Welcome Letter

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Medical Claim Form

FSA Enrollment Form

894 Euclid Avenue, Elmhurst, IL 60126 ■ 630.782.0633 ■ Fax: 630.782.0644
www.flexsourceone.com

Use Your Company Flexible Spending Account to Help Cure the Rising Costs of Medical, Dental and Dependent Care Expenses.

Dear Eligible Employee:

Health care costs, dentist bills and dependent care expenses always seem to be on the rise. Now, when you enroll in your company's flexible spending account, you can get help to pay for many of those expenses with dollars you can spend before they are taxed.

Just what the doctor ordered! Your company's employee benefits package includes a Flexible Spending Account option.

Your company is now offering you the opportunity to participate in a Flexible Spending Account (FSA). This valuable employee benefit gives you the choice of paying many unreimbursed medical, dental and dependent care expenses with pre-tax earnings. This means that you will pay lower federal taxes, Social Security, FICA taxes and state taxes, saving you money every year. Your FSA will help make budgeting for many expenses easier too.

A Flexible Spending Account is your prescription for savings on medical, dental and dependent care expenses.

You can use your FSA to cover expenditures for you, your spouse, or your eligible dependents (such as children, siblings, parents and others for whom you may claim an exemption at tax time). Covered expenses include:

- ✓ Medical costs that are not reimbursed, including medical deductibles and co-pays
- ✓ Child and dependent care costs
- ✓ Unreimbursed dental expenses
- ✓ Contact lenses, eyeglasses and exams
- ✓ And more (see the list of examples provided in the employee enrollment packet)

For complete details of eligible expenses, you can also check the IRS website at www.irs.ustreas.gov.

please read on . . .

If you choose to enroll in your company's FSA plan, each payday, an amount that you have specified is deducted from your paycheck without being taxed. The money is placed into your personal flexible spending account. Then, when you incur eligible out-of-pocket expenses for things like prescriptions, eyeglasses, dental work or child care, you simply submit a completed claim form along with the appropriate receipts to FlexSource, your FSA Plan Administrators. Your claim will be expediently handled. You will then receive a check that reimburses you for your expenses up to the maximum amount in your account for dependent care and up to your annual election for medical. Reimbursements are typically paid weekly.

It's easy to enroll.
And it's easy to get answers!

FlexSource has created an easy-to-understand Information and Enrollment package. Read the information in the package carefully, then use the included worksheet to work out how much you should contribute to your FSA each month. After that, fill out the enrollment form and return it to the appropriate department of your company.

Once you enroll, FlexSource administrators will be happy to help you anytime. If you cannot find the answers you need in the "Frequently Asked Questions" sheet included in your Information and Enrollment package, feel free to contact us. You can call or fax FlexSource any time during regular office hours.

We look forward to helping you enjoy the many benefits of your company FSA. If you do not already have an "FSA Information and Enrollment" package, then ask for one from your company or call FlexSource at **630.782.0633**.

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Frequently Asked Questions About Flexible Spending Accounts

Q: What is a flexible spending account?

A: A flexible spending account (FSA) is like a budgeting plan that allows you to use pretax dollars to cover certain expenses not covered by insurance. This plan passes on the cost savings to you by doing the following:

- Paying certain medical, dental and dependent care expenses from pretax earnings, including deductibles, co-pays, prescription drugs and day care or nursing care.
- Lowering your federal taxes, and in most cases your state taxes which results in more take home pay.
- Insurance premiums are not covered under the FSA. These expenses are taken pretax under the "Premium Only Plan".

Q: How does it work?

A: You decide how much money to set aside; up to $5000 a year for dependent care and/or up to your company's maximum amount per year for medical and dental expenses. Your contribution is deducted every pay period before taxes are taken out and deposited into your FSA account. Each time an expense is incurred, reimbursements are made using these pre tax dollars. Simply submit the claim form with receipts and you will be reimbursed at a minimum check amount of $25.00.

Q: How do I enroll?

A: It's easy! Just complete the "FSA Enrollment Form" designating the deduction for each pay period and the annual maximum amount that you want to contribute. This amount is automatically deducted from your paycheck. Contribution amounts cannot be changed during the calendar year, except for specific changes in status.

Q: When can I enroll?

