OptionALL

Section 125 Cafeteria Plan

- **Health Reimbursment Flexible Spending Account**
- **Dependent Care Flexible Spending Account**

Claims along with your signed FSA Withdrawal Request can be submitted either by fax at 517-333-6258 or mailing directly to MESSA at 1475 Kendale Blvd., Post Office Box 2560, East Lansing, MI 48826-2560.

If you have any questions, do not hesitate to contact MESSA OptionALL Department at 1-800-890-0393.

Toll free: 800-890-0393
Fax: 517-333-6258

FLEXIBLE SPENDING ACCOUNTS

Dependent Care

Up to $5,000 can be set aside per year per family

Unreimbursed Health

- Co-pays
- Deductibles
- Co-insurance
- Prescription Drugs
- Glasses and Contacts
- Braces and Dental Care
- Over-the-counter medications with prescription or special approval.

MESSA OptionALL

Two types of Flexible Spending Accounts (FSA) are available through OptionALL.

Health Reimbursment FSA

Dependent Care FSA

Flexible spending accounts are desiged to allow employees to pay for unreimbursed health expenses or dependent care on a pre-tax basis up to the annual maximum amount. This amount is set by the IRS and is subject to change each year.

The 2018 annual maximum is:

Health FSA:	**$2650**
Dependent Care FSA:	**$5000**

How FSAs work

Contributions to an FSA – Each year, during the Plan's open enrollment period, the employee determines their annual amount to contribute to the FSA. The annual amount is divided by the number of paychecks the employee will receive during the Plan year. The prorated amount is then deducted from each paycheck before taxes are withheld.

Withdrawls from an FSA – The employee *simply* completes an OptionALL Health or Dependent Care FSA Withdrawl Request form. These are located at www.messa.org. The employee submits the request, by fax or mail, to MESSA. MESSA processes the request and provideds a report to the employer indicating how much to reimburse the employee. We also provide a report to the employer indicating the employees balance.

NO personal health information is provided to your employer.

The maximum amount of the reimbursment is available at all times throughout the Plan year for health reimbursment accounts. However, dependent care accounts cannot reimburse beyond the current balance in the account.

Use it or lose it – NOT Anymore. If elected by your employer, money left over in your Health FSA account, at the end of the plan year up to a maximum of $500, can now be carried over to the next plan year.

Family status changes – If an employee has a change in family status during the Plan year (such as birth of a child, dealth of a dependent, divorce, etc.) the FSA contribution can be changed. Otherwise, the contribution amount cannot be changed until the next open enrollment period.

Examples of Flexible Spending Account Eligible Health Care Expense

Please note that these lists are not tax advice.
For more detailed information, please consult IRS Publication 502 or see your tax adviser.

- Acupuncture
- Chiropractic services
- Copayments
- Deductibles
- Contact solution
- Dentures
- Copayments
- LASIK/LASEK eye surgery
- Eye examinations
- Contact lenses
- Glasses
- Orthodontia
- Weight loss programs*
- Insulin
- Laboratory fees
- Medical alert (bracelet, necklace)
- Smoking cession programs
- Vitamins*
- Vaccinations
- Prescriptions
- Deaf services – hearing aid / batteries
- Nursing services
- Occlusal guards
- Physical exams (except for employment)

**if prescribed for a particular ailment or medical condition, provider letter or prescription required.*

Examples of
FSA Eligible Over-the-Counter Products

Copy of prescripiton as well as detailed receipt required for reimbursment.

Acne medication	Allergy & sinus, cold, flu & cough remedies	Antacids
Motion sickness remedies	Anti-gas & stomach remedies	Anti-itch & insect bite remedies
Digestive aids	First aid kits	Hydrogen peroxide
Nicotine patches & medications	Pain relievers	Sleep aids & sedatives

Eligible for Reimbursment with detailed receipt only (No prescription required)

Breast pumps for nursing	Braces & Supports	Contact lens solution
CPAP equipment	OTC varieties of insulin	Diabetic testing supplies/equipment
Durable medical equipment	Home diagnostic (pregnancy tests, blood pressure monitors, etc.)	Non-medicated bandages
Rolled bandages & dressings	Reading Glasses	

Examples of
FSA Non-Eligible Over-the-Counter Products

Baby bottles and cups		Baby wipes
Cotton swabs	Dental floss	Low calorie foods
Low-carb and low-fat foods	Hair regrowth preparations	Vitamins & supplements without a prescription.
Food	Fiber supplements	Cosmetics
Deodorants & antiperspirants	Shampoo & conditioner	Medicated shampoo & soaps

OptionAll Medical Expense Worksheet
for Estimating FSA Withholding

1 Deductible

What is your family's annual medical plan deductible? . . . . [ ]

2 Physician Office Copays

Do members of your family have any copay amounts for doctor office visits? How many, how often, and what is the typical cost of each?

*What is your **annual** out-of-pocket cost for physician copays?* . . . . [ ]

3 Prescriptions

Do members of your family have recurring prescriptions? How many, how often, and what is the typical cost of each?

*What is your **annual** out-of-pocket cost for prescriptions?* . . . . [ ]

4 Dental Care

Do members of your family have regular dental checkups each year? What is your typical copay for dental checkups? Do you have any out-of-pocket expenses for dentures, braces, retainers, etc.?

