

Flexible Benefit Plan

Section 125 A Guide For Employees

**Benefits
Design
Group, inc.**

P.O. Box 370 • Onalaska, WI 54650-0370
800-554-7213 or 800-342-8235

— IMPORTANT —

The information contained in this Employee Guide is general in nature. The Plan is governed by the provisions in the Plan Document adopted by your employer. You should refer to the current Summary Plan Description (SPD) for the details about your Plan. If you do not have a current copy of the SPD you can request a copy from the Plan Administrator.

HOW FLEXIBLE BENEFITS WORK QUESTIONS & ANSWERS

1. WHAT IS A FLEXIBLE BENEFIT PLAN?

A great way to help you increase your spendable income while reducing your payroll taxes! A Flexible Benefit Plan is a pre-tax payroll deduction plan under Internal Revenue Code Section 125 that allows an employer to sponsor a plan where employees can set aside dollars for eligible insurance, medical, dental, optical and daycare expenses before Federal, State, and Social Security payroll taxes are applied. The effect is a reduction of taxes paid which results in an increase in employees' spendable income. **That's an average savings of 25%!**

2. HOW DO I SAVE MONEY AND INCREASE MY SPENDABLE INCOME?

The following illustration gives an example of how you can increase your spendable income through participation in a pre-tax flexible benefit plan. The example is for an individual who earns \$1,600 per month, lives in Minnesota, and is married claiming 0 exemptions.

SAMPLE EMPLOYEE

	WITHOUT FLEX PLAN	WITH FLEX PLAN
Gross Pay Per Month	\$ 1,600.00	\$ 1,600.00
Pre-tax Deductions:		
Group Medical Premiums		50.00
General-Purpose Medical FSA		45.00
Dependent Care FSA		200.00
Wages Subject to Tax	1,600.00	1,305.00
Federal Tax Withheld	109.38	76.75
Social Security Tax	122.40	99.83
State Tax Withheld (varies by state)	63.98	48.20
Group Medical Premiums	50.00	
General-Purpose Medical FSA	45.00	
Dependent Care FSA	200.00	
Net Spendable Income	\$ 1,009.24	\$ 1,080.22
Net INCREASE in Spendable Income per month	\$ 70.98	
Annual INCREASE in Spendable Income	\$ 851.76*	

In the above example, the net cost to the employee for \$295.00 worth of benefits each month is \$224.02, a savings of \$70.98 per month, or approximately 25%. (* Assumes 15% federal tax bracket.)

3. HOW MUCH MONEY WILL COME OUT OF MY PAY CHECK IF I DECIDE TO PARTICIPATE?

Estimate your total expenses separately for each of the flexible benefit plan accounts you elect. The total is then divided by the number of times you will be paid during the plan year. (For example, \$360 plan year election divided by 24 pay periods = \$15.00 per pay period.) Keep in mind that amounts withheld pre-tax will have an immediate tax savings because your payroll taxes will be lower.

4. WHEN DO I NEED TO DECIDE WHETHER OR NOT I WANT TO PARTICIPATE?

You must complete an enrollment form prior to the beginning of the plan year, at which time you select benefit options and specify the annual elections for each option separately. The Plan Administrator will set the due date for enrollment forms. Please refer to your Summary Plan Description (SPD) to determine if mid-year plan entry is permitted for employees hired after the beginning of the plan year. Elections are irrevocable for the entire plan year except for a qualifying change in status. **Caution:** Changes you make mid-year must be consistent with the change in status event and you are not guaranteed permission to change all accounts.

5. DOES THE PLAN COVER MY FAMILY?

The plan covers you, your spouse, and your dependent children (as defined in the plan). Even if you are covered by an insurance plan other than your employer's, you may still set aside money in Flexible Spending Accounts (FSA) for out-of-pocket medical, dental, optical, and dependent care expenses under your employer's plan.

6. DO I HAVE TO USE ALL OF THE AVAILABLE ACCOUNTS TO BE ABLE TO PARTICIPATE IN THE PLAN?

You may use any combination of the available accounts in the flexible benefit plan sponsored by your employer or none at all. Participation in the plan is voluntary and can be reevaluated during open enrollment prior to the start of each plan year.

7. IF I PUT PRE-TAX DOLLARS IN A FSA, WON'T I HAVE LESS MONEY?

No, you will actually save money because you will not be paying payroll taxes on the money you elect to set aside in the Flexible Spending Accounts (FSA). You will also receive up to 100% reimbursement of the amounts elected by filing claims for eligible expenses. In the example shown in Question/Answer #2, the savings in payroll taxes almost offsets the additional amounts the employee was able to set aside for the FSA's each pay period.

8. CAN I CHANGE MY ELECTIONS AT ANY TIME?

Once the plan year begins, you cannot adjust your elections until the following plan year unless you experience a qualified change in status. Change in status events may include, but are not limited to: marriage, legal separation, divorce, birth or adoption of a child, death of a spouse or child, change of employment status of employee, spouse, or dependent, or a third party-initiated change, such as a change in the cost of insurance or daycare. Depending on your employer's plan, you will typically have 30 to 90 days to adjust your elections consistent with the qualifying event. A complete list of qualifying events and the time limit to change elections is available by referring to your Summary Plan Description (SPD). **Caution:** Not all accounts may be changed as a result of a qualifying event.

9. IF I HAVE MONEY LEFT IN ONE FSA AND HAVE RUN OUT OF MONEY IN ANOTHER, CAN I TRANSFER THE LEFTOVER MONEY TO ANOTHER FSA?