A: There is only one open enrollment period for the FSA: The initial enrollment that is done before the beginning of the plan year is for all eligible employees who have met eligibility requirements stated in the Summary Plan Description. The employees allowed to enroll mid-year are newly eligible employees (those who were not eligible for the initial open enrollment) or employees that have incurred a "change in status". An employee who was eligible for the initial enrollment but elected not to participate, will have to wait until the beginning of the next plan year.

Q: When can I change my elections for the FSA?

A: An annual election may not be changed during the plan year without a qualifying event. Typically, these status changes minimally include: birth/death of a dependent, marriage/divorce, change in employment status.

Q: Are their any disadvantages to participation?

A: If you choose to use the FSA for dependent care, you cannot use the federal tax credit to claim expenses for amounts reimbursed through the plan. Consult your tax advisor to see whether the FSA or IRS tax credit is more advantageous for your dependent care expenses.

Q: What else should I consider before participating in a FSA?

A: Be sure to budget carefully. Under federal law, money cannot be interchanged between medical, and dependent care, and unused money will be forfeited at the end of the plan year. Also, contribution amounts cannot be changed during the calendar year, except for changes in status. Use the account worksheet to consider vacation, sickness or other periods when childcare may not be required when planning your election for dependent care.

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Frequently Asked Questions about Flexible Spending Accounts

Q: What constitutes a change in status?
A: Changes in status includes marriage or divorce, death of your spouse or dependent, birth or adoption of a child, termination or commencement of spouses employment; change in employment status from part-time to full-time or vice-versa for you or your spouse or unpaid leave of absence by you or your spouse. Specific IRS rules govern these changes. If there are additional questions in this area, please contact FlexSource at 630.782.0633.

Q: How do I get reimbursed?
A: You incur the expenses first and the plan reimburses you for your eligible expenses from your account during the year. All claims are paid weekly. You will have up to 90 days after the end of the plan year or termination of your employment to receive reimbursement of expenses incurred during your participation in the plan. FlexSource handles all reimbursements. A master copy of the claim is included in this packet. Use it to make as many additional copies as you need. Remember to include receipts listing the dates of service and tax ID number of the day care provider (for dependent care expenses) with your reimbursement form.

Q: When can I expect to receive my reimbursement check?
A: FlexSource processes checks weekly every Wednesday. The checks will be forwarded to your employer for signature and distribution.

Q: What could delay my reimbursement?
A: Incomplete information is the most common reason for delays. For all claims, FlexSource is required to have written substantiation for each detail item. The receipts must include the patient name, name of the service provider, date(s) of service, dollar amount of the service and a description of the service incurred. Additionally, for claims such as orthodontia, a service agreement is necessary to determine which services will be considered as reimbursable under the defined plan year. Doctor's notes may be required for services and products that are not clearly defined as eligible expenses. Medical necessity will determine if these items may be covered.

Q: What is an account balance?
A: Your account balance is what you are immediately entitled to for reimbursement. For unreimbursed medical, the balance is representative of the difference between your annual election and claims already paid. A balance for the dependent care FSA is the difference between the current contribution total amount and the claims paid.

Q: Could a dependent care reimbursement check be issued for less than what I claimed?
A: There are two criteria for reimbursement for dependent care that must be met before a check may be issued: the service(s) must have occurred and there must be contributions available for reimbursement. If a sufficient balance is not available to reimburse a dependent care claim in full, a check will be issued in the amount in the account at the time the checks are prepared. Once the additional contributions made, a reimbursement check will be issued on the next check run for that pending balance.

Q: What events will allow me to adjust or revoke my plan election?
A: You may do so under the following conditions:

- When there is a significant change in the coverage of the core health benefits by a third party provider.
- There is a change in your status: marriage, divorce, death, birth, spouses employment, full-time to part-time status, unpaid leave of absence.
- Separation from employment.

To process any of these changes, you or your employer will have to complete the "Employee Change" section of your "Enrollment" Form.

Section 125 FSA Plan is Right For You!

Whether you are single parents, part of a dual-income household, or a family person with a non-working spouse, Section 125 FSA will provide you with additional benefits and more take-home pay.

Single Parents

In the illustration below, the single parent earns $28,000 and has one child. This parent uses the FSA plan to pay the cost of medical deductibles and dental care this year. In addition, the parent has opted to pay child care expenses out of pre-tax dollars. In this way, the take-home pay increases by $92.50 each month or $1110 this year.

