



**MEDICAL REIMBURSEMENT
AND
DEPENDENT CARE
INFORMATION**



Welcome to the MSMA Group Insurance Medical and Dependent Care Reimbursement accounts.

The following information will help explain the IRS programs that allow you, the employee, to have pre-tax deductions for certain dependent care, medical and dental expenses. That means you will pay less in federal and state taxes resulting in more take home income.

ELIGIBILITY:

If you are a full time employee you will be considered eligible to participate in the IRS programs. Except if you or your spouse are actively contributing to an HSA you are not eligible to participate in a traditional FSA.

An application will be provided to each employee to be filled out and returned to the office. All signed forms must be returned to the administration office at the specified time set by the Plan Administrator. If the Plan Administrator within the specified time frame does not receive your completed form you will be ineligible to participate in the IRS programs for the current plan year.

IRREVOCABILITY OF YOUR ELECTION:

Elections made under this program will be irrevocable for the plan year, subject to a change in your family status. A change in family status includes marriage, divorce, death of your spouse or child, birth or adoption, termination of employment of your spouse. If a change in family status does take place you will be required to fill out a new election form within 30 days of that change. A form received after the 30-day deadline will not be processed and any change will have to be made during open enrollment for the following plan year.

CLAIMS PROCESSING:

Administration of the IRS accounts is complicated and governed by IRS Code 125 (Medical/Dental Care Reimbursement) and 129 (Dependent Care Reimbursement). MSMA will process all claims for participants in our Augusta, Maine office. If you have any questions or need assistance please give our Customer Service Representative, Michelle, a call at 800-660-8484. She is available to answer your questions from 7:00 a.m. till 3:15 p.m. Monday through Friday.

Quarterly statements are available to participants on request. In addition, notices will be sent to each school district thirty (30) days before the end of the plan year to remind employees to use the balance in his/her account or risk forfeiture. IRS regulations allow medical reimbursement plans to rollover up to \$610 into the next plan year if there are funds left over in your account at the end of the current plan year. Any amount over \$610 will be forfeited after a 90-day run-off period at the end of the current plan year.

ADMINISTRATION FEES:

There is a per month/per employee administrative fee charged on an after tax basis. The fees for participation are as follows:

Dependent Care:	\$4.00 per month/per employee (after tax)
Medical Care:	\$4.00 per month/per employee (after tax)

If you participate in both accounts:	\$6.00 per month/per employee (after tax)
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MEDICAL CARE REIMBURSEMENT ACCOUNT EXPENSES

ELIGIBLE HEALTH CARE EXPENSES

The following is a list of expenses that the U.S Government has historically considered eligible for income tax purposes under Section 125.

PROFESSIONAL SERVICES	MEDICINES AND DRUGS	EQUIPMENT & SUPPLIES
Chiropodist Chiropractor Christian Science Practitioner Dermatologist Dentist Gynecologist Massage Therapist*** Neurologist Nurse Practitioner Optician Orthodontist Ophthalmologist Osteopath Payments to an unlicensed practitioner if type/quality of services are not illegal Pediatrician Physician Physiotherapist Plastic Surgeon Podiatrist Psychiatrist Psychoanalyst Psychologist Registered Nurse Specialist Surgeon	Cost of prescriptions Insulin Vitamins - expenses for vitamins prescribed by a physician and only available by prescription and used to treat a specific medical condition are reimbursable. Retin-A - only for treatment of acne, but not for wrinkles Rogaine - only when prescribed to treat a specific medical condition, but not to stimulate hair growth Birth Control Vaccines	Orthopedic shoes Oxygen and equipment Special mattress/plywood bed for relief of arthritis or spine*** Splints Telephone - installation, repair and cost of special telephone equipment for the deaf (TTY) Wheelchair Wig ***
	<u>HOSPITAL SERVICES</u>	<u>MEDICAL TREATMENTS</u>
	Anesthetist Hospital bills Inpatient services Outpatient services Oxygen mask/tent Operating room Private room	Abortion Acupuncture Alcohol and drug abuse treatment Blood transfusion Diathermy Electric shock treatment Hearing services Hydrotherapy Infertility/impotence Injections Massage therapy*** Nursing Organ transplant Psychoanalysis, psychiatric care Radial keratotomy; PRK; Lasik Radium therapy Sterilization Therapy Ultra-violet ray treatments Vasectomy Whirlpool baths*** X-ray treatments
	<u>EQUIPMENT & SUPPLIES</u>	
<u>DENTAL SERVICES</u>	Abdominal supports Air conditioner*** Ambulance Arches Artificial teeth, eyes, limbs Back supports*** Braces Canes Capital expenses - reasonable costs to accommodate a personal residence for a disabled condition. Refer to Code Section 213 for details Contact lenses and solutions required to maintain them Crutches Elastic hosiery Eyeglasses Fluoridation unit in home Hearing aids & batteries Heating devices*** Invalid chair Iron lung	<u>MISCELLANEOUS</u>
Cleaning teeth Dental x-rays Extracting teeth Fillings Gum treatment Oral surgery Straightening teeth Braces/Retainers/Appliances Dentures Restorative treatments		Asylum, nursing home, sanitarium and convalescent home Braille books - excess cost of Braille works over cost of printed editions Childbirth/Lamaze class for mother only Guide dog or other trained animal Human guide for blind person Organ donor's expenses Nurses board and wages Special school costs for physically and mentally handicapped children TTY and television adapter for closed captioning for deaf person
<u>LABORATORY FEES</u>		
You can include in medical expenses the amounts you pay for laboratory fees that are part of your medical care.		

