Flowing Wells Unified School District

Flexible Benefits

Employee Information Packet

2016-2017 Plan Year

UNDERSTANDING FLEXIBLE BENEFITS

Flexible Benefits started when Congress passed Section 125 of the Internal Revenue Code in 1978. Section 125 allows a certain amount, estimated for a given year, to be deducted directly from your paycheck and claimed for reimbursement when used for qualified expenses. These deductions are taken before taxes, reducing your total taxable income.

Example: Mary is single with three children and Mary earns $3,000 per month. She pays $125 a month in childcare expenses and $25 a month for prescriptions. The calculations below show how much Mary will save by participating in the Flexible Benefit Plan her company offers.

With Flexible Benefits		Without Flexible Benefits	
$3,000	Gross Wages	$3,000	Gross Wages
-150.00	FSA Expenses	-332.00	Federal Tax
$2,850.00	Taxable Income	-90.00	State Tax
-295.00	Federal Tax	-229.50	Soc Sec/Medicare
-85.55	State Tax	$2,348.50	Net Income
-218.02	Soc Sec/Medicare	-150.00	Expenses
$2,251.43	Mary's Net Income	$2,198.50	Mary's Net Income

****MARY WILL SAVE $52.94 EACH MONTH AND $635.15 A YEAR BY PARTICIPATING.****

Healthcare Reimbursement

Healthcare Reimbursement enables you to deduct medical, dental and vision expenses before taxes, up to the maximum annual amount set by your employer. A claim is then filed to receive reimbursements for the expense(s). Eligible expenses include, but are not limited to, charges for medical, dental or vision office visits, prescription drugs, x-rays, laboratory work, orthodontia, periodontics, bridges, crowns, eye exams, glasses, contacts, LASIK eye surgery, ambulance and emergency room fees, diabetic supplies and many other products and services. A more complete list of eligible and ineligible items can be found later in this packet.

Dependent Care Reimbursement

Dependent Care Reimbursement enables you to deduct childcare (day care) or elder care expenses before taxes, up to a maximum of $5,000 per year per family or $2,500 if married filing separately. A claim is then filed to receive reimbursement for the expense(s). Eligible expenses include charges for before and after school care or programs, babysitting, day care, summer camps and elder care.

The following rules apply:

- You must provide documentation for the expense with a receipt showing the date(s) of service, amount charged and the provider's name and federal tax ID or SSN
- A dependent must be under the age of 13 or disabled (any age).
- The service must be provided while you and your spouse work or attend school full-time.
- Expenses cannot exceed the lower income of either spouse.
- If using a day care center, it must be licensed.
- Babysitting services provided by a relative under age 19 are ineligible.
- Overnight camps are not eligible.

PROCEDURES & SERVICES

- All expenses for the Plan Year should be conservatively estimated. Any funds left in the account at the end of the grace period for the Plan Year will be forfeited back to your employer.

- During Open Enrollment for each new Plan Year, you will be given the opportunity to participate in the Plan. Elections are not carried over from year to year; **you must re-enroll.**

- Your election cannot be changed during the Plan Year unless there is a change in status that is a qualifying event. All changes must be consistent with your new election choice and must be made within 30 days of the qualifying event. A full list of events can be found at the end of this packet. To discuss options for a specific event, please contact our Customer Service team.

- As the contribution amount you elected is deducted from your paycheck, it is posted to your Healthcare and/or Dependent Care Reimbursement Account(s) based on the pay schedule provided by your employer.

- To receive funds from your account(s), you must complete an online claim form and submit it online or print and fax/email the claim form along with all supporting documentation.

- Documentation must show the date of the service, the **specific** type of service, and the amount you paid or owe. **Cancelled checks and credit/debit card receipts are not valid documentation.**

- Once the claim is reviewed and approved, a reimbursement will be issued in the form of a check or, if applicable, direct deposit. Checks are mailed the next business day following the date of processing. Direct deposit reimbursements may take 2-4 business days to post to your account, depending on your employer's chosen processing timeframe.

- Claims received by 5:00 p.m. EST on Mondays are processed on Wednesday. Claims received by 5:00 p.m. EST on Wednesdays are processed on Friday. These are guaranteed processing times. Claims may be processed more quickly depending on time of year.

- All claims must be for services incurred during your coverage period in the Plan Year. "Incurred" is defined as the date in which services are provided (not paid). "Coverage Period" is defined as the first of the month in which your first contribution is deducted and the last day of the month in which your last contribution is deducted.

- In the event that you terminate employment, the end of the month in which you last contributed to the Plan becomes your termination date. Services incurred after your termination date are not eligible for reimbursement.

- Be sure to notify your employer and/or our Customer Service team of any change in address. You can do so by updating it via the employee web portal, by completing and returning the Employee Change Form (included later in this packet) or by emailing us at 125@sheakley.com.

- Access to your online account is available to you 24 hours a day, 7 days a week at www.sheakley.com/flex-myrsc.asp. Account registration instructions are included at the end of this packet. We highly encourage you to register your online account because important updates regarding the Plan, account status letters, claims denied letters and other information is posted regularly.

For specific information regarding your Plan, the grace period, yearly limits, Plan Year dates, etc., please refer to your Summary Plan Description (on file with your employer) or contact our Customer Service team. Customer Service representatives are available to assist you from 8:00 a.m. to 5:00 p.m. EST Monday through Friday, except on holidays.

Sheakley Flexible Benefits Division
One Sheakley Way, Cincinnati, OH 45246
Phone: 800-877-6630 or 513-326-4662
Fax: 513-326-8082
Email: 125@sheakley.com

THE HEALTHCARE FSA

The Healthcare Flexible Spending Account allows Participants to set aside pre-tax dollars to pay for eligible medical, dental and vision expenses that are not covered by your insurance. Expenses for you, your spouse, your child(ren) and any other dependents you claim on your taxes are eligible for reimbursement under this plan.

The IRS considers medical expenses to be unpredictable, so the full annual election is available on the first day of the Plan Year. If the entire annual election is reimbursed early in the Plan Year, the remaining contributions that are made will go towards "paying back" the Plan the funds that were advanced.

A list of eligible and ineligible expenses is included with this packet. If a specific item or service is not listed, please contact a Sheakley Customer Service Representative for assistance.

***Note to HSA Owners:** If you currently participate in a high deductible health plan and have a Health Savings Account (HSA), contact your employer to determine your FSA eligibility. If you are eligible to participate, the Healthcare FSA will be a Limited Healthcare FSA and may only be used for dental and vision expenses. All medical expenses must be paid for with your HSA.

****Please note, due to a change in the IRS code in 2011, claims for over-the-counter (OTC) medicines can only be reimbursed when accompanied by a doctor's note stating the medical necessity.**

Healthcare Reimbursement

It is important to remember that claims are paid out based on date of service and not date of payment. Pre-payments for services are not eligible for reimbursement until the service has been rendered. Additionally, payments made on services that happened in a previous Plan Year are ineligible for reimbursement with current Plan Year funds.

