

## **DEPENDENT CARE REIMBURSEMENT ACCOUNT**

This Summary Plan Description describes the features of Dependent Care Reimbursement Account. It explains who is eligible, summarizes the benefits and outlines the procedures for filing claims and what happens if a claim is denied.

This Summary Plan description references, and is issued as part of the Capital Area Health Consortium Cafeteria Optional Plan Document.

### **PURPOSES OF DEPENDENT CARE REIMBURSEMENT ACCOUNT**

If you are eligible to participate in the Capital Area Health Consortium's Optional Plan, then you may elect to contribute (pursuant to a salary reduction agreement under the Optional Plan) a limited amount of pre-tax dollars to a Dependent Care Reimbursement Account. The amount credited to your Dependent Care Reimbursement Account will be used to reimburse you for dependent care expenses incurred by you in order that you (and your spouse, if applicable) can be gainfully employed or your spouse may qualify as a full time student. Both the amount by which you elect to reduce your salary as well as the amounts reimbursed will be excluded from your federal gross income. **Since you will reduce your earnings for Social Security tax purposes, your future Social Security benefits may be reduced if your reduced earnings are less than the current taxable wage base.** Contact the Capital Area Health Consortium if you have any questions.

### **BENEFIT OPTIONS AND LIMITS**

Single employees or married employees filing a joint return may, for each plan year, elect to deposit to your Dependent Care Reimbursement Account any amount up to a \$5,000 maximum (\$2,500 if you are married and file a separate federal income tax return).

The amount of dependent care expenses which may be excluded from your federal gross income in any given plan year shall not exceed your income for the plan year, or your spouse's income for the plan year, whichever is less. **The amount of dependent care expenses funded through your Dependent Care Reimbursement Account will reduce, dollar for dollar, any tax credit that may be available to you on your federal income tax return.**

### **SPECIAL RULES AND DEFINITIONS**

The Dependent Care Reimbursement Account is a "dependent care assistance program" within the meaning of Section 129 of the Internal Revenue Code and expenses paid from the fund will be excluded from your federal gross income only if the expenses satisfy the criteria set forth in Section 129.

Under Section 129, expenses reimbursed to you from the Dependent Care Reimbursement Account will be excluded from your gross income if they are "employment-related expenses." Expenses are considered to be "employment-related expenses" if they are incurred to enable you to be gainfully employed and they are paid for the care of one or more "qualifying individuals."

A person is considered to be a "qualifying individual" if he or she is (i) your spouse and is physically or mentally incapable of self-care, (ii) your dependent and is under the age of 13, or (iii) your dependent and is physically or mentally incapable of self-care regardless of age. The term "dependent" includes any individual for whom you are entitled to a personal federal income tax exemption.

The primary purpose of the expenses for the care of a "qualifying individual" must be to assure that individual's well-being and protection. Not all benefits which a "qualifying individual" receives are considered as provided for his or her care. Amounts paid to provide food, clothing, or education are not usually expenses paid for the care of a "qualifying individual." However, where the manner of providing care includes expenses for other benefits which are inseparable from the care, the full amount of the expense is considered to be incurred for care. Thus, for example, the full amount paid to a nursery school in which a qualifying child is enrolled is considered as being for the care of the child, even though the school also furnishes lunch and education services. However, educational expenses incurred for a child in the first grade or higher grade level are not expenses incurred for the care of a "qualifying individual."

Employment-related expenses incurred for services performed outside your household are permissible only if the expenses are incurred for the care of one or more of your "qualifying individuals" who are under the age of 13 or who are age 13 or older and regularly spend at least eight hours each day in your household.

### **PERIOD OF COVERAGE**

Your period of coverage under this Dependent Care Reimbursement Account commences each year on January 1 and terminates on December 31.

