Marshall & Sterling
EMPLOYEE BENEFITS

Town of Glenville
Medical Flexible Spending Account
2022 Benefit Summary & Enrollment Form

Prepared by
Marshall & Sterling Employee Benefits FLEX
42 South Street Glens Falls, New York 12801
T: 518.373.0069, Option 4 | F: 518.792.0226 | msflex.LH1ondemand.com

Town of Glenville 2022 Flexible Spending Account Options

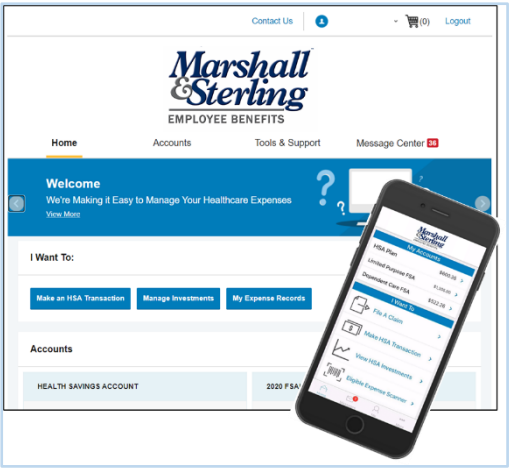
What are Flexible Spending Accounts?

Flexible Spending Accounts are tax-advantaged plans that help you pay for out-of-pocket costs not covered by your insurance. You elect the amount of money you want to contribute, and those funds are taken from your pay in equal installments throughout the year, reducing the amount of your income subject to taxes.

Your employer offers you a few types of Flexible Spending Accounts to choose from:

	Medical Flexible Spending Account (MFSA)	Limited Purpose Flexible Spending Account (LPMFSA)	Dependent Care Assistance Program (DCAP)
This might be for you if:	You are not enrolled in an HSA-Qualified health plan	You or your spouse are enrolled in an HSA-Qualified health plan and contribute to an HSA	You expect to incur qualified dependent care expenses
The money can be used to pay for:	Eligible healthcare expenses, as defined by IRC Section 213(d)	Qualified Vision, Dental, Post-Deductible or Preventative Care expenses	• Child or adult dependent care • An individual to provide care either in or out of your house • Nursery Schools and preschools (excluding kindergarten)
You can contribute up to:	**$2,850** in 2022		$5,000 (or $2,500 if married and filing separately) per calendar year
You should also know that:	Town of Glenville has adopted a provision allows you to carry forward up to **$570** of unused funds into the next plan year instead of forfeiting those funds!		Dependent care services must be for the care of a tax-dependent child under age 13 who lives with you, or a tax-dependent parent, spouse or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours (i.e., Saturday night babysitting does not qualify), and cannot be provided by another of your dependents.
When am I eligible?	Non-seasonal, part-time, and full-time non-represented and CSEA Town Hall Unit employees are eligible to participate as of date or hire. The plan year runs from 1/1/2022 – 12/31/2022, which means that expenses can be incurred between those dates. The deadline for filing reimbursement requests is 3/31/2023.		
What if my employment or eligibility terminates before the end of the Plan Year?	COBRA provisions generally allow you the option to continue your coverage after termination. Details will be provided to you if you experience a qualifying event that affects your FSA coverage.		There is no COBRA provision for DCAP accounts so your participation in the plan will not continue.

Your Spending Accounts are easy to use!



After you enroll, keep an eye out for an email helping you login to your **Online Account**. When you login, you can file claims, view account balances, scan, and upload receipts, sign up for direct deposit and much more! Your username is your first initial followed by your last name and the last 4 digits of your SSN (ex. jsmith1234). Your password (if it's your first-time logging in) is simply the word *password*. You will be prompted to change your password immediately after logging in.

With the **Flex Mobile App,** you can manage your accounts on the go, and even take pictures of your receipts that instantly upload into the system for review! Use the same username and password for the online portal to log into your mobile app. From there you can create a 4-digit passcode to quickly access your account via the mobile app. To download the app, search **JFA Flex** in your app store

To access your funds, you'll receve a **Flex Debit Card**, which is loaded with the value of your annual election. If you already have a Flex Debit Card, it will be activated with your new funds – no new Flex Debit Card will be mailed to you until your original card expires. With the debit card, there are no claim forms to complete, and you will not have to wait for a check in the mail. Simply swipe the card at checkout and the amount of your eligible expense will be automatically deducted from your account. **Remember to save your receipts as our system may request a detailed receipt to approve your debit card transaction.** You can also request reimbursement for eligible expenses you pay out of pocket via direct deposit or check.

