Flexbene™
PO Box 587
Pittsford, NY 14534
800-836-8100
www.flexbene.com

Suffolk County 2021 F-L-E-X Open Enrollment: 09/15/20 – 12/15/20

Dear Suffolk County F-L-E-X Participant, September 2020

Welcome to the 2021 Suffolk County Flexible Benefit Plan Open Enrollment! Set aside money from your paycheck – TAX FREE – and reimburse yourself for qualified out-of-pocket expenses within the available categories listed below.

The plan includes 5 SEPARATE reimbursement categories for your Pre-Tax contributions. ***Money cannot be transferred between categories*.***

The maximum contribution amount for each category is as follows:

Amounts May Change Per IRS Increases

1. **Unreimbursed Medical, Dental, Vision Expense** $2,750.00
2. **Dependent Care Assistance Program** $5,000.00
3. **Adoption Assistance** $14,300.00 Per Child
4. Payroll Deducted **AFLAC** Disability Insurance (**ONLY**) Cost of Coverage
5. Suffolk County Billed **COBRA** (**ONLY**) Cost of Coverage

This enrollment package contains the following materials:

- ✓ **Client Privacy Notice & Carryover Guidelines** **UPDATES** The Unreimbursed Medical, Dental, and Vision Category carryover has increased to $550. Unused amounts over this limit will be forfeited.
- ✓ **Eligible Expenses for Reimbursement:** This is a reference list for commonly reimbursed eligible expenses. Additional expenses can be found on www.flexbene.com.
- ✓ **Flexible Spending Confidential Worksheet:** This form is **not** required but can aid you in calculating your enrollment election amounts.
- ✓ **Enrollment Form:** This form must be completed in full, after reviewing ALL materials, and returned to Flexbene™ on or before December 15, 2020.
- ✓ **Electronic Communication Consent & Authorization Form:** Complete and consent to EMAIL & TEXT MESSAGING services effective 01/01/2021. Provide authorized persons to discuss and submit reimbursement claims to your F-L-E-X account on your behalf.

If you have any questions regarding the Suffolk F-L-E-X OR the materials in this package, PLEASE call Flexbene™ at 800-836-8100 or send an email to info@flexbene.com

Every eligible employee is provided the opportunity to ENROLL in the 2021 Plan Year during the Annual Open Enrollment Period from September 15, 2020 to December 15, 2020.

It is the responsibility of the participant to understand all details of Suffolk F-L-E-X upon enrollment.

Please see https://flexbene.com/suffolk-flex to read the Summary Plan Description.
PASSCODE: suffolk (all lowercase)

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CLIENT PRIVACY NOTICE 2021

At Flexbene™, our priority is to build and maintain your trust and confidence. The security measures and protocols we utilize are in the best interest of protecting the privacy and information of our valued clients. This notice is provided to you on behalf of Flexbene™.

Information We Collect: In connection with providing you with flexible benefits administration, we obtain nonpublic personal information about you, including:

- Information we receive from you on applications, claim forms, and enrollment forms.
- Information about your transactions with us or others, including your physician, your insurance carrier and/or day care provider; and
- Information from your employer and other third parties.

Information We Disclose: We will not disclose information regarding you or your account except under the following circumstances:

- To our employees for purposes of claims adjudication and payment.
- To your legal plan administrator for purposes of reviewing claims.
- To your employer as processed claims payment data for purposes of forwarding deductions to cover the cost of claims.
- To your union/department to report any unclaimed balance amounts in efforts of communicating to participants the risk of losing funds if no reimbursement claim is submitted.
- To government entities or other third parties in response to subpoenas or other legal process as required by law and/or in the event the Secretary of the United States Department of Health and Human Services is investigating or determining our compliance with the HIPPA privacy rule in the form of a government audit.
- To your spouse or representative ***ONLY*** if you have approved such disclosure as indicated on the Authorized Parties Form. Should a representative not be listed on this form or your enrollment form, further written documentation (i.e. Power of Attorney) must be presented designating such as your personal representative, attorney-in-fact, etc.

