Flexible Spending Accounts (FSAs) are a benefit that allow you to pay for certain items TAX-FREE.

Save on items not covered by your health insurance by setting aside tax-free deductions from each paycheck to fund your Flexible Spending Accounts.

Two main types of FSAs are for Healthcare and Dependent Care.

You decide on an amount to be set aside each pay period for these expenses. With a little planning, you can save more on things you normally purchase.

SAVE 25% to 40%

On the Dollars You Spend for Qualified Expenses

- Healthcare
- Dependent Care

Healthcare FSAs are a simple way to save $25 to $40 for every $100 you spend.

SAVINGS

5589 Cheviot Road Cincinnati, Ohio 45247
513.598.2929 800.598.2929 www.CustomDesignBenefits.com

FSA WORKSHEET

Use this worksheet to figure out what to deposit into your Flexible Spending Account for one year* and what you will save. Then complete an election form. After that, a portion of that amount will be deducted automatically from your paycheck *before taxes*.

After you enroll, the full amount of annual Healthcare FSAs are available at the beginning of the plan year. Dependent care is available only as funds from your paycheck are deposited.

Funds left over in your FSA may rollover. *You may be eligible to carry over up to $500 into the next plan year, so check with HR to learn the type of plan used by your employer.*

HEALTHCARE EXPENSES

FOR EXPENSES NOT COVERED BY INSURANCE

- ❑ Copayments to doctors $________________
- ❑ Eligible over-the-counter items $________________
- ❑ Prescription drugs $________________
- ❑ Office visits & checkups $________________
- ❑ Prescribed sunglasses & eyeglasses $________________
- ❑ Contact lenses, solutions & supplies $________________
- ❑ Eye exams, surgery & LASIK $________________
- ❑ Dental cleanings, fillings & x-rays $________________
- ❑ Sealants, crowns, bridges & dentures $________________
- ❑ Braces, spacers & retainers $________________
- ❑ Wisdom teeth, implants & oral surgery $________________
- ❑ Psychologist & psychiatrist fees $________________
- ❑ Obstetrics & fertility $________________
- ❑ Lab tests & body scans $________________
- ❑ Chiropractic & podiatrist fees $________________
- ❑ Oxygen, insulin, syringes & supplies $________________
- ❑ Hearing aids, batteries & exams $________________
- ❑ Artificial limbs & braces $________________
- ❑ Arches & orthopedic shoes $________________
- ❑ Walkers, canes & wheelchairs $________________
- ❑ Physical & speech therapy $________________
- ❑ Weight-loss program (prescribed by doctor) $________________
- ❑ Quit-smoking program & medications $________________
- ❑ Alcoholism & drug treatment $________________
- ❑ Medical alert bracelet & fees $________________
- ❑ Reconstructive surgery (birth defect, disease) $________________
- ❑ Wigs for hair loss caused by disease $________________
- ❑ Special school for disabled child $________________
- ❑ Travel & mileage to doctor or hospital $________________

TOTAL **1** $________________

DEPENDENT CARE EXPENSES

SO YOU CAN WORK

- ❑ Nanny & babysitter thru age 12 $________________
- ❑ Pre-K or nursery school $________________
- ❑ Before & after-school care thru age 12 $________________
- ❑ Day camp thru age 12 $________________
- ❑ Daycare for a disabled adult or child $________________
- ❑ Elder daycare for parent or dependent $________________

TOTAL **2** $________________

Federal Limits:
- Married Filing Jointly or Single: $5000 Maximum Allowable per year
- Married Filing Separately: $2500 Maximum Allowable per year

ESTIMATED ANNUAL EXPENSES & TAX SAVINGS

Save between 25% and 40% on FICA, federal & state income tax (in applicable states)

1 $________________

\+ **2** $________________

= $________________

Enter your tax: x________________%

YOU SAVE: $________________

Based on national averages, you'll save 25% if your annual household earnings are less than $30,000, 36% if you earn $30,000 to $60,000 or 40% if you earn more than $60,000.

Federal and/or plan limits apply to all options. See your summary plan description for plan limits.

Please check with your HR Department if you or your spouse contributed to a Health Savings Account (HSA).

*Some FSAs cover less than 12 months. Check with your HR Department to learn how your employer handles FSAs.

HOW YOUR FSA CARD WORKS

All FSA plans must comply with Internal Revenue Service (IRS) guidelines.

Over 80% of Healthcare FSA expenses are automatically approved so, in most cases, you won't need to submit claims or documentation for FSA Card* use. However, always keep copies of your receipts and other supporting documentation.

Your FSA Card can only be used for services rendered in the current plan year.