Get your money faster with direct deposit! Direct deposit is an electronic payment from one bank account to another – we will deposit your payment right into your bank account! It is faster, safer, and more convenient than hard copy checks. To set up direct deposit, just log into your account. From your home page, select **Accounts**, then **Banking/Cards** under the Profile heading. Select **Add Bank Account**, and then enter your account information and select "Submit."

Do you want someone else to be able to access your account or call on your behalf? Don't forget to complete the HIPAA Authorization form (found under the Tools and Support tab) to submit to Marshall & Sterling.

Marshall & Sterling is here to help!

Marshall & Sterling Employee Benefits - FLEX
42 South Street, Glens Falls, NY 12801
Tel: 518.373.0069, Option 4 | Fax: 518.792.0226
flex@marshallsterling.com

Reimbursement Request Form

Fax Completed Form to: 518.792.0226 | Questions/Assistance: 866.311.7110

Use this form for reimbursement of any out-of-pocket expenses. Missing or incomplete information may result in the denial or delay of your request. You can also file your claim online at https://jfaflex.lh1ondemand.com instead of completing this form.

Step 1: Participant Information	
Employer Name	Town of Glenville
Participant Name	
Participant Last 4 Digits Social Security Number	
Mailing Address	
Email Address	

Step 2: Reimbursement Information

Plan Type*	Did You File Online or Use Your Debit Card? Y/N	Date Expense Incurred	Merchant/Provider Name	Name Of Person Receiving Product/Service	Relationship	Amount
						$
						$
						$
						$
						$
						$
						$
						$

Any person who knowingly and with the intent to defraud, injure or deceive; submits a reimbursement request containing any materially false, deceptive incomplete or misleading information pertaining to such request, may be committing a fraudulent act which is a crime and may subject such person to criminal and/or civil penalties or denial of benefits.

Total Reimbursement Amount Requested	**$**

***PLAN TYPES (PLEASE REFER TO YOUR PLAN MATERIALS FOR THE PLANS APPLICABLE TO YOU):**

MFSA-Medical Flexible Spending Account; **LPMFSA**-Limited-Purpose Medical Flexible Spending Account; **DCAP**-Dependent Care Assistance Program

Step 3: Participant Certification

To the best of my knowledge, the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses, incurred by myself or eligible dependents, as defined by the IRS and by my employer-sponsored Plan, and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement from any other source. I understand that Marshall & Sterling Employee Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement and if any expenses are found to be ineligible, I will be responsible for reimbursing the plan. If submitting expenses for my Dependent Care Assistance Program account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Marshall & Sterling Employee Benefits by submitting the form, I certify the above. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. I further agree to use this reimbursement to pay the providers for any balance owed for these services incurred.

PARTICIPANT SIGNATURE:_____ DATE: _____

COMPLETION GUIDE

In General

- Please complete the Reimbursement Request Form fully and clearly. Missing, incomplete, or illegible information may result in the denial or delay of your request.
- Please do not highlight any of your documentation, as highlighted sections may be unreadable when reviewed.
- Please keep a copy of all documentation that you submit.

For Section 2: Reimbursement Information

- **Plan Type:** Enter the code located in the key to identify the Plan account from which you are requesting reimbursement. Note: In the event you are enrolled in/eligible for more than one Plan, and the expense you are submitting is eligible for reimbursement under more than one Plan, your employer's Plan reimbursement sequencing rules may apply.
- **Did You File Online?**: If you entered your reimbursement request information at https://jfaflex.lh1ondemand.com, please mark "Y" for "Yes".
- **Date Expense Incurred:** This is the date when you actually received the product or service, not necessarily when you paid for the expense. For instance, you may have visited the doctor on September 1st, but not been billed or paid for the office visit until October 1st. The "date incurred" is September 1st.
- **Merchant/Provider Name:** Provide the details on where the expense was incurred.
- **Name of Person Receiving Product/Service:** Provide your name or the name of the eligible dependent for whom the service was provided, or product purchased. If you are claiming reimbursement for someone other than yourself, the individual must meet the definition of "dependent" under your Plan.
- **Amount:** Provide the total amount requested for each expense. This amount should be your "total responsibility" to the merchant/provider, minus any other insurance coverage that may be providing a partial benefit.
- **Total Reimbursement Requested:** Please total the amounts for each of your requested expenses. Please use additional forms as needed.