*** This expense is only eligible when prescribed and substantiated by a physician to treat a physical defect or illness.

SEE OTHER SIDE FOR INELIGIBLE EXPENSES

MEDICAL CARE REIMBURSEMENT ACCOUNT EXPENSES

INELIGIBLE HEALTH CARE EXPENSES

The following is a list of expenses which have been deemed by the I.R.S. not reimbursable under Section 125.

Antiseptic diaper service	Ear piercing	Special foods/beverages - but excess cost of organic foods, over what would have normally been spent, (if medically necessary for allergies) can be reimbursed
Athletic club expenses	Electrolysis	Tattooing
Baby sitting fees to enable you to make doctor's visits	Employment related physicals	Toothpaste
Boarding school fees paid for healthy child while parent is recuperating from illness even if advised by doctor.	Funeral, cremation or burial or other related expenses	Transportation for cost of disabled person to/from work
Bottled water	Health programs offered by resorts, hotels, health clubs and gyms	Travel costs to look for a new place to live even on doctor's advice
Contact lens replacement insurance	Health insurance premium	Travel costs to a favorable climate
Cosmetic surgery or treatment	Illegal operations and drugs	Tuition and travel expenses to send a "non-disabled problem child" to a particular school for change in environment
Cost of divorce	Laetrile	Veterinary or other expenses for pets
Cost of hotel room suggested for sex therapy	Marijuana - even if prescribed for medicinal purposes	Tonics, homeopathic remedies
Cost of trips for a "change of environment" to boost morale of ailing person even if prescribed by doctor	Marriage counseling	Wigs for cosmetic purposes only
Dance lessons even if prescribed by physician	Maternity clothes	Your divorced spouse's medical bills
Dental bleaching & other cosmetic work	Over the counter medicines ***	
Domestic help	Personal use items	
	Premiums: life, disability, double indemnity, maintenance contracts, etc.	
	Scientology fees	

THE FOLLOWING EXPENSES ARE REIMBURSABLE ONLY IF THEY MEET THE CRITERIA AS SET FORTH BY THE INTERNAL REVENUE SERVICE:

Breast augmentation - Expenses related to breast augmentation (such as implants or injections) are not reimbursable because the procedure is cosmetic in nature. However, medical costs related to (1) the removal of breast implants that are defective/causing a medical problem or (2) require reconstruction due to surgery are reimbursable.

Breast reduction - Medical expenses related to breast reduction surgery are reimbursable only if a physician substantiates that the procedure is medically necessary and not for cosmetic purposes.

