



FLEXIBLE BENEFITS PLAN



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HOW NICE WOULD IT BE TO PAY FOR OUT-OF-POCKET MEDICAL COSTS WHILE INCREASING YOUR SPENDABLE INCOME? YOUR EMPLOYER IS OFFERING A BENEFIT PLAN THAT WILL ALLOW YOU TO DO JUST THAT. IF YOU PARTICIPATE, YOU WILL ELECT TO HAVE A SPECIFIED AMOUNT OF PRE-TAXED MONEY DEDUCTED FROM EACH PAYCHECK DURING THE PLAN YEAR. THESE DOLLARS ARE SET ASIDE IN AN ACCOUNT AND DEDUCTED FROM YOUR GROSS EARNINGS BEFORE TAXES BEING TAKEN OUT. WHEN YOU SUBMIT A RECEIPT FOR QUALIFYING EXPENSES, FOR YOU AND/OR DEPENDENT(S), YOU WILL BE REIMBURSED FROM THIS ACCOUNT.

WHAT ARE FLEXIBLE SPENDING ACCOUNTS (FSAs)?

FSAs ARE A WAY FOR YOU TO PICK UP THE TAB FOR MEDICAL EXPENSES NOT COVERED BY INSURANCE (SUCH AS COPAYS, COINSURANCE, AND DEDUCTIBLES) AS WELL AS DAY CARE EXPENSES, WITH MONEY YOU EARN BUT DIDN'T PAY FEDERAL, STATE, OR SOCIAL SECURITY TAXES ON. (SUBJECT TO APPLICABLE STATE REGULATIONS)

WHY SHOULD I PARTICIPATE?

YOU CAN SAVE 25% TO 45% (DEPENDING ON YOUR TAX BRACKET) ON EVERY DOLLAR YOU HAVE DEDUCTED FROM YOUR PAYCHECK PRE-TAX. PARTICIPATION IS HOW YOU INCREASE YOUR SPENDABLE INCOME (MORE TAKE-HOME PAY!)

HOW DO I DECIDE THE APPROPRIATE AMOUNT TO PLEDGE TO THE TWO SEPARATE SPENDING ACCOUNTS?

BE CONSERVATIVE – CONSIDER ONLY THOSE EXPENSES YOU KNOW YOU AND OR YOUR DEPENDENT(S) WILL INCUR DURING THE PLAN YEAR. IF YOU CONTRIBUTE DOLLARS AND DO NOT USE ALL YOU CONTRIBUTE, YOU WILL LOSE ANY REMAINING BALANCE IN YOUR ACCOUNT(S) AT THE END OF THE PLAN YEAR.

CAN I MAKE CHANGES TO MY CONTRIBUTION DURING THE PLAN YEAR?

YOU MAY ONLY INCREASE YOUR ANNUAL CONTRIBUTION IF YOUR EMPLOYER'S PLAN ALLOWS FOR ELECTION CHANGES. ADDITIONALLY, THE ELECTION CHANGE REQUESTED MUST BE MADE WITHIN A SPECIFIED PERIOD OF TIME AND MUST BE ON ACCOUNT OF OR CONSISTENT WITH THE EVENT.

WHAT HAPPENS IF MY EMPLOYMENT TERMINATES DURING THE PLAN YEAR?

YOU CAN SUBMIT ELIGIBLE RECEIPTS FOR EXPENSES INCURRED PRIOR TO YOUR BENEFIT TERMINATION, UP TO THE DATE AS ESTABLISHED BY YOUR EMPLOYER'S SPECIFIC PLAN. YOU MAY ALSO BE ELIGIBLE TO CONTINUE PARTICIPATION THROUGH COBRA.

WILL MY PARTICIPATION IN THE FLEXIBLE SPENDING ACCOUNTS AFFECT MY SOCIAL SECURITY BENEFITS?

YES, YOU WILL NOT PAY SOCIAL SECURITY TAX ON THE DOLLARS YOU CONTRIBUTE; THEREFORE, YOUR SOCIAL SECURITY BENEFITS MAY BE SLIGHTLY REDUCED.