Documentation Requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received, or purchase was made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable).

If you are enrolled in a Deductible Reimbursement plan, you are required to obtain and provide an Explanation of Benefits (EOB) statement from the health insurance carrier, instead of a merchant/provider receipt. The EOB clearly indicates what portion of your medical services are subject to deductible, and therefore eligible for reimbursement under your specific Plan.

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (please be advised that if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider.
- Tax ID or Social Security Number of Provider

Unacceptable forms of documentation include:

- Provider statements that only indicate the amount paid, balance forward, or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet been rendered.

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, please have the provider write "co-payment" on the receipt and sign it.

Send your Reimbursement Request & Documentation to:

MARSHALL & STERLING EMPLOYEE BENEFITS FLEX:
42 SOUTH STREET, GLENS FALLS, NY 12801
FAX: 518.792.0226
EMAIL: flex@marshallsterling.com

Town of Glenville
2022 MFSA|DCAP Enrollment Form

Tell Us About Yourself:

Name (First Name + MI + Last Name)	**Social Security #**	**GENDER** ☐ Male ☐ Female	**Date of Birth (MM/DD/YY)**	
Mailing Address (Street, Apt No.)	**City**	**State**	**Zip Code**	**Telephone**
Email Address (required if you elect debit card or direct deposit)				

Information About Family Members You Want Enrolled Under Your Plan:

Name (First Name + MI + Last Name)	Social Security Number	Date of Birth	Gender
Spouse			☐ M ☐ F
Dependent: ☐ Child ☐ Other			☐ M ☐ F
Dependent: ☐ Child ☐ Other			☐ M ☐ F
Dependent: ☐ Child ☐ Other			☐ M ☐ F

Which Plan Type(S) & Coverage Amount(S) Are You Enrolling In?

MFSA

☐ **General-Purpose (most will choose this MFSA): $2,850 Maximum**

$_____ per pay x _____ deductions in Plan Year = $_____ MFSA Annual Election †

☐ **Limited-Purpose (only choose this option if you are also enrolled in an HSA through your employer or your spouse's employer):**

$_____ per pay x _____ deductions in Plan Year = $_____ MFSA Annual Election †

DCAP

☐ **Dependent Care Assistance Program: $5,000 Maximum**

$_____ per pay x _____ deductions in Plan Year = $_____ DCAP Annual Election †

Claim Reimbursement:

☐ **MSEB Flex Debit Card—and choose:**

☐ **Direct Deposit—to a personal bank account** (*sign up for Direct Deposit online or using the mobile app*) **OR:**

☐ **Check—mailed to your home address**

Employee Certification:

I hereby certify that the above information is correct. I further certify that I have read and agree to the* Terms and Conditions *outlined on the reverse.

_____ _____

Employee Signature **Date Signed**

To Be Completed By Employer:

Date of hire: _____ Effective date: _____

Employer Signature: _____ Date Signed: _____

TERMS & CONDITIONS:

If I have elected to participate in a **Medical Flexible Spending Account (MFSA)** or **Dependent Care Assistance Program (DCAP)**, I understand that an amount equal to the annual contributions for the coverages I have elected, divided by the number of pay periods in the Plan Year, will be deducted on a pre-tax basis from each of my paychecks (unless another method is prescribed by the Plan Administrator) to pay for the coverages that I have elected.