When submitting claims, third-party documentation must be provided for each expense being claimed. The documentation must provide three items:

- The Date of Service (**not Date of Payment**)
- The Specific Type of Service
- The Amount Paid or Responsible to be Paid

****Credit/debit card receipts, online payment confirmations and check images are not valid documentation.**

ELIGIBLE & INELIGIBLE EXPENSES

To validate the expenses, you will need to submit documentation that clearly shows the **type of service, date of service and the amount you are responsible to pay** along with a completed claim form. For over-the-counter drugs and medicines, a doctor's note and receipt with the product name listed is required.

Eligible Items and Services

Dental & Vision Services

Artificial Teeth
Contact Lenses
Crowns/Bridges
Dental Implants
Dental Sealants
Dental X-rays
Dentures
Exams/Cleanings
Extractions
Fillings
Occlusal/Bite Guards
Orthodontia
Eye Exam
Glasses/Contacts
LASIK/PRK
Prescription Sunglasses
Reading Glasses

Insurance Related Items

Copay Amounts
Deductibles
Pre-existing Conditions
Expenses (medical)
Private Hospital Room Differential

Lab Exams/Tests

Blood Tests
Body Scan
Cardiograph
Colonoscopy
CT Scan
Echocardiogram
EKG
Endoscopy
Fluoroscopy
Laboratory Fees
Metabolism Tests
MRI
PET Scan
Sweat Tests
Ultrasound
Urine/Stool Analysis
X-rays

Obstetric Services

Childbirth Classes (Lamaze)
Lactation Consultant
Midwife Expenses
OB/GYN Exams
Prepaid Maternity Fees
Pre/Post-natal Treatment

Other Medical Treatments

Abortion (legal)
Acupuncture
Alcoholism (inpatient treatment)
Ambulance Services
Anesthesiology
Breast Reconstruction Surgery
Cancer Screening
Clinical Trials
Counseling
Dialysis
Drug Addiction Treatment
Gastric Bypass Surgery
Genetic Testing
Hearing Exams
Hospital Services
Infertility
In-vitro Fertilization
Norplant Insertion or Removal
Patterning Exercises
Physical Examination (if not employment related)
Physical/Occupational Therapy
Smoking Cessation Program
Speech Therapy
Sterilization
Temporary Cord Blood Storage (when used)
Temporary Egg and Sperm Storage (IVF)
Transplants (including organ donor)
Treatment for Handicapped
Tubal Ligation
Vaccinations/Immunizations
Vasectomy
Well Baby Care

Practitioners

Allergist
Cardiologist
Chiropractor
Dermatologist
Endocrinologist
Gastroenterologist
Genetic Counselor
Homeopath
Naturopath
Nephrologist
Oncologist
Ophthalmologist/Optometrist
Osteopath
Physician (licensed)
Physician Assistant
Psychiatrist/Psychologist

Other Equipment, Supplies & Services

Abdominal/Back Supports
Ankle/Wrist Supports
Automated External Defibrillator
Blood Pressure Monitoring devices
Blood Sugar Test Kits and supplies
Braille Books and Magazines
Breast Pump & Lactation supplies
Compression Hose/Stockings
Contact Lens Equipment/Solution
Cold/Hot packs for injuries
Condoms
CPAP Devices and supplies
Crutches/Walkers/Wheelchairs
Diabetic Supplies/Insulin
Ear Plugs
Elastic Bandages
Erectile Dysfunction Treatment
First Aid Kits/Bandages
Flu Shots
Glucose monitoring equipment
Guide Dog, care & training (for visually-impaired person)
Hearing Aids and Batteries
Heating Pads
Hospital Bed
Incontinence Supplies
Learning Disability Assistance (special school/teacher) Lodging for medical care (limited)
Mastectomy related bra
Medical Alert Bracelet or Necklace
Nicotine gum, lozenges or patches for smoking cessation purposes
Ostomy, Colostomy supplies
Ovulation Monitor
Oxygen Equipment
Pregnancy Test Kits
Prosthesis
Splints/Casts
Sunscreen (SPF 30 or higher)
Support Braces
Syringes
Thermometers
Transportation Expenses (essential to medical care)

Medications

Prescription Drugs

Over-the-Counter Drugs & Medicines

****May only be covered when accompanied by a doctor's note or prescription. Items must be used to treat a specific medical condition.****

Acid Controllers
Acne Mediations
Allergy & Sinus Medications
Antacids
Analgesics
Anti-Diarrheal Medication
Anti-Gas Products
Anti-Itch & Insect Bite Creams
Antihistamines
Antibiotic Ointments
Aspirin/Ibuprofen
Baby Rash Ointments & Creams
Birth Control & Contraceptive Pills
Cough, Cold & Flu Medicines
Decongestants
Digestive Aids
Eczema Treatments
Expectorants
Feminine Anti-Fungal Treatments
Fever reducing medications
First Aid Creams
Glucosamine & Chondroitin
Headache medications
Hemorrhoid Preparations
Laxatives
Lip products, medicated
Menstrual Pain Relievers
Motion Sickness Medications
Pain Relievers
Respiratory Treatments
Sleep Aids and Sedatives
Stomach Remedies
Throat Lozenges
Toothache Relievers
Visine and other Eye Drops
Wart Removal medication/kits
Yeast Infection Medications

Other Items

****These items may be covered when accompanied by a doctor's note or prescription. Items must be used to treat a specific medical condition.****

Cosmetic Surgery – covered only when treating a congenital abnormality, a personal injury resulting from an accident, trauma or disease
Dietary or herbal medicines to treat a specific medical condition
Ear Wax Removal Treatments
Equipment, supplies and materials related to physical or mental handicap
Fiber supplements to treat a Specific medical condition
Gym or health club monthly fee
Hand Sanitizer
Heart Rate Monitors
Hormone Therapy
Humidifier
Marriage Counseling
Massage Therapy
Medicated shampoos and soaps, unless prescribed by a medical practitioner for a specific scalp/skin infection
Nasal strips or sprays
Nutritionist
Orthopedic shoes, arch supports & inserts (for shoes, you may only be reimbursed for the extra cost over buying normal, non-orthopedic shoes)
Personal Trainer fees
Pills for persons who are lactose intolerant
Prenatal vitamins
Probiotics
Supplements treating a medical condition
Varicose Vein Treatment
Weight loss drugs to treat a specific disease
Wigs (for hair loss due to disease)

