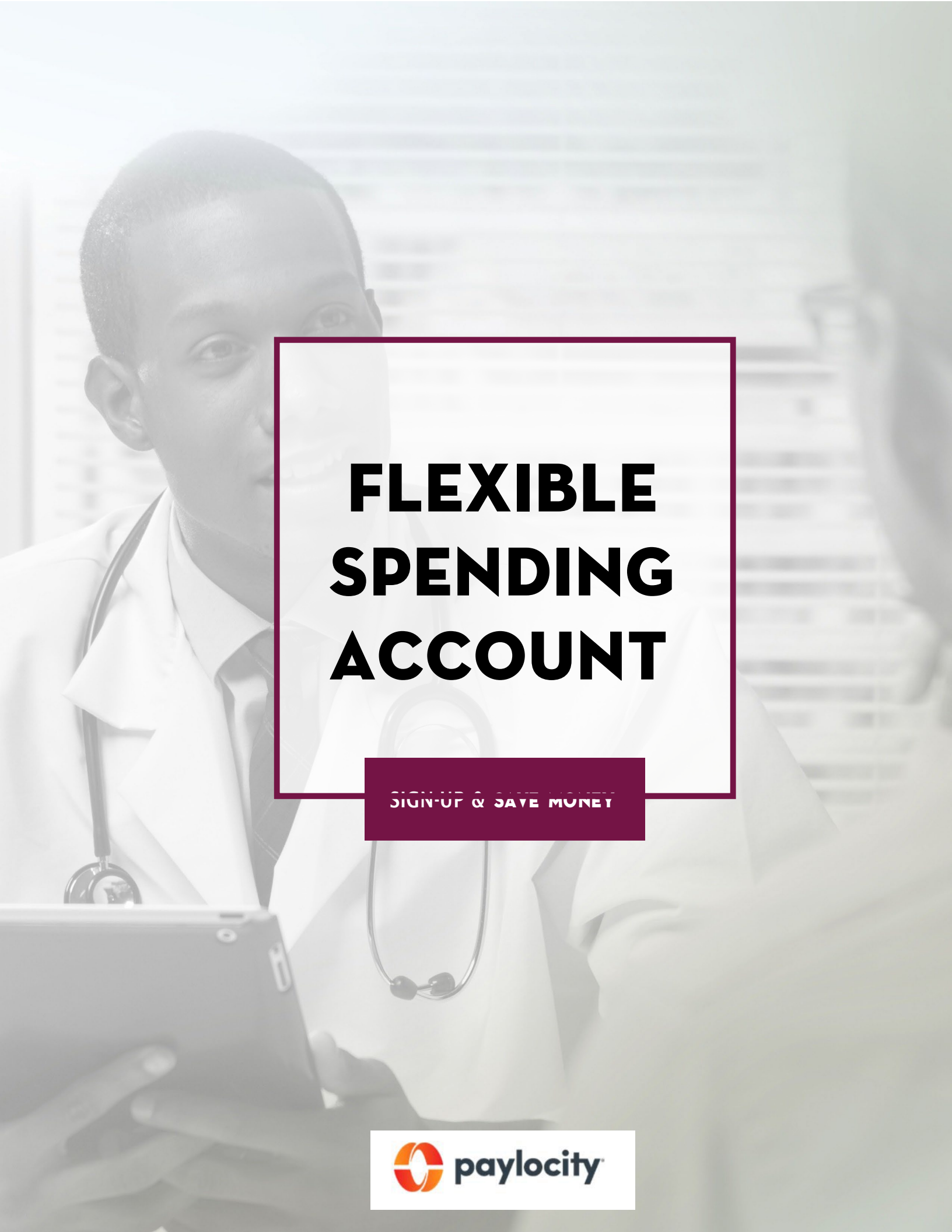

FLEXIBLE SPENDING ACCOUNT

SIGN-UP & SAVE MONEY

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WHAT IS AN FSA?

