

social security number or federal tax number of the provider, the dates the day care services were provided, the name of your dependent, and the cost of the day care. An important benefit of the Reimbursement Accounts is that you **do not** have to pay the expense first to receive reimbursement!

8. WHAT IF I DON'T USE ALL THE MONEY I CONTRIBUTE TO A REIMBURSEMENT ACCOUNT?

You should be conservative when estimating your medical and/or dependent day care expenses and contribute only an amount that you feel certain you will use. To discourage taxpayers from abusing Reimbursement Accounts or utilizing Accounts only to avoid taxes, Federal Regulations require that you "spend" any funds that you contribute to a Reimbursement Account. Any funds remaining in your Dependent Care Reimbursement Account that are not spent by the end of the Plan Year will be forfeited in accordance with Federal Regulations. Any funds remaining in your Medical Reimbursement Account not used by the end of the Plan Year will be carried forward temporarily (into the new year) for a period of two and a half months (through September 15th) to be used for eligible medical, dental and vision expenses. Funds not requested for reimbursement from your Medical or Dependent Care Account by September 30th (within 90 days at the end of the Plan Year) will be forfeited in accordance with Federal Regulations.

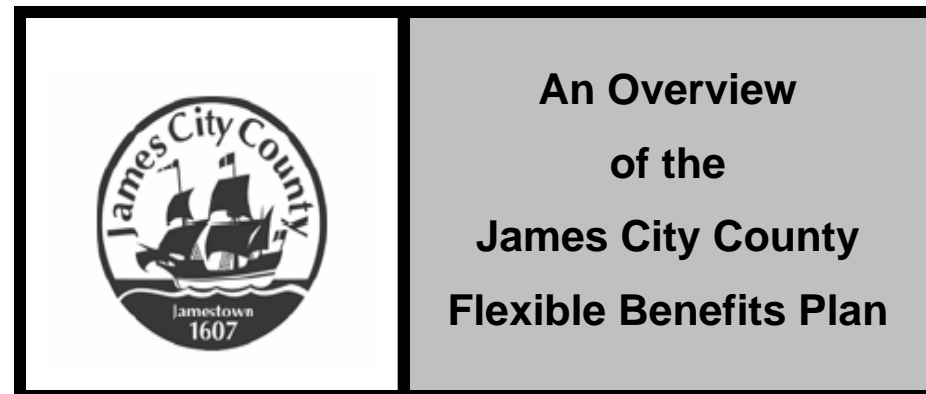
9. CAN I STOP OR OTHERWISE CHANGE MY DECISION OR CONTRIBUTIONS DURING THE YEAR?

One of the most important rules to remember about your Flexible Benefits Plan is that you must decide before the Plan Year begins, whether you want to establish a Medical or Dependent Care Reimbursement Account and how much (if any) you want to contribute. Once the Plan Year begins (July 1st), your election can only be changed if you experience a change in family status as defined by the IRS. You will, however, have the opportunity to change your elections before the beginning of each new Plan Year. But, during the Plan Year, you may not change your decision or vary the amount of your contributions for any reason other than an IRS sanctioned status change. If you experience a status change, you must notify EBS/Atlanta within 30 days of the status change to modify your election.

10. IS THERE ANY OTHER INFORMATION AVAILABLE THAT DESCRIBES THE FLEXIBLE BENEFITS PLAN?

Additional information concerning Medical and Dependent Care Information is available on EBS/Atlanta's website at www.ebsatlanta.com or you may call EBS/Atlanta, toll-free, at 1-800-647-3709.

We also encourage you to attend and ask questions at one of the scheduled meetings



1. WHAT IS "THE JAMES CITY COUNTY FLEXIBLE BENEFITS PLAN"?

It's an IRS sanctioned, tax-free benefit program. The Plan allows you to pay certain health, dental and other insurance premiums with pre-tax ... or **before** tax ... dollars. This means you pay no federal income tax, state income tax, or social security tax on the cost of your payroll deducted insurance coverage. You can even pay for various out-of-pocket health related expenses as well as your work-related dependent day care expenses ... all **TAX-FREE**.

2. WON'T I HAVE TO PAY THE TAXES AT A LATER DATE?

No. Unlike a tax-deferred plan where the taxes are due at a later date, the taxes you save under the Flexible Benefits Plan are never owed. This is why it is called a "tax-free" benefit program. Also, you have no additional reporting to do at the end of the year. Your tax savings are reflected automatically in each pay check. In other words, **you pay less taxes and take home more of your paycheck**.

3. HOW MUCH WILL IT COST ME TO JOIN THE PLAN?

It won't cost you anything. The Plan is simply an established way under the Tax Code for you ... as an eligible employee ... to take advantage of certain tax savings. There are accounting, administrative and plan management costs associated with the Plan, but these costs are paid for you by the County as an added benefit.

4. HOW DOES THE PLAN WORK?

There are three parts to the Program --

The first part relates to **Payroll Deducted** insurance premiums. This part of the Plan allows the County to treat most payroll deducted insurance premiums as tax-free benefits. This simply means that the Finance Department will deduct the premiums for the insurance coverages you have elected before your federal, state and social security taxes are calculated. Deducting your insurance before your taxes are calculated has the same impact as **reducing** the cost of your

insurance, but without changing any benefit you may receive from that insurance.