*What is your **annual** out-of-pocket cost for dental care?* . . . . [ ]

5 Vision Care

Do members of your family wear glasses or contacts, or have regular eye exams not covered by insurance? Do you use eye-wash, lens cleaner, etc.?

*What is your **annual** out-of pocket cost for eye care?* . . . . [ ]

6 Hearing Care

Do members of your family use a hearing aid, or have treatment for hearing loss? Do you have batteries to replace?

*What is your **annual** out-of-pocket cost for hearing care?* . . . . [ ]

7 Over-the-Counter Medical Items

Do members of your family use first aid supplies, vaporizers, eye care products, contraceptives, shoe inserts, crutches, etc.? Effective January 1, 2011, OTC medications (i.e., cold, flu, allergy medicines) will require a physician's prescription to obtain reimbursement from your FSA.

*What is your **annual** out-of-pocket cost for over-the-counter medical items?* . . . . [ ]

8 Total Annual Qualified Medical Expenses

Add the amounts from lines 1 - 7 . . . . [ ]

9 Complete the MESSA OptionAll Enrollment Form.

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MEA MEA-FS USO MESSA

What is a MESSA Flexible Spending Account (FSA)?

Summary
A flexible spending account allows you to reduce your taxable income, thereby reducing the taxes you pay, by taking into acocunt many of the out-of-pocket costs you spend on medical and dependent care expenses. This type of account is an excellent way to make your money work for

How it Works
In an FSA, you opt to have money taken from your gross pay before taxes are calculated. This reduces the amount of taxes you pay. The pre-tax money is put into an account that you draw from to pay for eligible expenses. The worksheet on this page shows many of the eligible expenses and will help you decide how much money you can effectively place into an FSA. It will also show you the estimated tax savings associated with your participation.

Instructions
Fill out the worksheet on this page to estimate your contribution and savings. When complete, take this sheet to your benefits coordinator.

Details and Exceptions
The money you put into your FSA must be used in that plan year so consider your contributions carefully. Over the Counter products must often be prescribed by a physician. See your plan document for

More Information
For more information on the substantial advantages of participating in a MESSA FSA, please contact your Field Rep or Field Services at 800.292.4910

MESSA Flexible Spending Account Worksheet

The following list highlights possible expenses that can be paid for with a FSA. Use this worksheet to estimate how many dollars you could effectively use in an FSA as well as the tax dollars you would save.

Dependent Care (a)

_______ ($5000 per family max)

Medical (b) (Sections b-e max TBD)

_______ Acupuncture
_______ Alcohol/Drug Treatment
_______ Allergy Services
_______ Ambulance
_______ Anesthesia
_______ Artificial Limbs
_______ Braille Books
_______ Chiropractor Fees
_______ Crutches, Wheelchairs
_______ Emergency Room
_______ Health Care Equipment
_______ Hospital Bills
_______ Immunizations
_______ Infertility Treatments
_______ Insulin & Diabetic Supplies
_______ Laboratory Fees
_______ Medical Deductibles
_______ Medical CoPays
_______ Mileage
_______ OB/GYN Exams
_______ Office Visits
_______ Osteopath Fees
_______ Certain Over the Counter Products
_______ Parking
_______ Physical Therapy
_______ Prescriptions
_______ Psychiatric Care
_______ Surgery
_______ Vaccinations
_______ X-Rays
_______ Medical Total (b)

Dental (c)

_______ Anesthesia
_______ Bondings
_______ Cleanings
_______ Crowns
_______ Bridges
_______ Exams
_______ Dentures
_______ Extractions
_______ Fillings
_______ Mileage
_______ Occlusal Guards
_______ Surgery
_______ Braces
_______ Root Canal
_______ X-Rays
_______ Dental Total

Vision (d)

_______ Contact lens Supplies
_______ Corrective Eye Wear
_______ Surgery
_______ Exams
_______ Mileage
_______ Prescription Glasses/Contacts
_______ Vision Total

Hearing (e)

_______ Hearing Aids
_______ Exams
_______ Mileage
_______ Telephone for the Hearing Impaired
_______ Hearing Total

Total Estimated Usable Contribution (a+b+c+d+e) $

Total Estimated Tax Savings (0.35 x Usable Contribution) $

MESSA

Good health. Good business. Great schools.

MESSA OptionALL

Medical / Dependent Care Flexible Spending Account

ELECTION AND SALARY REDUCTION AGREEMENT FORM

Employee name ______________________________
First *Middle* *Last*

Address ______________________________
Street *Apt. / lot #*

____
City *State* *Zip code*

Social security number ____________________ Gender ☐ male ☐ female

Job title ____________________ Date of birth ____________

School district where you're employed ______________________________

Daytime telephone number ______________________________

BENEFIT ELECTION

I am electing the following benefits:

ANNUAL EMPLOYEE CONTRIBUTION

_______ Dependent Care Reimbursement Plan ($5000 max) $ ____________

_______ Medical Reimbursement Plan ($2650 max) $ ____________

Number of pay periods ____________ First payroll deduction date ____________

DEPENDENT INFORMATION

First name	Middle initial	Last name	Social Security #	Relationship	Date of birth	Sex	F/T Student

I understand that this election will remain in effect in accordance with the rules and procedures of the MESSA OptionALL plan. I MUST complete a new Benefit Election form each plan year.

______________________________ ____________
Employee signature Date