Under IRS regulations, each FSA is separate and balances are not interchangeable. Qualified dependent care expenses may only be reimbursed under the Dependent Care FSA and qualified medical expenses may only be reimbursed through the General-Purpose or Limited-Purpose Medical FSA.

10. WHAT HAPPENS IF I DON'T USE ALL OF THE MONEY IN MY FSA?

Any funds remaining at the end of the plan year (or applicable grace period) are subject to the "Use-or-Lose" provisions of the IRS regulations and will be forfeited. Remaining account balances may not be refunded or "rolled over" to a future plan year. Be **CONSERVATIVE** when estimating your expenses and base your elections on predictable items that will be incurred in the plan year. Worksheets have been included within this guide to assist you in making your estimates. We suggest you look at your check register, insurance statements, and medical/dental bills for the past year to obtain an idea of how much you have had in out-of-pocket expenses over the course of the past year. This amount may be used as a guideline for predicting expenses for the upcoming plan year. It is better to run out of money before the year ends as opposed to having money left that you cannot claim and will forfeit.

11. IF I PARTICIPATE IN THIS PLAN, CAN I STILL RECEIVE TAX CREDITS AND ITEMIZE MEDICAL DEDUCTIONS ON MY TAX RETURN?

By participating in the General-Purpose Medical FSA, the Limited-Purpose Medical FSA and/or the Premium Conversion portion of the plan, you are already receiving the tax savings on the expenses on your paycheck and cannot claim them again as an itemized deduction on your tax return. In order to itemize your medical expenses have to be a minimum of 7.5% of your gross earnings. Most people are unable to itemize unless they experience a catastrophic expense. For certain expenses, such as child care, we recommend you consult with your tax advisor to determine whether the Dependent Care FSA or the Federal Child Care Tax Credit best fits your personal situation.

12. WILL PARTICIPATION IN THE PLAN AFFECT MY SOCIAL SECURITY RETIREMENT/ DISABILITY BENEFITS LATER ON?

Since your taxable wage base is reduced by the amount of pre-tax benefits you elect under the plan, the contribution to Social Security is less, and may affect your benefits if you become disabled or retire. Because the reduction is generally minimal, **investing a portion of your tax savings in your company's retirement plan or in a private savings plan will generally offset the possible reduction in benefits.** For more information consult the Social Security Administration about your personal situation.

13. HOW WILL MY PARTICIPATION IN THIS PLAN AFFECT MY TAXES AT THE END OF THE YEAR? WILL I HAVE TO DO ANYTHING DIFFERENTLY WHEN FILING MY TAX RETURN?

The amount of taxable wages reported on your W-2 will be automatically reduced by the amounts you elected to pre-tax under the plan. You simply use the amount shown on the W-2 as taxable income and complete your return as you always have done. Dependent Care FSA participants; however, must also attach Schedule 2441 to the tax return, reporting the name of the Dependent Care Provider, their tax identification number, and the amount withheld pre-tax for Dependent Care. The amount withheld pre-tax for the Dependent Care FSA will appear in Box 10 on the W-2 form. HSA contributions made through payroll pre-tax and/or employer contributions made under Section 125 must be reported in Box 12 of the W-2. Taxpayers must then report this on Schedule 8889 with their federal tax return (if applicable).

14. IF I PARTICIPATE IN A FSA, HOW DO I GET REIMBURSED?

1. Complete a FSA Claim Form.

(Forms can be obtained at our website: www.bdgflex.com)

2. Attach the appropriate required claims substantiation.

Examples: Explanation of Benefits (EOB), Billing Statements, Cash Register Receipts, Pharmacy Printouts, Co-pays Receipts, etc.

NOTE: Cancelled checks, balance due statements or received on account statements are NOT a valid proof of expense.

Per IRS regulations, claims substantiation must be from a third party and must include enough information to verify when the service was performed, who the service was for and whether or not the service was for an IRS approved expense.

Claims Processing will occur faster if your substantiation includes:

- a. Date the service happened. (Not necessarily the payment date.)
- b. Description of the Service. (i.e. Office visit, Surgery, RX name, etc.)
- c. Name of the Medication. (The name of the medication will be required for Rx expenses over \$50 so that we can verify whether or not the RX is for cosmetic or general health reasons. Any claims that are not clear will be returned for further information.)
- d. Provider Name. (Name of professional or institution providing the service.)
- e. Name of the Patient the expense is for. (List "self" if for yourself and list family member name if for dependents.)
- f. Dollar amount you are requesting. (Amount that is your responsibility and will not be covered by another source.)

3. REQUIRED: Sign the FSA Claim Form.

4. Submit your Claim for Processing

Forward by mail to: Benefits Design Group, Inc.
PO Box 370
Onalaska WI 54650

Or By Fax: (608) 781-4576

Or contact our office at 1-800-554-7213 to find out how you can send your claims by e-mail securely.

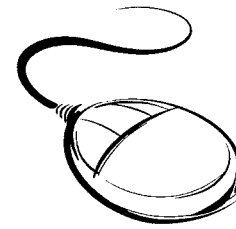
Remember: Claims will be delayed if you don't submit enough detail to substantiate your request or if your claim form is not signed. A letter will be sent to you explaining the detail needed to further process your request.

15. HOW SOON CAN I EXPECT TO RECEIVE MY REIMBURSEMENT CHECK?

Claim forms are processed on a daily basis. Reimbursement checks are generated according to the schedule as contracted with your employer. The checks are always issued to you, and cannot be issued to your providers directly.