Ineligible Items

Baby Formula
Breast Implants (cosmetic)
Burial Expenses
COBRA Premiums
Concierge/Boutique Practice Fees
Cosmetic Surgery
Cosmetics
CPR Classes
Dehumidifier
Dental bleaching/whitening
Diet Foods
Dietary supplements
Discount Plan expenses
Ear Piercing
Educational Classes
Electrolysis and other Hair Removal
Electronic Cigarettes
Exercise Equipment for General Health
Feminine Hygiene products
Facial Creams & Cleansers
Financing Charges
Home Drug Testing Kits
Hot Tubs/Jacuzzis
Household Help
Illegal operations, treatments and medications
Items paid or payable by insurance
Late Fees
Maternity Clothes
Mattresses
Missed Appointment Fees
Moisturizers
Newborn Care Classes
Nursing Pillows
Nursing Home fees
Personal Hygiene products
Prepayments for Services
Propecia and Rogaine for cosmetic hair growth
Premiums for health insurance
Special foods
Sports drinks
Suntan lotion
Tanning Salon
Teeth whitening kits
Toiletries
Toothpaste or Toothbrushes (electric or otherwise, even if a dentist recommends them for
Ultrasound, Voluntary pre-Natal
Veneers

This is not a complete list. If you have questions regarding a specific type of expense that is not listed or questions about items that are listed, please contact our Customer Service Team toll free at 1-800-877-6630 or via email at 125@sheakley.com.

HEALTHCARE WORKSHEET

This worksheet will help you estimate your family's annual medical, dental and vision expenses for the Plan Year. Please remember to deduct what your insurance will pay on each item before choosing an annual election. Not all eligible goods and services are listed below. This is a list of the most common expenses.

***Note to HSA Owners:** If you currently participate in a high deductible health plan and have a Health Savings Account (HSA), contact your employer to determine your FSA eligibility. If you are eligible to participate, the Healthcare FSA will be a Limited Healthcare FSA and may only be used for dental and vision expenses. All medical expenses must be paid for with your HSA.

Medical Expenses	Current Year Expenses	Next Year Estimates
Deductible	$_____	$_____
Co-Payments	$_____	$_____
Prescriptions	$_____	$_____
OTC Items (with note)	$_____	$_____
Chiropractors	$_____	$_____
Hospital Care	$_____	$_____
Physical Therapy	$_____	$_____
Routine Physical	$_____	$_____
Well Baby Care	$_____	$_____
Psychiatric Care	$_____	$_____
Other _____	$_____	$_____
Other _____	$_____	$_____
Vision Expenses		
Eye Glasses	$_____	$_____
Eye Exams	$_____	$_____
Contact Lenses	$_____	$_____
LASIK/Vision Correction	$_____	$_____
Dental Expenses		
Dental Exams	$_____	$_____
Cleanings	$_____	$_____
Extractions	$_____	$_____
Fillings	$_____	$_____
Crowns	$_____	$_____
Bridges	$_____	$_____
Orthodontia	$_____	$_____
Other _____	$_____	$_____

TOTAL ESTIMATED EXPENSES: $_____ NUMBER OF PAYCHECKS: _____

*PER PAYCHECK DEDUCTION: $_____

*To determine the per paycheck deduction amount, divide your total estimated expenses by the number of paychecks.
****Please be conservative when estimating annual expenses. Only include expenses you know will be incurred.**

THE DEPENDENT CARE FSA

The Dependent Care Flexible Spending Account allows Participants to set aside pre-tax dollars to pay for eligible daycare, preschool, babysitting and certain care expenses for disabled or elderly parents.

- Daycare Expenses: Childcare expenses incurred while both parents are working, actively seeking work or going to school full time are eligible for reimbursement. These expenses are covered until the child reaches the age of 13, at which time they are ineligible and the Participant MUST cease participation in the Plan.

- Pre-School Tuition: Since this Plan is designed to reimburse expenses for care and not education, the IRS allows pre-school tuition to be reimbursed as it is not deemed to be educational. Once your child enters kindergarten, only before and after school programs and childcare are eligible for reimbursement.

- Babysitting: Care provided by a relative, friend or neighbor may be reimbursed. The provider cannot be the Participant's child or stepchild who is under the age of 19 or someone that the Participant claims on their taxes.

- Camps: Summer day camps are eligible to the extent that the primary purpose is custodial in nature and not educational. Programs specifically designed to tutor are not eligible for reimbursement. **Overnight camps are not eligible for reimbursement.**

- Custodial and Elder Care: These expenses may only be covered if they are not for medical services and the individual cared for spends at least 8 hours each day in the Participant's household.

- Food Costs: Food costs can only be covered if they are included in the price of the daycare. If they appear as a separate line item on an invoice or receipt, they are not eligible for reimbursement.

Dependent Care Reimbursement

Dependent care reimbursement differs from healthcare reimbursement in that it's a "pay-as-you-go" program. Since the IRS considers dependent care expenses to be predictable, meaning that the Participant can plan for these expenses, claims are only paid out based on the amount you've contributed to the Plan at the time the request is made. **Your full annual election is not available on the first day of the Plan Year.**

- Example: If you submit a claim for $500, but have only contributed $250 to your account thus far, you will only be reimbursed for $250 right now. However, as you continue to contribute to your Plan, reimbursements will continue to be made until the amount of the original claim is paid in full.

Similar to the Healthcare Plan, dependent care reimbursements are based on date of service and not date of payment. If your provider requires you to pre-pay for a month of care, you will only be reimbursed after that month has passed and the service was incurred. When submitting for reimbursement, you may break down each monthly expense into a weekly amount so that you can receive funds at the end of each week instead of at the end of the month.

DEPENDENT CARE WORKSHEET

This worksheet will help you estimate your family's annual daycare or elder care expenses for the new Plan Year. If your child(ren) start school this year, only calculate partial daycare amounts for months when school is in session and then full amounts for summer months.

1. Daycare Expenses _____ per week x ____ weeks = $_____

   _____ per week x ____ weeks = $_____

2. Elder Care Expenses _____ per week x ____ weeks = $_____

   _____ per week x ____ weeks = $_____

3. Total Estimated Expenses (Line 1 + Line 2) = $_____

4. Number of Paychecks _____

5. Per Paycheck Deduction (Line 3 / Line 4) = $_____

***Please remember to factor in anticipated increases or decreases in provider cost when estimating your expenses.**

****Please also remember to be conservative when estimating your expenses. Any unclaimed funds left in this account at the end of the run-out period will be forfeited.**

THE REIMBURSEMENT PROCESS

1. Reimbursements are based on Date of Service, not Date of Payment:

One of the biggest misconceptions is that if you pay for a service you are eligible for reimbursement. This isn't necessarily true. Once a service has been performed, regardless of whether or not payment has been made, you become eligible for reimbursement.

Bills for services incurred in a previous Plan Year may not be submitted for reimbursement with funds from the current Plan Year.

Please remember that all services for which you seek reimbursement must have been incurred while you were actively covered by the plan. **Services incurred before or after your coverage period are ineligible.**

2. Providing the correct Documentation to ensure speedy Reimbursement:

When submitting a claim for reimbursement, either online or manually, you are required to provide third party documentation for all expenses. A service invoice from the provider, a cash register receipt listing purchased items or an Explanation of Benefits from your insurance company are all acceptable forms of Third party Documentation.