Lodging and meals - The cost of lodging and meals NOT provided in a hospital or similar institution while an employee is away from home is reimbursable if four requirements are met: (1) lodging is primarily for and essential to medical care; (2) medical care is provided by a doctor in a licensed hospital or in a medical facility related to, or the equivalent of, a licensed hospital; (3) the lodging is not lavish or extravagant; and (4) there is no significant element of personal pleasure, recreation or vacation in the travel away from home. Lodging is included for a person who is travelling with the person receiving medical care. The reimbursable amount cannot exceed \$50.00 for each night for each person. (maximum of \$100 per night).

Smoking program - The cost of an "over-the-counter" program to stop smoking for the improvement of general health is not reimbursable. However, if the program is prescribed by a doctor, and filled by a pharmacy, the expense can be reimbursed. The physician will be required to substantiate this treatment.

Tuition - Charges for medical care included in the tuition of a college or private school are reimbursable if the charges are separately stated. Health services received at educational institutions will still need to go through insurance before being reimbursed.

Weight loss programs - The cost of a weight loss program for general health is not reimbursable, even if suggested by your doctor. However, if the program is prescribed to treat a specific medical condition (such as cardiac disease), the expense can be reimbursed. The physician will be required to substantiate this treatment.

DEFINITION:

"Medical Care" expenses include 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 or illness. Expenses for solely cosmetic reasons are not expenses for medical care.

Resources:

Department of Treasury/Internal Revenue Service; Publication numbers: 502 & 503
Thompson Publishing Group, Inc.; Flex Plan Handbook

SEE OTHER SIDE FOR ELIGIBLE EXPENSES



MEDICAL CARE REIMBURSEMENT ACCOUNT

The medical reimbursement account gives you an opportunity to pay for healthcare and dental expenses with tax-free dollars (when not paid by a medical or dental insurance plan). The maximum amount an employee may elect is subject to the cap set by the school district.

If you need to determine if an expense is eligible an IRS list describing eligible and ineligible healthcare expenses has been attached for your use.

The medical care reimbursement account offers attractive tax savings, however, there are certain IRS rules that need to be considered:

- 1) *Expenses reimbursed through this account cannot be claimed as an income tax deduction.*
- 2) *Employees cannot change their election amount until the next plan year unless a family status change has taken place.*
- 3) *At the end of the plan year up to \$610 can be rolled over to the next plan year. Any amount over \$610 will be forfeited.*
- 4) *Health insurance premiums cannot be funded through this account.*
- 5) *If you or your spouse are actively contributing to an HSA you are not eligible to participate.*

If you terminate your employment you will cease to be a member of this program. Expenses incurred prior to the date of your termination are eligible for payment from the account.

Quarterly statements are available to participants on request. In addition, notices will be sent to each school district thirty (30) days before the end of the plan year to remind employees to use the balance in his/her account or risk forfeiture. All remaining funds are subject to forfeiture except for the \$610 rollover option allowed by IRS regulations.

Filing Claims There are 3 options for filing Medical Reimbursement claims:

- Debit Cards at pharmacy or medical/dental professional. (Bill will be required for claim substantiation for anything other than a co-pay or prescription. Must have provider name, patient name, date of service, description of expense, amount of expense, patient paid portion.)
- Mailing medical receipts to MSMA along with the medical reimbursement claim form. This results in a check or direct deposit sent to the member no later than 2 weeks after claim is received.
- Uploading medical receipts onto your consumer portal at <https://msma.lh1ondemand.com>. **Dependent care claims can only be mailed or uploaded, debit cards are not available for that program. Be sure to include the dependent care claim form which is also found on the tools and support tab on the portal.**

We recommend that you keep a copy of your claims in case questions arise during processing.

Domestic Partner expenses are not eligible for reimbursement, as a domestic partner does not meet the definition of dependent under Section 152 of the Internal Revenue Code.



Health Care Reimbursement Worksheet

This worksheet has been developed to help estimate your out of pocket health care and dental expenses for the coming plan year. Suggestions in each category are listed below. As a guide you can use your prior year expenses in order to calculate your deduction.

Medical

\$ _____

Such as: deductibles, co-insurance payments, routine exams(e.g., OB_GYN, physicals, etc.), office co-payments (e.g., \$20.00 per visit), prescription co-payments, hearing aids and exams, vision care (e.g., eye exams, contact lenses, prescription eye wear), medically required equipment (e.g., wheelchair, prosthetic devices), chiropractor and emergency room charges.

