Give Yourself A *Pay Raise!*

Can Make It Happen For You!

A Valuable Benefit That Reduces Your Taxes and Increases Spendable Income

PayFlex™ Systems USA, Inc. • P.O. Box 3039 • Omaha, NE 68103-3039
www.mypayflex.com

Is that really possible?

With PayFlex™ Flexible Spending Accounts, it is!

Health Care and Dependent Care Flexible Spending Accounts (FSA) Benefit Plan

Flexible spending accounts are a tax-advantaged way to pay for qualified out-of-pocket health care expenses, and work-related day care expenses. This benefit allows you to pay your expenses with "pre-tax" dollars, which means you get a tax deduction for these expenses before you ever file your tax return.

Authorized by the IRS, these accounts let you set aside money from your pay *before* taxes are withheld. As you incur health care expenses or dependent day care expenses throughout the year, you submit a claim for those expenses and are reimbursed with tax-free dollars from your account.

The Health Care Account reimburses you for out-of-pocket health care expenses for medical, dental, vision, hearing and pharmaceutical expenses. The Dependent Care Account reimburses you for dependent day care expenses you incur in order to allow you and, if married, your spouse to work. When you use these accounts, you reduce your taxable income, so you will pay less in income taxes.

How the Accounts Work

You decide if you want to use the Health Care and/or the Dependent Care Account. This is how it works:

- You estimate the amount you will spend on out-of-pocket health care expenses and/or day care expenses during the year. Estimate conservatively, and review prior year's expenses to help you determine what to anticipate for this year. Plan only for predictable expenses.
- You decide how much you wish to set aside into your Health Care Account and/or your Dependent Care Account. Then, complete the necessary enrollment forms through your employer.
- The amounts you wish to set aside into your accounts will come out of your paycheck in equal amounts on a schedule established by your employer.
- As you incur health care or day care expenses throughout the year, you submit a claim form along with documentation of your expenses. Reimbursements from your accounts are made on a schedule determined by your employer, and you may file claims as often as you wish.
- Reimbursements may be made by check sent to your home address or by direct deposit to a bank account of your choice.
- Dollars left over in your account at the end of the year are forfeited. You can avoid forfeitures if you plan carefully (review prior year's expenses to estimate what you will have the next year, be conservative, and plan only for predictable expenses).

The Tax Advantage

Remember, the advantage of using flexible spending accounts is that you don't pay Federal income or Social Security taxes on this money before it goes into your account, and you don't owe taxes on it when it is paid out to you. In most states, you don't pay state taxes either.

By paying your out-of-pocket health care and day care expenses through the spending accounts, you can lower your taxable income and that means you lower your income taxes. In this way, you add dollars to your spendable income and that means you have more take-home pay and more money in your pocket! The following illustration will give you a good idea of how the tax savings are calculated.

	Without PayFlex	With PayFlex
Total Annual Income	$30,000	$30,000
Annual Health Care Expenses	–	720
Annual Dependent Care Expenses	–	3,600
Total income subject to taxes	$30,000	$25,680
Less Deductions:		
Federal/State Taxes	5,400	$ 4,622
Social Security/FICA	2,295	1,965
After Tax Income	$22,305	$19,093
Less Deductions:		
Annual Health Care Expenses	720	–
Annual Dependent Care Expenses	3,600	–
Spending Income	$17,985	$19,093
Annual increase in spending income		*$ 1,108
Monthly increase in spending income		*$ 92

**Your increase in spendable income may vary based on withholding elections and state income tax. This illustration assumes 15% Federal tax, 3% state tax, and 7.65% Social Security/FICA tax.*

Special Plan Rules

- You may enroll in this plan **ONLY** during open enrollment or when you first become eligible. This enrollment covers your pay periods only from your effective date through the end of your plan year.
- Once you establish your plan year contribution, you may only change it if you experience a change in status as described below.
- Any amounts left in your accounts at the end of the plan year will be forfeited. It is important that you establish your account carefully to avoid forfeitures. You can avoid forfeitures by reviewing prior year's expenses, being conservative, and planning only for predictable expenses. You may file plan year claims through the run-out period as established by the plan.
- You don't have to enroll in your employer's health insurance plan in order to participate in the health care account. If you or family members are covered for health insurance elsewhere, you can still claim qualifying out-of-pocket health care expenses under the health care account.
- Remember that your expenses must be incurred during your period of coverage. Expenses are considered as having been incurred when you are provided with the health or dependent care that gives rise to the expense, and not when you are formally billed, charged for, or pay for the care.

