FSAGUIDE

TAX SAVINGS FOR

Medical and Dependent Care Expenses

BASIC®

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WHAT IS A FLEXIBLE SPENDING

Flexible Spending Accounts (FSA) are part of Section 125, established by the IRS. Section 125 allows employees to set aside money for future medical and child care costs on a pre-tax basis.

A Medical FSA can be used to cover:

- Insurance deductibles
- Co-payments and coinsurance
- Prescriptions
- Dental or vision expenses
- Over-the-counter medicine
- Menstrual products

SAVINGS

You save between 15%-40% by not having to pay federal, most state and local taxes, as well as Social Security and Medicare taxes for every dollar elected for an FSA.

The savings really add up.

Without an FSA		With an FSA	
Gross taxable wage	$500.00	Gross taxable wage	$500.00
Federal, FICA & State Tax	-113.25	Group Insurance premium contribution	-40.00
Group Insurance premium contribution	-40.00	Average weekly out-of-pocket medical expenses	-50.00
Take home pay	$346.75	Taxable wage	$410.00
Average weekly out-of-pocket medical expenses	-50.00	Federal, FICA & State Tax	-92.86
Amount left to spend	$296.75	Amount left to spend	$317.14
FSA Tax Savings per week			$20.39

• *Assuming 15% Federal tax, 7.65% FICA Tax (Social Security and Medicare)*

ACCOUNT?

MEDICAL FSA

Below is an example of a how a current participant calculated the amount they elected for medical FSA. Be sure to base YOUR estimate on known expenses.

The full amount of your medical election is available for reimbursement upon the first day of your plan year.

When you incur an eligible out-of-pocket expense, submit your itemized documentation to BASIC and receive a tax free reimbursement.

	Charges	Savings
Deductible	$500	$113
Co-pays	$450	$101
Prescriptions	$480	$108
Contacts/Vision services	$220	$49
Dental	$100	$22
Over-the-counter items+	$75	$16
Total	$1825	$409

• *Assuming 15% Federal tax, 7.65% FICA Tax (Social Security and Medicare)*

\+ *Over-the-counter items require a letter of medical necessity*

IRS regulations govern the eligibility of claims which include those that are not fully covered by a health care plan and are prescribed by a physician or other licensed professional, primarily for preventing, treating or mitigating a physical defect or illness. The IRS does not allow reimbursement for the following: cosmetic surgery, insurance premiums, teeth bleaching / whitening, nutritional supplements/vitamins, marriage counseling, debt counseling, eyeglass sun clips and prepayment of services. For more details, refer to IRS Publication No. 502.

LIMITED PURPOSE FLEX

DESIGNED FOR INDIVIDUALS WITH A HEALTH SAVINGS ACCOUNT (HSA)

IRS regulations do not allow you to contribute to an HSA and participate in a standard Medical FSA, however, you may enroll in a Limited Purpose FSA. If you or your spouse change to an HDHP option (with HSA) during your Flex plan year and you are enrolled in a standard Medical FSA, you are not allowed to make or receive HSA contributions or change your FSA Plan type.

The difference between Medical FSA and a Limited Purpose FSA is eligible expenses. A Limited Purpose FSA plan is only for dental and vision expenses.

A Limited Purpose FSA works just like a regular FSA, except for the limited type of eligible expenses. You designate a certain amount of money to be taken out of each paycheck to be deposited into your LPFSA account.

You cannot use funds from both your LPFSA and your HSA to cover the same eligible expense, even if the expense is considered eligible under both plans.

An HSA Account does not affect your eligibility for a dependent care account.

QUALIFIED EXPENSES

IRS regulations govern the eligibility of items and claims. As a Flex Administrator, BASIC helps ensure that you and your employer stay within these regulations.

MEDICAL, DENTAL & VISION

Co-pays
Co-insurance
Deductibles

MEDICAL*

Acupuncture
Chiropractor
Podiatrist
Doctor fees
Office visit
Prescriptions
Hospital bills
Laboratory fees
Medic alert bracelet
Dermatologist
Immunizations
Obstetrical expenses
Routine physicals
X-rays
Well baby checkups

DIABETIC SUPPLIES*

Insulin
Glucometer
Syringes/Needles
Test Strips

HEARING*

Hearing exam
Hearing aids
Special batteries

THERAPY*

Physical therapy
Learning disability
Psychologist fees for medical care
Psychiatric care

VISION*

Glasses
Eye exam
Contact lenses
Contact solution
Prescription sunglasses
LASIK surgery
Visine and eye drops
Reading glasses
Eyeglass repair kits
Orthokeratology
Seeing eye dog (buying, training, and maintaining)