Dental

\$ _____

Such as: deductibles, co-insurance payments, orthodontia (e.g., braces, retainer ****read special rules applying to orthodontic care below****), other (non-cosmetic) dental expenses not covered by insurance

TOTAL HEALTH CARE & DENTAL EXPENSES

\$ _____

(Transfer this amount to your enrollment form)

To determine the amount of money you may want to contribute to your FSA each paycheck, divide your Total Health Care Expenses by the number of pay periods in the plan year.

\$ _____ / _____ = \$ _____ per paycheck contributed to your FSA
(total expenses listed above) (number of pay periods)

Please Note Special Rules For Orthodontic Care

- Initial requests for reimbursement should include a copy of the orthodontic care contract.
- Payment must be made in order to be reimbursed, prepayment is not allowed.
- The date a payment is made to the provider is considered the date of service, not the date the payment is due.



DEPENDENT CARE REIMBURSEMENT ACCOUNT

The dependent care reimbursement account gives you an opportunity to pay for certain dependent care expenses with tax-free dollars. This account can be used only for dependents that can be claimed on employee's income tax return, under the age of 13 or mentally or physically disabled. This also includes elderly parents and disabled children of any age.

IRS guidelines allow an employee to deposit up to \$5,000 per year if single or married filing jointly; \$2,500 per year if married and filing separate returns. If both the employee and spouse contribute to dependent care accounts and file a joint tax return, the maximum combined annual contribution is \$5,000. If the employee's spouse is a full time student or disabled, he/she may contribute up to \$2,400 a year for one dependent and \$4,800 for two or more.

The dependent care account may be more valuable than the dependent care tax credit for individuals with household incomes of \$39,000 or more. We do encourage employees to consult their tax advisors as to whether or not it would be advisable to participate in the dependent care reimbursement account.

Employees who incur qualified dependent care expenses must send receipts with claim form to our office for processing. The receipt needs to be a written statement from an independent third party stating that the expense has been incurred and providing the total amount of the expense and signed by the provider. The receipt should also contain the following information: employee's name, dependent's name, period during which the services were rendered; name, address and taxpayer identification number (TIN) of the individual or organization providing services and a description of the service provided. A sample form has been included in this packet for your information. Payments are made weekly as long as there is enough money in the account to cover the claim.

The dependent care reimbursement account offers attractive tax savings, however, there are certain IRS rules that need to be considered:

- 1) *Expenses reimbursed through this account cannot be claimed as income tax credits.*
- 2) *Employees cannot change their elections until the next plan year unless they have a family status change.*
- 3) *Any money left in the account at the end of the plan year is forfeited.*
- 4) *The employee must file form 2441 with the IRS.*

Employees can use the dependent care account to pay for: after school care, care provided in or outside your home by someone other than another dependent, daycare centers, nursery school, pre-school tuition.



MEDICAL CARE EXPENSE REIMBURSEMENT REQUEST

INSTRUCTIONS: Complete this form and attach a copy of an invoice/receipt from the provider that clearly identifies the following: (1) Patient Name; (2) Provider Name; (3) Date of Service; (4) Description of Service or Product; (5) Total Cost of Service or Product; and (6) Total Amount Owed by Patient as Determined by the Provider. **Do not send copies of checks or charge-card receipts.**

FOR A CLAIM FORM OR CURRENT LIST OF REIMBURSABLE EXPENSES PLEASE GO TO OUR WEBSITE @ WWW.MSMAWEB.COM

Employee Name: _____ Employer: _____

Please fill out the information only if a change has taken place since your enrollment or last claim submission	
Home Phone: _____	Work Phone: _____
Email Address: _____	
Mailing Address: _____	

Please list the name and relationship of all dependents for whom expenses were incurred:

NAME	RELATIONSHIP
_____	_____

TOTAL EXPENSES SUBMITTED\$ _____

CERTIFY THAT: all items submitted for reimbursement comply with the Section 125 Reimbursement Plan and such items have not and will not be paid by any other plan of any employer or any other person. I also certify that such items will not be deducted or taken as tax credits on my personal federal or state income tax return any year.

