



# Group Marketing Services, Inc.

Group Insurance That Benefits Small Business

## A Flexible Benefits Plan helps your paycheck buy more!

Sometimes referred to as a cafeteria plan, flex plan, or a Section 125 plan — a Flexible Benefits Plan lets you set aside a certain amount of your paycheck into an account — before paying income taxes. During the year you have access to this account for reimbursement of expenses you regularly pay for, such as healthcare and dependent daycare.

When you use tax-free dollars to pay for these expenses, you realize an increase in your spending power, and substantial tax savings.

### Reimbursable expenses can include:

- Deductibles, Co-pays, and Prescription Drugs
- Expenses not covered by insurance
- Dental Services & Orthodontics
- Eyeglasses, Contacts, Solutions & Eye Surgery
- Weight-loss programs (associated with a specific disease)
- Chiropractic care & Psychologist's fees
- Smoking Cessation programs
- Adult & Child Care Services
- And More!

### Here's how it works...

**Example:** An employee makes \$2,000 each month and decides to participate in her employer's Flexible Benefits Plan. As a result, her insurance premiums and health and daycare expenses are paid with tax-free dollars, giving her an additional \$100 each month!

#### Without the Plan

Gross Earnings	\$ 2,000
FICA, Federal, State Taxes	- \$500
Insurance Premium	- \$100
Health and Day Care Expenses	- \$300
<b>NET EARNINGS</b>	<b>\$ 1,100</b>

#### With the Plan

Gross Earnings	\$ 2,000
Insurance Premium	- \$100
Health and Day Care Expenses	- \$300
Adjusted Gross Earnings	\$ 1,600
FICA, Federal, State Taxes	- \$400
<b>NET EARNINGS</b>	<b>\$ 1,200</b>

### It's as easy as...

# 1

Carefully read this material and choose which options make sense for you to participate in.

# 2

Determine how much you expect to spend during the year for each option.

# 3

Complete the attached Participation Form and return it to your Human Resources Department.

# Step I: Your Options

There are three accounts you can participate in with the Flexible Benefits Plan. *Please note: This section is a summary of each spending account. While it is informative, it is not meant to be all inclusive. To see a full description of these accounts refer the applicable Internal Revenue Code Sections.*

## I: Healthcare Reimbursement Account

This account reimburses you for healthcare expenses not covered by insurance. You set aside money, tax-free, through regular payroll deductions. During the year, you can be reimbursed directly from your account for those qualified healthcare services provided that are not covered by insurance.

*Common expenses that qualify for reimbursement are — doctor visits, deductibles, co-payments, prescriptions, mental health care, dental services and orthodontics, chiropractor services, eye exams, glasses and contacts.*

## II: Dependent Care Reimbursement Account

This account reimburses you for daycare expenses for eligible children and adults. Through regular payroll deductions, you set aside part of your income to pay for these expenses on a tax-free basis. To qualify, your dependents must be:

- a child under the age of 13, or,
- a child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least 8 hours a day in your household.

*Qualified expenses for reimbursement include — adult and child daycare centers, preschool and before/after school care.*

*To qualify for this account, you must pay these expenses so you can work or look for work.*

**Please note:** If your family’s annual income is over \$20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. You will also receive your tax savings throughout the year, rather than once a year when you file your taxes.

## III: Premium Savings Account

This account allows you to pay for your health and other insurance premiums with tax-free dollars. If you are covered under your employer’s health and/or other insurance plans, you are automatically enrolled in this account! Be sure to let your employer know if you don’t want your premiums paid tax-free.

# Step II: Determining Your Reimbursable Expenses

By completing the following information, you can calculate your annual reimbursable expenses. Take into consideration the services to be provided during the upcoming year for you and your dependents.