Working Couples

The husband and wife both work. They have two children. The couple collectively earns $45,000 per year. They use the FSA plan to help pay for out-of-pocket medical expenses and pay for the children's orthodontist bills. With both of them working, they also utilize the plan to pay for necessary child care expenses. The chart shows that this couple increases their monthly take-home by $143.75 or $1725 this year. That gives them additional money for emergency expenses.

Family Person with Non-Working Spouse

With grown children, and only one spouse working, this couple has no child care expenses. The annual salary of the working spouse is $40,000. They use the FSA plan to pay for out-of-pocket medical expenses, and to pay for dental expenses. The FSA plan gives this couple an additional $46.25 monthly take-home or $555 this year . . . a nice raise for the family budget.

	Single Parent		**Working Couples**		**Family Person**	
	Without FSA	**With FSA**	Without FSA	**With FSA**	Without FSA	**With FSA**
Total Monthly Income	$2333.00	$2333.00	$3750.00	$3750.00	$3333.00	$3333.00
Less Pre-Tax Benefits						
Insurance Premiums	0	110	0	200	0	110
(1) Medical/Dental Exp	0	60	0	75	0	75
(2) Child Care Exp	0	200	0	300	0	0
Total	$2333.00	$1963.00	$3750.00	$3175.00	$333.00	$3148.00
(Federal, State, FICA)	$583.25	$490.75	$937.50	$793.75	$833.25	$787.00
Post Tax Income	$1749.75	$1472.25	$2812.50	$2381.25	$2499.75	$2361.00
Post Tax Benefits						
Insurance Premium	110	0	200	0	110	0
Medical/Dental Exp.	60	0	75	0	75	0
Child Care Exp.**	200	0	300	0	0	0
Spendable Income	$1379.75	$1472.25	$2237.50	$2381.25	$2314.75	$2361.00
Employee Monthly Savings		**$92.50**		**$143.75**		**$46.25**
Employee Annual Savings		**$1110.00**		**$1725.00**		**$555.00**

* Examples assume a 25% tax bracket
** Does not include any available tax credit for child care expenses

(1) FSA Contributions for Medical/Dental expenses
(2) FSA Contributions for Child Care expenses

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Cafeteria Enrollment Worksheet

Internal Revenue Code Section 213 determines what are eligible medical expenses when taxpayers are itemizing medical expenses for deduction purposes. IRS 213 is therefore the guideline for what is an eligible expense for a Cafeteria Plan. IRS Publication 502 has been developed by the IRS to help taxpayers determine what is eligible under IRS 213. While IRS Publication 502 is very helpful, there are two items that are eligible for itemizing medical expenses for deduction purposes that are not eligible for reimbursement under rules for a Cafeteria Plan — Insurance Premiums and HMO Premiums.

The following is a **brief** list of **medical** expenses commonly claimed for reimbursement under a Cafeteria Plan.

Expense	Eligible
Ambulance	Yes
Artificial Limbs & Teeth	Yes
Aspirin	Yes. Over-the-counter drugs are now eligible for reimbursement.
Birth control pills	Yes
Chiropractors	Yes
Coinsurance amounts and deductibles	Yes
Contact Lenses	Yes. Includes amounts for necessary materials and equipment, such as saline solution.
Cosmetic Surgery	Generally no. Amounts that are surgically necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease may be covered.
Dental Treatment	Yes. Includes amounts for X-rays, fillings and orthodontia
Dentures	Yes
Eye Exams and Glasses	Yes. Includes amounts for prescription eyeware and eye examinations.
Fertility Treatments	Yes, to treatments that affect the participant. No, to invitro surrogates.
Fitness Programs	No
Flu Shots	Yes
Health Club Dues	No
HMO Premiums	No. These are allowed under IRS 213 but not under a Cafeteria Plan.
Immunizations	Yes
Insulin	Yes
Insurance Premiums	No. These are allowed under IRS 213 but not under a Cafeteria Plan.
Laboratory Fees	Yes
Laser Eye Surgery	Yes. Includes radial keratotomy and corneal ring segments
Nursing Services	Yes. Includes wages and other amounts paid for nursing services.
Operations	Yes. Legal operations that are not for unnecessary cosmetic surgery.
Osteopath	Yes
Psychiatric Care	Yes. Includes amounts paid for psychoanalysis and psychologists.
Smoking Cessation Programs	Generally yes.
Special Foods	Yes. Only when the foods are prescribed by a physician and only to the extent the costs exceed the costs of normally available food products.
Vitamins	Generally no for all over-the-counter vitamins. Probably yes to those only available by prescription, such as prenatal vitamins.
Vision Discount Programs	No. The costs for the program are not eligible, but the cost for medical treatment actually received is eligible.