The documentation submitted MUST include the following:

1. The Date of Service (note the Date of Payment)
2. The Specific Type of Service or Item Purchased
3. The Amount you paid or are responsible to pay. (Proof of payment is not required for reimbursement.)
4. Federal Tax ID or SSN of the provider (Dependent Care Claims ONLY)

Cancelled checks, credit/debit card receipts and credit card or bank statements are not considered valid documentation and will not be accepted.

If a claim does not have the correct documentation, it will be denied and you will receive a notice in your online account providing the reason for the denial. You may then submit the required additional documentation for review.

Please do not submit a second form for the denied claim. This may result in the second claim being denied as a duplicate.

3. Payment Processing and Disbursement of Payments

Claims are processed for payment twice per week, on Wednesdays and Fridays (except for holidays).

Any claims received Monday by 5:00pm EST are processed for payment on Wednesday and any claims received Wednesday by 5:00pm EST are processed for payment on Friday. This is our guaranteed processing schedule, however claims may be processed more quickly depending on the time of year.

Check reimbursements are mailed on the next business day immediately following the date of processing (except for holidays).

Direct deposit reimbursements, if applicable, take 2 or 4 business days to post to your account, depending on the schedule chosen by your employer.

Sheakley

Flexible Spending Account Enrollment Form

Section 1: Participant Data

Please write legibly using blue or black ink.

Employee Name (First / Last)			Social Security #	
Home Address		City	State	Zip Code
Hire Date	Birth Date	Email Address		
Employer Name	**Flowing Wells Unified School District**			

Section 2: Elections

Enter the amount you wish to be withheld for your Annual Election. Determine the per pay period amount by dividing your Annual Election by the number of pay periods in the Plan Year. Also enter the date of the first paycheck in which a deduction will be withheld.

Plan Year: 7/1/2016 – 6/30/2017	Annual Election	# of Pay Periods	Per Pay Contribution	Effective Paycheck Date
Health Care Reimbursement (Annual Limit: $2,550.00)	$	#	$	
Dependent Care Reimbursement (Annual Limit: $5,000 per household or $2,500 if married filing separately)	$	#	$	

Section 3: Pre-Tax Premiums

I understand that my insurance premiums, for benefits offered by my employer only, will be deducted on a pre-tax basis unless I note otherwise, in writing, to my Human Resources Office.

Section 4: Plan Information

Please read the following information regarding this enrollment. If you do not wish to participate in the Flexible Benefit Plan, sign the declination line below. If you wish to enroll in the Flexible Benefit Plan, sign the participation line.

I wish to participate in and deposit funds into a Flexible Spending Account (FSA) as shown above. I understand that my election may not be terminated or changed unless I have a qualifying life event as outlined by the IRS. I understand that all claims must be for services provided (not paid) during my coverage period. I further understand that the IRS requires a forfeiture of any remaining balance in my account as of the last day of the run-out period in which I am allowed to submit claims. I understand that, upon termination of my coverage (due to a qualifying life event or termination of employment), I cannot continue to incur additional expenses and that I may only submit claims for services performed prior to my termination date. Upon termination of my Healthcare Flexible Spending Account, I may be able to elect COBRA to continue my coverage. In order to receive reimbursement from this account, I must complete and sign a claim form and attach all necessary documentation for myself, my spouse and/or my dependent(s). I understand the plan provisions have been outlined in the Summary Plan Description available to me from my employer.

In addition, I understand that, if I have a Health Savings Account (HSA), it is my responsibility to review the FSA plan information to ensure my eligibility to participate in both the HSA and the FSA. If my plan allows for participation in both, I understand that I can only submit dental and vision expenses to my FSA.

PARTICIPATION SIGNATURE: _____ **DATE:** _____

Waiver: ***At this time, I wish to waive participation in the Flexible Benefit Plan.***

DECLINATION SIGNATURE: _____ **DATE:** _____

****All enrollment forms must be submitted to your HR Department for processing.**

EMPLOYER SIGNATURE: _____ **DATE:** _____

DIRECT DEPOSIT

This option is a great way to receive your reimbursements quickly by having them deposited directly into your checking or savings account. There are a few things to remember with regards to direct deposit:

1. To set up direct deposit for your Flexible Spending Account, please complete the form on the following page and submit it to Sheakley for processing.

   **Although a check is no longer required, we ask that you ensure that the information provided is accurate to avoid any delays in reimbursement due to invalid account/routing numbers.

2. **If you currently have direct deposit set up with Sheakley, you do not need to submit a form for each new Plan Year.** Your banking information remains in our system until you notify us that you no longer wish to be reimbursed via direct deposit.

3. Direct deposits can be delayed by bank closures due to national holidays.

4. If your banking information changes, it is important to notify Sheakley of the new information by submitting a new direct deposit form.

Sheakley
THE HUMAN RESOURCES PEOPLE

Office Use Only
Date Received: _____
Entered by _____ on _____
Verified by _____ on _____

Authorization for Direct Deposit Reimbursement

This authorizes Sheakley Pension Administration to send Flexible Spending reimbursements electronically, or by any other commercially accepted method, to my account indicated below.

Name of Bank _____

Routing Number _____ Account Number _____

If possible, please attach a voided check with this completed form.

Name _____

Last Four of Social: XXX-XX-_____

Employer Name **Flowing Wells Unified School District**

Participant Signature _____

Date _____

Completed forms may be faxed to 513-326-8082 or emailed to 125@sheakley.com. If you have any questions, please contact us at 800-877-6630.

THE FSA DEBIT CARD

Your employer has chosen to provide you with the MySourceCard debit card as part of their FSA program. The card can be used to pay for eligible expenses including medical copays, prescriptions, hospital charges, dental procedures, day care fees (if allowed by your employer) and parking/transit passes (if applicable to your plan).

The implementation of the debit card program by the IRS allows participants to pay for services at point of sale, without having to send in a request for reimbursement. **This does not mean that you will not have to submit documentation for any expenses paid for with the card.**

Due to your privacy rights, the information provided on debit card transactions is very limited. If the nature of the transaction isn't apparent or could possibly be for an ineligible expense, IRS regulations require Sheakley to request additional documentation to substantiate (validate) the expense. If a transaction requires additional documentation, you will receive an email with the request.

Additional documentation must be provided within 21 days or the transaction will be deemed ineligible and your card blocked until you repay the Plan or submit the requested documentation. While the card is blocked, any manual claims that are submitted will offset the ineligible card swipe until it is "paid" in full.