HOW MUCH CAN I SAVE?

THE BELOW SAVINGS EXAMPLE IS FOR ILLUSTRATION ONLY

	W/O FLEX	WITH FLEX
	\$30,000	\$30,000
	\$0	\$3,000
	\$30,000	\$27,000
	\$9,000	\$8,100
	\$3,000	\$0
	\$18,000	\$18,900
YOUR ANNUAL TAX SAVINGS	\$0	\$900

HOW CAN I FIND OUT HOW MUCH I HAVE AVAILABLE IN MY ACCOUNT(S)?

1. GO TO WWW.BETTER-BENEFITS.COM AND CLICK ON EMPLOYEE LOG-IN
2. CREATE AN ACCOUNT WITH USERNAME AND PASSWORD
3. YOU MAY THEN ENTER YOUR LOGIN AND PASSWORD TO SIGN ONTO THE ACCOUNT SCREEN
4. FROM HERE YOU CAN CHECK YOUR ACCOUNT BALANCE, ACCOUNT HISTORY, PRINT A STATEMENT OF YOUR ACCOUNT, ETC.

TAX CREDITS VS. DEPENDENT CARE FSAs

IF YOU PARTICIPATE IN THE PLAN, YOU CANNOT CLAIM CREDITS ON YOUR INCOME TAX RETURN FOR THE SAME EXPENSES. ALSO, AMOUNTS REIMBURSED UNDER THIS PLAN WILL REDUCE THE AMOUNT OF OTHER DEPENDENT CARE EXPENSES YOU CAN CLAIM FOR PURPOSES OF TAX CREDITS.

PLEASE REFER TO YOUR EMPLOYER'S SUMMARY PLAN DESCRIPTION (SPD) FOR SPECIFICS.

**NON-REIMBURSED MEDICAL EXPENSES
EMPLOYEE TAX SAVINGS WORKSHEET**

ESTIMATED FAMILY ANNUAL MEDICAL/DENTAL/VISION EXPENSES – NOT COVERED BY INSURANCE:

DEDUCTIBLES, COINSURANCE, COPAYS\$	_____
HEARING EXPENSES\$	_____
MEDICAL EQUIPMENT/REPAIR\$	_____
PHYSICAL EXAMS\$	_____
PRESCRIPTION DRUGS\$	_____
CHIROPRACTIC CARE\$	_____
DENTAL, INCLUDING ORTHODONTIA\$	_____
VISION, EXAMS AND HARDWARE\$	_____
DIABETIC SUPPLIES\$	_____
OTHER EXPENSES\$	_____
TOTAL ANNUAL OUT-OF-POCKET\$	_____
MULTIPLY BY ESTIMATED		
TAX SAVINGS OF 30%x30%	
YOUR ESTIMATED ANNUAL TAX SAVINGS\$	_____

DEPENDENT DAY CARE FSA EXPENSES

ELIGIBLE EXPENSES MUST BE NECESSARY FOR YOU AND YOUR SPOUSE (IF MARRIED) TO BE GAINFULLY EMPLOYED, LOOK FOR WORK, OR ATTEND SCHOOL.

ELIGIBLE EXPENSES INCLUDE CARE FOR A DEPENDENT UNDER AGE 13 AND/OR CARE OF A DEPENDENT PHYSICALLY OR MENTALLY INCAPABLE OF SELF CARE. ALSO ELIGIBLE IS CUSTODIAL OR ELDER CARE (DEPENDENT MUST LIVE IN YOUR HOME A MINIMUM OF 8 HOURS PER DAY).

ELIGIBLE DAYCARE PROVIDERS INCLUDE STATE LICENSED DAYCARE CENTERS, FRIENDS (MUST SUBMIT SOCIAL SECURITY NUMBER OR TAX IDENTIFICATION NUMBER), RELATIVES (CAN NOT BE A DEPENDENT YOU ARE CLAIMING IN THE CURRENT TAX YEAR), AU PAIR SERVICES, MONTESSORI SCHOOLS, NANNY (FICA AND FUTA), AFTER SCHOOL/BEFORE SCHOOL.