## Healthcare Expenses

### Medical (1)\*

Deductibles	\$ _____
Co-payments	\$ _____
Doctor visits	\$ _____
Prescriptions	\$ _____
Other	\$ _____
<b>Total</b>	\$ _____

### Vision (2)

Exams	\$ _____
Eye Surgery	\$ _____
Lenses/Frames	\$ _____
Contacts	\$ _____
Solutions	\$ _____
Other	\$ _____
<b>Total</b>	\$ _____

### Dental (3)\*

Routine Check-ups	\$ _____
Fillings/Crowns	\$ _____
Orthodontics	\$ _____
Other	\$ _____
<b>Total</b>	\$ _____

## Dependent Daycare Expenses

Children	\$ _____
Adults	\$ _____
<b>Total</b>	\$ _____

\* *Cosmetic Procedures such as teeth bleaching and face lifts are not eligible expenses for reimbursement.*

## Estimated Annual Expenses and Tax Savings

Total Healthcare Expenses (add 1 + 2 + 3)	\$ _____
Total Dependent Daycare Expenses	\$ _____
Total Expenses	\$ _____
Tax Bracket Percentage (see below)	_____ %
Annual Tax Savings	\$ _____
<i>(Multiply total expenses by tax bracket percentage)</i>	
<b>Savings Amount Per Paycheck</b>	\$ _____
<i>(divide total expenses by number of paychecks you receive each year - 52, 26, 24 or 12)</i>	

## Tax Estimate Table

Rates are based on a combination of social security, federal and state income taxes.

<u>If your annual household earnings are:</u>	<u>Estimated tax rate is:</u>
Less than \$30,000.....	25%
\$30,000 to \$40,000.....	29%
\$40,000 to \$70,000.....	31%
Greater than \$70,000 .....	33%

*These tax rates are estimates based on national averages and may not reflect your actual tax rate.*

# Step III: Complete the Participation Form

Using the information you calculated in Step II, complete the attached Participation Form and return it to your Human Resources Department.

# Questions & Answers

## What is a Flexible Benefits Plan?

A benefit provided by your employer that lets you set aside a certain amount of your paycheck into an account before paying income taxes. Then, during the year you can be directly reimbursed from your account for qualified healthcare and daycare expenses.

## Why should I participate in the Healthcare Reimbursement Account when I already have health insurance?

This account is used to pay for expenses not covered by insurance. For example — annual physicals, co-payments, eye exams, glasses, orthodontics, prescription drugs, and hospital care to name a few.

## If I set aside part of my pay, won't I make less money?

No. Your net take-home pay will increase by the amount of taxes you did not pay. An example of how it may work for you is detailed on the inside of this brochure.

## Can I change my contributions during the year?

Only if you have a change in status such as: marriage, birth, adoption, or a change in your, your spouse's, or your dependent's employment status.

## What if I currently take the dependent care credit on my annual tax return?

If your family income is over \$20,000, you will most likely benefit from this plan rather than taking advantage of the current income tax credit. The amount you deposit in your Dependent Care Reimbursement Account reduces the amount, dollar for dollar, that you can claim as a credit on your tax return.

## How do I get reimbursed for my expenses?

If you have elected to automatically deduct any group insurance expenses from your account, you will receive a reimbursement check soon after utilizing any insurance benefit where there is out-of-pocket expenses (i.e. deductible, coinsurance, copay or non-covered). If you have an expense for items that are not processed through any of your group insurance plans or you have elected not to have expenses automatically deducted from your account, simply complete a claim form, attach a copy of the healthcare or dependent care bill, and mail or fax the form to your plan administrator. Within a short time, you will receive your reimbursement.

## Do I have to wait for the money to be deposited in my account in order to make a claim for reimbursement?

The annual amount you have allocated for the Healthcare Reimbursement Account is available to you at any time throughout the plan year. The amount available to you from your Dependent Care Reimbursement Account is the amount you have contributed to date.

## How do I know how much is available in my accounts?

Each time you are reimbursed you will receive a statement attached to your reimbursement check that shows the dollar amount you have set aside as well as the amount you have been paid to date. Contact your plan administrator for further options.

## What happens to my accounts if I terminate my employment?

You will be able to request reimbursement for healthcare and daycare expenses for services provided prior to your termination.

## What if I don't use all of the money I set aside in my accounts?

Carefully review your estimated expenses before making the decision to participate. Any contributions that are not used during the plan year may not be paid to you in cash or used in a later plan year.

## What if I am not covered under my company's health insurance plan?

Good news! You and your family can still participate in the Healthcare or Dependent Care Reimbursement Accounts.

## How do I benefit by participating?

Your biggest advantage is the tax savings. Every dollar you set aside in your account reduces your income taxes, and you can be reimbursed for qualified expenses that you are already paying for!

## Are there any negatives that I should know about?

Yes, because you are not paying any social security tax on that portion of your income that has been redirected, your social security benefits may be slightly reduced.