EMPLOYEE SIGNATURE:

Send your request for reimbursement to:

**MSMA-GIT/125
49 Community Drive
Augusta, ME 04330**

DATE:

(MSMA USE ONLY)

APPROVED _____ DATE _____

Please call with any questions:

Out of state: 1-800-660-8484

In state: (207) 622-3473

CLAIMS CANNOT BE FAXED



DAYCARE RECEIPT

Daycare Provider:

Address: _____

Tax ID#: ____ _____

Date: _____

Received from _____

In the amount of \$ _____

Daycare provided for

For dates of service _____ to _____

Daycare provider signature:



Date Received

MSMA USE ONLY

DEPENDENT CARE EXPENSE REIMBURSEMENT REQUEST

FOR A CLAIM FORM PLEASE GO TO OUR WEBSITE WWW.MSMAWEB.COM

INSTRUCTIONS: Complete this form and attach a receipt, which includes a description of the expense, date(s) of service, amount paid, the provider's name, address and federal tax-payer identification number. Do not send copies of checks or charge-card receipts.

Employee Name: _____ Employer: _____

Please fill out this information only if a change has taken place since your enrollment or last claim submission

Home Phone: _____ Work Phone: _____

Email Address: _____

Mailing Address: _____

Please complete the following:
NAME

RELATIONSHIP

DATE(S) DAYCARE EXPENSES WERE INCURRED	AMOUNT PAID
TOTAL AMOUNT PAID \$	

I CERTIFY THAT: all items submitted for reimbursement comply with the Section 125 Reimbursement Plan and such items have not and will not be paid by any other plan of any employer or any other person. I also certify that such items will not be deducted or taken as tax credits on my personal federal or state income tax return any year. *Note: prepare to file the IRSform 2441 with your tax return*

EMPLOYEE SIGNATURE:

DATE:

Send your request for reimbursement to:
MSMA-GIT/129
49 Community Drive
Augusta, ME 04330
Out of state: 1-800-660-8484
In state: (207) 622-3473

(FOR OFFICE USE ONLY)

APPROVED _____ DATE _____



Frequently Asked Questions on the FSA Prepaid Benefits Card

General Questions on the FSA Prepaid Benefits Card

1. What is the FSA Prepaid Benefits Card?

The FSA Prepaid Benefits Card is a special-purpose Visa® Card that gives participants an easy, automatic way to pay for eligible health care/benefit expenses. The Card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs).

2. How does the Prepaid Benefits Card work?

It works like a Visa® Card, with the value of the participant's account(s) contribution stored on it. When participants have eligible expenses at a business that accepts Visa debit cards, they simply use their Card. The amount of the eligible purchases will be deducted – automatically – from their account and the pre-tax dollars will be electronically transferred to the provider/merchant for immediate payment.

3. How does the FSA Prepaid Benefits Card change how the participant is reimbursed for expenses?

Before the FSA Prepaid Benefits Card became available, participants had to pay for their eligible expenses at the time of purchase, submit claim forms along with all receipts, and then wait for the reimbursement to be processed. Checks were issued and mailed to the participants, who then cashed the checks. In essence, participants “paid twice” – through payroll deduction and then at the point of sale – then they had to wait for reimbursement.

However, with the FSA Prepaid Benefits Card, participants simply swipe their Cards and the funds are automatically deducted from their respective benefit account(s) for payment. The Card eliminates most out-of-pocket cash outlays and paperwork, as well as the need to wait for reimbursement checks.

4. Is the FSA Prepaid Benefits Card just like other Visa® Cards?

No. The FSA Prepaid Benefits Card is a special-purpose Visa Card that can be used only for eligible health care/benefits expenses. It cannot be used, for instance, at gas stations or restaurants. There are no monthly bills and no interest.

5. How many FSA Prepaid Benefits Cards will the participant receive?

On or around July 1st, the participant will receive two Cards at no cost. If participants would like additional Cards for other family members, they should contact MSMA. There is a \$5 fee per card for additional cards.

