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**Utilize the benefits that are available to you!**

The University of Louisiana at Lafayette’s cafeteria plan offers employees use of a Flexible Spending Account (FSA). This reference guide is to be used to understand how an FSA can save you and your family tax money. We have two types of FSAs, Medical Expense Reimbursement FSA and Dependent Care Reimbursement FSA. For more detailed information on FSAs, you may refer to www.irs.gov, publication 502 or 969.

**Human Resources**

P.O. Box 40196
Lafayette, LA 70504
(337) 482-6242

**IMPORTANT DATES TO REMEMBER**

OPEN ENROLLMENT: OCTOBER 1 - DECEMBER 7

PLAN YEAR: JANUARY 1 - DECEMBER 31

CLAIMS DEADLINE: MARCH 15
Flexible Spending Accounts

With a Flexible Spending Account, you can set aside pre-tax money to use on medical expenses or dependent care expenses.

Flexible spending accounts reserve a portion of your paycheck to pay for dependent care expenses or eligible medical services and supplies that are normally not covered by insurance. Two types of FSA’s are available: Medical Expense Reimbursement FSA (Medical Expense FSA) and Dependent Care Reimbursement FSA (Dependent Care FSA).

Medical Expense FSA funds are available to you in full at the beginning of the plan year and are deducted before federal and state taxes are calculated on your paycheck. Dependent Care FSA funds are also deducted before tax however; they are only available as they are deducted from your paycheck.

With either FSA, you benefit from having less taxable income in each of your paychecks, which means your federal and state taxes will be lower than if you did not have an FSA.

Once you decide on your annual election/contribution amount (see Sample Election Form on page 12) of your Medical Expense
FSA and/or Dependent Care FSA, the amount is deducted in small, equal amounts from your paychecks during the plan year.

As part of the Patient Protection and Affordable Care Act (PPACA), effective January 1, 2013, the maximum contribution amount for a Medical Reimbursement FSA is $2500.

How to use your FSA

Filing a Medical Expense Reimbursement FSA Claim:
To file a claim, complete the university’s claim form in full and attach all supporting documents (See sample on page 13).
Supporting documents can be in the form of an itemized, third-party receipt or the Explanation of Benefits (EOB) from your insurance company. A receipt should include the following:
- Provider Name—Facility name or person who provided the service.
- Dates of Service—Service start and end date for services provided.
- Service Description—Detailed description for services provided.
- Amount—The amount incurred for the services.
- Patient Name—Person who received the service.

Receipts for prescriptions must have the patient’s name, prescription amount, and date of prescription. Keep a copy for yourself and submit all documents to the Human Resources Department. Human Resources will process your request for reimbursement and mail your reimbursement check to you within 7–10 business days.
FSA Savings Example*

<table>
<thead>
<tr>
<th></th>
<th>(With FSA)</th>
<th>(Without FSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Gross Income</td>
<td>$32,000</td>
<td>$32,000</td>
</tr>
<tr>
<td>FSA Contribution</td>
<td>2,500</td>
<td>0</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>29,500</td>
<td>32,000</td>
</tr>
<tr>
<td>Estimated Tax Withholding</td>
<td>6,092</td>
<td>6,608</td>
</tr>
<tr>
<td>Net Pay (Spendable Income)</td>
<td>$23,408</td>
<td>$22,892</td>
</tr>
<tr>
<td>Estimated Tax Savings</td>
<td>$516</td>
<td></td>
</tr>
</tbody>
</table>

*The estimated tax savings provided are for illustrative purposes only, and should not be construed as tax advice. Consult a licensed tax professional for appropriate advice given your circumstance.

Filing a Dependent Care Reimbursement FSA:

Once you have paid for your child’s day care service, send a completed claim form to Human Resources, along with documentation showing the following:

- Provider Name—Facility name or person who provided the service.
- Tax ID or SSN—Tax ID or social security number
- Dates of Service—Service start and end date for services rendered.
- Service Description—Detailed description for services rendered.
- Amount—The amount incurred for the services.
- Dependent Name—Person who received the service.

Your request will be processed and mailed to your home or office within 7–10 business days.
Examples of Eligible Expenses
Eligible expenses are defined by the IRS. [Click here for a full list]

Eligible Medical Expenses*
Acupuncture
Ambulance service
Birth control pills and contraceptives
Breast pumps
Chiropractic Care
Contact lenses (corrective)
Dental fees (non-cosmetic)
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Eyeglasses
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Insulin and diabetic supplies
Optometrist fees
Orthodontic treatment
Over-the-counter items, e.g. Band-Aids, glucosamine (some require prescription)
Prescriptions
Smoking cessation programs/treatments (w/ prescription)
Transportation for medical care
Weight-loss programs/meetings
Wheelchair

Eligible Dependent Care Expenses*
After school care  In-home services
Nursery and pre-school  Adult day care
Day care services  Summer day camps

*IRS-qualified expenses are subject to federal regulatory change at any time during a tax year.
Who is Eligible?