The reimbursement check stub provides a breakdown of your current account activity, including the amounts paid, the service date, claims pending, and the remaining account balance. A replacement FSA Claim Form can be obtained on our website under Forms & Instructions at: www.bdgflex.com. FSA participants also receive periodic account statements, which summarize year-to-date activity.

Employee Account info as easy as 1, 2, 3...



Here's what you need to do ...

1. Go to www.bdgflex.com.
2. Click on "**Employees.**"
3. Click on "**First Time?**"
This is where you set up your Personal Identification Number (PIN).
4. Enter your Social Security Number.
5. Enter your Zip Code.
6. Enter your current e-mail address and then re-enter it to confirm.
7. Click on "**Submit.**"
8. We will then send you a PIN via e-mail. (If you don't get your PIN in an hour, please register again.)

You are registered!

Here's how to access your account info:

1. Go to www.bdgflex.com.
2. Click on "**Employees.**"
3. Click on "**Login Now.**"
4. Enter your Social Security number and your PIN, click "Submit."
NOTE: This is a secure website through a certificate by Verisign

Now you can:

Check year-to-date contributions and balances, look at details of account transactions, or review the details of your claims, notify us of address changes, change your PIN, or change your e-mail*

**You'll receive an e-mail to alert you when changes have been made to your account.*

If you forget your PIN:

1. Go to www.bdgflex.com.
2. Click on "**Employees.**"
3. Click on "**Forget Your PIN?**" Enter the information asked for and we'll send your PIN via e-mail (see #8 above).

Benefits Design Group, Inc.
701 Sand Lake Rd. PO Box 370 Onalaska, WI 54650
www.bdgflex.com



WE MAKE PARTICIPATION SIMPLE!

- Competent staff available to answer questions regarding your Flexible Spending Account (FSA).
- Toll-free customer service assistance provides:
 - a. Assistance with enrollment
 - b. Assistance with reimbursement
 - c. Current account information

- All forms necessary for participation, reimbursements and adjustments to your account are **ONLINE** at **www.bdgflex.com**

- FSA Claim Form
- Authorization for Release of Information
- Direct Deposit Authorization

- Account summary statements per reimbursement and during the last quarter of the plan year.

- Reimbursements as scheduled.

- Internet Access to account information and forms at www.bdgflex.com



Check out our Website for:

- **Forms**
- **Claim Filing Tips**
- **Tax Law Updates**
- **Listing of Eligible Expenses & Much More**

**Check
your
account** →



FLEXIBLE BENEFIT PLAN REVIEW

Before returning your completed enrollment form, please review the following major provisions of the program. If you have any questions, please call our office at the number indicated on the cover of this booklet.

1. Benefit elections are made annually during the open enrollment period, which is generally the month before a new plan year, unless you have a qualified "change in status". Change in status events may include, but are not limited to: change in employee's legal marital status; change in number of tax dependents; termination or commencement of employment by the employee, spouse, or dependent; change in work schedule; dependent satisfies (or ceases to satisfy) dependent eligibility; change in residence or worksite of employee, spouse, or dependent. Depending on your employer's plan, you will have 30 to 90 days to report such a situation, and change your elections consistent with that change. A complete listing of qualifying events is available in your Summary Plan Description (SPD).
2. Pre-tax contributions to the Flexible Spending Accounts (FSA) are subject to the "Use-or-Lose" provisions. Claims incurred in the plan year (or grace period if applicable) and not filed within the forfeiture period at the end of your plan year (usually 60 days) will be reported as forfeited by law.
3. Your first "FSA Claim Form" form is included in this guide. You may also download forms under "Forms and Instructions" on our website www.bdgflex.com.
4. FSA Claims may be submitted at any time. FSA Claims submitted and received by your employer's designated cut-off date will be reimbursed with the next scheduled check process, provided there are balances available in your account or in your employer's pool. If your check processing date falls on a weekend or holiday, the checks will be issued the next business day.
5. General-Purpose or Limited Purpose medical expenses in excess of current account balances, but less than or equal to your annual election, will be paid out based upon availability of funding from your employer. (Reimbursement cannot exceed your annual election.)
6. Employee Account Summaries are provided to each FSA participant at the end of the plan year. Any other questions, or request for account status at other times, may be directed to Benefits Design Group, Inc. or view account information on-line via our website at www.bdgflex.com.

PREMIUM CONVERSION ACCOUNTS

Premium conversion accounts allow you to elect to pay premiums for qualifying insurance coverage through your employer with pre-tax dollars. There is no reimbursement process involved; the amount you elect is simply taken out of your check BEFORE the payroll taxes are calculated.

PREMIUM CONVERSION WORKSHEET

Indicate the amount deducted from your payroll check per pay period for each of the following insurance types (as applicable) and transfer those amounts to the appropriate line on the enrollment form.

INSURANCE TYPE	AMOUNT PER PAY PERIOD
1. Medical Premium	\$ _____
2. Dental Premium	\$ _____
3. Disability Premium*	\$ _____
<i>* Any benefits received under this policy type will be taxed if you elect to pre-tax premiums for this coverage.</i>	
4. Term Life Insurance Premium (employee only) (maximum \$50,000 death benefit)	\$ _____
5. Other Premium (Cancer, Vision, Accident, Hospital Indemnity, etc.)	\$ _____

Please transfer the above amounts to the lines indicated under the "Premiums" portion of the enrollment form.

NOTE: All insurance types listed above may not be included in every plan. Please refer to your Summary Plan Description (SPD) for the details about your specific plan design.

