



**STAFF LEASING**

**STAFF LEASING'S  
FLEXIBLE SPENDING  
GUIDE**

**2009 Plan Year  
January 1st—December 31st**





## ***WHAT IS AN FSA?***

An FSA (Flexible Spending Account) is a program that the Federal Government allows your employer to sponsor. It allows you (the employee) to save federal, state and social security taxes on the money you use to pay for eligible expenses. This will increase your take home pay.

Take advantage of a benefit choice that can increase your spendable income - a flexible benefits plan. You can enhance your benefits package by participating in this valuable option, available through your employer.

## ***How it Works***

This plan consists of three separate accounts – group insurance deductions, unreimbursed medical, dental, vision expenses, and dependent care assistance plan. At the time of enrollment, you must determine how much you would like to contribute to each of the three accounts for the coming year (group insurance deductions are based on what your employer requires you to pay for coverage). The remaining accounts are determined individually by you, the participant. You may participate in any or all of the accounts. When you participate in a flexible benefits plan, you elect to have a specified number of pretax dollars deducted from your paycheck each pay period. These dollars are subtracted from your gross earnings before taxes are taken out.

## ***Your Spendable Income Increases***

When you contribute pretax dollars to a flexible benefits plan, you lower your taxable income; therefore, you pay fewer taxes and increase your spendable income. Depending on your tax bracket, this plan can save you 30% to 40% on qualifying expenses.

## **IMPORTANT FACTS TO REMEMBER**

### ***THE "USE IT OR LOSE IT" RULE***

Remember the important "use it or lose it" rule when deciding how much to place in your account. If you contribute dollars to a reimbursement account and do not use all of the monies you deposit, you will lose any remaining balance in the account at the end of the plan year. Because of the tax advantages of a flexible benefit plan, the IRS has established strict guidelines for monies not used by the end of the plan year. For this reason, plan carefully how much to place in your account. Only contribute those dollars you are confident you will use to pay for qualified expenses incurred during the plan year.

Plan participants have until March 31st of the following year to submit requests for reimbursement for the previous plan year.

### ***ONCE ENROLLED, YOU MAY NOT CHANGE***

To comply with IRS regulations, you may only make a change in your election at the beginning of each plan year. This means you may not make a change in your elections after the open enrollment period, unless you experience a family status change. Examples include - marriage, divorce, birth, adoption, death, loss of spouse's employment, etc.

## **ACCOUNTS AVAILABLE UNDER THE FSA**

### ***OUT OF POCKET MEDICAL EXPENSES***

Covers eligible out-of pocket medical, dental, vision expenses that are only partially covered or not covered at all by insurance, such as deductibles and co-pays. Your estimated non-covered expenses for the plan year are deducted uniformly from each paycheck throughout the plan year. The maximum allowable amount that can be contributed to the Medical Flexible Spending Account is \$2500.00. See enclosed pages labeled "Eligible vs. Ineligible Medical Expense Listing" and "Over-The-Counter Drugs" for more information regarding the unreimbursed medical prerequisites for reimbursement.

If you choose to participate in this valuable benefit, you and your eligible dependants can pay for medical, dental, vision expenses and dependent care expenses on a tax-free basis. This will increase your take home pay. Use this guide as a quick reference to questions you may have throughout the year.

### ***DEPENDENT CARE***

The maximum annual contribution is \$2500 for one child and \$5000 for two or more children (\$2,500 for married participants filing a separate income tax return), but no more than the lesser of the earned income of the employee or his spouse. If your spouse is a full-time student or incapacitated, the maximum annual election is \$2,400 for one child or \$4,800 for two or more children.

A dependent under age 13 who qualified as a dependent for income tax purposes;

- A spouse who is physically or mentally unable to care for himself or herself
- A dependent who is unable to care for himself or herself and who qualifies as a dependent for income tax purposes

# INELIGIBLE MEDICAL EXPENSE LISTING

## Health Care Expenses That Are Not Reimbursable:

Any illegal treatments  
Baby Formula  
Cosmetic procedures (unless medically necessary)  
Remedial reading classes for non-disabled child  
Dancing or ballet, even when Dr. recommended  
Diaper Service

Dietary Food Supplements  
Gym Memberships and Personal Training  
Health and beauty aids  
Insurance premiums  
Teeth whitening  
Weigh reduction programs for general well-being

## OVER THE COUNTER ALLOWABLE EXPENSES

Allergy medications  
Antacids  
Antibiotic creams  
Anti-diarrhea medications  
Anti-fungal medications  
Anti-itch medications  
Anti-gas medications  
Arthritis creams  
Bandages (band-aids)  
Blood pressure monitors  
Bug bite medication  
Calamine lotion  
Carpal tunnel (wrist) support  
Cholesterol test equipment  
Cold medicine  
Cold/hot packs for injuries  
Condoms (contraceptives)  
Contact lens solutions  
Contraceptives /suppository  
Cough/cold/ flu/fever reducers  
Crutches  
Diabetic supplies  
Diaper rash ointments  
Drugs, previously prescription  
Ear care / swimmer's ear  
Eye drops  
Eye Patches  
First aid creams/ointments  
Gauze  
Head lice treatment  
Hearing aid batteries  
Heartburn/indigestion meds  
Hemorrhoid creams/suppositories  
Incontinence supplies  
Joint support bandages/hosiery  
Laxatives  
Liquid adhesive