****Sheakley will not contact third-party providers to obtain additional information on card transactions. It is your responsibility to provide this upon request.**

Important Things to Remember:

- Each time you use your debit card, you will receive an initial email confirming the use of your card. If you feel a transaction is fraudulent, you must notify Sheakley as soon as possible. **A fraudulent claim notice must be filed with the card company within 30 days of the original transaction.**
- **The MySourceCard is good for up to 3 consecutive Plan Years and should not be discarded** at the end of the Plan Year or when you exhaust your funds. There are fees associated with replacement cards.
- You are not required to complete a new debit card enrollment agreement each year you participate in the Plan.
- You are allowed up to 2 cards at no additional cost. If you wish to have a second card, please indicate the name on the second card in the space provided on the enrollment agreement. **Please note, the 2nd card cannot have the same name as the primary card.**
- If you have not participated in consecutive Plan Years, you will have to contact Sheakley to have your debit card account reactivated. New cards will be issued and any old cards you have may be discarded.

Sheakley

MySourceCard Enrollment Agreement

As a participant in one or more of your Employer Plans or as an account holder under HSAtoday program, you will receive a MySourceCard MasterCard Debit Card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used ***exclusively*** for Qualified Expenses as defined by the plan(s) in which you participate. If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the Card. Upon request, you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck or other option(s) established by your employer.

Please Note: Additional terms and conditions would apply is you use the Card to access your funds in you HSA under the HSAtoday program. In such event, these additional terms and conditions would be set forth in an HSA Addendum to your HSA custodial account agreement.

For proper Cardholder identification, please complete the following information.
Your card will not be issued until this completed form is received by your Plan Service Provider.

Employer: **Flowing Wells Unified School District**

Name on Card *(please print)*: _____
Maximum of 21 Characters

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Phone: _____

Email Address: _____
****REQUIRED**** Emails regarding card transactions will go to the email address listed above.

Name on 2nd Card *(please print)*: _____
Maximum of 21 Characters

Signature: _____ Date: _____

*****ALL FIELDS ARE REQUIRED*****

If you currently have a MySourceCard, you are not required to complete this form.
****The MySourceCard is good for 3 consecutive Plan Years and should not be discarded****

Completed forms may be faxed to 513-326-8082 or emailed to 125@sheakley.com. If you have any questions, please contact us at 800-877-6630.

WEBSITE REGISTRATION INSTRUCTIONS

To:Flowing Wells Unified School District Employer Participants

Below are instructions to register your Flexible Benefits Account online. This is a password protected website where you can keep up with various benefit news and information, including your Account Balance and Year-to-Date Claims Paid and Payments. It is highly recommended that you register your account as soon as possible. To log in to *my*RSC for the first time, follow the steps below:

- Go to http://www.sheakley.com/myrsc.asp.
- Click on **REGISTER**.

-OR-

- Go to https://secure.myrsc.com/index.asp.
- Click on **REGISTER** under "First Time Logging In?"
- Click on **myRSC Temporary Login ID and Employer Code**.

1. Enter your SSN (no dashes or spaces) in the Login ID field and click **CONTINUE**.
2. Enter **13517153** in the Employer Code field and click **CONTINUE**.
3. Enter a login ID of your choice that is at least 6, but not more than 100, characters in length. **Note: Since Social Security Numbers are no longer used as the login ID, the login ID you create may not be 9 characters in length.**
4. Select an existing email address or enter a new one to be used when requesting a forgotten password.
5. Enter a secret question or use a pre-defined secret question to aid recovering a forgotten password.
6. Enter the answer to the secret question.
7. Click **SUBMIT**.
8. Enter a password in the Password field.
9. Re-enter the password in the Confirm Password field.
10. Click **CONFIRM PASSWORD**.
11. You are now logged in to *my*RSC!

If you have any questions or are unable to retrieve a forgotten password, please call our Customer Service Department any time Monday through Friday from 8:00am – 5:00pm EST at 800-877-6630.

EMPLOYEE INFORMATION CHANGE FORM

Please complete and sign this form. Return to your Human Resources Department for processing. They will forward the form to Sheakley via fax to 513-326-8082 or via email to 125@sheakley.com.

_____ _____ - _____ - _____
Employee Name *Social Security Number*

Flowing Wells Unified School District _____ / _____ / _____
Company Name *Effective Date of Change*

Change in Name

_____ _____
Old Name *New Name*

Change in Address

_____ _____ _____ _____
New Street Address / PO Box # *City* *State* *Zip Code*

_____ _____
Employee Signature (required) ***Date***

***Unsigned forms will not be processed. Please make sure to sign the completed form.**

Sheakley

CHANGE IN STATUS FORM

_____ _____ - _____ - _____
Employee Name *Social Security Number*

Flowing Wells Unified School District _____/_____/_____
Company Name *Effective Paycheck Date*

	Current Per Pay Contribution	New Per Pay Contribution	New Annual Election
Health Care	$	$	$
Dependent Care	$	$	$

Termination of Employment
(Termination does not allow change in annual election)

_____/_____/_____ _____/_____/_____
Termination Date *Date of Final Paycheck Deduction*

Qualifying Events
***All changes must be consistent with the Qualifying Event and all Qualifying Events do not apply to all plans. For informational purposes, we have attached a list of changes that can be made for the FSA plan. Please choose which event is applicable to the change.*

☐ Marriage ☐ Birth/Adoption ☐ Death ☐ Divorce/Legal Separation
☐ Family Medical Leave *(check one)*: ☐ Beginning ☐ Return
☐ Leave of Absence *(check one)*: ☐ Beginning ☐ Return
☐ Change in Day Care Provider ☐ Change in Rates of Day Care Provider
☐ Eligibility changes due to a change in Employment Status

At this time I wish to make a change to my current Flexible Benefit Elections as shown above. I understand the change must be consistent with the reason marked and the change affects either my eligibility status or that of my spouse and/or dependents. I certify that the above reason selected to make this change has occurred within the last 30 days and is in fact a true statement. I further understand my Employer may request documentation to support the change.

_____ _____
Employee Signature *Date*

****All Change of Status forms must be submitted to your HR Department for processing.**

_____ _____
Employer Signature *Date*

QUALIFYING EVENTS

To be a qualified life event the change must coincide with the following: listed as an IRS approved event, consistent with the type of change being requested and affects eligibility of either the employee or his/her dependents. Some life events are not applicable to all benefit types, please see below. If a life event has occurred and is not listed below, contact your HR or Benefit Administrator.