Premium Conversion under Section 125 **DOES NOT COVER:**

Long-Term Care, Whole Life, Universal Life, and policies with cash surrender value. Also not covered are premiums from a spouse's employer or withheld from pension checks from another employer.

INDIVIDUAL PREMIUM FSA

If you have purchased an insurance policy for yourself or any of your eligible dependents, you may elect to set aside those premiums on a pre-tax basis through this Flexible Spending Account (FSA). In order to be eligible, the policy must be **owned by the employee** and the premiums must be paid by you directly to the insurance carrier and may not be part of an employer sponsored insurance program. See the list below for the eligibility of the premiums for pre-tax treatment.

NOTE: Dollars received by you from your employer as part of a credit arrangement MAY NOT be used in this category; the election must be a pre-tax reduction from your salary.

Individual Premium Reimbursement DOES cover:

Health	Medicare Supplement
Dental	Health Supplement (GAP plan)
Vision	Intensive Care
Hospital Indemnity	Disability*
Cancer	Accident

* Any benefits received under this policy type will be taxed if you elect to pre-tax the premiums for this coverage.

Individual Premium Reimbursement DOES NOT cover:

- Life Insurance
- Policies with cash surrender value or return of premium
- Spousal premiums through the spouses employer
- Policies that are owned by someone other than the employee
- COBRA from a previous employer
- Health insurance deducted out of pension checks from a previous employer
- Long-Term Care Insurance

A participant in the Individual Premium FSA must submit to Benefits Design Group, Inc., each plan year, verification of the type of policy, proof of ownership, and proof of current coverage. A copy of the “dec page” of the policy, a billing statement from the insurance carrier, or a letter from the carrier will be sufficient. In order for the policy to qualify for Individual Premium, the employee must show proof that they are the owner of the policy. The policy must be in the employee’s name and cannot be owned by the employee’s spouse or dependent.

On an ongoing basis, a participant in the Individual Premium FSA must submit a completed FSA Claim Form along with proof of coverage dates and premium payment. Proof may be a copy of your bank statement or a billing statement sent to your home.

Reimbursements will be processed based upon your current account balance. Any claims exceeding the account balance will be automatically reprocessed when new funds become available through future payroll deduction.

INDIVIDUAL PREMIUM FSA WORKSHEET

Use this form to help you determine your projected expenses for the plan year. Do not allocate more than what you know you will have in premium expenses. If your premium changes during the plan year, you will be able to adjust your election in this account, provided the premium change is a result of an adjustment initiated by the insurance company. You must complete a Change of Elections/Status Form and forward it to your Human Resources to process any eligible payroll deduction changes.

QUALIFYING INDIVIDUAL PREMIUMS

PLAN YEAR COST

(Employee Owned Policies Only)

1. Medical Premiums.....\$ _____

2. Dental Premiums.....\$ _____

3. Cancer Premiums\$ _____

4. Disability Premiums\$ _____

5. Vision Premiums\$ _____

6. Supplemental Medicare Premiums\$ _____

7. Other Premiums\$ _____

TOTAL PROJECTED EXPENSES PER PLAN YEAR\$ _____

TOTAL NUMBER OF PAY PERIODS IN PLAN YEAR..... _____

DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS\$ _____

(enter result on enrollment form under Individual Premium)

PLEASE NOTE: Under the Use-or-Lose provisions of the regulations, if you allocate too much money to your account and cannot use the money by the end of the plan year (or applicable grace period), you forfeit the remaining balances. It is, therefore, important to be conservative when estimating your expenses. Each account is separate and balances may not be transferred to any other FSA.

LIMITED-PURPOSE MEDICAL FSA - HSA Compatible

The Limited-Purpose Medical Flexible Spending Account (FSA) is available for employees who also have a Health Savings Account (HSA) and want to make contributions to the HSA. It generally is limited to dental, vision, and preventative care expenses only.

Under the Limited-Purpose Medical FSA, you are able to withdraw up to your annual election at any time during the plan year upon presentation of proof of eligible expenses. Examples of common dental, vision and preventative care expenses eligible for reimbursement under the Limited-Purpose Medical FSA are listed below, to assist you in determining whether or not this account would fit your situation. This list may not include all eligible expenses, so if you have a question about an expense not listed, please contact our office at the toll free number listed on the cover of this booklet. **Some expenses do require a doctor's letter stating that the treatment is medically necessary or constitutes preventative care** before the Plan can process your request for reimbursement. An updated doctor's letter is required each plan year for expenses that span longer than one plan year.

DENTAL/VISION EXPENSE

ELIGIBLE

- Prescription Glasses and Sunglasses
- Lasik Eye Surgery
- Eye Exam
- Contact Lens and Contact Lens Supplies
- Dental Fees (crowns, bridges, cleanings)
- Orthodontia

INELIGIBLE

- Clip-on or Non-Prescription Sunglasses
- Cosmetic procedures (i.e. Teeth Bleaching)

PREVENTATIVE CARE

“Preventative Care” includes, but is not limited to: periodic health evaluations (including diagnostic procedures ordered in correlation with the evaluation); well-baby and/or well-child care; immunizations for adults and children; tobacco cessation and obesity weight loss programs; screening devices for cancer, heart disease, and other infectious diseases. **See IRS Notice 2004-23 for additional examples.**

YOU CANNOT OBTAIN REIMBURSEMENT FOR:

- Premiums for current health coverage sponsored by the employer of your spouse
- Childcare expenses
- Cosmetic procedures
- Hygiene and general health items
- Medical expenses and over-the-counter medications, except for expenses associated with items classified as “preventative care” that are obtained by prescription.
- Medical expenses that are part of the deductible under the high deductible health plan

PARTICIPATION IN THE LIMITED-PURPOSE MEDICAL FSA CONSTITUTES PERMISSIBLE DENTAL, VISION OR PREVENTATIVE CARE COVERAGE UNDER IRC§223, AND YOU, YOUR SPOUSE AND/OR DEPENDENTS ARE ELIGIBLE TO CONTRIBUTE TO A HEALTH SAVINGS ACCOUNT (HSA) OR RECEIVE EMPLOYER CONTRIBUTIONS TO A HSA UNDER IRC§223.