INELIGIBLE EXPENSES INCLUDE: KINDERGARTEN, FIELD TRIPS, REGISTRATION FEES, LATE PAYMENT FEES, LUNCHES, SUPPLIES, OVERNIGHT CAMPS, TRANSPORTATION FEES, CARE OF A DEPENDENT WHO LIVES OUTSIDE THE EMPLOYEE'S HOME.

EXCLUSION FROM INCOME FOR PAYMENTS UNDER A DEPENDENT DAY CARE PLAN IN A CALENDAR YEAR ARE LIMITED TO THE SMALLEST OF THE FOLLOWING AMOUNTS:

- \$5,000 IF THE EMPLOYEE IS MARRIED AND FILING A JOINT RETURN OR IF THE EMPLOYEE IS A SINGLE PARENT (\$2,500 IF THE EMPLOYEE IS MARRIED, BUT FILING SEPARATELY);
- THE EMPLOYEE'S EARNED INCOME; OR
- IF THE EMPLOYEE IS MARRIED AT THE END OF THE TAXABLE YEAR, THE SPOUSE'S EARNED INCOME.

**ELECTION FORM AND SALARY REDUCTION AGREEMENT
NON-REIMBURSED MEDICAL FLEXIBLE SPENDING ACCOUNT**

PLEASE PRINT CLEARLY

PLAN YEAR: ____/____/____ - ____/____/____

EMPLOYER: _____ LOCATION: _____

NAME: _____
FIRST LAST

MAILING ADDRESS: _____
ADDRESS CITY STATE ZIP

SSN: ____/____/____ EMAIL ADDRESS: _____@_____

DATE OF BIRTH: ____/____/____ DATE OF HIRE: ____/____/____ EFFECTIVE DATE: ____/____/____

PURSUANT TO MY EMPLOYER'S FLEXIBLE BENEFITS PLAN ("PLAN"), I UNDERSTAND I MAY ELECT TO HAVE MY SALARY REDUCED BY THE TOTAL PRE-TAX SPECIFIED BELOW. I AUTHORIZE MY EMPLOYER TO APPLY THAT AMOUNT TOWARD ANY OR ALL OF THE FOLLOWING PLAN COMPONENTS:

- PREMIUM PAYMENT COMPONENT, UNDER WHICH I CAN PAY FOR MY SHARE OF ELIGIBLE INSURANCE PREMIUMS WITH PRE-TAX DOLLARS;
- NON-REIMBURSED MEDICAL SPENDING ACCOUNT, UNDER WHICH I CAN ELECT COVERAGE THAT WILL REIMBURSE ME FOR MY ELIGIBLE MEDICAL CARE EXPENSES, UP TO A PLAN YEAR LIMIT AS DESIGNATED BY THE PLAN, AND
- DEPENDENT DAYCARE SPENDING ACCOUNT, UNDER WHICH I MAY ELECT COVERAGE THAT WILL REIMBURSE ME FOR MY ELIGIBLE DEPENDENT DAYCARE EXPENSES, UP TO A CALENDAR YEAR LIMIT OF \$5,000 (\$2,500 IF MARRIED AND FILING SEPARATE TAX RETURNS)

ELECTION OF PRE-TAX BENEFITS UNDER THE SALARY REDUCTION PLAN

I ELECT TO RECEIVE THE FOLLOWING COVERAGES UNDER THE PLAN. I UNDERSTAND AN AMOUNT EQUAL TO THE ANNUAL PREMIUMS, DIVIDED BY THE NUMBER OF PAY PERIODS IN THE PLAN YEAR, WILL BE DEDUCTED FROM EACH OF MY PAYCHECKS TO PAY FOR THE COVERAGES THAT I ELECT.