Change in Status Rules

Internal Revenue Service guidelines allow you to change your plan contribution during the plan year only upon:

- Change in legal marital status (marriage, divorce, legal separation, annulment, death of spouse)
- Change in number of tax dependents (birth, adoption, death)
- Change in employment status that affects eligibility
- Dependent satisfying or ceasing to satisfy coverage requirements (reaching limiting age, gain/loss of student status, marriage)
- Change in residence that affects eligibility

To apply for a change, you must complete a change in election form through your employer's HR/Benefits department within 30 days of the date of the event. The requested change must be consistent with the event. Your employer will review the request and make a final decision as to whether the requested change qualifies.

HEALTH CARE EXPENSES

Health care expenses include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or to prevent a physical or mental defect or illness. Expenses for solely cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to one's general health are not expenses for medical care. **In some cases, you may be asked to provide a letter from your attending physician to substantiate your claim.**

You may be reimbursed for qualified health care expenses that meet certain requirements as described below. Reimbursements can be made up to your plan year elected amount, less prior reimbursements, regardless of the amount actually contributed to your account.

1. The expenses must be incurred for services rendered after the effective date of your election and during the plan year to which it applies. **Expenses are treated as having been incurred when you are provided with the care that gives rise to the expense, and not when you are formally billed, charged for, or pay for the care.**
2. Each individual for whom you incur the expense is:
   a. a dependent under age 19 or, if older, is a full-time student whom you are entitled to claim as a dependent on your federal income tax return;
   b. A spouse; or,
   c. Other tax dependent who is physically or mentally incapable of self-care.
3. The expenses must be for services incurred and already provided, not for services to be provided in the future.
4. The expenses cannot have been reimbursed, and must not be reimbursable by insurance or any other source; and you cannot claim the same expenses as a deduction on your annual income tax return.
5. Individual insurance premiums, other group insurance premiums, and long-term care expenses are not eligible.

Qualifying Health Care Expenses

Medical
Deductibles, co-pays, coinsurance
Prescription drugs, allergy shots, insulin & syringes, annual physicals
Over-the-counter (OTC) medicines and drugs
Chiropractor treatments, psychiatric/psychologist fees
Smoking cessation programs, weight loss programs for disease
Wheelchair/crutches or other durable medical equipment

Dental
Deductibles, co-pays, coinsurance
Routine exams, x-rays, fillings, root canals
Crowns, bridges, dentures, orthodontia

Vision
Eye Exams, prescription eyeglasses and prescription sunglasses
Corrective eye surgery (LASIK, cataract, corneal rings, etc.)
Contact lenses, cleaning solutions, storage case

Hearing
Hearing exams, hearing aids & batteries

Note: Ineligible Health Care Expenses
Cosmetic procedures and medications
(teeth whitening, chemical peels, Retin-A, etc.)
Marriage/Family counseling
Insurance premiums, long term care
Lamaze/Childbirth classes
Health club memberships/dues
Home exercise equipment for general health
Massage therapy for general health
Payment of services not yet provided
Payment of service not incurred during the period of coverage
Treatments for general health
Vision service contracts, sunglasses
Vitamins and dietary supplements for general health