An eligible expense is defined as those expenses paid for care as described in Section 213 (d) of the Internal Revenue Code. Below are two lists which may help determine whether an expense is eligible.

These lists are to serve as a quick reference and are provided to you with the understanding that Group Marketing Services, Inc. is not engaged in rendering tax advice. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses," Catalog Number 1500Q. Publications can be ordered directly from the IRS by calling 1-800-TAXFORM. If tax advice is required, you should seek the services of a competent professional.

Deductible Medical Expenses		
<ul style="list-style-type: none"> <li>• Abdominal supports</li> <li>• Acupuncture</li> <li>• Air conditioner (when necessary for relief from difficulty in breathing)</li> <li>• Alcoholism treatment</li> <li>• Ambulance</li> <li>• Anesthetist</li> <li>• Arch supports</li> <li>• Artificial limbs</li> <li>• Autoette (when used for relief of sickness/disability)</li> <li>• Birth Control (by prescription)</li> <li>• Blood tests</li> <li>• Blood transfusions</li> <li>• Braces</li> <li>• Cardiographs</li> <li>• Chiropractor</li> <li>• Contact Lenses</li> <li>• Contraceptive devices (by prescription)</li> <li>• Crutches</li> <li>• Dental Treatment</li> <li>• Dental X-rays</li> <li>• Dentures</li> <li>• Dermatologist</li> <li>• Diagnostic fees</li> <li>• Diathermy</li> <li>• Drug addiction therapy</li> <li>• Drugs (prescription)</li> <li>• Elastic hosiery (prescription)</li> <li>• Eyeglasses</li> </ul>	<ul style="list-style-type: none"> <li>• Fees paid to Health Institute prescribed by a Doctor</li> <li>• FICA and FUTA tax paid for medical care service</li> <li>• Fluoridation unit</li> <li>• Guide dog</li> <li>• Gum treatment</li> <li>• Gynecologist</li> <li>• Hearing Aids and batteries</li> <li>• Hospital bills</li> <li>• Hydrotherapy</li> <li>• Insulin treatment</li> <li>• Lab tests</li> <li>• Lead paint removal</li> <li>• Legal fees</li> <li>• Lodging (away from home for outpatient care)</li> <li>• Metabolism tests</li> <li>• Neurologist</li> <li>• Nursing (including board and meals)</li> <li>• Obstetrician</li> <li>• Operating Room costs</li> <li>• Ophthalmologist</li> <li>• Optician</li> <li>• Optometrist</li> <li>• Oral Surgery</li> <li>• Organ transplant (including donor's expenses)</li> <li>• Orthopedic shoes</li> <li>• Orthopedist</li> <li>• Osteopath</li> <li>• Oxygen and Oxygen equipment</li> </ul>	<ul style="list-style-type: none"> <li>• Pediatrician</li> <li>• Physician</li> <li>• Physiotherapist</li> <li>• Podiatrist</li> <li>• Postnatal treatments</li> <li>• Practical Nurse for medical services</li> <li>• Prenatal care</li> <li>• Prescription medicines</li> <li>• Psychiatrist</li> <li>• Psychoanalyst</li> <li>• Psychologist</li> <li>• Psychotherapy</li> <li>• Radium Therapy</li> <li>• Registered Nurse</li> <li>• Special school costs for the handicapped</li> <li>• Spinal fluid test</li> <li>• Splints</li> <li>• Sterilization</li> <li>• Surgeon</li> <li>• Telephone or TV equipment to assist the hard-of-hearing</li> <li>• Therapy equipment</li> <li>• Transportation expenses (relative to health care)</li> <li>• Ultra-violet ray treatment</li> <li>• Vaccines</li> <li>• Vasectomy</li> <li>• Vitamins (if prescribed)</li> <li>• Wheelchair</li> <li>• X-rays</li> </ul>
Eligible Over-the-Counter Drugs		
<ul style="list-style-type: none"> <li>• Antacids</li> <li>• Allergy Medications</li> <li>• Anti-diarrhea medicine</li> <li>• Antibiotic ointments</li> <li>• Calamine Lotion</li> </ul>	<ul style="list-style-type: none"> <li>• Cold medicine, cough drops and throat lozenges</li> <li>• First Aid creams</li> <li>• Motion sickness pills</li> <li>• Nicotine Medications and Nasal sprays</li> <li>• Pain Relievers</li> </ul>	<ul style="list-style-type: none"> <li>• Pedialyte</li> <li>• Sinus Medications and Nasal sprays</li> <li>• Sleep aids</li> <li>• Suppositories and creams for hemorrhoids</li> <li>• Wart removal medication</li> </ul>
Non-Deductible Medical Expenses		
<ul style="list-style-type: none"> <li>• Advancement payment for services to be rendered next year</li> <li>• Athletic Club membership</li> <li>• Automobile insurance premium allocable to medical coverage</li> <li>• Boarding school fees</li> <li>• Bottled Water</li> <li>• Commuting expenses of a disabled person</li> <li>• Cosmetic surgery and procedures</li> <li>• Cosmetics, hygiene products and similar items</li> <li>• Funeral, cremation, or burial expenses</li> <li>• Health programs offered by resort hotels, health clubs, and gyms</li> <li>• Illegal operations and treatments</li> <li>• Illegally procured drugs and non-prescription medications</li> </ul>	<ul style="list-style-type: none"> <li>• Maternity clothes</li> <li>• Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits</li> <li>• Scientology counseling</li> <li>• Social activities</li> <li>• Special foods and beverages</li> <li>• Specially designed car for the handicapped other than an autoette or special equipment</li> <li>• Swimming pool</li> <li>• Travel for general health improvement</li> <li>• Tuition and travel expenses of a problem child to a particular school</li> </ul>	
Ineligible Over-the-Counter Drugs		
<ul style="list-style-type: none"> <li>• Toiletries (including toothpaste)</li> <li>• Acne Treatments</li> <li>• Lip balm (including Chapstick or Carmex)</li> <li>• Herbs</li> </ul>	<ul style="list-style-type: none"> <li>• Suntan lotion</li> <li>• Medicated shampoos and soaps</li> <li>• Vitamins (daily)</li> <li>• Cosmetics (including face cream and moisturizer)</li> </ul>	<ul style="list-style-type: none"> <li>• Fiber supplements</li> <li>• Dietary supplements</li> </ul>