6. Will participants receive a new FSA Prepaid Benefits Card each year?

No, participants will not receive a new Card each year. If the participant will again have a benefit associated with the Card for the following plan year – and he/she used the Card in the current benefit year – the participant will simply keep using the same Card the following year. The Card will be loaded with the new annual election amount at the start of each plan year or incrementally with each pay period, based on the type of account(s) the participant has.

7. What if the Card is lost or stolen?

Participants should call MSMA to report a Card lost or stolen as soon as they realize it is missing, so the MSMA can turn off their current Card(s) and issue replacement Card(s). There is a \$5 fee for any replacement cards.

Getting Started and Activating Your Card

1. How do participants activate the Card?

Participants should call the toll-free number on the activation sticker on the front of the Card or visit the web site on the back of the Card.

Participants can use both Cards once the first Card is activated – they do not need to activate both. They should wait one business day after activation to use their Cards. Each Card user should sign the Card with his or her own name.

2. What dollar amount is on the FSA Prepaid Benefits Card when it is activated?

For Health Care FSAs, the dollar value on the Card will be the annual amount that participants elected to contribute to their respective employee benefit account(s) during their annual benefits enrollment. It's from that total dollar amount that eligible expenses will be deducted as participants use their Cards or submit manual claims.

Using the Card

1. Where may participants use the FSA Prepaid Benefits Card?

IRS regulations allow participants to use their Prepaid Benefits Cards in participating pharmacies, mail-order pharmacies, discount stores, department stores, and supermarkets that can identify FSA-eligible items at checkout and accept Visa® prepaid cards. Eligible expenses are deducted from the account balance at the point of sale. Transactions can be fully substantiated by the merchant, and therefore no paper follow-up is needed. Participants can find out which merchants are participating by visiting the web site on the back of the Card or consulting MSMA.

Some plan designs may also allow participants to use their Cards in pharmacies that have certified that 90% of the merchandise they sell is FSA-eligible. However, since these pharmacies cannot identify the eligible items at the point of sale, another form of auto substantiation or paper follow-up will be required.

Participants may also use the Card to pay a hospital, doctor, dentist, or vision provider that accepts Visa®. In this case, EB uses its auto-substantiation technology to electronically verify the transaction's eligibility according to IRS rules. If the transaction cannot be auto substantiated, paper follow-up will be required.

2. Are there places the FSA Prepaid Benefits Card won't be accepted?

Yes. The Card will not be accepted at locations that do not offer the eligible goods and services, such as hardware stores, restaurants, bookstores, gas stations and home improvement stores.

Cards will not be accepted at pharmacies, mail-order pharmacies, discount stores, department stores, and supermarkets that **cannot** identify FSA-eligible items at checkout. The Card transaction may be declined. Participants can find out which merchants are participating by visiting the web site on the back of the Card or consulting MSMA.

3. If asked, should participants select “Debit” or “Credit”?

Your FSA Prepaid Benefits Card is actually a prepaid card. But, since there is no “prepaid” selection available, participants should select “Credit.” Participants do not need PIN and cannot get cash with the FSA Prepaid Benefits Card.

4. How does the Card work in participating pharmacies, discount stores, department stores, and supermarkets?

- a. Bring prescriptions, vision products, eligible OTCs and other purchases to the register at checkout to let the clerk ring them up. (Please note: The list of eligible OTC items changed per the Patient Protection and Affordable Care Act of 2010. Contact your Plan Administrator for more information.)
- b. Present the Card and swipe it for payment.
- c. If the Card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the products are FSA-eligible), the amount of the FSA-eligible purchases is deducted from the account balance and no receipt follow up is required. The clerk will then ask for another form of payment for the non-FSA-eligible items.
- d. If the Card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.
- e. The receipt will identify the FSA-eligible items and may also show a subtotal of the FSA-eligible purchases.
- f. In most cases, the participant will not receive requests for receipts for FSA-eligible purchases made in participating pharmacies, discount stores, department stores, or supermarkets.