Below is a table to help guide you when using your FSA Debit Card.

** Not all flexible spending plans utilize the debit card. Please disregard this information if your FSA plan does not utilize a debit card.*

FSA CARD ACTION	TYPE OF VENDOR OR TYPE OF SERVICE	HELPFUL HINTS
No Substantiation Required The FSA Card will work without anything further from you! Please keep a copy of documentation just in case.	**Healthcare Providers with Copays:** Hospitals Pharmacy Physician's Office Vision Care Providers Urgent Care Outpatient Surgery Centers Prescriptions that can be purchased at participating retailers.	**Coinsurance is not the same as Copay.** With Coinsurance, the employee pays a percentage of the cost. Using your debit card to pay for coinsurance may require you to submit supporting documentation. You will receive a letter if IRS guidelines require supporting documentation. It's important that you keep all of your supporting documentation.
May require supporting documentation	**The FSA Debit Card can only be used at Healthcare providers like Dentists, Doctors or Vision Care Providers.** Some expenses may require documentation. You will receive a letter if you use your FSA Card to pay for these common types of expenses: ■ Deductibles or Coinsurance ■ Spouse's insurance out-of-pocket expenses ■ Caregivers for Dependents (Dependent Care)	You will receive a letter if more information is required. Please submit requested documentation* no later than 30 days after the reminder letter is sent to your home to avoid having your card suspended. ***Documentation must include the following items: Provider name, patient name, date of service, amount and description of services. Insurance Explanation of Benefits (EOB) forms or Doctor statements are acceptable.**
Cannot use the FSA Card	■ **Over-the-Counter Medications.** The Affordable Care Act does not allow you to purchase over-the-counter (OTC) medications with your FSA card. ■ **Any non-qualified expense** (such as cosmetic services, teeth bleaching, or pre-payment of services or expenses not incurred in the plan year). ■ Any provider, merchant or retailer that does not accept FSA Debit Cards as a form of payment.	Expenses for OTC medications may be eligible for reimbursement from your FSA plan as long as you have a doctor's prescription. A doctor's prescription must be submitted with any claim for Over-the-Counter medications. Use a different form of payment for items that are qualified expenses within the current plan year. Then, submit your claim with the supporting documentation.

IMPORTANT: Although it is a Debit Card, please ask cashiers to run your FSA Card as a Credit Card

USING YOUR FSA CARD

INSTRUCTIONS FOR FILING A CLAIM

FSA CARD USERS	Please do not send documentation unless you receive a letter from CDB. Nearly 80% of FSA Card transactions do not require anything further.	
ONLINE	• Login to the Custom Design Benefits FSA portal. • Select the **Submit a Claim** button • Follow prompts to complete your claim form electronically • Email, fax or mail your documentation to Custom Design Benefits. • Retain a copy of this for your records. Smartphone App available for Android and Apple devices. FREE download from the App Store (Search for "My Flex").	www.CustomDesignBenefits.com/MyFlexLogin Available on the App Store App Store
EMAIL	Complete the FSA Claim Form & attach scanned documentation to the email. All other questions and forms should be emailed to our Flex email address.	FlexClaims@CustomDesignBenefits.com FLEX@CustomDesignBenefits.com
FAX	Complete the FSA Claim Form & fax with documentation.	513.598.2901
MAIL	Complete the FSA Claim Form & mail with documentation. (Please keep copies of your documentation.)	5589 Cheviot Road Cincinnati, OH 45247
QUESTIONS?	513.598.2929 Local in Cincinnati 800.598.2929 Toll-Free 866.598.2939 Toll-Free 24-Hour Balance Inquiry	

GETTING ONLINE

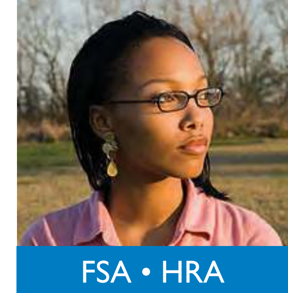
To learn more about FSAs, visit our website at **www.CustomDesignBenefits.com.**

- **FSA Savings Calculator** – Calculate what you normally spend and estimate tax savings by using an FSA for Qualified Expenses you normally buy anyway.
- **Qualified Expenses** – Review a summary of expenses that qualify for FSA savings. A more detailed list is available to FSA participants by logging in to MyFlexOnline.
- **Forms** – Print forms or download electronic forms that can be emailed with claims.
- **Frequently Asked Questions** – Answers to common questions about FSAs.

Once you become an FSA participant, you can review your account online.

From our home page, click on MyFlexOnline (see image at right).

The first time you access your account, click New User to register and set up your own Username and Password.