Health Care Planning Worksheet

UNREIMBURSED HEALTH CARE EXPENSES

	Annual Estimate
Medical Expenses not covered by Insurance	
Deductibles, co-pays, coinsurance	$________
Physician visits/routine exams	________
Prescription Drugs	________
Insulin/Syringes	________
Annual physicals	________
Chiropractic treatments	________
OTC medicines/drugs (allergy, antacids, cold medicines, pain relievers)	________
Other________	________
Subtotal medical	$________
Dental Expenses not covered by Insurance	
Checkups/cleanings	$________
Fillings	________
Root canals	________
Crowns/bridges/dentures	________
Oral Surgery	________
Orthodontia	________
Other________	________
Subtotal dental expenses	$________
Vision/Hearing Expenses not covered by Insurance	
Exams	$________
Eyeglasses/reading glasses	________
Prescription sunglasses	________
Contact lenses & cleaning solutions	________
Corrective eye surgery (LASIK, cataract etc.)	________
Hearing exams/hearing aids & batteries	________
Other________	$________
Subtotal vision/hearing	$________
TOTAL UNREIMBURSED HEALTH CARE EXPENSES	$________

DEPENDENT DAY CARE EXPENSES

You can be reimbursed for qualifying dependent care expenses that meet certain requirements as described below. Reimbursements can be made up to the amount actually contributed to your account, less prior reimbursements.

1. The expenses must be incurred to enable you to be gainfully (earning income) employed. Gainful employment does not include unpaid volunteer work, or work for a nominal salary. The expense must be incurred for services rendered after the effective date of this election and during the plan year to which it applies. **Expenses are treated as having been incurred when you are provided with the care that gives rise to the expense, and not when you are formally billed, charged for, or pay for the care.**
2. The expenses must be for a qualifying individual. This includes a dependent of yours under age 13 when the care is provided; or a spouse or other dependent of yours who is physically or mentally incapable of self-care and for whom you can claim an exemption.
3. The services must be provided by an eligible provider of childcare. This includes a licensed daycare facility that complies with applicable state and local laws; and any individual who is not a tax dependent of yours, or a child of yours age 19 or older.
4. The expense must be for services incurred, not for services to be provided in the future.
5. The annual expense reimbursement may not exceed the lesser of:
   a. your earned income,
   b. if married, your spouse's earned income; or,
   c. $5,000 ($2,500 if married, filing separate income tax returns).
6. You must file Form 2441 annually with your individual tax return identifying all your dependent care providers.

Note: The amount which you may consider in calculating the tax credit under the Federal Tax Credit is reduced, dollar-for-dollar, by any amount that you place into the Dependent Care Account. The tax credit limits are $3,000 for one qualifying dependent, and $6,000 for two or more qualifying dependents. **You should carefully review the benefits of the Federal Tax Credit with the benefits of the Dependent Care Account and seek advice from your personal tax advisor before making your final decision.** Visit our tax credit wizard at www.mypayflex.com for assistance.

Qualifying Dependent Care Expenses

- Work-related expenses incurred so that you and, if married, your spouse can work
- Custodial care for qualified tax dependents; before/after school care
- Preschool/nursery school for pre-kindergarten; day care center expenses for custodial care
- Au pair or nanny dependent care expenses; adult day care expenses
- Looking for work expenses

Note: Ineligible Dependent Care Expenses

- Educational/tuition – kindergarten, first grade or higher
- Registration/reservation/holding fees
- Activity fees or fees for supplies or materials/field trip expenses
- Overnight camp (not even the portion attributable to the daytime cost)
- Transportation expenses, food, clothing, entertainment expenses
- Payment of services not yet provided (advance payments)
- Payment of services while you are off work due to illness, maternity or other leave, or vacation
- Payment of services where you are not the custodial parent (in divorce situations)

Dependent DAY Care Planning Worksheet

This worksheet will help you determine the dollar amount you will spend for dependent day care during the plan year. Keep the following in mind when estimating your expenses:

- Reimbursements can be made up to the amount actually contributed to the account, less prior payments.
- Amounts you pay for dependent day care while you are off work because of vacation, holidays or illness/injury are not eligible expenses.
- If your dependent is a student, your expense may be different when school is not in session.
- Your, or your spouse's, work schedule may affect your total expenses.
- Estimate your expenses on a monthly basis, since the amounts may fluctuate throughout the plan year.