Event	Increase	Decrease	Add Coverage	Drop Coverage
Marriage	HFSA / DFSA	HFSA / DFSA	DFSA	HFSA / DFSA
Divorce/Separation	HFSA / DFSA	HFSA / DFSA	HFSA / DFSA	DFSA
Birth/Adoption	HFSA / DFSA	-----	HFSA / DFSA	-----
Death	DFSA	HFSA / DFSA	DFSA	DFSA
Spouse/Dependent Gains Eligibility under their Employer Plan	DFSA	HFSA	DFSA	DFSA
Spouse/Dependent Losses Eligibility under their Employer Plan	HFSA/DFSA	-----	HFSA/DFSA	DFSA
Dependent Gains Eligibility under the Employee's Plan	HFSA/DFSA	-----	HFSA/DFSA	-----
Dependent Losses Eligibility under the Employee's Plan	-----	HFSA/DFSA	-----	-----
Employee Moves out of HMO Area	-----	-----	-----	-----
Employer Replaces One Benefit Option with a similar Option	-----	-----	-----	-----
Change in Day Care Provider	DFSA	DFSA	-----	-----
Begin FMLA Leave of Absence	-----	-----	-----	HFSA/DFSA
End FMLA Leave of Absence	-----	-----	HFSA/DFSA	-----

Health Flexible Spending Account (HFSA) and Dependent Care Flexible Spending Account (DFSA)

Online Claims Entry Tutorial

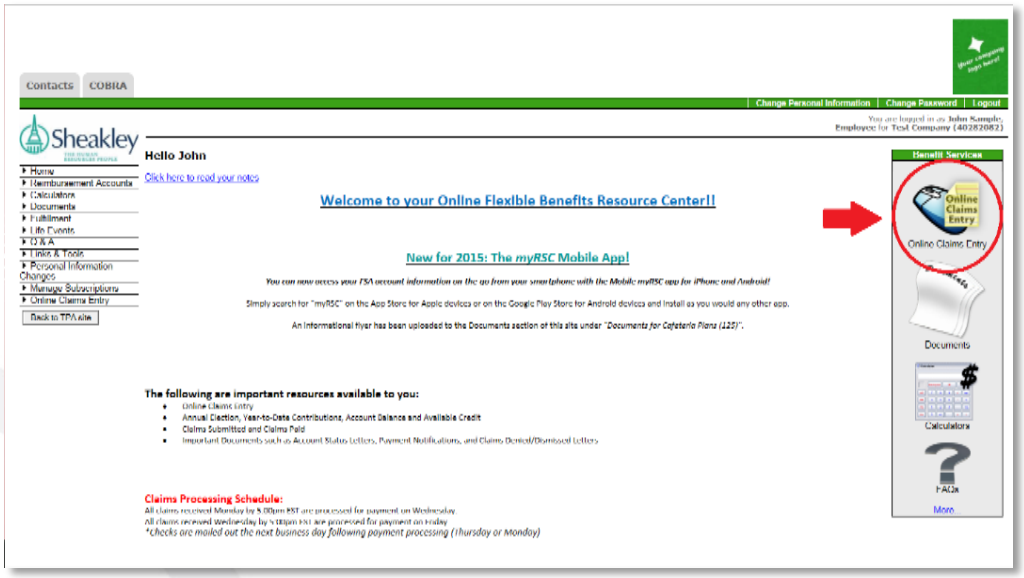
This guide will walk you through the steps needed to enter claims using the Online Claim Entry system on myRSC.com. This method of claim entry bypasses the need to complete a hand-written claim form and reduces turnaround time on reimbursement.

Claims entered online can be submitted in two ways:

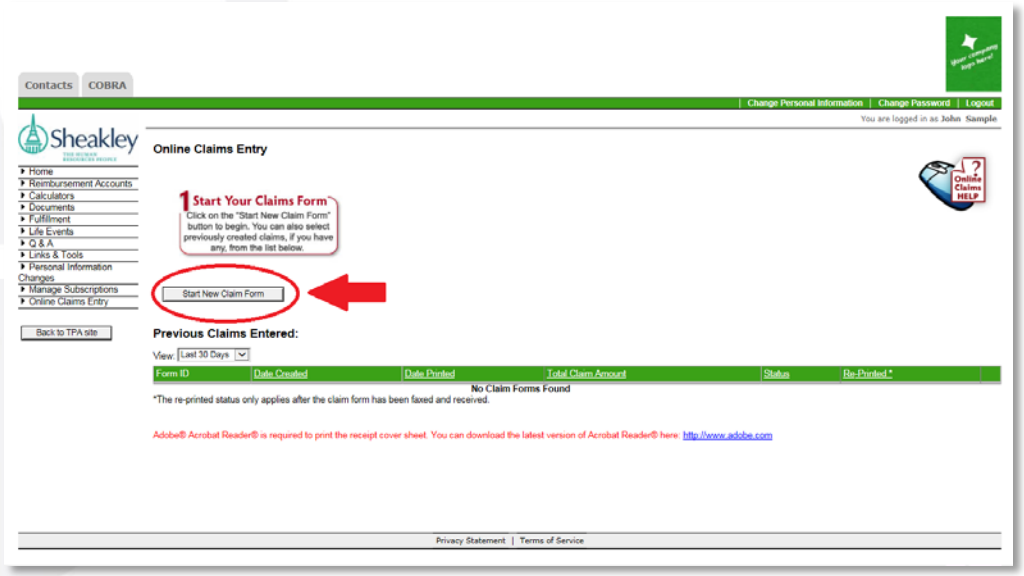
- Online – requires you to upload electronic copies of your claim documentation using a scanner or smart phone
- Manually via Fax, Email or Regular Mail – requires you to print the Receipt Cover Sheet to send with your documentation

Getting Started:

To begin, log in to your Sheakley online account and click the **ONLINE CLAIMS ENTRY** button located in the menu bar on the right side of the home page.