FSA • HRA

MyFlexOnline Login

MyPlan Login

Qualified FSA Expenses

FSA Savings Calculator

How It Works

Forms & FAQs

FSA CLAIM FORM

(Flexible Spending Account)

Submit Claims To:
Custom Design Benefits, Inc.
5589 Cheviot Road
Cincinnati, Ohio 45247
Ph: (800) 598-2929
Fax: (513) 598-2901
FlexClaims@CustomDesignBenefits.com

Employer:____

Employee Name: ____ Employee or Social Security #: __________________________

☐Check here if new address Address:____

City: _______________________________ State:________________ Zip:_______________ Date of Birth:______________________

Email: ____ Phone: ____

IMPORTANT!

When using the FSA Card, please do NOT mail anything in unless requested to do so. Most items will be automatically approved. Please keep copies for your records.

CHANGES FOR OVER-THE-COUNTER MEDICATIONS. If your physician prescribes an Over-the-Counter medicine to take ongoing, such as DAILY aspirin or antihistamine, please submit a copy of the prescription with the claim for faster claims processing. If you have already provided a copy of the prescription with a prior claim and need us to access history, please check this box: ☐

DEPENDENT CARE REIMBURSEMENT				
Name and Age of Dependent(s)	Period Covered From	To	Name, Address & Taxpayer Identification Number of Service Provider	Claim Amount
Provider's Signature (required if not on receipt):			**Total Dependent Care Claims**	

TO ENSURE WE CAN PROCESS YOUR CLAIM: Provide **proper supporting documentation**, including copies of bills indicating name of provider, name of patient, service/product provided, date the service was provided and amount of the expense not covered by other insurance. Please note: credit card statements do not contain enough info for submitting claims.

HEALTH CARE REIMBURSEMENT For expenses not paid using the *Take Care* FSA Card				
Patient Name and Relationship	Date of Service From	To	Name of Service Provider and Description of Expense	Claim Amount
			Total Health Care Claims	

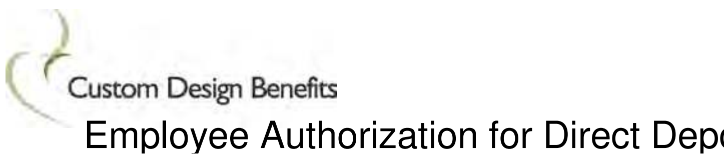
Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Flexible Spending Benefit Plan with respect to such expenses and that the health expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the validity and accuracy of all information relating to this claim which is provided by the undersigned, and that 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. Please do not include original receipts, since, after the claim is substantiated, your receipts may not be readily accessible. **Claims will not be processed unless all above information is completed.**

____ ____________________

Employee Signature Date

View your account, including the status of your claim, online at www.MyFlexOnline.com.

More information & resources are available at www.CustomDesignBenefits.com



Employee Authorization for Direct Deposit

Submit Form To:
Custom Design Benefits, Inc.
5589 Cheviot Road
Cincinnati, Ohio 45247
Ph: (800) 598-2929
Fax: (513) 598-2901
Flex@CustomDesignBenefits.com

Please check one of the boxes below (allow 1-2 pay periods for processing):

☐ **ADD** Please deposit my reimbursements into the bank account listed below

☐ **CHANGE** I would like to change the account where my current direct deposit reimbursement is sent

☐ **CANCEL** I would like to stop sending funds directly to my account and have future funds by check mailed to me at the address on file.

Employer Name: ______________________________________

Employee Name: ______________________________________ Employee SSN or #: ____________________________

Financial Institution: ____

Branch: _______________________ City: _________________________ State: _________ Zip: __________________

Bank Routing Number (9 digits):_________________________

Checking Account _______________________________or Savings Account ___________________________________

I hereby authorize Custom Design Benefits, Inc. to initiate credit entries to the checking account indicated on this form as the depository financial institution for transactions related to my Flexible Spending Account or Health Reimbursement Account. Additionally, I authorize the Company to initiate any necessary debit reversal entries only for the correction of erroneous or duplicate entries previously credited to my account indicated on this form. It is acknowledged that the origination of ACH transactions to my account must comply with the provisions of United States law.

This authorization is to remain in full force and effect until Custom Design Benefits, Inc. has received written notice of its termination in such time and in such manner to afford Custom Design Benefits, Inc. and the financial institution a reasonable opportunity to act on it.

Authorized Signature: ____ **Date:** ________________________________

ATTACH A VOIDED CHECK FROM THE ACCOUNT HERE

A voided check should be attached so there is no question as to the bank and account where funds are to be debited or credited.

For assistance, call **800.598.2929** or (for local Cincinnati area) **513.598.2929**