January	$
February	$
March	$
April	$
May	$
June	$
July	$
August	$
September	$
October	$
November	$
December	$
Total	**$**

CUSTOMER SERVICE

Where To File Claims

Mail To: PayFlex™ Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039

Fax To: (402) 231-4310

PayFlex™ FSA Service Center: www.mypayflex.com

The FSA Service Center is your personal service representative 24 hours a day, seven days a week! It's quick…it's easy….and it's there when you need help! Through the PayFlex™ FSA Service Center, you can….

- Register to access your personal and detailed account information
- See if a claim was processed or paid; see why a claim was denied
- Obtain a direct deposit form to have reimbursements sent directly to your bank account
- Sign up for e-Notify™ email alerts when your claim is processed
- Obtain claim forms and detailed instructions
- Calculate your potential tax savings
- View an extensive list of eligible/ineligible expenses
- Access important IRS forms and publications

PayFlex™ Info Line: 1-800-284-4885 or (402) 345-0666

The Info Line is updated daily and available 24 hours a day, seven days a week! The PayFlex™ Info Line allows you to…

- Check your PayFlex™ account balance and the most recent claim payment amount and date
- Receive personal assistance during normal business hours when you have questions about unique situations. To protect your privacy and comply with regulations, you will need to provide your full name, employer name, and social security or other identifying number. In some cases, we may decline to disclose certain information.

Health/Dependent Care Flexible Spending Accounts-FSA Enrollment Form

Employer Use Only

Re-enrollment __ New __ Change __
Effective Date ______________
1st Deduction Date ____________
Payroll Mode W B S M Q
Division Code ______________

I. Personal Information (Please print clearly and provide complete and accurate information.)

Your Employer ____

SSN ________ - ______ - __________ **Your Name** ____
(Last) (First) (MI)

Address ______________________________ **City** ____________________ **State** _____ **Zip** _________-________

☐ *Check if this address is new within last year.* **Date of Birth** _____/_____/_____ **Hire Date** _____/_____/_____

II. Election Information (Please check the appropriate box to indicate if you wish to enroll, or do not wish to enroll, and sign below.)

☐ Yes, I wish to participate in the flexible spending account plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ I have been offered the opportunity to enroll in the flexible spending account plan and do not wish to enroll at this time. However, my employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

BENEFIT CHOICES	PER PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		PLAN YEAR AMOUNT
Health Care Reimbursement Account	$________.____	X	________	=	$__________.____
Dependent Day Care Reimbursement Account (If married, this amount is less than my spouse's earned income)	$________.____	X	________	=	$__________.____

I understand that:

- This election can only be changed or revoked during the Plan Year if I have a change in status as defined in the Plan or if I am no longer eligible to participate. The new election must be consistent with my change in status, must be applied for within 30 days of the change, and is subject to final approval by my employer.
- This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required employer-sponsored benefit contributions increase or decrease.
- The maximum exclusion under a Dependent Care Reimbursement Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- Any amounts remaining in my reimbursement accounts at the end of the Plan Year will be forfeited.
- Salary contributed into one reimbursement account cannot be transferred and used for expenses in any other account.
- A new Enrollment Form must be completed each Plan Year. If I do not complete and return an Enrollment Form during Open Enrollment, I forfeit the opportunity to participate in the Benefit Choices outlined above.
- Social Security and Medicare taxes are not being withheld on the amount of my salary reduction under this election.
- The amount of salary reductions may not be claimed on my or my spouse's income tax returns.
- If my employment terminates, only medical expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- I understand all claims submitted for reimbursement are subject to substantiation requirements and I am required to, and agree to, provide documentation as requested.
- If using the PayFlex Debit Card, I agree to use the card for eligible expenses only and retain all itemized receipts/statements. I agree to read and adhere to the cardholder statement I receive with the card and I understand the card is subject to inactivation if I do not comply with the provisions or upon termination of employment.
- Any expenses I pay for with the PayFlex Debit Card or for which I claim reimbursement will not have been nor will I seek to have reimbursed elsewhere.

III. Pre-Authorization for Direct Deposit (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

☐ I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements.
This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement.
A "VOIDED" CHECK MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

Employee Signature ________________________________ ***Date*** ________________

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