DENTAL*

Orthodontic
Dentures/bridge/crowns
Fluoride treatments & seals
Cleanings and fillings
Root canals
Extractions
Dental x-rays
Occlusal guards
Reconstruction/implants

BIRTH CONTROL DEVICES*

Condoms
Prescriptions
Sterilization

PHYSICAL IMPAIRMENTS*

Wheelchair
Crutches
Walker
Custom made orthopedic shoes and inserts

SPECIAL NEEDS*

Transportation to and from doctor/hospital (call for current mileage rates and guidelines)

OVER-THE-COUNTER ITEMS*

Acid controllers
Acne medication
Antibiotic products
Anti-diarrheas/gas
Anti-itch/insect bite
Antiparasitic treatments
Baby rash creams
Band-aids
Carpal tunnel wrist supports
Cold sore remedies
Cold/hot packs for injuries
Cough, cold & flu
Digestive aids
Feminine anti-fungal/anti-itch
Hemorrhoidal preps
Home pregnancy tests
Incontinence supplies
Laxatives
Liquid adhesive for small cuts
Nasal strips
Pain relief
Sleep aids & sedatives
Stomach remedies
Stop smoking programs/ items
Sunscreen

MENSTRUAL PRODUCTS*

Tampons
Pads and liners
Menstrual cups

Visit www.basiconline.com/Medical-FSA-Election-Worksheet.pdf for a qualified expense worksheet to help you estimate your out of pocket costs.

EXPENSES THAT REQUIRE A LETTER OF MEDICAL NECESSITY

The IRS allows reimbursement of the following, with a copy of the physician's statement of medical necessity, that includes the specific product/service and a diagnosis. Treatment cannot be for general health or well being. A copy needs to be submitted with every reimbursement request and a new letter needs to be reinstated every 12 months.

Health club fees/gym memberships

Nutritional supplements/vitamins

Massage therapy

Weight loss programs (i.e. Weight Watchers and Jenny Craig) - Program fees are eligible but food portions are not.

* **PLEASE NOTE:**
This list is a broad overview of eligible expenses; not all services provided by a provider or practitioner are eligible under the IRS regulations.

Please call BASIC regarding your specific item or treatment, prior to election, to confirm eligibility.

EXAMPLES OF INELIGIBLE EXPENSES

The IRS does not allow reimbursement for the following:

Cosmetic surgery

Insurance premiums

Marriage/debt counseling

Eyeglass sun clips

Eyeglass or contact warranty

Prepayment of services

Special (dietary) foods

Personal care items

Diapers

Deodorant

Chapstick

Face cream or moisturizers

Eye serums or wrinkle creams

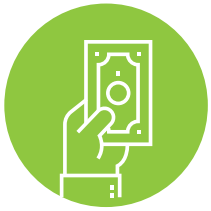
Teeth bleaching/whitening

Toothbrushes/toothpaste

Floss/flossing devices

Mouthwash

Protein shakes/meal replacement



CALCULATE SAVINGS

Visit www.basiconline.com/fsasavingscalculator to use our calculator to estimate the size of your tax saving, annually or per pay check, when you choose to participate in BASIC Flex!

DEPENDENT CARE FSA

A single parent or a married couple filing jointly can elect up to $5,000 per family, while a married person filing separately can elect up to $2,500 per person, but equal $5,000 for the family. Just as with Medical FSA, you save between 15%-40% by not having to pay federal, most state and local taxes, as well as Social Security and Medicare taxes for every dollar elected for Dependent Care FSA.

Unlike a Medical FSA, Dependent Care FSA is a pay-as-you-go account. Funds are not advanced by your employer.

Without an FSA		With an FSA	
Gross taxable wage	$500.00	Gross taxable wage	$500.00
Federal, FICA & State Tax	-113.25	Dependent care election *($5,000 divided by 52 weeks)*	-96.15
Take home pay	$386.75	Taxable wage	$403.85
Average weekly out-of-pocket medical expenses	-96.15	Federal, FICA & State Tax	-91.47
Amount left to spend	$290.60	Amount left to spend	$312.36
FSA Tax Savings per week			$21.78
Annual Savings			$1132.56

• Assuming 15% Federal tax, 7.65% FICA Tax (Social Security and Medicare)

DEPENDENT ELIGIBILITY

- You and your spouse must be employed or actively seeking employment or attending school full time.
- Child must be a dependent under 13 years of age and be in your custodial care more than 50% of the calendar year. Once your child turns 13 during the plan year, expenses are no longer eligible for reimbursement.
- A spouse or dependent who is incapable of self-care and regularly spends at least eight hours per day in your home (i.e. an invalid parent).

