Saratoga County 2024 Flexible Spending Account Options

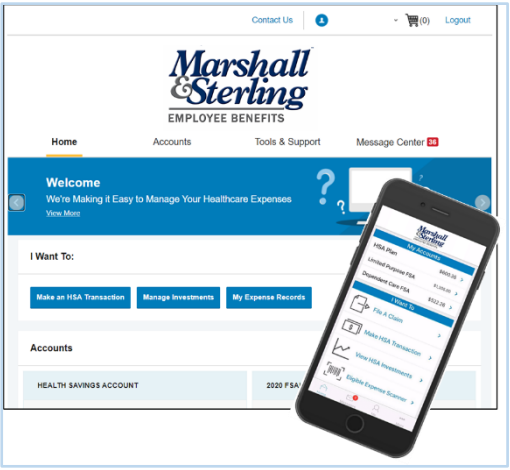
What are Flexible Spending Accounts?

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:	$3,200 in 2024		$5,000 (or $2,500 if married and filing separately) per calendar year
You should also know that:	Saratoga County has adopted a provision allows you to carry forward up to $640 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?	Full-time employees are eligible to participate the 1st of the month following date or hire. The plan year runs from 1/1/2024 – 12/31/2024. Expenses can be incurred from the date you enroll in the plan until the end of the plan year or upon termination from the plan. The deadline for filing reimbursement requests is 3/31/2025.		
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 **MSEB 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://msflex.lh1ondemand.com instead of completing this form.

Step 1: Participant Information	
Employer Name	Saratoga County
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://msflex.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

Direct Deposit Form

Fax Completed Form to 518.792.0226 | Questions/Assistance: 518.373.0069, Option 4

THE FASTEST AND EASIEST WAY TO ENROLL IN DIRECT DEPOSIT IS ONLINE AT https://msflex.lh1ondemand.com OR ON THE FLEX MOBILE APP. Use this form ONLY if online enrollment is not an option for you. Under Federal law, use of this form requires that we verify your account using a microdeposit which you are required to confirm within 3 days (this extra step is not required when you sign up online). You do not need to reenroll in direct deposit each year at open enrollment unless you are making a change to your bank account.

Step 1: Participant Information	
Employer Name	Saratoga County
Participant Name	
Participant Last 4 SSN	
Email Address	
Step 2: Financial Institution Information	
Important Note: A voided or photocopied check is required for all checking accounts; deposit slips cannot be accepted for checking accounts. If you remit this form without a voided check copy, MSEB will not be held responsible for any misdirected direct deposits because of incorrect information that is simply written below.	
Please CHECK ONE	I am ☐ beginning ☐ canceling ☐ changing a Direct Deposit account.
Account Type	☐ Checking ☐ Savings
Routing Number (must be 9 digits)	
Account Number	
Financial Institution Name & Address	
Step 3: Participant Authorization	
I hereby certify that the information provided on this form is accurate. Further, I understand my completion and submission of this form authorizes Marshall & Sterling Employee Benefits to issue payment directly to the specified account unless I notify them otherwise. I understand that I will be provided with notification of the amount and date of each direct deposit made. If I have provided an email address to MSEB, I understand that such notification will be made to me via email, and that neither the Plan, Employer, nor any agent of the Plan or Employer, shall be held liable for my not having received any communication by virtue of the inability to receive the communication at the email address provided. In the event funds are deposited erroneously into my account, I authorize Marshall & Sterling Employee Benefits to debit my account(s), not to exceed the original amount of the credit. I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.	
Participant Signature	
Date	
Step 4: Voided Check/Copy	
(Attach check copy here)	

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://msflex.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:** Saratoga County
If signed by a patient representative, printed Representative Name:	**Relationship to patient, including authority for status as Representative:**