Under the second part of the Plan, you can choose to establish a special account with the County called a "**Medical Reimbursement Account**". You use this Account to reimburse yourself for the out-of-pocket health, dental and vision expenses that you, your spouse or dependents incur during the twelve month period beginning July 1st and ending June 30th and the applicable grace period. If you know, or are fairly certain, that you or a family member will incur health-related expenses between July 1st and June 30th and the applicable grace period that will not be paid by insurance or will only partially be paid by insurance, then you may want to consider setting some funds aside tax-free in a Medical Reimbursement Account. Then, as you or a family member incurs an eligible, out-of-pocket medical, dental or vision expense during the Plan Year, you may request reimbursement from your Account. The reimbursements you receive from your Medical Reimbursement Account are all **tax-free** as well. You do not pay any federal or state income tax, or social security tax on the amount of your reimbursed health-related expenses, and this could save you several hundred dollars over the course of a year! There is no requirement that you have your insurance coverage with the County to establish a Medical Reimbursement Account, and you can take advantage of this Account even if you, your spouse or your family members are covered under insurance elsewhere.

The third part of the Plan allows you to establish a **Dependent Care Reimbursement Account**. This Account is very similar to the Medical Reimbursement Account except that it is used to reimburse work-related dependent day care expenses such as sitters, nurseries, or day care centers. To be eligible for a Dependent Care Reimbursement Account, you and your spouse (if you are married) must be gainfully employed, the dependent care expenses must be necessary to allow you and your spouse to remain employed, and your dependent child or children must be under the age of 13 years old (unless your dependent is mentally or physically handicapped and incapable of self-care). As you pay or incur an eligible care expense during the Plan Year, you may request reimbursement from your Dependent Care Reimbursement Account. All reimbursements made to you are free of federal and state income tax as well as social security taxes!

5. WHAT KIND OF MEDICAL EXPENSES ARE REIMBURSABLE?

A few examples of expenses that are eligible for tax-free reimbursement from your Medical Reimbursement Account include **prescription drugs, physicals, prescription eyeglasses, prescription contact lenses, eye exams, dental exams, certain over-the-counter medications**, as well as many of the expenses that fall under an **insurance plan deductible** or **co-payment**.

Medically necessary orthodontia expenses are also reimbursable, however, federal regulations impose certain restrictions on how you can be reimbursed for these expenses. Generally, reimbursement of orthodontic expenses must be pro-rated over the course of the prescribed treatment plan. This means that even though you may pay the orthodontia fee at the beginning of the treatment,

or pay the orthodontist on a quarterly or semi-annual basis, you cannot be reimbursed an amount greater than the actual number of treatments received during the Plan Year. Reimbursements of other pre-paid expenses, including many maternity expenses, pose unique circumstances that you should be aware of. Additionally, it is important to remember that some expenses are not eligible for reimbursement. A few examples of expenses not eligible for reimbursement include **cosmetic procedures and weight loss programs (not medically necessary)** or **over-the-counter items for general health (such as vitamins and herbal supplements)**. Always check with EBS/Atlanta, our Plan Managers, for information regarding reimbursement of a specific procedure before you elect to contribute to a reimbursement account. You can reach EBS/Atlanta by calling toll-free, 1-800-647-3709 or visit EBS/Atlanta's website: www.ebsatlanta.com.

6. HOW DO I ESTABLISH A REIMBURSEMENT ACCOUNT?

You first determine whether a Medical Reimbursement and/or a Dependent Care Reimbursement Account is right for you. If it is, you specify on your Election Form a specific dollar amount that you want to contribute and to which account you want this money credited. You can contribute any amount up to \$5,000 per plan year to a Medical Reimbursement Account and any amount up to \$5,000 per plan year* to a Dependent Care Reimbursement Account (* up to \$2,500 per plan year if you are married and file separate federal income tax returns). Then, beginning July 1st, the Finance Department will make a special payroll deduction from each paycheck that you will receive during the Plan Year. These special deductions are made **before** your taxes are calculated. As each tax-free deduction is made from your paycheck, it will be credited to your Reimbursement Account. This means that the funds you contribute to your Reimbursement Accounts are all **tax-free**. As you or a member of your family incurs an eligible expense during the Plan Year, you simply request reimbursement from your Account. The reimbursements you receive are all **tax-free** as well. You do not pay any federal, state income tax or social security tax on the amount of your reimbursed medical and/or dependent care expenses!

7. HOW DO I GET REIMBURSED AND WHEN AM I REIMBURSED?

Simply present your Take Care® Card at the time of service, for immediate payment from your account! To receive reimbursement for manual claim submissions, you first complete a Claim Form and submit it to EBS/Atlanta. For reimbursement of medical expenses, you must attach a copy of the Explanation of Benefits (EOB) statement that you receive from your insurance carrier. This means that you will need to first submit the expense to the insurance company before you make a claim for reimbursement. If you or your family are covered under a Health Maintenance Organization (HMO), you will need to attach a copy of the statement that you receive from your HMO provider. If you do not have insurance coverage for the medical, dental or vision expense, simply attach a copy of the statement that you receive from the doctor, dentist, or other provider. [The statement must show the provider's name, address and telephone number, the date the service was provided, the nature of the service provided, for whom the service was provided and the cost of the service.] For reimbursement of dependent care expenses, you will need to provide the name, address,