LIMITED-PURPOSE MEDICAL FSA EXPENSE WORKSHEET

Use this worksheet to project your expenses for the coming plan year. Be **CONSERVATIVE** and estimate only those expenses you are reasonably certain you will incur during the plan year.

ELIGIBLE EXPENSES	PLAN YEAR COST
Dental Deductibles & Co-pays	\$ _____
Dental Expenses (exams, cleaning, fillings, crowns, etc.)	\$ _____
Orthodontia.....	\$ _____
Vision Care (exams, contacts, glasses, laser eye surgery)	\$ _____
Preventative Care/Preventative Screenings.....	\$ _____
Well Baby Care	\$ _____
Routine Exams	\$ _____
Tobacco Cessation Programs	\$ _____
Weight Loss Programs (Letter of medical necessity required.) ...	\$ _____
Other Eligible Expenses.....	\$ _____
Other Eligible Expenses.....	\$ _____
TOTAL PROJECTED EXPENSES FOR THE PLAN YEAR.....	\$ _____

NUMBER OF PAY PERIODS IN PLAN YEAR _____

DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS\$ _____

(enter result on enrollment form under Limited-Purpose Medical FSA)

PLEASE NOTE: Under the Use-or-Lose provisions of the regulations, if you allocate too much money to your account and cannot use the money by the end of the plan year (or applicable grace period), you forfeit the remaining balances. It is, therefore, important to be conservative when estimating your expenses. Each account is separate and balances may not be transferred to any other FSA.

GENERAL-PURPOSE MEDICAL FSA

The General-Purpose Medical Flexible Spending Account (FSA) covers out-of-pocket medical, dental and optical expenses not covered under an insurance program or reimbursable through another source. Under the General-Purpose Medical FSA, you are able to withdraw up to your annual election at any time during the plan year upon presentation of proof of eligible expenses.

Although not all expenses are listed below and are subject to change by the IRS, examples of commonly reimbursed items are listed to assist you in determining whether or not this account would fit your family situation. If you have a question about an expense not listed, please contact our office at the toll free number listed on the cover of this booklet. ***Some expenses do require a doctor's letter stating that the treatment is medically necessary for a specific current medical condition (i.e. massage therapy, exercise programs/equipment, vitamins, weight loss treatment).*** *An updated letter will be required each plan year.*

Acupuncture	Hearing aids/batteries	Psychiatric care
Ambulance hire	Home improvements (capital expenditures) motivated by medical considerations	Psychologist fees
Artificial limbs	Hospital bills	Reconstructive procedures due to medical condition
Braces	Hypnosis for treatment of an illness	Routine physicals
Birth control	Laboratory fees	Smoking cessation programs
Braille books and magazines	Medical supplies	Special Diets
Car controls for the handicapped	Medications	Surgical fees
Chiropractors	Nursing fees (including room, board and Social Security tax where paid by taxpayer)	Telephone and Television audio display equipment for the deaf
Co-insurance and Co-Pays	Obstetrical expenses	Therapeutic care for drug and alcohol addiction
Contact lenses and supplies	Orthodontia	Therapy treatments related to medical conditions
Crutches	Orthopedic shoes	Transportation expenses incidental to medical care
Deductibles	Physician fees	Tuition fee (part), if school furnishes breakdown of medical charges
Dental fees	Physician-prescribed pool/spa equipment costs and maintenance motivated by medical considerations	Vision correction procedures
Dentures	Pregnancy Test/Ovulation Kits	Vitamins by prescription
Diabetic Supplies	Prescription drugs*	Wheelchair
Diagnostic fees		X-rays
Drug and medical supplies		<i>*Name of medication required for items over \$50</i>
Eyeglasses, including examination fee		
Fee associated with the education and medical care of individuals with developmental disabilities		
Guide dog and upkeep		

WARNING: Effective January 1, 2011, over-the-counter (OTC) medications are only tax deductible (reimbursable) if obtained by a prescription. A doctor's letter is not sufficient.

YOU CANNOT OBTAIN REIMBURSEMENT FOR:

- Premiums incurred by a spouse through his/her employer
- Childcare expenses through a medical FSA
- Items for general health
- Cosmetic Procedures (i.e. **teeth bleaching**, elective plastic surgery, etc.)
- Uniforms
- Maternity Clothes
- Hygiene Items
- Marriage Counseling

CAUTION: PARTICIPATION IN THE GENERAL-PURPOSE MEDICAL FSA BY YOU, YOUR SPOUSE AND/OR DEPENDENTS WILL CAUSE YOU TO BE INELIGIBLE TO CONTRIBUTE TO A HEALTH SAVINGS ACCOUNT (HSA) OR RECEIVE EMPLOYER CONTRIBUTIONS TO A HSA UNDER IRC§223.

GENERAL-PURPOSE MEDICAL FSA EXPENSE WORKSHEET

Use this worksheet to project your expenses for the coming plan year. Be **CONSERVATIVE** and estimate only those expenses you are reasonably certain you will incur during the plan year.