BY REDUCING YOUR TAXABLE INCOME WITH AN FSA, **YOU SAVE** FICA, FEDERAL, STATE, AND LOCAL TAXES AND INCREASE YOUR TAKE-HOME PAY.

An FSA allows you to contribute money into an account with each paycheck to pay for qualified expenses on a pre-tax basis. You can then use these tax-free funds to pay for qualified out-of-pocket medical costs and other eligible expenses. With an FSA, you save FICA, federal, state, and local taxes by reducing your taxable income, an increasing your take-home pay.

HOW IT WORKS

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

Without the Plan

Monthly Expenses	
Employee's Gross Earnings	$2,000
FICA, Federal, State Taxes	- $500
Insurance Premium	- $100
Health and Daycare Expenses	- $300
Net Earnings	**$1,100**

With the Plan

Monthly Expenses	
Employee's Gross Earnings	$2,000
Insurance Premium	- $100
Health and Daycare Expenses	- $300
Adjusted Gross Earnings	$1,600
FICA, Federal, State Taxes	- $400
Net Earnings	**$1,200**

FSAs MADE EASY

You have 24/7 access to your FSA benefit plan and funds. With the self-service portals, modern mobile app, and debit smart card, manage your account anywhere, anytime. We make accessing TPA benefit plans convenient and intuitive with:

Self-Service Employee Portal
Fully engage with benefit accounts and funds with our HIPAA-compliant portal. Enroll in benefits, submit claims, upload receipts, track expenses, view balances and activity, and much more.

Mobile App
Conveniently access your FSA balances, submit claims, and more with our Mobile App! Rest easy knowing sensitive account information is never stored on the device and secure encryption is used to protect all transmissions.

Debit Smart Card
Pay for qualified expenses with a debit card loaded with account balances. No more claim forms. No more paying out-of-pocket. No more hassle.

USING YOUR FSA

YOUR OPTIONS

Healthcare FSAs provide reimbursement for out-of-pocket medical, dental, and vision care expenses, such as deductibles, prescriptions, check-ups, and more.

Dependent Care FSAs help pay for eligible child and adult care services, such as preschool, before or after school programs, daycare, summer camps (not overnight camps), and more. Eligibility includes:

- a child under the age of 13, or
- a child, spouse, or other dependent who is physically or mentally incapable of self-care and resides with you for more than half the year and regularly spends at least 8 hours a day in your home.

Limited FSAs can be used for qualified dental, vision and preventive expenses when enrolled in an HSA plan.

Premium Only Plans allow you to pay for employer-provided 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 typically automatically enrolled. Notify your employer if you don't want your premiums paid tax-free.

LEFTOVER FUNDS

Your plan may include the*$660 carryover* or grace period option. The $660 carryover allows you to rollover up to $660 of unused medical/limited FSA funds at the end of the plan year. Alternatively, the grace period option allows for an extended period of time at the end of the plan year (usually 2.5 months) in which you can continue to incur expenses to use your remaining FSA balance. Refer to your Summary Plan Description (SPD) for detailed information regarding your plan.

FAQs

How do you benefit by participating?
The biggest advantage is the tax savings. Every dollar set aside in your FSA account reduces your income taxes and can be used on qualified expenses.

Why should you participate in the FSA when you already have health insurance?
This account is used to pay for qualified expenses not covered by insurance.

Can you change your contributions during the year?
Only if you have a change in status such as: marriage, divorce, birth, adoption, or a change in employment status for you, your spouse, or your dependent.

What if you currently take the dependent care credit on your annual tax return?
Whether or not to participate in the daycare portion of this plan depends on your income, filing status, number of dependents, and annual daycare expenses. The amount deposited into your Dependent Care Account reduces the amount, dollar for dollar, that can be claimed as a credit on your tax return. Contact a tax advisor for further information.

How do you get reimbursed for qualified expenses?
Use your Benefit Card, if applicable or submit claims online in the Employee Portal or Mobile App. Manual claims may be submitted with a claim form via fax, secure email, or mail.