# FLEXIBLE SPENDING ACCOUNTS PARTICIPATION FORM

Plan Year Effective \_\_\_\_\_ through \_\_\_\_\_

Employer Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employee Name \_\_\_\_\_ E-mail \_\_\_\_\_

Home Address \_\_\_\_\_  
street city state zip

Home phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

First Payroll Deduction Date: \_\_\_\_\_ Frequency:  weekly  every 2 weeks  twice a month  monthly

**An election must be made for each of the following accounts. Either elect to participate in the account or elect to decline participation.** If electing to decline participation in any of the accounts, you will lose all tax savings that you may have received as a participant in that account.

## Healthcare Reimbursement Account Election

- I elect to contribute \$ \_\_\_\_\_ Per Paycheck (before tax), to fund my account for reimbursements of qualified healthcare expenses not covered under my insurance plans.

**If electing to contribute to this account, select one of the following options:**

- Automatically deduct eligible GLEA Group Insurance Plan expenses from this account (i.e. Copays, Deductible, Coinsurance, Ineligible or Over Usual & Customary)
- Do not automatically deduct any expenses from this account. A claim form will be completed and submitted for each reimbursement request.

- I decline to participate in this option for this plan year. I waive all tax savings I may have received as a participant in this account.

## Dependent Care Reimbursement Account Election (Select one of the following)

- I elect to contribute \$ \_\_\_\_\_ Per Paycheck (before tax) to fund my account for reimbursement of qualified dependent care expenses. (Maximum amount per calendar year is the lesser of; (1) \$5,000 for married filing joint or \$2,500 for married filing separate; (2) your spouse's total annual compensation; or (3) 1/2 of your total annual compensation. If you are single, the maximum amount is \$5,000.)

- I decline to participate in this option for this plan year. I waive all tax savings I may have received as a participant in this account.

## Premium Savings Account Agreement (select one of the following)

- I have enrolled in certain employer-sponsored GLEA insurance benefits. I understand that my share of the premium for these insurance benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my taxable income will automatically be adjusted to reflect that increase or decrease.

- I decline to participate in this option for this plan year. I waive all tax savings I may have received as a participant in this account.

*My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summary Plan Description.*

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Employer Approval** \_\_\_\_\_ **Date** \_\_\_\_\_