ELIGIBLE EXPENSES	PLAN YEAR COST
Medical Deductibles & Co-pays	\$ _____
Dental Deductibles & Co-pays	\$ _____
Well Baby Care	\$ _____
Prescription Drugs/Co pay	\$ _____
Vision Care (exams, contacts, glasses, laser eye surgery)	\$ _____
Routine Exams	\$ _____
Other Medical Providers (Chiropractic & Podiatrists).....	\$ _____
Medical Supplies (bandages, blood pressure cuff, wheelchair, etc.)..	\$ _____
Dental Expenses (exams, cleaning, fillings, crowns, etc.)	\$ _____
Orthodontia.....	\$ _____
Transportation for Health Care.....	\$ _____
Any Other Eligible Expenses.....	\$ _____
TOTAL PROJECTED EXPENSES FOR THE PLAN YEAR.....	\$ _____

NUMBER OF PAY PERIODS IN PLAN YEAR _____

DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS\$ _____
(enter result on enrollment form under General-Purpose Medical FSA)

PLEASE NOTE: Under the Use-or-Lose provisions of the regulations, if you allocate too much money to your account and cannot use the money by the end of the plan year (or applicable grace period), you forfeit the remaining balances. It is, therefore, important to be conservative when estimating your expenses. Each account is separate and balances may not be transferred to any other FSA.

DEPENDENT CARE FSA

Under the Dependent Care Flexible Spending Account (FSA), you are able to deduct pre-tax dollars for work-related child care or adult day care expenses. The expenses must be incurred during the plan year. Both you and your spouse (if married) must be working, or be a full-time student, to have expenses eligible for reimbursement through the FSA. In the event of divorce, the custodial parent can claim the dependent care expense. Be **CONSERVATIVE** and estimate only those expenses you are reasonably certain you will incur during the plan year. Be careful to allow for sick days, vacation time, and other times of the year when you may not be paying the same amount per week for the dependent care.

ELIGIBLE

Care for dependents (under age 13) of gainfully employed guardians

Care for dependents who are mentally or physically incapable of self-care

Baby-sitter, Daycare Provider, Home Care Provider

Licensed daycare centers caring for more than 6 non-resident people

Daycare centers caring for less than 6 non-resident people

Daytime camps or training programs

Pre-School

All Latch Key Programs

INELIGIBLE

Educational programs for dependents

Care provided by person(s) claimed as a dependent on your, or your spouse's, tax return

Care provided by child/stepchild under age 19 at end of plan year

Cost of food, clothing, entertainment unless costs are incidental to care and cannot be separated from the cost

Care provided by someone not reporting their daycare income

Overnight camps and transportation

Field trips

Child Support Payments

* Any contributions toward an employer-sponsored Dependent Care FSA will be reported on the employee's W-2 form. The employee must fill out and attach Schedule 2441 to his/her federal tax return. To substantiate the tax credit that the employee receives through the payroll reduction of the Dependent Care expenses, the Social Security number or Federal Tax ID number of the day care provider(s) must be disclosed on Schedule 2441. Failure to do so will result in the addition of the Dependent Care FSA total contributions to the taxable wages for the year.

LIMITATIONS:

1) Contribution Limits

- Married filing separately \$2,500*
- All others \$5,000*

*Contribution cannot exceed the lesser of the participant's income as reduced by the dependent care salary reduction amount or the spouse's income. (Note: Up to \$1000** of expense for two or more qualifying individuals that exceeds the Dependent Care FSA limit of \$5000, may be claimed as Federal Childcare Tax Credit on your personal income tax return. Please consult your tax advisor.)

2) Both you and your spouse (unless spouse is disabled or a full-time student) must work. If a spouse is a full-time student or disabled, the spouse is deemed to have earned an income of \$3,000** (if dependent care expenses apply to one qualifying individual) or \$6,000** (if dependent care expenses apply to two or more qualifying individuals).

**** Amounts based upon extension of Bush tax cuts through 12/31/12, under the 2010 Tax Relief Act, unless otherwise extended by Congress. Please consult your tax advisor for the current limits and tax rates.**

3) You CANNOT use any FSA funds allocated for Dependent Care expenses for any other purpose. Under the Use-or-Lose provisions, any account balance remaining at the end of the year that cannot be substantiated for Dependent Care services rendered within the plan year will be forfeited by law.

DEPENDENT CARE FSA EXPENSE WORKSHEET

Use this worksheet to project your expenses for the coming plan year. Be **CONSERVATIVE** and estimate only those expenses you are reasonably certain you will incur. Take into consideration vacation days, sick days and holidays when the expenses may not be as high.

QUALIFIED DEPENDENT CARE	PLAN YEAR COST
1. Day care for qualifying individuals	\$ _____
2. Pre-School.....	\$ _____
3. Latch Key Programs (before and after school).....	\$ _____
4. Summer Day Camp.....	\$ _____
5. Other	\$ _____
TOTAL PROJECTED EXPENSES PER PLAN YEAR	\$ _____
NUMBER OF PAY PERIODS IN PLAN YEAR . _____	
DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS	\$ _____
(enter result on enrollment form under Dependent Care)	

PLEASE NOTE: Under the Use-or-Lose provisions of the regulations, if you allocate too much money to your account and cannot use the money by the end of the plan year (or applicable grace period), you forfeit the remaining balances. It is, therefore, important to be conservative when estimating your expenses. Each account is separate and balances may not be transferred to any other FSA.

FEDERAL CHILD CARE TAX CREDIT

VS.