Cafeteria Enrollment Worksheet

By enrolling in a Dependent Care Assistance Plan (DCAP), the Internal Revenue Service allows an employee to pay for dependent care costs with pretax dollars. Note: Employees with adjusted income that would place them in the 15% tax bracket may want to weigh the benefits of the "Dependent Care Tax Credit" versus enrollment in a DCAP. Please seek individual tax guidance on this issue.

Enrollment in a DCAP allows for the reimbursement of expenses that are "employment-related expenses." That means that if the employee is married, the employee's spouse must also be employed or a full-time student. Unmarried employees with dependents obviously don't have to meet this requirement. Dependents are children of the employee age 12 or younger, or dependent parents of the employee.

The following is a **brief** list of **dependent care** expenses that are commonly claimed for reimbursement under a Cafeteria Plan. Please note, some items listed are not eligible for reimbursement.

After-school care or extended day programs	Eligible as long as the programs are generally custodial in nature
Amounts paid to minor baby-sitter	Eligible unless baby-sitter is a child of the employee (or spouse) under age 19
Custodial or elder care	Eligible, but not costs attributable to medical care and services
Educational Expenses — Kindergarten and above	Ineligible as expenses, are considered to be educational in nature and not custodial
Educational Expenses — pre-kindergarten and younger	Eligible as long as the care provided is considered to be primarily custodial and not educational in nature
Expenses paid to child of participant	Eligible if child is age 19 or older
Family Member under Age 19 Providing Service	No
Food Expenses	Ineligible if itemized separately from dependent care expense
Household services such as a maid, cook or housekeeper	Generally ineligible. May be eligible if services provided are incidental to childcare
Incidental expenses such as diapers or activity charges	Ineligible if itemized separately from dependent care expense
Looking for work	Eligible to the extent expenses are incurred to enable employees to seek employment
Overnight Camp	No. This is true even if the facility allocates expenses separately for daytime and overnight
Pre-School	Eligible as long as the program is considered to be primarily custodial and not educational in nature
Registration fees	Ineligible when billed in addition to the costs of childcare
Sick-child center	Generally eligible if expenses are incurred to allow employee to work when the child is ill
Summer day-camp	Eligible as long as the program is considered to be primarily custodial and not educational in nature
Transportation Expenses	Ineligible if itemized separately from dependent care expense

Cafeteria Enrollment Worksheet

The following is a worksheet to help you determine the benefit amounts you should enroll in for the coming Plan Year. By going through this worksheet you should have a pretty good idea of what your annual budget for unreimbursed medical expenses and dependent care expenses will be.

Medical Flexible Spending Account Expenses

Regular Monthly Costs

Monthly prescription costs	$______________	
Diabetic Supplies	$______________	
Contact Lens Supplies	$______________	
Over-the-Counter Drugs	$______________	
Other (________________________)	$______________	
Total	$______________	Times 12 = $______________

Expected One-Time Costs

Dependent Medical Care Expenses	$______________	
Well-baby care	$______________	
Immunization and Flu Shots	$______________	
Dentist Cleanings	$______________	
Braces and other Orthodontia	$______________	
Regular Eye Exams	$______________	
Prescription Eyeware	$______________	
Family Deductible	$______________	
Smoking Cessation Program	$______________	
Other	$______________	
Total		$______________
Grand Total		$______________

Dependent Care Assistance Plan Expenses (Annually)

After School Care	$______________	
Regular Day Care	$______________	
Summer Camp	$______________	
Other	$______________	
Total		$______________

Monthly Dependent Care Claim Form
Flexible Spending Account

Claim Request

As a participant in my employer's Section 125 Plan, I hereby request FlexSource to reimburse me for:

	Date				Weekly Amount
Week 1	____/______	to	____/______	$	______________
Week 2	____/______	to	____/______	$	______________
Week 3	____/______	to	____/______	$	______________
Week 4	____/______	to	____/______	$	______________
Week 5	____/______	to	____/______	$	______________
			TOTAL MONTHLY AMOUNT	**$**	______________

Employee Name: ____

Social Security Number: ______________________________________

Company Name: ____

I incurred the expenses for which reimbursement is requested on behalf of my dependent for properly reimbursable items under Section 125 of the Internal Revenue Code.