Our Security Policy: Only those individuals who need it to perform their jobs are authorized to have access to confidential client information. We maintain physical, electronic, and procedural security measures that comply with applicable state and federal regulations to safeguard confidential client information.

Closed or Inactive Accounts: If you decide to close your account(s) (and can do so given the requirements under your employer's summary plan description for this Plan) or become an inactive participant, we will adhere to the privacy policies and practices as described in this notice.

Changes to this Privacy Policy: We reserve the right to change the terms of this Notice and make new provisions regarding your protected health information that we maintain, as allowed, or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Policy by mail to your last known address and/or on the Flexbene™ website, www.flexbene.com.

SUFFOLK F-L-E-X CARRYOVER INFORMATION 2021

Please read the following information carefully.

UP TO $550.00 of ONLY Unreimbursed Medical, Dental, Vision Expense pre-tax dollars remaining in your 2020 account can be carried over to reimburse expenses incurred during the 2021 Plan Year.

The amount to be carried over is equal to the lesser of (1) any unused amounts from 2020 or (2) $550.00

NEW You DO NOT need to enroll in the Unreimbursed Medical, Dental, Vision Expense category for the 2021 Plan Year to carryover unused funds. The carryover, without an active enrollment, will only carryover once.

Your carryover balance will not show up on your FSA Balance Report until AFTER the run-out period for the 2020 Plan Year, Wednesday, March 30th, 2021.

Unused amounts remaining cannot be cashed out or converted to any other taxable or nontaxable benefit.

Any unused amount remaining in your Unreimbursed Medical, Dental, Vision Expense category as of termination of employment will be forfeited after the 90-day run-out period (unless applicable COBRA continuation coverage is elected with respect to the Health FSA). Contact us should you contemplate or experience termination of employment.

FLEXIBLE SPENDING ACCOUNT ELIGIBLE EXPENSES 2021

Flexbene™
PO Box 587
Pittsford, NY 14534
631.863.8887 / 800.836.8100
Fax 585.248.2488

This is a reference list intended to provide examples of what may be an eligible expense for your FSA

Please Note – when submitting an expense, you MUST include the condition and/or diagnosis being treated on the reimbursement voucher

Eligible Expenses

- ✓ Acupuncture
- ✓ Alcohol/Substance Abuse Programs
- ✓ Ambulance
- ✓ Band Aids/Bandages
- ✓ Blood Pressure Monitor
- ✓ Body Scan
- ✓ Childbirth Classes (Lamaze)
- ✓ Chiropractic
- ✓ Christian Science Practitioners
- ✓ Condoms
- ✓ Co-insurance
- ✓ Contact Lenses & Solution
- ✓ Co-payments
- ✓ Counseling *(not career or marriage counseling)*
- ✓ Crutches
- ✓ Deductibles
- ✓ Dental Care – non cosmetic *(cleanings, x-rays, fillings, crowns, orthodontia)*
- ✓ Diabetic Supplies
- ✓ Eyeglasses, Reading Glasses, Prescription Sunglasses
- ✓ Eye Exams
- ✓ Flu Shots
- ✓ Fertility Treatments
- ✓ Hearing Aids & batteries
- ✓ Health Screenings
- ✓ Heart Rate Monitor
- ✓ Home Diagnostic Tests
- ✓ Immunizations
- ✓ In Vitro Fertilization
- ✓ Lab Fees
- ✓ Laser Eye Surgery
- ✓ Medical Alert Bracelet/Necklace
- ✓ Medical Records
- ✓ Mileage to & from Dr. Appts *(as of 1/1/20 0.17 cents/mile)*
- ✓ Occupational Therapy
- ✓ Orthotics (*with a doctor prescription)*
- ✓ Out-of-Network Fees
- ✓ Ovulation Monitor
- ✓ Parking Fees & Tolls for Medical Visit
- ✓ Physical Therapy
- ✓ Pregnancy Tests/Aids
- ✓ Prescription Drugs *(non-cosmetic)*
- ✓ Preventive Care Screenings
- ✓ Prosthetics
- ✓ Psychiatric Services and Care
- ✓ Smoking Cessation Programs
- ✓ Sterilization Procedures
- ✓ Ultrasounds
- ✓ Vision Care
- ✓ Walkers/Wheelchairs/Shower Chairs