SERVICE REQUIREMENTS

- Provider may not be a minor child or dependent for income tax purposes (i.e. an older child).
- Service provider must claim payments as income and comply with state regulations.
- Services must be for the physical care of the child, not for education, meals, etc.
- Overnight camps are not eligible for reimbursement.
- Expenses paid for Pre-K are eligible but kindergarten and higher is not.

If you qualify for the Child Care Credit, the same IRS rules apply. If you have 2 or more children and spend more than $5,000 for child care, you may have additional tax credits available to you. For more details, refer to IRS Publication No. 503

ADDITIONAL DETAILS

PLAN RULES ARE COMPANY SPECIFIC

While this booklet provides general information about a plan, a Summary Plan Description (SPD) containing further details is available. If you have specific questions regarding your particular situation, you may want to consult your company Benefits Coordinator, an attorney or accountant.

Refer to the Summary Plan Description (SPD) to find out how long you have to submit remaining claims after your plan year or coverage has ended.

CHANGES TO YOUR CONTRIBUTIONS

You may change your annual election if you have a qualified change in status (marriage, birth, adoption, death or divorce). The change in status must correlate with the event and be made within 30 days of the event. For example, if the event is a birth, you may increase your election, not decrease it.

END OF YEAR BALANCE

According to the IRS, money left in your account may become the property of your employer and cannot be returned to you. Please see the Summary Plan Description (SPD) for further details. Most people use all their funds by good planning . . . such as getting a physical, dental checkup or new glasses. Rarely is there ever more than 5% left in the account, and the tax savings more than outweigh this amount.

ELIGIBILITY

Flex Benefits end upon termination of employment and/or participation.

Services must be rendered during your current period of coverage. For new employees entering the plan during the plan year, services must be rendered after your eligibility or election date, whichever is later.

FSA BENEFIT DEBIT CARD

ELIMINATE PAYING OUT-OF-POCKET AND WAIT FOR REIMBURSEMENT.

FSA Benefit Debit Cards can be used at qualified locations including hospitals, physician, dental offices, pharmacies and merchants with specific certification.

The IRS regulates the rules regarding eligible expenses; therefore, there will be some transactions that need to be substantiated for eligibility. At BASIC, we have an 87% auto substantiate rate for debit card purchases. There are, however, some instances when participants will be required to submit itemized documentation for their FSA Benefit Debit Card purchases.

In all cases, itemized documentation for transactions should be kept.

Debit Cards will be suspended if documentation is not provided.

Debit Card availability is determined by your employer. Please check with your benefits department to find out if a debit card is available.

If you have questions at anytime call 800-372-3539 and speak to a BASIC Flex Account Manager.

FSA Enrollment Form

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: _____

Participant Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Birthdate: _____

E-mail Address: _____ (Notification of direct deposit payments are only sent via e-mail)

Pay Period: ☐ Weekly ☐ Semi-Monthly (twice a month) ☐ Bi-Weekly (every other week) ☐ Monthly

PREMIUM CONTRIBUTIONS

☐ I elect to participate (check all that apply)

☐ Health Insurance ☐ Group Life Insurance ☐ Disability Insurance ☐ Dental Insurance

☐ HSA Contributions ☐ Vision Insurance ☐ Other(s)_____

The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.

☐ I elect NOT to participate

EMPLOYER USE

Please complete for mid-year enrollments

Date of first deduction:

_____

Eligibility date:

_____

MEDICAL REIMBURSEMENT ACCOUNT

☐ I elect to participate $_____ annually (may not exceed employer limit of $_____)

Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

☐ This Medical Reimbursement Account is a Limited Purpose Account for HSA eligibility (see page 2)

☐ I elect NOT to participate

DEPENDENT CARE ACCOUNT

☐ I elect to participate $_____ annually (may not exceed $5000 or $2500 if married filing separately)

Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

☐ I elect NOT to participate

DIRECT DEPOSIT *(NOT ALL EMPLOYERS ALLOW DIRECT DEPOSIT AS A REIMBURSEMENT OPTION)*

☐ I elect NOT to participate

☐ Use account information on file ☐ Use account information below ☐ No Direct Deposit

☐ Checking account OR ☐ Savings account

Financial Institution: _____

Routing Number: _____ Account Number: _____

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year may be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

TEAR ALONG THIS LINE