DEPENDENT CARE FSA

Amount of Federal Child Care Credit*	Adjusted Gross Income		Percentage
	Over	But not over	
	\$0	15,000	35%
	15,000	17,000	34%
	17,000	19,000	33%
	19,000	21,000	32%
	21,000	23,000	31%
	23,000	25,000	30%
	25,000	27,000	29%
	27,000	29,000	28%
	29,000	31,000	27%
	31,000	33,000	26%
	33,000	35,000	25%
	35,000	37,000	24%
	37,000	39,000	23%
	39,000	41,000	22%
	41,000	43,000	21%
	43,000	No Limit	20%
	84,900	FICA Limit	20%

To determine the amount of your credit, multiply your work-related expenses (after applying the earned income and dollar limits) by a percentage. This percentage depends on your adjusted gross income. The following table shows the percentage to use based on adjusted gross income.

Note: Federal Childcare Tax Credit is a nonrefundable tax credit that is used to reduce federal tax liability.

***NOTE:** The following examples above are based upon extension of Bush tax cuts through 12/31/12, under the 2010 Tax Relief Act, unless otherwise extended by Congress.

EXAMPLES

The following examples show how to figure the credit for child and dependent care expenses.

EXAMPLE 1 WITH FEDERAL TAX CREDIT Child Care — One Child

Jerry and Ann Jones are married and keep up a home for their three year old child. They claim their child as a dependent and file a joint return using Form 1040A. Their adjusted gross income (AGI) is \$27,500. Jerry earned \$12,500 and Ann earned \$15,000. During the year, they pay work-related expenses of \$3,000 for child care for their son Daniel at a neighbor's home and \$2,200 for child care at Pine Street Nursery School.

They figure their credit as follows:

Child Care by neighbor	\$3,000
Child Care by nursery school	+ \$2,200
Total work-related expenses	<u>\$5,200</u>
Dollar Limit	<u>\$3,000</u>
Lesser of expenses paid (\$5,200) or dollar limit (\$3,000)	\$3,000
Percentage for AGI of \$27,500	<u>28%</u>
Amount of credit (28% of \$3,000)	<u>\$ 840</u>

EXAMPLE 2 WITH DEPENDENT CARE FSA Child Care — One Child

Ann elects to set aside \$5,000 for dependent care through her Employer's Flexible Benefit Plan. This \$5,000 is shown in box 10 of her Form W-2, but is not included in her taxable wages in Box 1.

She figures the tax savings as follows:

Child Care by neighbor	\$2,200
Child Care by nursery school	+ \$3,000
Total work-related expenses	<u>\$5,200</u>
Maximum Dollar Limit	<u>\$5,000</u>
Lesser of expenses paid (\$5,200) or dollar limit (\$5,000)	\$5,000
Average Percentage for Payroll Tax Savings	<u>25%</u>
Approximate Payroll Tax Savings	<u>\$1,250</u>

Flexible Benefit Plan Advantage \$410

Please consult with your tax advisor for the current tax rate, child care limits and help determining the best option for you.

Notes...

FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

INSTRUCTIONS: FAILURE TO COMPLETE ALL SECTIONS OF THE FORM WILL DELAY THE PROCESSING OF YOUR CLAIM. Complete all personal information in **Part I**. Complete all claims information in **Part II**. Indicate the type of expense (Medical, Dental/Vision, Preventative Care, Dependent Care or other), the incurred date(s) of the expense, a brief description (i.e. Orthodontia, Prescription, Dental, Office Visit, OTC, etc.) Attach **COPIES** (do not send originals) of documentation that will prove the **incurred date/service date (not paid date)** and service type that is eligible. An Explanation of Benefits (EOB), billing statement, co-pay receipt, cash register receipt, etc. should be submitted for each expense. Received on account receipts, balance due statements, and cancelled checks are **NOT** acceptable. **If you are submitting more than one expense, number the copies to correspond to the line number on this form.** Please read **Part III** below and **SIGN** the claim form, attach copies of the proper documentation, and forward by fax **OR** by mail (**not both**) for processing.

PART I. EMPLOYEE INFORMATION (Please print)

Social Security Number _____ - _____ - _____ (last 4 digits required) Check if New Address _____
 Name _____ Daytime Phone _____
 Address _____
 City _____ ST _____ ZIP _____
 Employer _____

PART II. REIMBURSEMENT INFORMATION

TYPE CODES: M = General-Purpose Medical DV = Dental/Vision PC = Preventative Care D = Dependent Care O = Other Eligible Expense

ADULT

CHILD CLAIM*	TYPE CODE	SERVICE DATES START DATE – END DATE	AMOUNT	PROVIDER NAME/ DEPENDENT NAME <i>(i.e. XYZ Hospital/John)</i>	OFFICE USE
<input type="checkbox"/> 1.	_____	_____ - _____	_____	_____	_____
<input type="checkbox"/> 2.	_____	_____ - _____	_____	_____	_____
<input type="checkbox"/> 3.	_____	_____ - _____	_____	_____	_____
<input type="checkbox"/> 4.	_____	_____ - _____	_____	_____	_____
<input type="checkbox"/> 5.	_____	_____ - _____	_____	_____	_____
<input type="checkbox"/> 6.	_____	_____ - _____	_____	_____	_____

TOTAL _____ (For additional claims, use another form)

***Reimbursement for medical expenses incurred by an adult child who is not a dependent for purposes of income tax filing may be reported as income and subject to the applicable income taxes.**