PRE-TAX PREMIUM PAYMENT BENEFITS: ON A SEPARATE BENEFIT ENROLLMENT FORM(S), I HAVE ENROLLED FOR CERTAIN INSURANCE COVERAGES AND I HAVE BEEN PROVIDED WITH A SCHEDULE SHOWING MY SHARE OF THE PREMIUMS FOR SUCH COVERAGE.

NON-REIMBURSED MEDICAL - YOU MUST FILL IN ALL 3 BLANKS IN THE LINE BELOW
\$ _____ PER PAY PERIOD X _____ # OF PAY PERIODS = \$ _____ ANNUAL PLEDGE

DEPENDENT DAYCARE - YOU MUST FILL IN ALL 3 BLANKS IN THE LINE BELOW
\$ _____ PER PAY PERIOD X _____ # OF PAY PERIODS = \$ _____ ANNUAL PLEDGE

I DO NOT WISH TO PARTICIPATE IN MY EMPLOYER SPONSORED FLEXIBLE BENEFIT PLAN. I UNDERSTAND I WILL NOT BE ELIGIBLE TO PARTICIPATE AS OF ANY DATE PRIOR TO THE NEXT PLAN YEAR EFFECTIVE DATE, UNLESS A CHANGE IN ELECTION EVENT OCCURS AND ALL CONDITIONS TO CHANGING MY ELECTION ARE SATISFIED, AS PROVIDED IN THE PLAN.

**ELECTION FORM AND SALARY REDUCTION AGREEMENT
FLEXIBLE BENEFITS PLAN, CONTINUED**

YOU MAY BE PROVIDED WITH A BENEFITS CARD, AS ALLOWED BY THE IRS UNDER APPLICABLE SECTIONS OF THE TAX CODES. YOU MAY USE THE CARD ONLY AT QUALIFIED LOCATIONS FOR ELIGIBLE PRODUCTS AND SERVICES UNDER YOUR SPECIFIC PLAN.



USING YOUR BENEFITS CARD:

1. SIGN THE BACK OF YOUR CARD BEFORE USING IT.
2. RETAIN ALL RECEIPTS AND DOCUMENTATION FROM YOUR BENEFITS CARD TRANSACTIONS TO PROVE EXPENSES ARE ELIGIBLE UNDER YOUR PLAN GUIDELINES AND APPLICABLE REGULATIONS ESTABLISHED BY THE IRS. IF REQUESTED BY THE ADMINISTRATOR, INNOVATIVE EMPLOYEE BENEFITS, INC. (IEB), YOU ARE OBLIGATED TO SUBMIT YOUR BENEFITS CARD TRANSACTION RECEIPTS AND/OR ANY OTHER RELATED CLAIM INFORMATION AND DOCUMENTATION AS DEEMED NECESSARY TO SUBSTANTIATE THE ELIGIBILITY STATUS FOR THE SERVICE/PURCHASE. FAILURE TO SUBMIT SUCH DOCUMENTATION MAY RESULT IN: 1) THE EXPENSE BEING DEEMED INELIGIBLE IN WHICH CASE YOU WOULD BE OBLIGATED TO REPAY THE AMOUNT TO THE PLAN AND/OR 2) IMMEDIATE SUSPENSION OR REVOCATION OF THE CARD; AND/OR 3) TAXABLE, PAYROLL DEDUCTIONS BY YOUR EMPLOYER OF THE INELIGIBLE EXPENSES.
3. VISIT WWW.BETTER.BENEFITS.COM TO OBTAIN UP-TO-DATE ACCOUNT BALANCE INFORMATION; TO VIEW OR PRINT YOUR STATEMENT OF ACTIVITY, AND/OR TO REPORT YOUR CARD LOST OR STOLEN.