____

Signature of Employee   Date

- ***Claim payments are processed on a weekly basis every Wednesday.***
- ***Dependent Care Claims will be reimbursed to the participant up to the balance available in the account.***

Certification from Provider

We certify that we are providing Dependent Care Services for the above employee for the month of

______________ in the year of ________ for ______________________________

(Child's name)

____

Name of Day Care Provider

Federal ID # or Social Security # ______________________________

Signature of Day Care Provider ____________________ Date ____________

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Medical Flexible Spending Account Reimbursement Claim

Please type or print all information

Company Name

Employee Name

Employee Phone Number
(   )

Social Security Number

Street Address | City | State | Zip

I certify the information here is true and correct; that the expenses incurred were for myself, spouse; or dependents, that these expenses are not reimbursable under any other health plan coverage; and that these expenses are medically necessary as defined in Internal Revenue Code Section 213.

Employee Signature | Date

Supply Additional Information Below

Member Name	Social Security Number	Relationship to Employee	Amount	Date(s) of Service	Provider of Service	Description	Claim Ref. #
		Self/Spouse Child/Other (Specify)					01
							02
							03
							04
							05
							06
							07
							08

Instructions

1. All receipts must include patient name, date of service, a description of service provided, dollar amount of charges and name & address of service provider.
2. Copies of all bills for reimbursement must be enclosed with claim form.
3. Did you sign your claim form and include your company name?

Note: Regarding faxed claims. Any missing pages or illegible copies will be the responsibility of the sender.

If you have any questions, please contact : FlexSource at (630) 782-0633

Mail to:
FlexSource, LLC
P.O. Box 828
Elmhurst, IL 60126

Fax: (630) 782-0644

Election Form / Salary Reduction Agreement
Flexible Spending Accounts

Employee Information

Add __________ Change* __________ Employee Termination* __________
*(*Must provide reason on back of form and must be authorized by employer)*

Company/Client Name

Employee Name | Key ______ Highly Compensated ______ | Date of Hire

Social Security Number | Birthdate | Employee Phone Number ( )

Street Address | City | State | Zip

Number of Paychecks Received Annually

Weekly (52x) ______ Bi-Weekly (26x) ______ Semi-Monthly (24x) ______ Monthly (12x) ______ Other ______

		$/Pay Period		# of Pay Periods		Annual Election
______	Medical/Dental Reimbursement	______	*	______	=	______
______	Dependent Care Reimbursement	______	*	______	=	______

* *In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.*

I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning ____/____/____ and ending ____/____/____ . Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. As a participant, I understand that:

- I cannot change or revoke this agreement at any date prior to the next plan year unless I have a change in status as set forth in the Adoption Agreement and Summary Plan Description. Prior to my next plan year I will be offered the opportunity to change my benefit election for the following year.
- My pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected, continuing for each succeeding pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that change.
- The plan administrator may change the amount of my pay reduction or otherwise modify this agreement if he believes it is to satisfy provisions of the Internal Revenue Code.

- The amount of my compensation reduction will be credited to the appropriate reimbursement account on my employer's books for payment of eligible expenses incurred within the plan year.
- Reimbursement will be available only for qualifying expenses as described on the attached form. I agree to notify the employer if I have a reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the employer for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive on a non-qualifying expense.
- If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount.

The pay reduction will not be effective for any pay period that begins before you have signed this form and returned it to the Plan Administrator.

Changes / Terminations

Date of event: ______/______/______

First paycheck date that change will be processed: ______/______/______

_________ Change in Employment Status of Participant or Participant's Spouse
_________ Marriage/Divorce of Participant
_________ Adoption, Birth or Death of Child or Dependent
_________ Coming of Age of Child or Dependent
_________ FMLA (Family Medical Leave) Leave of Absence
_________ Participant Beginning or Ending Adoption Proceedings
_________ Medicare or Medicaid Entitlement
_________ HIPAA Special Enrollments
_________ Judgement, Decrees or Orders
_________ COBRA Qualifying Event

Signature of Employee Date

Signature of Employer Date

Return This Form To:

FlexSource, LLC
P.O. Box 828
Elmhurst, IL 60126

REMINDER: Please advise your payroll department of these employee deductions.