PART III. CERTIFICATION AND AUTHORIZATION

I authorize the above expenses to be reimbursed from my flexible spending account(s). I certify that: 1) the above information is correct and that the expenses claimed were incurred by me, my spouse, or by my eligible dependents as defined in the Plan document after my effective date of coverage in my employer's flexible benefit plan; 2) the submitted expenses are either valid Qualified Medical Expenses or valid Dependent Care Expense, within statutory limits, as defined in the Plan Document; 3) none of the above expenses have been or will be submitted for reimbursement or payment from any other source; and 4) I have not and will not claim the above expenses on my personal income tax return. I acknowledge that upon request, I must provide additional substantiation concerning my claims (i.e. doctor's letter detailing the specific medical condition being treated). I understand that it is my responsibility to file IRS Form 2441 with my tax return along with any required taxpayer identification number for any reimbursed Dependent Care Expenses. I acknowledge that unless my coverage under the medical flexible spending plan constitutes permitted non-HDHP coverage I am not eligible for health savings account contributions (HSA), while covered under the flexible spending plan.

EMPLOYEE

SIGNATURE _____ **DATE** _____

Signature REQUIRED for processing

BENEFITS DESIGN GROUP, INC.

P.O. BOX 370, Onalaska, WI 54650 1-800-554-7213 or 1-800-342-8235 Fax (608) 781-4576

BDG-005BU 9/10

HOW TO FILE A CLAIM

To receive reimbursement for eligible expense, mail **OR** fax (not both) a completed claim form along with IRS-required substantiation of the expense which **must include ALL of the following**:

- Date of service/purchase
- Name of service provider and name of dependent receiving service
- Type of service/supply provided
- Amount for service that is not reimbursed by insurance or another source

**CANCELLED CHECKS DO NOT QUALIFY AS THIRD-PARTY DOCUMENTATION AND ARE NOT ACCEPTED BY THE IRS.
Be sure to provide all the information requested on the form. If the form is incomplete or unsigned, it will be returned.**

GENERAL-PURPOSE MEDICAL EXPENSES (“M”)-NOT HSA Compatible

Medical expenses include payment you make for the diagnosis, treatment, or prevention of disease or for treatment affecting any part of function of the body and the amounts you pay for transportation to get medical care. CAUTION: Participation in the General-Purpose Medical FSA and reimbursement for general medical expenses will disqualify you from making or receiving Health Savings Account (HSA) contributions.

The following is a partial listing of medical, dental/vision and preventative care expenses which are allowed and disallowed through your FSA. Many of the same medical expenses that are allowed deductions on your federal income taxes (IRC Section 213(d)) are also reimbursed expense through your flexible spending account (FSA).

ELIGIBLE

- Deductibles and Co-pays
- Diagnostic Tests (Lab, X-ray, etc)
- Massage Therapy to treat medical condition*
- Weight Loss programs to treat a medical condition*
- Prescription medications
(Name of medication required for items over \$50)
- Hearing Aids & Batteries
- Medical Supplies (Bandages, Diabetic Test Strips, Crutches, etc.)
- *Doctors' letter required (must be updated once per plan year)

INELIGIBLE

- General Parenting Classes
- Massage Therapy to reduce stress
- Weight-loss programs for general health
- Cosmetic procedure to enhance appearance (i.e. face lift)
- Marriage Counseling
- Uniforms
- Maternity Clothes
- Insurance premiums through a spouse's employer
- Hygiene Items (toothpaste, deodorant, etc.)

DENTAL/VISION EXPENSE (“DV”)-HSA Compatible

ELIGIBLE

- Prescription Glasses and/or Prescription Sunglasses
- Lasik Eye Surgery
- Eye exam
- Contacts and Contact Lens Supplies
- Dental fees (crowns, bridges, filings, cleanings)
- Orthodontia

INELIGIBLE

- Clip-on or Non-Prescription Sunglasses
- Cosmetic procedures (i.e. Teeth Bleaching)

PREVENTATIVE CARE (“PC”) (See IRS Notice 2004-23)-HSA Compatible

“Preventative Care” includes, but is not limited to any out-of-pocket cost for: periodic health evaluations (including tests and diagnostic procedures ordered in correlation with the evaluation); well-baby and/or well-child care; immunizations for adults and children; tobacco cessation and obesity weight loss programs; screening devices for cancer, heart disease, and other infectious diseases.

DEPENDENT CARE FSA (“D”)

Under the Dependent Care FSA you are able to deduct pre-tax dollars for work-related child care or adult day care expenses. The expense must be incurred during the plan year and both you and your spouse (if married) must be working, or be a full-time student, to have expenses eligible for payment through the FSA. In the event of divorce, only the custodial parent can claim the dependent care expense. Be conservative and estimate only those expenses you are reasonably certain you will incur during the plan year. Be careful to allow for sick days, vacation time, and other times of the year when you may not be paying the same amount per week for care.

ELIGIBLE

- Care for dependents (under age 13), or dependents mentally or physically incapable of self-care
- Baby-sitter, Daycare Provider, Home Care Provider
- Licensed daycare centers caring for more than 6 non-resident people
- Daycare centers caring for less than 6 non-resident people
- Pre-School
- All Latch Key Programs

INELIGIBLE

- Educational programs for dependents
- Care provided by persons(s) claimed as a dependent on your, or your spouse's tax return
- Care provided by child/stepchild under age 19 at end of plan year
- Cost of food, clothing, entertainment unless costs are incidental to care and cannot be separated from the cost
- Care provided by someone not reporting their daycare income
- Overnight camps and transportation
- Field trips

CAUTION: Changes in the IRS rules may happen at any time and may affect the Eligible and/or Ineligible Expense categories above. Change of election may not be permitted.