I WOULD LIKE TO HAVE AN EXTRA BENEFITS CARD FOR MY SPOUSE AND/OR MY DEPENDENTS I HAVE LISTED BELOW:

NAME	SOCIAL SECURITY NUMBER	NAME	SOCIAL SECURITY NUMBER

1. I UNDERSTAND THAT I CANNOT CHANGE OR REVOKE THIS AGREEMENT AS OF ANY DATE PRIOR TO THE NEXT PLAN YEAR EFFECTIVE DATE, UNLESS A CHANGE IN ELECTION EVENT OCCURS AND ALL CONDITIONS TO CHANGING MY ELECTION ARE SATISFIED, AS PROVIDED IN THE PLAN. I UNDERSTAND MY BENEFIT ELECTIONS MAY NOT BE REDUCED BELOW THE AMOUNT THAT HAS BEEN TAKEN PRE-TAX AS OF THE DATE OF THE ELIGIBLE ELECTION EVENT.
2. ANY FUNDS REMAINING IN MY REIMBURSEMENT ACCOUNTS AT THE END OF THE PLAN YEAR WILL BE FORFEITED BY IRS REGULATIONS TO MY EMPLOYER'S PLAN.
3. IF MY EMPLOYMENT TERMINATES FOR ANY REASON, I UNDERSTAND EXPENSES MUST BE INCURRED AND SUBMITTED WITHIN THE TIME FRAMES SET OUT IN THE PLAN.
4. I UNDERSTAND THE PROCEDURES FOR REQUESTING REIMBURSEMENT AND ANY REIMBURSEMENT MUST BE FOR AN ELIGIBLE EXPENSE INCURRED DURING THE APPLICABLE PLAN YEAR.
5. BEFORE THE FIRST DAY OF EACH PLAN YEAR, I WILL BE OFFERED THE OPPORTUNITY TO MODIFY MY ELECTIONS FOR THE FOLLOWING PLAN YEAR.
6. MY EMPLOYER MAY REDUCE OR CANCEL THE ELECTION OF ANY NON-TAXABLE BENEFIT OR OTHERWISE MODIFY MY ELECTION IN ACCORDANCE WITH THE PLAN IF MY EMPLOYER IN ITS DISCRETION, DEEMS THAT ACTION ADVISABLE TO SATISFY THE REQUIREMENTS OF THE INTERNAL REVENUE CODE OR THE REGULATIONS THEREUNDER.

EMPLOYEE'S SIGNATURE*

DATE*

**YOUR SIGNATURE AND THE DATE (WHICH MUST BE PRIOR TO THE PLAN YEAR EFFECTIVE DATE) ARE REQUIRED TO PROCESS YOUR ENROLLMENT.*

TO BE COMPLETED BY EMPLOYER

INDICATE APPLICABLE PAY CYCLE:

() W = WEEKLY () B = BI-WEEKLY () S = SEMI-MONTHLY () M = MONTHLY

NON-REIMBURSED MEDICAL FSA EXPENSES

THE FOLLOWING LIST, WHILE NOT INTENDED TO BE COMPLETE, ILLUSTRATES MEDICAL-RELATED EXPENSES WHICH MAY BE REIMBURSED UNDER A NON-REIMBURSED MEDICAL FLEXIBLE SPENDING ACCOUNT, WHEN INCURRED DURING THE FLEX PLAN YEAR. FOR A MORE EXTENSIVE LIST, SEE QUALIFYING MEDICAL CARE EXPENSES, UNDER INFORMATION FORMS, AT WWW.BETTER-BENEFITS.COM. EXPENSES UNDER THIS PLAN ARE TREATED AS BEING “INCURRED” WHEN YOU ARE PROVIDED WITH THE CARE THAT GIVES RISE TO THE EXPENSE, NOT WHEN YOU ARE BILLED, CHARGED, OR PAY FOR THE MEDICAL CARE. QUALIFYING MEDICAL EXPENSES INCLUDE ONLY THOSE EXPENSES INCURRED BY YOU, YOUR SPOUSE, AND/OR DEPENDENTS.