5. Why do participants need to save all of their itemized receipts?

Participants and their other eligible users should always save itemized receipts for FSA purchases made with the FSA Prepaid Benefits Card. They may be asked to submit receipts to verify that their expenses comply with IRS guidelines. Each receipt must show: the merchant or provider name, the service received or the item purchased, the date of service, the amount of the purchase, and any insurance payments made on service. The IRS requires that every card transaction must be substantiated. This can occur through automated processing as outlined by the IRS (e.g. copay matching, etc.). If the automated processing is unable to substantiate a transaction, the IRS requires that itemized receipts must be submitted in order to validate expense eligibility.

6. How long do participants need to save their itemized receipts?

Participants should save itemized receipts for FSAs until the end of the benefit year and/or grace period (if applicable).

7. What if participants lose their receipts or accidentally swipe the Card for something that’s not eligible?

Usually the service provider can recreate an account history and provide a replacement receipt. In the event that a receipt cannot be located, recreated, or if the expense is ineligible for reimbursement, the participant can send a check or money order to MSMA for the amount so it can be credited back to the participant’s FSA account.

8. May participants use the FSA Prepaid Benefits Card for prescriptions ordered prior to activating the Card?

No. The Card must be activated prior to the order and/or purchase date of prescriptions. In some cases, participants need to wait 1 business day after activating the Card to purchase prescriptions at their pharmacy. For example, if the Card is activated on Tuesday, a prescription can be ordered and picked up on Wednesday.

9. May participants use the FSA Prepaid Benefits Card if they receive a statement with a Patient Due Balance for a medical service?

Yes. As long as they have money in their account for the balance due, the services were incurred during the current plan year, and the provider accepts Visa® debit cards, participants can simply write the Card number on their statement and send it back to the provider.

10. Sometimes the participant is asked for the CVV when paying the balance due or when placing an order by phone or online. What is this and where is it found?

CVV stands for “Card Verification Value.” It is a 3-digit number that can be found on the back of the card to the right of the signature panel.

11. How do participants know how much is in their account?

They can visit their personal Account Summary page at <https://msma.lh1ondemand.com> on MSMA’s web site and view their account activity and current balance. Or, they can call MSMA at the phone number on the back of the Card to obtain their current balance. Participants should always know their account balance before making a purchase with the Card.

12. What if participants have an expense that is more than the amount left in their account?

By checking their account balance often – either online or by calling MSMA at the phone number shown on the back of the Card – participants will have a good idea of how much is available. When incurring an expense that is greater than the amount remaining in their account, participants may be able to split the cost at the register. (Check with the merchant.) For example, participants may tell the clerk to use the FSA Prepaid Benefits Card for the exact amount left in the account, and then pay the remaining balance separately. Alternatively, participants may pay by another means and submit the eligible transaction manually via a claim form with the appropriate documentation to MSMA.

13. What are some reasons that the FSA Prepaid Benefits Card might not work at point of sale?

The most common reasons why a Card may be declined at the point of sale are:

- a. The Card has not been activated.
- b. The Card has been used before the 24-hour period after activation is over.
- c. The participant has insufficient funds in his or her employee benefit account to cover the expense.
- d. Non-eligible expenses have been included at the point-of-sale. (Retry the transaction with the eligible expense only.)
- e. The merchant is encountering problems (e.g. coding or swipe box issues).
- f. The pharmacy, discount store, department store, or supermarket cannot identify FSA/HRA-eligible items at checkout according to IRS rules.

14. Is the participant responsible for charges on lost or stolen cards?

If the MSMA and the issuing bank are notified within 2 business days, the participant will not be responsible for any charges. If the notification is after 2 days, the participant may be responsible for the first \$50 or more. Replacement Cards may be purchased.

15. Whom do participants call if they have questions about the FSA Prepaid Benefits Card?

Call MSMA at the phone number shown on the back of the Card.

16. How will a participant know to submit receipts to verify a charge?

The participant will receive a letter or notification from MSMA if there is a need to submit a receipt. All receipts should be saved per the IRS regulations.

17. What if a participant fails to submit receipts to verify a charge?

If receipts are not submitted as requested to verify a charge made with Prepaid Benefits Card, then the Card may be suspended for not providing the proper documentation to MSMA. The participant may be required to repay the amount charged. MSMA will advise the participant that the Card has been suspended, if a receipt is not received. Submitting a receipt or repaying the amount in question will allow the Card to become active again.