You are eligible if you are a full-time permanent employee, including temporary faculty employed for a one-academic-year contract. The expenses of spouses and qualified dependents of eligible employees are eligible for reimbursement through the medical expense reimbursement FSA.

What is Eligible?

IRS Code, Section 213(d) defines eligible medical expenses as amounts paid for the diagnosis, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be to alleviate or prevent a physical defect, illness or condition; and cannot be cosmetic in nature. Examples of cosmetic expenses include those for face lifts, teeth whitening, and electrolysis or hair transplants. Also, expenses that are beneficial to one’s general health, such as vitamins and supplements, are not considered eligible medical expenses, except if recommended by a physician to alleviate a medical condition. In this case your doctor must give you a Letter of Medical Necessity (LMN) for the item. Most over-the-counter medicines require a doctor’s prescription, except for insulin.
Annual Contribution Limits

For Medical Expense FSA:*
Maximum Annual Contribution Amount: $2500

For Dependent Care FSA:*
The maximum contribution depends on your tax filing status.
- Married and filing separately, $2500
- Married and filing jointly, $5000
- Single and head of household, $5000
- Single, $2500

*There is no minimum contribution amount for either account.

Important FSA Dates:

- Your Medical Reimbursement FSA (Health Care FSA) has a 2 ½ month grace period (ending March 15). During this grace period you may submit claims for expenses incurred during the first 2 ½ months of the new plan year, and any remaining funds in your account from the prior plan year can be reimbursed. Claims received during the first 2 ½ months of the new plan year will be automatically applied to any remaining prior year account balances.

- The three month run-out period (ending March 31) is the period of time after the plan year ends to claims for reimbursement for all FSA expenses incurred during the prior plan year (until March 15).
A Closer Look at FSA’s

Medical Expense FSA

Medical Expense FSA’s are used to pre-pay eligible medical expenses not covered by insurance. Eligible expenses include co-insurance payments, co-payments, prescriptions and other qualified medical expenses, such as dental and vision expenses. Over-the-counter (OTC) medicines (other than insulin) are not considered qualified medical expenses for FSA purposes. However, OTC medicines could be eligible if their purpose is to treat a diagnosed medical condition AND your doctor gives you a LMN. Otherwise, the medicine requires a prescription.

Qualified medical expenses are those incurred by the following persons.

1. You and your spouse.
2. All dependents you claim on your tax return
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,800 or more, or
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else’s tax return.
4. Your child age 26 or under at the end of the tax year.

Ineligible Medical Expenses

- Insurance premiums
- Vision warranties and service contracts
- Cosmetic surgery, vitamins/supplements, and massage therapy not deemed medically necessary to treat a medical condition

For a full list click here
Balance in an FSA

Flexible spending accounts are “use–it–or–lose–it” plans by IRS guidelines, meaning funds in the account at the end of the plan year cannot be carried over to the next year. The 2 ½ month grace period, however, allows you to incur qualified medical expenses before March 15 and receive reimbursement from prior year funds, as long as the claims are submitted within the three month run–out period (before March 31). Otherwise, prior year funds will be forfeited.

Dependent Care FSA

The Dependent Care FSA is a great way to save taxes on the money you spend on child care expenses that enable you and your spouse to work. Once enrolled for the Dependent Care FSA, funds are available to you as they are deposited into your account. In other words, every payroll date funds will be deposited into your account and will be available to you for reimbursement. Unlike a Medical Expense FSA, the entire maximum annual amount is not available all at once, but rather only after your payroll deductions are received.

Eligible Dependents

- Children 12 years old and under who reside in your household
- Adults or children who are physically or mentally incapable of self–care and spend at least 8 hours per day in your household
Ineligible Dependent Care Expenses

- Books/supplies
- Deposits/Registration fees, unless a part of a tuition fee
- Meals, transportation fees
- Kindergarten tuition and fees

Termination of Employment
If your employment with the University of Louisiana at Lafayette terminates, you may submit claims for reimbursement of funds for eligible expenses incurred prior to your termination date. Claims submitted for expenses incurred after your termination date will not be reimbursed. Requests for reimbursement may be submitted until the end of the plan year for both medical and dependent care accounts.