1. MEDICINE, DRUGS, BIRTH CONTROL PILLS AND VACCINES.
2. MEDICAL DOCTORS, DENTIST (INCLUDES X-RAYS, FILLINGS, CROWNS, IMPLANTS, BRIDGES, DENTURES, PERIODONTAL SERVICES), ORTHODONTISTS, EYE DOCTORS (INCLUDES EYE EXAM, GLASSES, CONTACT LENSES AND SUPPLIES, CORRECTIVE SURGERY, RX SUNGLASSES), CHIROPRACTORS, OSTEOPATHS, PODIATRISTS, PSYCHIATRISTS, PSYCHOLOGISTS, PHYSICAL THERAPISTS, ACUPUNCTURISTS, AND PSYCHOANALYSTS (MEDICAL CARE ONLY).
3. MEDICAL EXAMINATION, X-RAY AND LABORATORY SERVICE, INSULIN TREATMENT (INCLUDES TEST STRIPS, LANCETS, ETC.) AND WHIRLPOOL BATHS THE DOCTOR PRESCRIBED.
4. NURSING HELP. IF YOU PAY SOMEONE TO DO BOTH NURSING AND HOUSEWORK, YOU CAN ONLY BE REIMBURSED FOR THE COST OF THE NURSING HELP.
5. HOSPITAL CARE (INCLUDES MEALS AND LODGING), CLINIC COSTS AND LAB FEES.
6. MEDICAL TREATMENT AT A CENTER FOR SUBSTANCE ABUSE.
7. MEDICAL AIDS SUCH AS HEARING AIDS (AND BATTERIES), DENTURES, EYEGASSES, CONTACT LENSES, BRACES, ORTHOPEDIC SHOES, CRUTCHES, WHEELCHAIRS, OXYGEN EQUIPMENT AND SUPPLIES, BLOOD PRESSURE MONITOR, GLUCOSE MONITOR.
8. ASSISTANCE FOR DISABLED PERSONS INCLUDING SPECIAL EDUCATION FOR THE BLIND, TUITION AT SPECIAL SCHOOL FOR HANDICAPPED, GUIDE DOGS (PURCHASE AND CARE).
9. AMBULANCE SERVICE AND OTHER TRAVEL COSTS TO GET MEDICAL CARE. IF YOU USED YOUR OWN CAR, YOU CAN CLAIM WHAT YOU SPENT FOR GAS AND OIL TO GO TO AND FROM THE PLACE YOU RECEIVED THE CARE; OR YOU CAN CLAIM PER CENT A MILE (VARIES DEPENDING ON THE YEAR). ADD PARKING AND TOLLS TO THE AMOUNT YOU CLAIM UNDER EITHER METHOD.
10. OVER-THE-COUNTER MEDICINES, DRUGS AND SUPPLIES. MUST BE MORE THAN MERELY BENEFICIAL TO GENERAL HEALTH AND MUST NOT INVOLVE UNREASONABLE STOCKPILING. MUST BE FOR (A) DIAGNOSIS OF DISEASE, (B) THE CURE, MITIGATION, TREATMENT OR PREVENTION OF DISEASE, OR (C) FOR THE PURPOSE OF AFFECTING ANY STRUCTURE OR FUNCTION OF THE BODY.*

YOU CANNOT CLAIM REIMBURSEMENT FOR:

1. INSURANCE PREMIUMS.
2. NURSING CARE FOR A HEALTHY BABY.
3. ILLEGAL OPERATIONS OR DRUGS, INCLUDING THE PURCHASE OF DRUGS FROM CANADA.
4. EXPENSES INCURRED THAT ARE GENERALLY COSMETIC IN NATURE: SPIDER VEIN TREATMENT, TEETH BLEACHING, CHEMICAL PEELS.
5. OVER-THE-COUNTER ITEMS MERELY BENEFICIAL TO GENERAL HEALTH SUCH AS TOILETRIES, TOOTHBRUSHES AND TOOTHPASTE, LIP BALMS, SUNTAN LOTION, VITAMINS AND DIETARY SUPPLEMENTS, COTTON BALLS AND Q-TIPS.*

*SEE OTC GUIDELINES, UNDER INFORMATIONAL FORMS, AT WWW.BETTER-BENEFITS.COM FOR SPECIFICS.