Over-The-Counter Items / Medications

Acid Controllers
Acne Medications
Allergy & Sinus Medicine
Antibiotics
Anti-Diarrheal
Antifungal
Anti-Gas Products
Anti-Itch & Insect Bite
Anti-Parasitic Treatments
Antiseptics & Wound Cleansers
Baby Electrolytes & Dehydration
Baby Rash Ointments/Creams
Cold Sore Remedies
Contraceptives
Cough, Cold & Flu
Denture Pain Relief
Digestive Aids
Ear Care
Eye Care
Feminine Anti-Fungal/Anti-Itch
Fiber Laxatives
First Aid Burn
Foot Care Treatment
Hemorrhoidal Preps
Homeopathic Remedies
Incontinence Protection & Treatment Products
Laxatives (Non-Fiber)
Mediated Respiratory Treatments
Medicated Nasal Sprays, Drops, Inhalers
Motion Sickness
Oral Remedies & Treatments
Pain Relief Oral & Topical
Skin Treatments
Sleep Aids & Sedatives
Smoking Deterrents
Stomach Remedies

NEW
Feminine Protection, Menstrual Care Products

- Cups
- Liners
- Pads
- Tampons
- Disposable & Non-Disposable Underwear for Menstruation
- Sponge

*****No Rx Required For These Items*****

Potentially Eligible Expenses**

Air purifier
Automobile Modifications
Blood Storage *(not to exceed six months)*
Calcium Supplements (*osteoporosis)*
Cord Blood Storage *(specific condition required)*
Dietary Supplements/Vitamins *(to treat a specific medical condition)*
Electrolyte Replacements *(Pedialyte)*
Fiber Supplements
Glucosamine *(arthritis)*
Hair Loss Treatment *(due to a specific medical condition)*
Herbal Remedies *(by a licensed provider)*
Homeopathic Medicines *(by a licensed provider with Rx)*
Hormone Supplements
Humidifiers *(treat specific medical condition)*
Lodging *(up to $50 per night, subject to additional conditions)*
Massage Therapy *(to alleviate pain due to a medical condition)*
Nutritionist
Orthodontia for adults
Orthopedic shoes *(only custom-fitted shoes)*
Oxygen
Probiotics
Retin-A *(for the treatment of acne)*
Sperm Storage (1 yr. ONLY)
Sunscreen (30SPF+ History of CA)
Vitamin B-12 Injections
Wigs *(loss of hair from disease or treatment)*

*****REQUIRED*****

These expenses REQUIRE a Letter of Medical Necessity from your health care provider is to be *considered* for reimbursement.

Visit Flexbene.com for LMN form

Submitting the Letter of Medical Necessity *does not* guarantee that the expense will be reimbursed.
You *must* submit a new letter each year – these are not approved indefinitely.

Not Eligible Expenses

- × Aromatherapy
- × Athletic Mouth Guard
- × Autopsy
- × Baby Diapers
- × Cosmetic Dentistry
- × Cosmetic Procedures
- × Cosmetics
- × Deodorant
- × Face Cream
- × Finance Charges
- × Fitness Device (i.e. Fitbit, Apple Watch, Miss Fit, etc.)
- × Funeral/Burial Expenses
- × Health Club Dues (for purposes of general health)
- × Hair Removal Products
- × Hair Transplant
- × Late Payment Fees
- × Lens Replacement Insurance
- × Lotion
- × Electrolysis
- × Maternity Clothes
- × Marriage Counseling
- × Meals/Food
- × Microdermabrasion
- × Missed Appointment Fees
- × Mouthwash
- × Non-prescription Sunglasses
- × Nursing Home Expenses
- × AFLAC Premiums
- × Shampoo
- × Soap
- × Sports Energy Drinks
- × Teeth Whitening/Bleaching
- × Toiletries
- × Toothbrushes
- × Toothpaste
- × Transportation to and from work
- × Wrinkle Reducers
- × Weight Loss Procedures/Programs (i.e. Gym Membership)
- × *Medical Marijuana is federally illegal and remains ineligible for reimbursement*

SUFFOLK COUNTY 2021
FLEXIBLE SPENDING ACCOUNT
CONFIDENTIAL WORKSHEET

Flexbene™
PO Box 587
Pittsford, NY 14534
800.836.8100 or 631.863.8887
info@flexbene.com

Use this worksheet to estimate your eligible out-of-pocket expenses for the upcoming Plan Year.
Keep in mind that these should only be expenses that will not be paid by any insurance.
You are required to have valid documentation to verify the expenses you paid out-of-pocket.
This form is for YOUR use only; it does NOT need to be returned to Flexbene™.