*Important Information for **MFSA** Participants: If you are separately electing to participate in a Health Savings Account (HSA), HSA benefits cannot be elected unless the Limited-Purpose Medical Flexible Spending Account option is selected. In addition, if the MFSA includes a Grace Period, and if you have an election for the MFSA benefit (other than the Limited-Purpose MFSA option that is in effect on the last day of a Plan Year), you cannot elect HSA benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in your MFSA (determined on a cash basis) is zero as of the last day of the Plan Year. For more information about how MFSA benefits can affect your eligibility to make HSA contributions (and your spouse's eligibility to do so, if you are married), please see your employer's Plan Summary.*

Income Exclusion for **DCAP** Benefits: I understand that the amount of DCAP benefits that I am able to exclude from my income may be less than the $5,000 maximum permitted under the Plan. I have no reason to believe that the amount of DCAP benefits that I am electing will exceed my applicable statutory limit *(Note: Your applicable statutory limit is the amount you can exclude from income for DCAP benefits and will depend on your marital status, tax filing status, and your own and your spouse's earned income. For example, certain individuals who are married and file a separate tax return can only exclude $2,500 of DCAP benefits from their income.)*

For the **MFSA** and **DCAP**, I understand that I cannot change or revoke this election ("Agreement") as of any date prior to the next Plan renewal date, unless a Change in Election Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the Change in Election Event, as described in the Plan.

For the **MFSA** and **DCAP**, I agree that my compensation will be reduced by the amount of my required contribution for the benefits that I have elected under the Plan, and that such Salary Reductions will continue for each pay period until this Agreement is amended or terminated. Salary reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes. If any unused amounts remain in my MFSA or DCAP accounts after reimbursing my eligible expenses incurred during the Plan Year or Grace Period (if applicable), these amounts will be forfeited. Prior to the end of each Plan Year, I will be offered the opportunity again to elect coverage for the following Plan Year. If I do not complete and return a new Agreement at that time, then I will be treated as having elected to waive all pretax benefits under the Plan and my pretax coverage will cease at the end of the Plan Year, subject to any rights I may have to be reimbursed for medical care expenses incurred during any applicable 2 1/2 –month Grace Period following the Plan Year from unused amounts in my accounts.

By enrolling in the group health plan, you are agreeing to enrollment in the integrated **Health Reimbursement Arrangement**. By enrolling in the Health Reimbursement Arrangement, you are agreeing to use any funds reimbursed to you to pay the providers of service for the claims submitted on your behalf.

For All Plans:

I consent to receive electronic communications at the email address specified in this Form, for any and all matters permitted by law regarding the Reimbursement Plan which is sent by, or on behalf of, the Plan or my employer. I certify that I have access to the above email address and am able to receive electronic messages with attachments at that email address. Should I subsequently provide the Plan Administrator with a different email address to use for these communications, this consent shall apply to that email address also. I understand that I may request a paper copy of any correspondence provided electronically at no charge by contacting the Plan Administrator in writing. Neither the Plan, nor the Employer, nor any agent of the Plan or Employer, shall be held liable for my not having received any communication by virtue of my inability to receive the communication at the email address I have provided. Any electronic communication sent shall be deemed to have been received by me. I may revoke this consent at any time by notifying the Plan Administrator in writing. If I should no longer have access to the email address last provided to the Plan Administrator, I shall immediately provide a new email address or revoke this consent.

I agree to notify the Plan Administrator in writing of any changes to my personal information that may affect the administration of my reimbursement benefits. This includes but is not limited to: changes in my mailing address; change of first or last name; change in email address (if provided); change of election amount (in the event of a qualifying event); and change of direct deposit banking information (if provided). I understand that neither my employer nor the Plan Administrator will be held liable for any delays or problems in the administration of my Plan or issue of my reimbursements, in the event that I fail to provide them with this information in an accurate and timely manner.

I agree to be responsible for paying any fees associated with having the Plan Administrator reissue reimbursement checks to me, in the event that initial payments issued to me are lost, stolen, misplaced, or otherwise not received by me in a timely manner. I agree to notify the Plan Administrator in writing, in the event that I wish a check to be reissued.