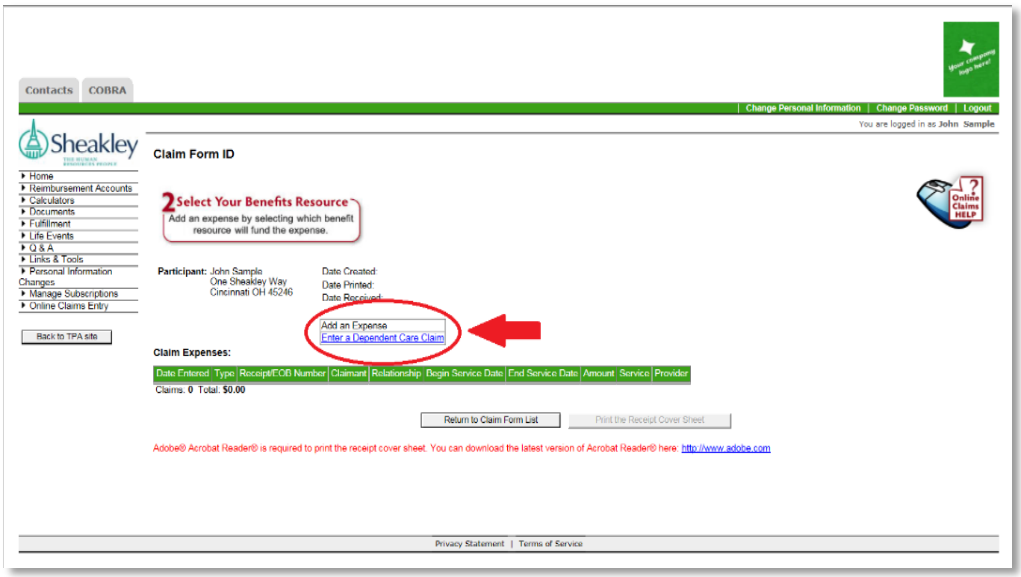


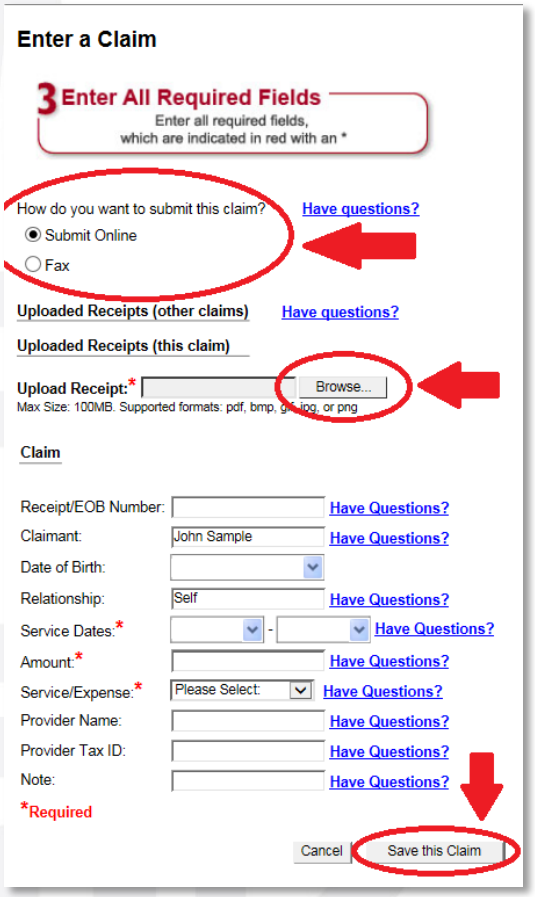
Next, click on the **START NEW CLAIM FORM** button to begin entering your expenses.



Entering your Expenses and Submitting your Claim:

Select the type of claim you wish to enter by clicking the appropriate link located in the "Add an Expense" box. (*The options listed in the box will be populated based on the type(s) of coverage you have in our administration system.)*





On the next page, you will need to choose your desired method of submission: **SUBMIT ONLINE** or **FAX**.

- If you choose **SUBMIT ONLINE**, you will be required to upload your documentation in the form of a **.pdf, .bmp, .gif, .png or .jpg** file.
- If you choose **FAX**, you will only need to fill out the "Required" claim form fields and print the Receipt Cover Sheet. You can submit your claim via Fax, Email or Regular Mail (addresses and fax numbers are provided at the end of this guide).

If you chose the **SUBMIT ONLINE** option, click on **BROWSE** to upload your electronic documentation.

Please keep in mind that the same documentation requirements apply to online claims as manual claims.

- *The receipt/invoice must contain the **Date of Service** (not Date of Payment), specific **Type of Service** and the **Amount Paid/Owed**.*
- *Check images and credit/debit card receipts are **NOT** valid forms of documentation.*
- *Dependent care claim documentation **must** list the **SSN or Federal Tax ID** of the childcare provider. If not provided on the receipt, it must be listed on claim form in the "Provider Tax ID" field.*

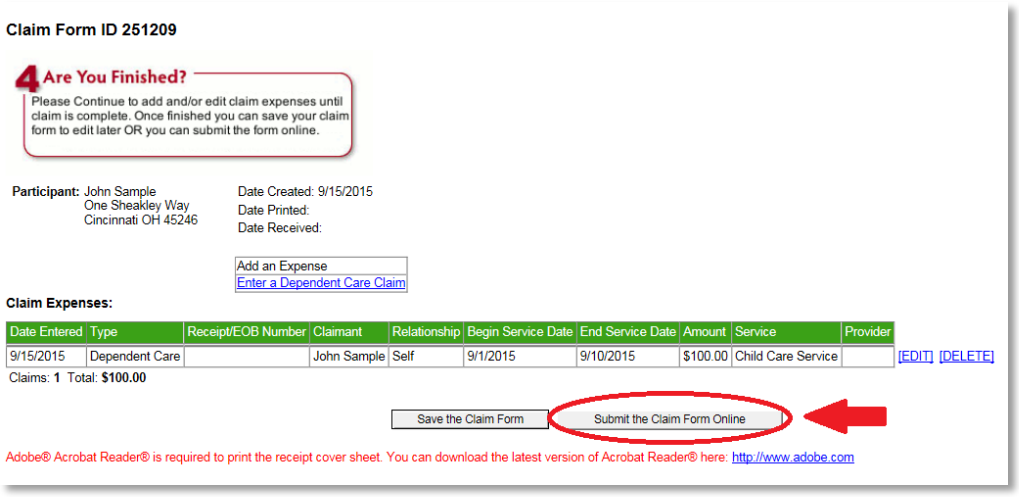
Click **OK** when asked to verify the upload. Click on the **VIEW** link next to the file to view the uploaded document and ensure that it's readable.

Complete the claim fields marked as "Required" with a red asterisk and click **SAVE THIS CLAIM**.

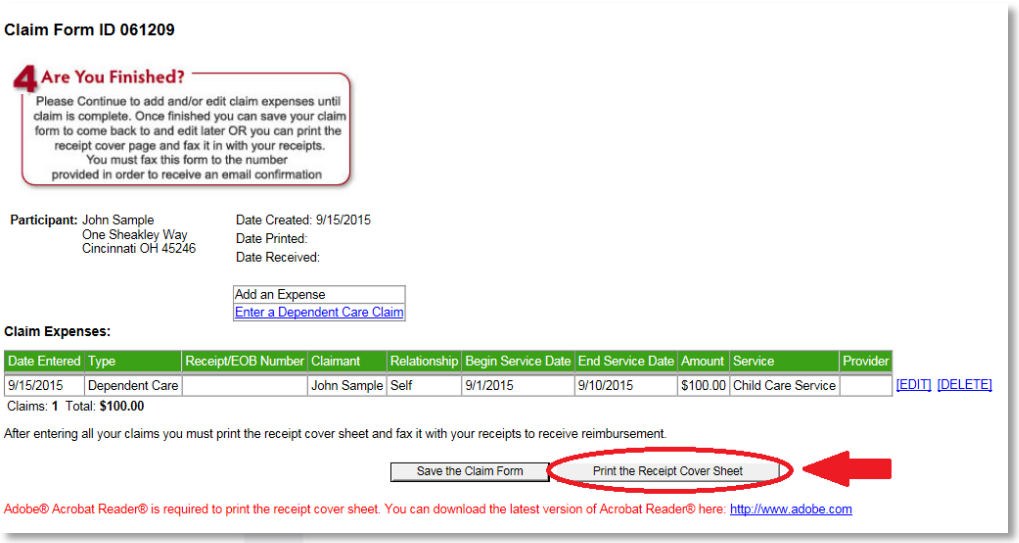
**If you chose the SUBMIT ONLINE option, you cannot save your claim unless you've attached a receipt file.*

You can continue to enter multiple claims and, if submitting online, upload/attach receipts on the same claim form. If you wish to save the claim and continue working on it at a later date, you may click **SAVE THE CLAIM FORM**.