Do you have to wait for the money to be deposited in your account in order to make a claim for reimbursement?
The annual amount allocated for the Medical/ Limited Flexible Spending Account is available to you at any time throughout the plan year. The amount available to you from your Dependent Care Account is the amount you have contributed to date.

How to check your account balance?
Check your account balance using the Employee Portal, Mobile App or Interactive Voice Response System (IVR). For manual claims, you will receive a statement attached to your check or advice of deposit indicating your election amount and claims paid-to-date.

What happens to your account if you terminate your employment?
Most FSA plans include a run-out period for terminated employees. During this time, you can submit claims for reimbursement on qualified expenses incurred on or before the date of termination. Check your Summary Plan Description for any additional rights or benefits provided by your company's plan.

What if you don't use all of the money set aside in your accounts?
You should carefully review your expenses prior to selecting your annual election amount and refer to your SPD for plan details. Unused funds at the end of the plan year will not be paid to you in cash.

What if you are not covered under your company's health insurance plan?
Good news! You can still participate in the Medical/Limited or Dependent Care Flexible Spending Accounts as long as you are eligible for their group medical plan.

Are there any negatives to know about?
Yes, because you are not paying social security tax on the portion of your income that has been redirected, your social security benefits may be slightly reduced.

ELIGIBLE EXPENSE LIST

MEDICAL EXPENSES

Per IRS regulations, the following, while not intended to be complete, illustrates examples of section 213 eligible medical or medical-related expenses. Expenses must be incurred during the Plan Year from which you are requesting reimbursement. Expenses are considered incurred when service is rendered, not when service is billed or payment is made. Expenses cannot be reimbursed in advance of the date service is rendered.

- Acupuncture
- Ambulance fees
- Braille – books and magazines
- Breast pump
- Childbirth classes mother-to-be expenses only; partner's expenses not eligible
- Chiropractic care
- Coinsurance
- Contact lens(es), solutions, and cleaners
- CPAP Devices and Apparatus Cleaner
- Crutches
- Deductibles
- Dental fees
- Dentures
- Denture adhesives
- Diagnostic testing fees
- Prescription eyeglasses
- Gloves *eligible if purchased to prevent the spread of COVID
- Guide dog
- Hearing aids and batteries
- Hospital bills
- Insulin and diabetic supplies
- Laboratory fees
- Laetrile by prescription
- Masks *eligible if purchased to prevent spread of COVID
- Nurse fees
- Obstetrical expenses
- Operations
- Orthodontia
- Osteopath fees
- Oxygen
- Personal Protective Equipment (PPE) *eligible if purchased to prevent the spread of COVID
- Physician fees
- Practical nurse fees
- Prescribed drugs - see cosmetic exceptions below
- Psychiatric care
- Psychologist fees or individual therapy
- Radial keratotomy/ Laser eye surgery
- Routine physicals
- Special communication equipment for the deaf
- Smoking cessation prescriptions
- Surgical fees
- Therapeutic care for drug and alcohol addiction
- Prescribed therapy treatments
- Transplants
- Transportation expenses/mileage to receive medical care or services
- Wheelchairs
- X-rays

EXPENSES THAT MAY NOT BE CLAIMED AS PART OF THE PLAN

- Cosmetic surgery or treatment not done for the primary purpose of proper functioning of the body or to prevent or treat illness or disease; including but not limited to face lifts, whitening or capping of teeth, hair transplants, or treatments including Retin-A and vein surgery.*
- Diaper service for infants
- Ear piercing by a physician
- Employment-related expenses (physicals, transportation)
- Fitness programs or physical therapy for general health benefits
- Illegal treatments
- Insurance premiums, including contact lens insurance programs
- Hygiene items
- Expenses reimbursed by an HSA or HRA.

*To be eligible, treatments must be proven medically necessary.

OVER-THE-COUNTER

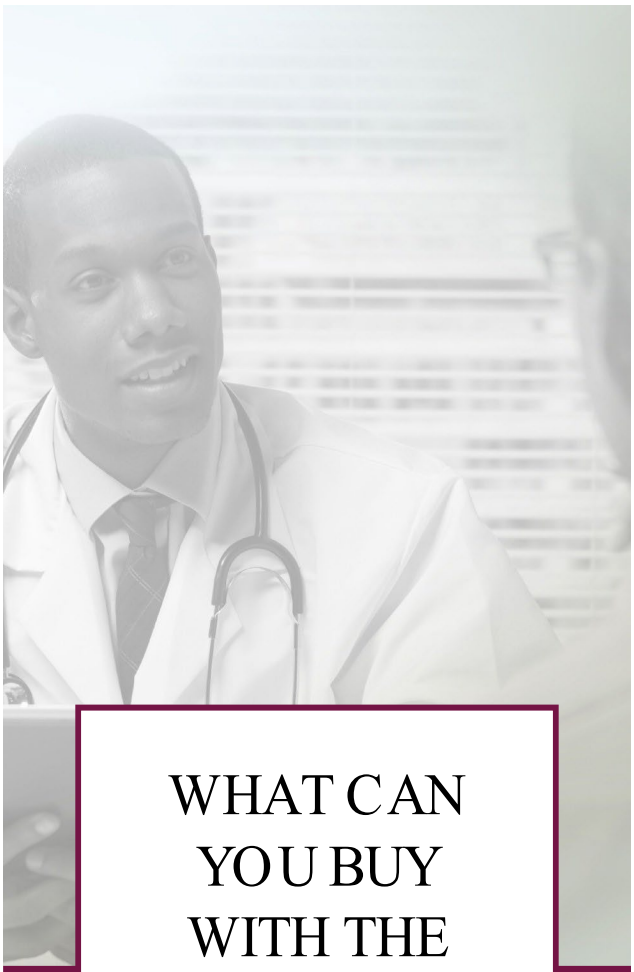
Over-the-Counter Items that **DO NOT REQUIRE** a Doctor's Prescription.

- Acid controllers
- Allergy & Sinus
- Antibiotic products
- Anti-itch & insect bite
- Anti-parasitic treatments
- Asthma flow meters
- Callous, corn, & wart removers
- Cholesterol tests
- Cold sore remedies
- Contact Lens Solution
- Cough, Cold, & Flu
- Crutches
- Diabetes care: blood test strips, glucose kits, monitors, and tests
- Gauze & Gauze pads
- Heating pads
- Hemorrhoidal preps
- Incontinence Supplies for Adults
- Medical bracelets/necklaces
- Medical tape
- Menstrual Productss
- Nasal Strips
- Nebulizers
- Ointments
- Orthopedic shoe inserts
- Pain Relief
- Personal Protective Equipment (PPE)
- Reading Glasses
- Respiratory treatments
- Rubbing Alcohol
- Sleep aids
- Stomach remedies
- Sunburn Creams
- Sunscreen (SPF 15+)
- Supports & braces
- Thermometers

DUAL USE
(REQUIRES DOCTOR LETTER)

- Accommodations made for disabling medical conditions
- Activity trackers*
- Baby Rash Ointments
- Femine anit-Fungal/anti-itch
- Foot spa
- Gloves and masks
- Herbs
- Humidifier
- Massagers
- Minerals, Vitamins, & multivitamins
- Orthopedic shoes only the cost above a regular shoe qualifies
- Special supplements
- Weight Loss Programs

**Activity trackers (aka fitbits, step counter) are a wearable device with the primary purpose of tracking activity. The device's purpose is to record a person's daily physical activity, together with other data relating to their health, the number of calories burned, heart rate, number of steps someone walks, sleep quality etc.*



WHAT CAN YOU BUY WITH THE CARRYOVER IN AN FSA?

Save on federal, state, and local taxes when you contribute to a Flexible Spending Account!

In fact, FSA participants save an average of 30 percent each year on eligible out-of-pocket expenses.

Experience **$153.31** in tax savings by purchasing these items with your tax-free FSA funds!

Doctor Visit Copay	$30
Chiropractic Care (6 Visits)	$180
Pair of Eyeglass/Contact Lenses	$211
Maintaining Health Cost	**$421**

Prescription Copay	$20
Motrin/Tylenol	$13.05
Tylenol Cold & Flu	$7.93
Tums	$5.10
OTC & Prescription Drug Cost	**$46.08**

First Aid Kit	$15
Boxes of Band-Aids	$8.67
Coppertone Sunscreen (15+ SPF)	$11.99
Hot/Cold Reusable Pack	$8.29
First Aid & Sunscreen Cost	**$43.95**

TOTAL COST: $511.03

****FSA TAX-SAVINGS: $153.31**

***Example is based on a 30% tax bracket. Actual tax savings is dependent upon your state and/or annual income and tax bracket.*

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PLAN PARTICIPATION FSA

To participate in a Flexible Spending Account (FSA) Plan, with a plan effective date of_____, please fill out this form.

ACCOUNTHOLDER INFORMATION			
Name:		Company:	
Email:		Department/Division:	
Home Phone:		Work Phone:	
Date of Birth:		Hire Date:	
Home Address:		First Payroll Effective Date:	
		Remaining # Pay Periods this Plan Year:	
SSN:		Pay Frequency:	

MEDICAL FLEXIBLE SPENDING ACCOUNT

☐ I elect to contribute $_____(before taxes) per pay period, which is $____per plan year, to fund my account for reimbursement of qualified out-of-pocket healthcare expenses not covered under my health and other insurance plans.

☐ I decline to participate in this option for this plan year.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

☐ I elect to contribute $_____(before taxes) per pay period, which is $_____per plan year, for funding reimbursement of qualified dependent daycare 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) 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.

LIMITED FLEXIBLE SPENDING ACCOUNT AGREEMENT

☐ I elect to contribute $_____(before taxes) per pay period, which is $____per plan year, for funding reimbursement of qualified Limited FSA expenses. A Limited FSA may cover dental, vision, and post-deductible expenses.

☐ I decline to participate in this option for this plan year.

PREMIUM ONLY PLAN

☐ I have enrolled in certain employer-sponsored 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.

WAIVER OF TAX BENEFITS

☐ I have been given the opportunity to enroll in these tax-savings plans and have declined to participate. I understand that I will lose all tax savings that I may have received as a participant.

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. I acknowledge that I have received, read, and understand the Summary Plan Description.

Signature: _____ Date: _____

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CLAIM FSA

EMPLOYEE INFORMATION

Employee Name:		Employee Address:	
Company:			
Last Four Digits of Social Security #:		Has your address changed? Yes: ☐ No: ☐	

DEPENDENT CARE EXPENSES

	Service Start Date mm/dd/yyyy	Service End Date mm/dd/yyyy	Recurring Frequency ex: wkly/mnthly	Service Provider Tax ID# or SS#	Service Provider Name and Address	Dependent's Name	Age	Amount
1.								
2.								
3.								
						Total Dependent Care Expenses Requested		

I provided the dependent care as stated above. If a recurring claim is selected, I attest to providing care for the dates of service provided above.

Provider Signature: _____ Date: _____

HEALTH CARE EXPENSES

Please select a service with each claim.

	Patient	Service Start Date mm/dd/yyyy	Service End Date mm/dd/yyyy	Recurring Frequency ex: wkly/mnthly	Medical	Rx	Dental	Vision	OTC	Mileage $0.22 per mile**	Amount
1.											
2.											
3.											
4.											
5.											
										Total Health Care Expenses Requested	

ORTHODONTIA ONLY *Contract and Proof of Payment Necessary

Banding Date (when appliance were applied):		Recurring Frequency	
For full initial payment, list full cost ($):		*Full Amount eligible for reimbursement*	
For installment plan, list installment amount ($):		*Monthly installment amount eligible upon each due date*	

*Please arrange documentation in order listed above.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed were incurred during the current period under the company's Cafeteria Plan. The undersigned participant in the Plan understands that expenses are "incurred" when a service is performed or care is provided, not when the bill is paid. The undersigned certifies that all expenses for which reimbursement or payment is claimed on this form were incurred on the dates of service stated above. The undersigned fully understands that he or she is alone fully responsible for the sufficiency, accuracy, and veracity of all the information relating to this claim and unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State, or City income tax on amounts paid from the Plan which relate to such expense.

Employee Signature: _____ Date: _____

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GUIDELINES FOR CLAIMS SUBMISSION

THE INTERNAL REVENUE CODE PROVIDES THE FOLLOWING GUIDANCE

MEDICAL REIMBURSEMENT

The best receipt is an Explanation of Benefits from your insurance company.
If other receipts are submitted, they must show the following:

1. Who rendered the service (name and address).
2. What type of service was rendered.
3. Date Service was provided, not billing or due date.
4. Amount of Charge
5. Any insurance payment, if applicable.

Canceled checks and credit card slips are not allowable receipts. Any amount claimed which is a "Previous Balance" or "Balance Forward," etc. cannot be paid unless the information stated in items 1-5 above is shown on the receipt.

Receipts must show all expenses incurred. Any over-payment, pre-payment, etc., for which no services are listed, cannot be reimbursed.

NOTE: In order to process your claim, all 5 pieces of information must be on each receipt.
This includes receipts for orthodontic services.

OVER-THE-COUNTER (OTC) ITEMS

Receipts must show the following information:

1. When and Who Sold the product (date, name, and address).
2. Type of OTC purchased. Must show product or brand name.
3. Amount of charge.

NOTE: Every claim requiring a prescription or letter of medical necessity to be eligible must be attached for each submitted claim. Prescriptions or letters of medical necessity are not kept on file.

MILEAGE REIMBURSEMENT

Mileage incurred to and from your home or office to receive medical care is reimbursable through the FSA at the rate of $ 0.16 per mile. If rate has changed, amount will be adjusted at processing. Mile claim must include substantiation. (i.e. provider invoice, receipt, ect.)

DEPENDENT CARE REIMBURSEMENT

All receipts must show the following information:

1. Who rendered the service (name and address).
2. What type of service was rendered.
3. Date of original service, not a billing date.
4. Amount of charge.
5. Federal ID number (facility) or social security number (individual)

If your daycare facility does not provide a copy of a valid receipt, then you may have the provider sign off on this claim form attesting to the validity of these charges. Canceled checks and credit card slips are not allowable receipts.

RECURRING EXPENSE

Recurring expenses can be requested upfront and auto paid as services are rendered.

Examples of expenses considered as recurring:

1. Daycare
2. Prescriptions
3. Therapy
4. Orthodontics

The best documentation for recurring expenses is a service agreement or payment plan. The documentation provided must show:

1. Who rendered the service (name and address).
2. What type of service was rendered.
3. Date service was provided, not billing or due date.
4. Amount of Charge
5. Any insurance payment, if applicable
6. Frequency and duration of recurring expense

Note: The participant is responsible for maintaining receipts for recurring expenses even though the receipts are not being submitted. The participant is also responsible to notify Paylocity if recurring expense is not incurred according to original documentation submitted.

TO SUBMIT A CLAIM:

Please review claim guidelines on the back of this sheet before submitting.

Submit your claim electronically through the Employee Portal

Submit your medical or dependent care claim on our mobile app, (available on App Store or Google Play), or

Send your claim form along with all supporting documentation directly to Paylocity via a secure email: batinfo@paylocity.com, fax: 314.909.6983 or mail: 615 Crescent Executive Ct, Ste. 524, Lake Mary, FL 32746

Please do not submit a claim for reimbursement if you used your Debit Smart Card.
Paylocity issues checks on the followingThursday for all claims received by Friday at 3:00 p.m. CST.
**Mileage to and from provider to your home. If rate has changed, amount will be adjusted at processing.

1400 AMERICAN LANE
SCHAUMBURG, IL
60173
batinfo@paylocity.com
PAYLOCITY.COM