If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the Plan, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

If I am enrolled in a benefit for which a MSEB Flex Debit Card is issued to me or my eligible dependents, I certify that I will only use the MSEB Flex Debit Card to purchase eligible healthcare and/or dependent care products and services, as defined by the Plan. I certify that I will not seek reimbursement from any other source for the expenses paid for with the MSEB Flex Debit Card. If I receive reimbursement erroneously, or do not provide timely substantiation when requested, I agree to repay the Plan, and have my MSEB Flex Debit Card deactivated until such repayment is made. I agree to allow my employer to deduct ineligible debit card expenses/purchases from my wages, in the event that I do not provide timely substantiation of my transactions to the Plan Administrator, or if I otherwise utilize the MSEB Flex Debit Card in a non-compliant manner.

FRAUD NOTICE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, the insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

By enrolling in the group health plan, you are agreeing to enrollment in the integrated Health Reimbursement Arrangement. By enrolling in the Health Reimbursement Arrangement, you are agreeing to use any funds reimbursed to you to pay the providers of service for the claims submitted on your behalf.

†*Employer "rounding rules" may apply, which may result in a slightly lower annual withholding than elected*
‡*Employees enrolling in both the FSA and HRA need complete this Form only one time*

** HICN is the Medicare eligibility number. In accordance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Jaeger & Flynn is required to report HRA eligibility to the federal government. Note: If the Medicare-enrolled individual is under age 65, please indicate if the individual is entitled to Medicare due to End-Stage Renal Disease (ESRD).*

Authorization for Release of Protected Health Information (HIPAA Form)

Fax Completed Form to: 518.792.0226 | Questions/Assistance: 518.373.0069

Use this form if you wish to permit Marshall & Sterling Employee Benefits (MSEB) to discuss the details of your Health Plan, including any integrated or associated Flex Plans (HRA, FSA, HSA, etc.) with someone other than you. This may include information on your reimbursement request status, payments, denials, and account balances. The Notice of Privacy Practices can be found at http://jfaflex.lh1ondemand.com or www.marshallsterling.com/employee-benefits. If you would like a paper copy of the Notice of Privacy Practices, please email flex@marshallsterling.com.

This form must *also* be completed by any individual age 18 (spouse or child) and over who is covered by your Plan, if that individual permits MSEB to discuss his or her protected health information with you, even though you are the Plan holder, and may be requesting reimbursement for expenses incurred by that individual.

Instructions

This form is to document the designation of one or more Authorized Representative(s) for a participant. This form authorizes the release of personal health information as it relates to medical information to the name representative(s). This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any direct care decisions or account management. If you wish to set up a power of attorney or living will, please discuss this with your attorney. We will not condition benefit payments, enrollment, or eligibility for benefits on the execution of this form.

This form does NOT authorize the release of psychotherapy notes. This form does not constitute legal advice and is provided "as is." This form is based upon current federal law and is subject to change based upon changes in federal law or subsequent interpretive guidance. This form must be modified to reflect state law where the state law is more stringent.
You may refuse to sign this form.

Authorization & Disclosure

- I hereby authorize the use and disclosure of my individually identifiable health information as described below.
- I understand that signing this Authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.
- I understand that I am entitled to receive a copy of this form upon signing it.
- I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I have a right to revoke this Authorization, but that I must send a written revocation to the address below. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Patient & Authorized Representative Information

Your Name:	
ID Number (health plan, if applies):	
Your Date of Birth (MM/DD/YYYY)	
Person or organization authorized to RELEASE my health information (name, address, telephone)	Marshall & Sterling Employee Benefits, Flex 42 South Street, Glens Falls, NY 12801 (518) 373-0069
Person or organization authorized to RECEIVE my health information (name, address, telephone)	
Specific description of information to be disclosed: ☐ All of my health information ☐ Changes to online profile including resetting password ☐ HIV/AIDS-related information and/or records ☐ Mental health information and/or records ☐ Drug/alcohol diagnosis and treatment information ☐ Other:	This Authorization will expire on (date or event): ☐ As of this date: _____ ☐ After ___ months after death ☐ Upon divorce ☐ Upon my termination from the employer listed below ☐ Once I am no longer enrolled in any plans administered by MSEB ☐ Other:
What is the purpose of the disclosure?	

Signed:	**Date (MM/DD/YYYY):**
Printed Name:	**Name of Employer:** Town of Glenville
If signed by a patient representative, printed Representative Name:	**Relationship to patient, including authority for status as Representative:**