If you're finished with the form and ready to finalize your claim, you may click the **SUBMIT THE CLAIM FORM ONLINE** button (for "SUBMIT ONLINE" claims)…



or **PRINT THE RECEIPT COVER SHEET** (for "FAX" claims). When sending your Receipt Cover Sheet, please remember to sign and date the form and include documentation for each expense listed (*addresses and fax numbers can be found at the end of this guide*).



If you have selected to receive emails (in the **MANAGE SUBSCRIPTIONS** page), you will receive a notification that the claim has been received by Sheakley.

Please keep in mind that you will not receive a notification that the claim has been entered, but you may check your **REIMBURSEMENT ACCOUNTS** detail to see the claims that have been entered.

Important Things to Remember:

- Our claim processing schedule is as follows:

  Claims received Monday by 5:00pm EST are processed for payment on Wednesday.
  Claims received Wednesday by 5:00pm EST are processed for payment on Friday.

  This schedule can vary due to holidays, office closures and inclement weather. Please check the Notes on your home page for communications affecting claim processing or reimbursement.

- To ensure timely processing, please make sure to include valid documentation for all claims submitted.
- If submitting your claim online, please review the uploaded documents to ensure that they're readable as attached.
- Dependent Care claims must include the SSN or Federal Tax ID of the provider, either on the receipt or enter into the "Provider Tax ID" field of the claim form.
- Claims **faxed** using the Receipt Cover Sheet may result in a "Claim Not Received" email. This does not necessarily mean that we did not receive the claim, but that an imperfection in the barcode in the faxed copy prevented our system from automatically reading the form.
  If you receive this message after faxing a claim, you may either check your Reimbursement Accounts detail to see that the claim was entered or call our Customer Service team for verification.

You may submit your Receipt Cover Sheet and documentation…

Via Fax to: **513-326-8082 (Main Line)**
513-326-4661 (Alternate Line)

Via Email to: **125@sheakley.com**

Via Regular Mail to: **Sheakley Flexible Benefits**
One Sheakley Way
Cincinnati, OH 45246

If you have any questions regarding online claim entry, please contact our Customer Service team toll-free at 1-800-877-6630 or via email at 125@sheakley.com.

Sheakley

WELCOME TO MOBILE myRSC®!

Flexible Benefits at your fingertips

You can now access your FSA account information on your smartphone with the Mobile myRSC app for iPhone and Android

What You Can Do with Mobile myRSC

VIEW ACCOUNTS — Including detailed account and balance information

VIEW CARD ACTIVITY — Account Information

MANAGE SUBSCRIPTIONS — Set up email notifications to keep you up-to-date on all account and health debit card activity

SNAPCLAIM™ — Our Mobile App for iPhone® and Android® with integrated SnapClaim™ technology allows claims filing using your smartphone! Just open a claim using the mobile app, fill in some details onscreen, take a photo of your receipt with your smartphone camera, and upload. Claims filing couldn't be easier!

Locating and Loading the Mobile myRSC App

Simply search for "myRSC" on the App Store℠ for Apple devices or on the Google Play™ Store for Android devices, and then load as you would any other app.

Logging In

Access the mobile services using the same username and password you use to log in to the full myRSC® website. After logging in, you will be on the home page which will list your options.

Getting Help

Click the **Help** button at the bottom right of all Mobile myRSC® pages to access contact information for your administrator, who will be able to provide assistance.

Going Home

Press the **Home** button on the bottom left corner of any page to return to the home page.

Download on the App Store

GET IT ON Google play

MOBILE QUICK START GUIDE

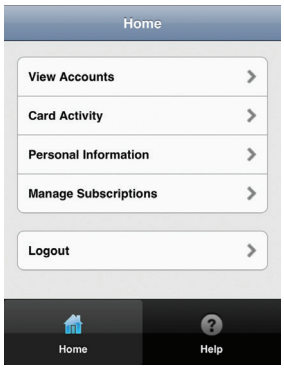
Logging In

Open the Mobile myRSC® app or point your browser to: https://mobile.myrsc.com. The first page that loads is the login screen. Use the same username and password that you use to log in to the full myRSC®website.

NOTE: The mobile site is optimized to work on Safari on iOS, the default Android Browser, or Chrome on Android 4.x. If you are using an older browser, you will automatically be redirected to the classic myRSC® site.

The Home Page

Once you log in, you are on the Home page. This page lists all available options you have on the mobile site:



VIEW ACCOUNTS

View the balance and details of your Flexible Spending Account

CARD ACTIVITY

View card transactions and details

PERSONAL INFORMATION

View or edit your personal information

MANAGE SUBSCRIPTIONS

Change the emails and notifications sent by myRSC®

LOGOUT

Logs you out of your account

HOME AND HELP

Home brings you back to this screen and Help provides contact information regarding your benefits

SNAPCLAIM™

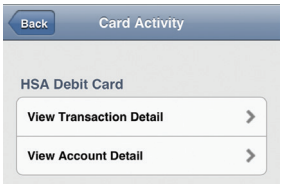
Integrated SnapClaim™ technology lets you file claims on the spot using your smartphone camera.

Account Summary

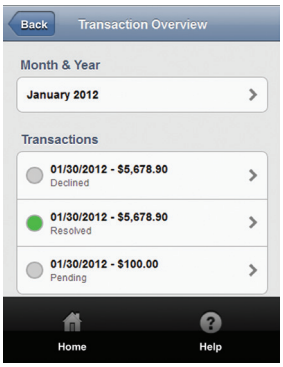
When you select the View Accounts option, the page displays only the benefits for which you are subscribed. (Your display may look very different than the screen shot pictured here.) Select the benefit you wish to view to see unresolved transactions, benefit summary data, and details of claims and reimbursements.

Card Activity

The Card Activity page gives you the option to view the transaction details or account details of your debit card.



Selecting View Transaction Detail takes you to the Transaction Overview page. Select the month and year for the card activity you want to view. Only the transactions for the month and year you choose will be displayed. Clicking on a particular transaction lets you see the details of that card swipe.



Selecting View Account Detail lists all cardholders on your plan. You can then select the person's name and see the account details associated with that card. You also have the option of blocking a card.

Contact Sheakley today for more information.

Sheakley
IT'S DONE.

One Sheakley Way | Cincinnati, OH 45246
800.877.6630 | 125@sheakley.com | Sheakley.com