASE BE SURE TO PROVIDE AN EXPLANATION OF BENEFITS (EOB) OR CO-PAYMENT RECEIPT.**

PATIENT NAME	RELATIONSHIP	TYPE OF SERVICE PROVIDED	DATE OF SERVICE	REIMBURSEMENT REQUEST AMOUNT
			Total	

D. CERTIFICATION

I CERTIFY THAT THE EXPENSES FOR WHICH I AM REQUESTING REIMBURSEMENT MEET ALL OF THE FOLLOWING CONDITIONS:

- They were incurred for services or supplies by me or my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date of my employee spending account.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

EMPLOYEE SIGNATURE *(REQUIRED)*	DATE

BOON-CHAPMAN
P.O. Box 9201 / Austin, TX. 78766
512-454-2681 / Fax 512-459-1552

125 CAFETERIA PLAN CHANGE IN STATUS FORM

Section I – Participant Data

Employer Name: Victoria County

Participant Name: _____ SSN: _____

Participant Address: _____

City: _____ State: _____ Zip: _____

Section II – Payroll Changes

Please change my deduction **(per pay period)** as follows: Py effective date: _____

	Current	Revised	YTD Deduction Before Change
Medical Premium:	$ _____	$ _____	$ _____
Voluntary Dental:	$ _____	$ _____	$ _____
Voluntary Vision:	$ _____	$ _____	$ _____
Unreimbursed Medical:	$ _____	$ _____	$ _____
Dependent Care:	$ _____	$ _____	$ _____
Administrative Fees (if applicable):	$ _____	$ _____	$ _____
Other _____	$ _____	$ _____	$ _____
TOTAL	$ _____	$ _____	$ _____

Section III – Change in Status

The participant has incurred a status change during the current plan year due to the following reason: (circle one)

Marriage	Divorce	Birth or Adoption of Dependent
Death	Leave of Absence	Return from Leave of Absence
Retirement	Dependent Begins Working	Dependent Ends Working
Change from Part Time to Full-time	Change from Full Time to Part Time	Lay Off or Termination
Change in Insurance Coverage	Eligibility for Medicare/Medicaid	Dependent ceases to satisfy Dependent eligibility
Change in dependent Care Provider	Child is 13 and not eligible for Dependent Care	

Other: _____

Date the above status change took place _____. **A participant making a new election under this Section must do so within 30 days of the event. Only changes that are made on account of and consistent with the event are allowable.**

Section IV – Date of Change

The first Pay Date the new election amount will be deducted _____/_____/_____.

Section V – Verification Statement

I verify that I have read and understand the information on this page and that it is true and correct to the best of my knowledge. I understand that this information will be submitted to Boon Chapman.

_____ _____

Participant's Signature & Date Accepted by Plan Administrator & Date