Menstrual cramp/pain products  
Motion sickness pills  
Mouth pain  
Nasal decongestant  
Nausea/ vomiting remedies  
Nicotine gum  
Nicotine patches  
Night guards for teeth grinding  
Ointments for burns/sunburn  
Pain relievers / fever reducers  
Pain relievers - muscle pain  
Pedialyte for child's dehydration  
Poison treatment  
Pregnancy test kits  
Rashes: diaper rash/ fever blisters  
Rashes: poison oak/ivy/sumac  
Reading glasses  
Rubbing alcohol  
Sinus medications  
Sleeping aids for insomnia  
Smoking cessation treatment  
Spermicidal foam-contraceptives  
Stomach & digestive relief  
Sun Block  
Take-home screening kits (for detecting colon cancer /hepatitis C)  
Thermometers  
Throat lozenges  
Urinary pain relief  
Vaporizers and Humidifiers  
Vaginal product / yeast infection  
Wart removal treatments  
Wheel Chair  
**(Vitamins unless prescribed, toiletries, Cosmetics, Nutritional & Dietary Supplements are ineligible, and are not reimbursable)**



## Flexible Spending Account Worksheet For Out of Pocket Medical Expenses

Type of Expense	Estimate of Annual Expense
Health	
Deductible	
Dr. Office Visits	
Physical	
Immunizations	
Prescription Drugs	
Other	
Dental	
Deductible	
Fillings	
Bridges	
Crowns	
Dentures	
Orthodontia	
Exams	
Cleaning	
Other	
Vision	
Exams	
Lenses	
Frames	
Contact Lenses	
Hearing	
Exams	
Hearing Aids	
Annual Grand Total	\$

### Dependent Care Expenses

Type of Expense	Estimate of Annual Expense
Babysitters, Daycare Centers, Nursery School	
After-School Programs, Day Camp	
Elder Care	
Annual Grand Total	\$

Health Care Expenses		Dependent Care Expenses	
Annual Amount	\$	Annual Amount	\$
Per Pay Period Amount (Divide Annual Amount by pay periods left in plan year to get Per Pay Period Amount)	\$	Per Pay Period Amount (Divide Annual Amount by pay periods left in plan year to get Per Pay Period Amount)	\$

This is not an enrollment form – this is just a tool for you to calculate your annual Health and Dependent Care Expenses.  
Please Keep a copy for your records





## FLEX SPENDING ENROLLMENT FORM

149 Northern Concourse  
North Syracuse, NY 13212  
315-641-3600 Phone

[flex@staffleasing-peo.com](mailto:flex@staffleasing-peo.com)

\*\*\*\* ONCE COMPLETED PLEASE MAIL OR EMAIL THIS FORM TO THE ABOVE ADDRESSES.  
NO FAXES WILL BE ACCEPTED

<b>Name: Last</b>	<b>First</b>	<b>MI</b>	<b>Social Security Number</b>
<b>Email Address</b>	<b>Plan Year</b>	<b>Contact Phone Number</b>	<b>Worksite Employer</b>
<b>Address</b>		<b>City</b>	<b>State, ZIP</b>

*To add family members, complete this area:*

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		

Indicate the benefits you wish to pay through tax-free salary reduction by checking the appropriate boxes and entering the necessary information below. **Calculate contributions carefully as unused funds are forfeited at the end of the plan year or termination (whichever is sooner).** If provided, we will notify you via email that we have received your claim for processing. **Please be sure your email address is legible.**

	FLEX Reimbursement Account	Annual Amount	Pay Period Amount
<input type="checkbox"/>	<b>Medical Expense</b> - Indicate the amount you wish to contribute. Medical expenses are limited to \$2500. The amount deducted is calculated by the annual amount divided by remaining pay cycles in the calendar year.	\$ _____	\$ _____
<input type="checkbox"/>	<b>Dependent Care Expense</b> – Indicate the amount you wish to contribute. Dependent Care expenses are limited to \$2500 for one child and \$5000 for two or more children. The amount deducted is calculated by the annual amount divided by remaining pay cycles in the calendar year.	\$ _____	\$ _____

- I hereby authorize my employer to reduce my gross salary before federal, state, and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and they cannot be changed until the next plan year or unless there is a qualifying event or I am terminated.
- I understand that any amount remaining in any Flex Reimbursement Account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year. **Please estimate your annual election conservatively.**
- **I understand that reimbursements will be processed on a semi-monthly basis. It is defined as any completed claims received prior to the 15<sup>th</sup> of the month will be processed on the last day of that month. Any completed claims received from the 16<sup>th</sup> to the end of the month will be processed on the 15<sup>th</sup> of the following month.**
- I understand that incomplete vouchers or acknowledgement forms may delay processing or result in a denial of claims.

<b>Employee Signature</b>	<b>Date</b>