(1) ANNUAL FAMILY UNREIMBURSED MEDICAL, DENTAL, VISION EXPENSES	Estimate for 2021
Medical Expenses (office visit co-pays, emergency or urgent care, surgery, lab work, therapy)	$
Prescription Drugs (copayments for eligible retail or home-delivery)	$
Over the Counter (OTC) Medications (must be used to treat an illness or condition, not a preventative item such as vitamins and supplements).	$
Vision Care Expenses (exams, lenses, frames, contact lenses, solution, Lasik surgery)	$
Dental/Orthodontia Expenses (cleanings, fillings, x-rays, dentures, extractions, bridges, crowns)	$
Hearing Care Expenses (exams, hearing aids, batteries)	$
Certain other eligible health care expenses that may not be covered by insurance (transportation costs essential to medical care, drug/alcohol treatment programs, psychologist)	$
Total – Transfer this amount to category (1) on the 2021 FLEX Enrollment Form	$

(2) ANNUAL DEPENDENT DAY CARE ASSISTANCE PROGRAM	Estimate for 2021
Dependent Care Fees (qualifying child daycare services – children UNDER the age of 13)	$
Nursery School Fees (excludes Kindergarten)	$
Before-/After-School Care	$
Private Sitter (for expenses while you, and spouse if married, work, look for work or attend school)	$
Day Camp, Summer camps (excluding overnight camps), Activities in lieu of Day Care	$
Total – Transfer this amount to category (2) on the 2021 FLEX Enrollment Form	$

(3) *ANNUAL PAYROLL DEDUCTED AFLAC DISABILITY INSURANCE OPTION*	Estimate for 2021
Step 1: How much do you contribute towards your AFLAC Disability Insurance each pay period? (Look at your paystub for Code 0324 – AFLAC Insurance)	$
Step 2: Multiply your per pay period amount listed next to Code 0324 – AFLAC Disability Insurance by 26 (# of bi-weekly Pay Periods each year)	× 26
Step 3: Equals the amount you pay POST-tax for your AFLAC Disability Insurance annually	$
Total – Transfer this amount to category (3) on the 2021 FLEX Enrollment Form	$

Use these amounts as an estimate for your elections for the 2021 Plan Year.

Once you are satisfied with the election amounts for the pre-tax options you would like to enroll in, transfer these totals onto the *Flexible Benefits Enrollment Form.*

2021 Suffolk County Flexible Benefits Enrollment Form

Department/ Union:

You MUST Check One: ☐ County ☐ College **Pay Schedule:** ☐ Biweekly ☐ 10-Months

First	Last	FULL Social Security Number	
Address	City	State	Zip Code
Email Address		BEST Phone Number To Reach You	
Date of Hire:	Date of Birth:	Marital Status: ☐Married ☐Single	

Employee Benefit Options: Important: For employees on a regular 26-pay period schedule, the County begins deductions on the 2nd pay period of the year over the course of 25 pay periods	Per Pay Reduction	# of Paychecks	Annual Election
(1) Unreimbursed Medical, Dental, Vision, Rx Expenses (Max. $2750 / Carryover $550)	$	× 25 =	$
(2) Dependent Care Assistance Program (Max. $5000 / Children UNDER 13 / Must complete MANDATORY DC Registration Statement every year)	$	× 25 =	$
(3) Payroll Deducted AFLAC Disability Insurance – NO OTHER DISABILITY WILL BE ACCEPTED EFFECTIVE 01/01/2021 (Max. equal cost of coverage billed by the County)	$	× 25 =	$
Adoption Assistance (Max. $14,300 per child)	$	× 25 =	$
Suffolk County Billed COBRA (ONLY) (Max. equals cost of coverage)	$	× 25 =	$
PBA / Probation Group Insurance Reductions (Not a reimbursement account. You are electing to have PBA/Probation Major Medical Deduction taken Pre-Tax. MUST be a member of the PBA/Probation to enroll. Automatic enrollment each year if previously enrolled)	☐ Single ☐ Family	☐ Police ($4.68 / $10.84) ☐ Probation ($5.20 / $11.33)	