Changing Your Coverage

Changing your FSA election amount is not permitted during the plan year unless you experience a qualifying event. Within 30 days of a qualifying event, you must submit a Change in Status form and supporting documentation to the Human Resources Office. Upon approval of your election change request, your existing FSA elections will be stopped or modified as needed. See the following page for a summary of qualifying change in status events.
## Change in Status Events*

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td>Marriage, death of a spouse, divorce or annulment (legal separation not recognized in LA)</td>
</tr>
<tr>
<td>Change in Number of Dependents</td>
<td>A change in number of dependents resulting from marriage, birth, death, adoption and placement of adoption</td>
</tr>
<tr>
<td>Change of Employment Status</td>
<td>Change in employment status of the employee, spouse or dependent that affects eligibility, including beginning or end of employment</td>
</tr>
<tr>
<td>Change in Residence</td>
<td>Change in employment status of the employee, spouse or dependent that affects eligibility, including beginning or end of employment</td>
</tr>
<tr>
<td>Change in Residence</td>
<td>Change in place of residence of employee, spouse, or dependent that affects eligibility</td>
</tr>
<tr>
<td>Court order, judgment, or decree</td>
<td>Court order, judgment, or decree from a divorce, annulment, or change in legal custody that requires child(ren) to be enrolled in health coverage under the plan of the employee, spouse, or former spouse</td>
</tr>
<tr>
<td>Medicare/Medicaid</td>
<td>Employee or dependent becomes eligible or ineligible for Medicare or Medicaid</td>
</tr>
<tr>
<td>Cost and Coverage Change</td>
<td>A change to a Dependent Care FSA is permitted if there is a change in dependent care providers, producing a change in expense.</td>
</tr>
</tbody>
</table>

*Documentation with proof of change is required*
UL Lafayette Cafeteria Election Form

1. Personal Information (Complete all information. Please print)

Employee Social Security Number ___________________________ Department _______________ 12MO, 10MO or BW Employee

Last Name ___________________________ First Name ___________________________ Initial _______________

Full Address (Street or P.O. Box, Apt. Number, City, State and Zip Code) ___________________________ Phone Number ___________________________

2. Salary Conversion Plan

__ I choose to pay my medical, dental, life, AFLAC, and vision contributions through the Salary Conversion Plan on a before-tax basis.

__ I choose not to participate in the Salary Conversion Plan and my contributions should remain on an after-tax basis.

If you DO NOT return this form, your contribution will remain on an after-tax basis.

3. Health Care Spending Account

__ I choose to participate in a Health Care Spending Account (Maximum - $2,500).

__ I choose not to participate in a Health Care Spending Account.

My total election for the Plan Year is $ ____________.

4. Dependent Care Spending Account

__ I choose to participate in a Dependent Care Spending Account (Maximum - $5,000 or $2,500, if married and filing separately).

__ I choose not to participate in a Dependent Care Spending Account.

My total election for the plan year is $ ____________.

I understand that my election cannot be more than my annual salary or my spouse's (if married), whichever is less, and that reimbursement from all employer plans CANNOT exceed $5,000.

5. Signature

By signing this form, I understand that:

• My elections for the year cannot be changed unless my family circumstances change.

• Any money remaining in my account(s) after March 15th will be forfeited.

• The deductions I have elected are made in accordance with the Plan Document and will be deducted in equal installments from my paychecks.

• There is a small monthly fee for the handling and processing of claims related to your account(s).

Signature ___________________________ Date _______________

Insurance Effective Date: ___________________________

Employment Date: ___________________________

For the Plan Year beginning ________________________, 20_____.

Please return this form to the Human Resources Office.
**SPENDING ACCOUNT CLAIM FORM**

This request is for reimbursement of: (check only one)

- [ ] Health Care Expenses
- [ ] Day Care Expenses

**Please fill out every question from 1 through 4. Thank you.**

1. Name

2. Social Security Number ___________________________ Department ________

3. How are you paid? (Check only one)  
   Bi-weekly ________  Monthly ________  10-Month ________

4. Where would you like your check mailed? (Check only one)  
   Home ________  Department ________

   (If you are requesting your check at home, please verify your home address here. _____________________________)

---

**List of Expenses:**

List each service provided and attach bills, statements, or other evidence of these expenses (a cancelled check or a credit card receipt alone is not sufficient evidence regarding services rendered).

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Payment made to</th>
<th>Service provided (Medical, Dental, Vision, Day Care)</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Total Expenses Claiming:** $ __________

**Signature:**

I certify that the above expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. My health care plan or any other health care plans such as my spouse’s has not reimbursed these expenses. Bills, statements, or other evidence of these expenses are attached. In claiming reimbursement for dependent care expenses, I certify that my spouse and I WILL NOT receive reimbursement in excess of $3,000.00 from an employee sponsored dependent care spending account plan.

Signature: ___________________________  Date: __________

---

**For Human Resources ONLY**

Claim Number: ___________________________  Amount: __________

Claim Category: ___________________________  Total: __________
FLEXIBLE SPENDING ACCOUNTS

Human Resources Department
104 University Circle
P.O. Box 40196
Lafayette, LA 70504
Martin Hall, Room 170
(337) 482–6242 phone
(337) 482–1452 fax
humanresources@louisiana.edu