### **SPECIAL REPORTING REQUIREMENTS**

Expenses reimbursed to you from the Dependent Care Reimbursement Account must be reported by you on your federal income tax return. You must provide the name, address and social security number or Tax Identification Number (TIN) of the provider, or demonstrate that you have diligently tried to provide that information.

### **CLAIMS PROCEDURES**

Claims for reimbursement from your Dependent Care Reimbursement Account must be made on and in accordance with forms provided by the Capital Area Health Consortium and you must submit claims for qualified expenses directly to Karen Simpson at the Consortium. She will process the claims and provide for reimbursement for "qualifying individual" expenses. Claims for expenses incurred during the plan year will be processed through March 31 of the year following the end of the Plan Year. The amount of the reimbursement may not exceed the amount available in your Dependent Care Reimbursement Account at the time of such reimbursement.

Expenses under the Dependent Care Reimbursement Account are considered incurred when the services related to the dependent care expenses are delivered and not when you are billed or pay for, the dependent care. In addition, expenses are not eligible for reimbursement if such expenses are incurred before your employment with the Consortium or before the beginning of the calendar year.

If your claim for reimbursement is denied, in whole or in part, you may request a review of that decision by writing to Capital Area Health Consortium within 60 days after receipt of the denial. You will usually be notified of the decision following review within 30 days (or 60 days under special circumstances).

## **FUNDING**

The Dependent Care Reimbursement Account is funded by contributions made by participants only. Amounts deposited in the Account will be segregated from the Capital Area Health Consortium's general assets.

## **FORFEITURES**

At the end of each Plan year, including the 90 day claim submission period, any amounts remaining in your Dependent Care Reimbursement Account will be forfeited in accordance with IRS regulations. These forfeited amounts are returned to the Capital Area Health Consortium and will be used to offset plan expenses.

## **TERMINATING PARTICIPANTS**

If you terminate employment prior to the end of the plan year, you have until 90 days following your termination date to submit claims for reimbursement of expenses incurred prior to your termination date.

## **TERMINATION OF AMENDMENT**

The Capital Area Health Consortium intends to maintain the Dependent Care Reimbursement Account for an indefinite period of time; provided, however, that the Capital Area Health Consortium in its sole discretion may amend or terminate the Dependent Care Reimbursement Account at any time by a written instrument to be attached to and form part of this document.

# ENROLLMENT APPLICATION

Initial Enrollment       Plan Year Enrollment       Change

*(Please Print)*

Employee Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Employment: \_\_\_\_\_ Number of Dependent Children: \_\_\_\_\_

## DEPENDENT CARE REIMBURSEMENT ACCOUNT

I hereby authorize the Capital Area Health Consortium to reduce my earnings for the plan year by \$\_\_\_\_\_ for deposit into my Dependent Care Reimbursement Account and to make this money available to me for the reimbursement of out-of-pocket dependent care expenses. I agree to have \$\_\_\_\_\_ per pay check deducted beginning pay date \_\_\_\_\_ for a total annual amount of \$\_\_\_\_\_.

I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY INTERNAL REVENUE CODE SECTION 125.

I FULLY UNDERSTAND THAT MY FUTURE SOCIAL SECURITY BENEFITS MAY BE AFFECTED AS A RESULT OF MY PARTICIPATION IN THIS OPTIONAL BENEFIT PLAN.

I UNDERSTAND IT IS MY RESPONSIBILITY TO REQUEST A NEW ENROLLMENT APPLICATION AND MAKE THE NECESSARY ADJUSTMENTS IN THE YEAR I PLAN ON TERMINATION OF EMPLOYMENT ON JUNE 30th (FINAL 6 MONTHS OF SERVICE).

I ACKNOWLEDGE I HAVE BEEN INFORMED OF THE ABOVE.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** Salary reduction elections must be made in whole dollar amounts. These elections will be divided by the number of pay periods in the plan year, and be credited to your Account or Accounts on a monthly basis. Your salary reduction is made on a pre-tax basis, in accordance with the IRC Section 125 guidelines.