If your employment is temporarily interrupted or you do not receive pay, your pre-tax per paycheck reduction amount may be adjusted during the Plan Year. You are required to pay your full annual election as stated in the SPD.

Eligible Dependent Information:	Relationship	Date of Birth

Employee Participation Authorization Agreement:
I certify the above information to be correct and true to the best of my knowledge and that the children listed above either reside with me in a parent-child relationship or are a legally dependent that I support. I understand that any remaining dollars in my account(s) not used for eligible expenses incurred in the elected category, during the Plan Year, will be FORFEITED in accordance with current Plan provisions and tax laws. Please discuss ANY pre-tax contributions with your tax advisor OR agent to determine future tax liabilities. I understand that the Flexible Compensation reduction(s) will be in effect for the Plan Year and cannot be revoked unless I experience a qualified change in status or terminate employment. (See Suffolk County SPD). I understand that the flexible compensation reductions MAY influence my social security benefits.

By signing this enrollment form, you acknowledge the above statements and agree to the terms and regulations of your companies Flexible Benefits SPD which is made available to you through your employee benefits unit, www.flexbene.com, or by request.

Employee Signature	Date Signed

DUE: December 15, 2020 – Enroll for TEXT Alerts to receive Enrollment Confirmation!

[USPS: M.A. Services, PO Box 587, Pittsford, NY 14534 / Fax: 1-585-248-2488 / Email: info@flexbene.com]

See Reverse for Release of Information to Authorized Parties and Electronic Communication Consent

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Authorizations

☐ I authorize my spouse to discuss my Suffolk F-L-E-X account, without restrictions:

Spouse Name: Participant Signature:

☐ I authorize 'OTHER' to discuss my Suffolk F-L-E-X account, without restrictions:

Name & Relationship to Participant: Participant Signature:

☐ I authorize my Department/Union to be notified only if I have a positive remaining balance in my Suffolk F-L-E-X account at the end of the Plan Year, so that they can relay this message to me.

Department/Union Name: Participant Signature:

** By authorizing your Department/Union to be notified at the end of the Plan Year, you may receive additional calls, emails, text messages, or mail from that Department/Union who will attempt to help you claim the unused balance in your account by the close of the Plan Year.

Electronic Consent & Text Messaging Opt-In

To Opt-In, complete the requested information below and provide the cell phone number where you would like to receive text messages with the following information:

- ✓ Enrollment Form confirmation
- ✓ Enrollment Change Form confirmation
- ✓ Claim has been approved, partially or fully denied
- ✓ Claim payment sent

Notice: Your cell phone number will NOT be used for ANY other purposes by FLEXBENE and the text provider.

I consent to receive electronic communications for all matters permitted by law regarding the Suffolk County FLEX Plan, which is sent by, or on behalf of, the plan. I certify that I have access to the above email address and can receive electronic messages with attachments at that email address. Should I subsequently provide the Plan Administrator with a different email address to use for these communications, this consent shall apply to that email address also.

I understand that I may request a paper copy of any correspondence provided electronically at no charge by contacting the Plan Administrator in writing.

Suffolk FLEX, nor any agent of the Plan or Employer, shall not be held liable for my not having received any communication by virtue of my inability to receive the communication at the email address I have provided.
Any electronic communication sent shall be deemed to have been received by me.

I may revoke this consent at any time by notifying the Plan Administrator in writing. If I should no longer have access to the email address last provided to the Plan Administrator, I shall immediately provide a new email address or revoke this consent. Please note, you will be able to OPT-OUT at any time.

Participant Signature:	Date of Consent:
Cell Phone Number:	Email Address: