



AMERICAN BENEFITS GROUP

Empowering Technology. Exceptional Service.

Sign Up Now For A Pay Raise!



*With the ABG Flex Plan, you set aside money from your paycheck,
place it in a Flexible Spending Account to
pay for certain medical expenses before taxes are taken from your pay.*

Your Flexible Spending Account

Your employer offers you a way to increase your spendable income. This benefit is referred to as a Flexible Spending Account (FSA) or Flex Plan. Two reimbursement accounts are available, the Health (FSA) and the Dependent Care Assistance Plan (DCAP). Using these plans will save you money by allowing you to pay for medical and dependent care expenses with pre-tax instead of after-tax dollars.

Quick Tips

- In a child care center (if the center cares for more than six children, it must comply with all applicable state and local regulations); or
- By a housekeeper whose services include, in part, providing care for an eligible dependent.

TAX CONSIDERATIONS. It may not always be in your best advantage to make use of the DCAP because expenses reimbursed from this account may not be used as a federal income tax credit. You'll have to determine which approach is best for your particular circumstances.

The IRS regulations state that the maximum amount you may be reimbursed in a calendar year for DCAP is \$5,000 per family (or the taxable income of the lowest paid spouse if less than \$5,000). If you are married and filing separately, the maximum is \$2,500 per person filing.

The Importance of Planning

To get the most tax savings from your Flexible Spending Accounts, you should plan your contributions carefully. It is important that you be conservative when estimating your expenses for the plan year. IRS regulations that apply to your FSA state that any money set aside in these accounts that is not used for expenses incurred during the plan year or grace period must be forfeited. This is referred to as the **use-or-lose** rule. The unused dollars contributed cannot be returned to you. However, if your employer has adopted the Carryover Provision for your Health FSA, up to \$500 of your FSA balance will rollover into the new plan year.

To avoid losing any money, you should estimate what your eligible expenses will be before you decide how much to contribute – and then commit to a little less. For example, if you know you're going to have medical expenses that are not covered by your medical plan, such as co-payments, vision or dental work, put enough in your Health FSA to cover these expenses. If you terminate employment, you will only be reimbursed for expenses incurred prior to your termination date unless you qualify for, and elect COBRA.

In addition, IRS regulations prohibit transferring funds from one account to another during the plan year. Money in the DCAP cannot be used to pay medical expenses, nor can money in the health FSA be used to pay dependent care expenses.

The IRS also does not permit duplication of coverage. Therefore, all applicable medical charges must first be submitted to your standard plan of benefits.

If Your Needs Change After You Enroll

Since the elections you establish now are binding until the next enrollment period, it's very important that you plan your expenses accurately. You cannot change your election after your plan year begins. The only exception to this is if you have a **Qualifying Status Change Event**. When one of these changes occurs, contact your benefits administrator. The change must be on account of, and consistent with, one of the following events:

- Change in employee's legal marital status
- Change in number of dependents
- Change in employment status
- Dependent satisfying or ceasing to satisfy dependent eligibility requirements
- Entitlement to Medicare or Medicaid
- Judgment, decree or court order

The following status change events permit changes to insurance premium contributions only. Changes to FSA benefit elections are not allowed for these status changes:

- Change in benefit cost, benefit coverage or plan options
- Change in residence

Why is my card being declined?

The ABG Benefits Card may be declined when you use it for one of a few reasons:

1. You are using your card at an ineligible location.
2. You're using it to pay for an expense that is not eligible under the Flex Plan.
3. Your card has been temporarily suspended due to an unsubstantiated or ineligible expense.

Documentation Request Notification

You will be requested to submit receipts to validate certain transactions. While many pharmacies use an inventory system (IIAS) that validates Rx purchases at the point of sale, many other merchants do not have this capability. Although the debit cards will reduce the amount of paperwork on your part, it will not eliminate the need to submit documentation.

You will receive Documentation Request Notices by email if you have an email address on file, and mailed to your home. The emails will come from claims@amben.com, they are not spam, so be sure to watch for them.

Please, do not submit requested documentation attached to a claim form.

Do not send in statements or receipts unless you receive a Documentation Request Notification.



Domestic Partners

Only medical expenses of a domestic partner who is a tax dependent of the employee are eligible for tax-free reimbursement from an employee's health FSA. Medical expenses for a domestic partner who is not a tax dependent are not eligible, even if the employer offers domestic partner health insurance benefits.



Avoid the Hassle of Out-of-Pocket Expenses

With the ABG Benefits Card, you have these benefits:

- **Convenience** – no more claim forms to file and no more waiting for reimbursement. Use your card and pay your provider directly; the funds will be instantly deducted from your reimbursement account. You may be requested to submit documentation to verify the eligibility of your card transaction.
- **Multi Purse Feature** – all of your reimbursement accounts may be accessible with the swipe of one debit card (check with your employer).
- **Auto Substantiation** – in certain cases because of IIAS (Inventory Information Approval System) you will not be required to provide any additional documentation or receipts after you use your debit card.

Always keep statements and receipts – it is an IRS requirement.

Never use your card to pay for an expense that was incurred (the service was provided) in a previous plan year.

3-Year Effective Date

Save your ABG Benefits Card, even after you use up your FSA funds or when the Plan Year ends, your card is good for three years. New plan year funds will be loaded on your card the first day of the new plan year.

Get Your Benefits On The Go! WealthCare Mobile App



- Account Balances
- Recent Transactions
- Claims Details
- Upload Statement/Receipt images taken with your mobile device, Submit Claims or Substantiate Card Transactions

Available for iPhone



Available for Android



Employee Tax Savings Example

These examples have been designed to help you understand the value of your Flexible Spending Accounts. They are intended as sample illustrations only. Also, see our Tax Savings Calculator at www.amben.com/fsa choose Tools and Calculators.

Example #1:

This example is based on the individual salary of Mary Jane Doe. She is single, earns \$28,500 a year and claims the standard deduction. She contributes \$2,000 to her Health FSA account. It does not take into account any potential savings for contributions toward her insurance premiums or retirement accounts.

	Current		With FSA	
Gross Income	\$28,500		\$28,500	
FSA Contributions				-\$2,000
W-2 Income	\$28,500	\$28,500	\$26,500	\$26,500
Standard Deduction		-\$6,350		-\$6,350
Exemptions		-\$5,500		-\$5,500
Taxable Income		\$16,650		\$14,650
Federal Income Tax				-\$2,475
Social Security Tax				-\$1,274
State Tax				-\$571
Medical Expenses				-\$2,000
Net Income		\$21,680		\$22,721
FSA Tax Savings:				\$541

Example #2:

John Doe and his spouse earn \$42,500 a year, file a joint return and claim the standard deduction. They have one 10 year old child and contribute \$5,000 to their Dependent Care Assistance Plan. This example does not take into account any potential savings for contributions toward their insurance premiums or retirement accounts.

	Current		With DCAP	
Gross Income	\$42,500		\$42,500	
FSA Contributions				-\$5,000
W-2 Income	\$42,500	\$42,500	\$37,500	\$37,500
Standard Deduction		-\$7,200		-\$7,200
Exemptions		-\$8,250		-\$8,250
Taxable Income		\$27,050		\$22,050
Federal Income Tax				-\$4,058
Child Care Credit				\$552
Social Security Tax				-\$2,069
State Tax				-\$858
Dependent Care Expenses				-\$5,000
Net Income		\$31,067		\$31,922
FSA Tax Savings:				\$855



AMERICAN BENEFITS GROUP

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AMERICAN BENEFITS GROUP

FLEXIBLE SPENDING ACCOUNTS - ELECTION FORM

To make your election, you must complete and return this Election Form to your employer, who will forward it to American Benefits Group. Please print.

Name: _____ Social Security #: _____

Home Address: _____ Email: _____

City, State, Zip: _____ Phone: _____

Employer/Division: _____ Date of Birth: _____

I hereby authorize my employer to reduce my salary (on a pre-tax basis) by the amount necessary to pay for the coverages indicated below.

I understand that I must use all my flexible benefit contributions or forfeit them, in accordance with the design of my employer's FSA plan, including any Grace Period or Carryover Provision, if applicable.

Health Flexible Spending Account (FSA):

(Maximum Annual Election is \$2,550)

Yes No

\$ _____
ANNUAL AMOUNT

Dependent Care Assistance Plan (DCAP):

(Maximum Annual Election is \$5,000)

Yes No

\$ _____
ANNUAL AMOUNT

Please complete the following dependent information and indicate if requesting a debit card:

Last Name _____ First Name _____ Date of Birth _____

Dependent SS#: _____ Relationship: Spouse Dependent Card: Yes No

Last Name _____ First Name _____ Date of Birth _____

Dependent SS#: _____ Relationship: Dependent Card: Yes No

Last Name _____ First Name _____ Date of Birth _____

Dependent SS#: _____ Relationship: Dependent Card: Yes No

Your election to participate in any pre-tax eligible benefits will constitute an election under your employers Section 125 Cafeteria Plan and any contributions you are required to make under any such plan will be deducted from your (examples: Group Health, Dental and Vision Plan) salary on a pre-tax basis unless you requested otherwise.

Employee Signature

Date

Employer Authorization (REQUIRED)

Date

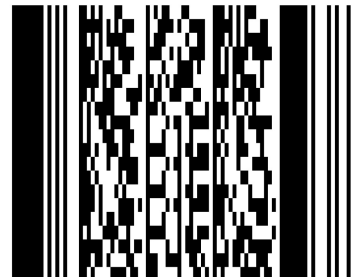
REQUIRED: EMPLOYER – PLEASE COMPLETE

Benefit Effective Date _____

Pay Date for 1st Contribution _____ Number of Pay Periods _____

Fax: 877-723-0147 or email: processing@amben.com

Mail: American Benefits Group • PO Box 1209, Northampton, MA 01061-1209 • 800-499-3539



In signing the reverse of this form, I understand and agree to the following:

The Company and I hereby agree that my cash compensation will be reduced by the amounts I have elected on this form on a per pay-period basis during the plan year (or during such portion of the year as remains after the date of this agreement).

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE COMPANY'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a status change event (including marriage, divorce, death of a spouse or child, birth or adoption of a child, change in employment status, change in job schedule of participant or spouse, dependent satisfying or ceasing to satisfy dependent eligibility requirements, entitlement to Medicare or Medicaid, judgment, decree or court order or such other events as the Plan Administrator determines will permit a change or revocation of an election).

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code. The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

The amount of my compensation reduction during the year will be credited to an insurance, medical reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed for qualified expenses incurred during the plan year. If I terminate employment, I will only be reimbursed for expenses incurred prior to my termination date unless I qualify for, and elect COBRA coverage.

My Social Security benefits may be slightly reduced as a result of reduced taxable income due to my election(s).

If required contributions for elected benefits are increased or decreased while this agreement remains in effect, the compensation reduction will automatically be adjusted to reflect that increase or decrease.

Health Flexible Spending Account (FSA) will be available only for "qualifying medical care expenses" which are those types of medical expenses normally deductible on your federal income tax return with certain exceptions (i.e., premiums for health insurance cannot be reimbursed from your Health FSA). I agree to notify the company if there is reason to believe that any expense for which reimbursement has been obtained is not a qualifying expense. I also agree to indemnify and reimburse the company on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

Dependent Care Assistance Plan (DCAP) will be available only for "qualifying dependent care expenses" as described below. I agree to notify the company if there is reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense, I also agree to indemnify and reimburse the company on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

I agree to provide the Plan Administrator with the name, address, and taxpayer identification number of each dependent care service provider.

Qualifying Dependent Care Expenses:

1. The expenses are incurred for services rendered after the date of this election and during the plan-year to which it applies.
2. Each individual for whom you incur the expenses is (a) a dependent under the age 13 whom you are entitled to claim as a dependent* on your federal income tax return or (b) a spouse or other tax dependent* who is physically or mentally incapable of caring for himself or herself.
*or a child or other dependent under age 13 whom you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce.
3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 2(a) above, or who regularly spends at least 8 hours a day in your household.
5. The expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the Facility), which complies with all applicable state and local laws and regulations.
6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.
7. The expenses are not paid or payable to an individual for whom you or your spouse are entitled to a personal tax exemption.
8. The reimbursement (when aggregated with all other reimbursements received by you under the Plan during the same year) may not exceed the least of the following limits: (a) The maximum allowed under the Plan. (b) \$5,000 if you are filing a joint tax return or \$2,500 if separate returns are filed. (c) Your taxable compensation (after all compensation reduction elections). (d) If you are married, your spouse's actual or deemed earned income.

This agreement will automatically terminate if the Plan is terminated or discontinued.