

YOU'RE GOING TO NEED A
BIGGER BANK.



GET MORE OUT OF YOUR PAYCHECK.

Do you pay medical expenses? How about insurance premiums? Child care? If you answered yes to any of these questions then keep reading because we are going to put more money in your pocket. The IRS established Section 125 to help reduce some of the burden of medical, dental, vision and dependent care bills. With BASIC Flex, you elect to have a certain dollar amount transferred from your paycheck into a special account to pay for expenses as they occur. This money is taken from your gross pay prior to taxes. You save by not having to pay federal and most state and local taxes, as well as Social Security and Medicare taxes, on the amount you set aside.

EXAMPLE OF SAVINGS FOR A WEEKLY PAYROLL CHECK

| Without a Flexible Spending Plan | | With a Flexible Spending Plan | |
|---------------------------------------|----------------|---------------------------------------|---------------|
| Gross taxable wage | \$500.00 | Gross taxable wage | \$500.00 |
| Federal, FICA & State Tax | -113.25 | Average weekly out-of-pocket expenses | |
| Insurance premium contribution | -40.00 | Insurance premium contribution | -40.00 |
| Take home pay | \$346.75 | Medical/Dental/Vision | -50.00 |
| Average weekly out-of-pocket expenses | | Taxable wage | \$410.00 |
| Medical expenses | -50.00 | Federal, FICA & State Tax | -92.86 |
| Amount left to spend | \$296.75 | Amount left to spend | \$317.14 |

*assuming 15% Federal tax, 7.65% FICA tax (Social Security and Medicare)

The savings really add up. This example leads to a \$20 a week savings. Where would you rather have the money go; in your pocket or toward taxes? In a year, an extra \$1060 could help pay increasing gas prices or help fund your entertainment budget. With BASIC Flex you can put the money back in your pocket. Visit www.basiconline.com BASIC Flex section to access a Flex Calculator to find out what your savings would be.



MEDICAL REIMBURSEMENT

With BASIC Flex you can save 15%-40% on your out-of-pocket medical expenses. Simply calculate your estimated medical expenses for the year and have that amount set aside in a Medical Reimbursement Account. The money is taken before taxes, so you don't pay federal, state, Social Security and Medicare taxes on that amount. It's like paying wholesale instead of retail.

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

We have provided an example of how a current participant calculated the amount they elected for BASIC Flex. Be sure to base YOUR estimate on known expenses because left over money is forfeited. Only 1 in 500 participants ever lose any money.

| | Charges | Savings |
|------------------------|---------------|--------------|
| Deductible | \$500 | \$113 |
| Co-pays | \$450 | \$101 |
| Prescriptions | \$480 | \$108 |
| Contacts | \$220 | \$49 |
| Dental | \$100 | \$22 |
| Over-the-counter items | \$75 | \$16 |
| Total | \$1795 | \$409 |

*assuming 15% Federal tax, 7.65% FICA tax (Social Security and Medicare)

When you incur an eligible out-of-pocket expense; you fax, e-mail or mail your documentation to BASIC and receive a tax free reimbursement. Reimbursement requests are processed daily, five days a week.

If you have questions at any-time regarding BASIC Flex simply call 800.444.1922 x 1 and speak to a BASIC Flex Customer Representative.

MEDICAL ELECTION WORKSHEET.

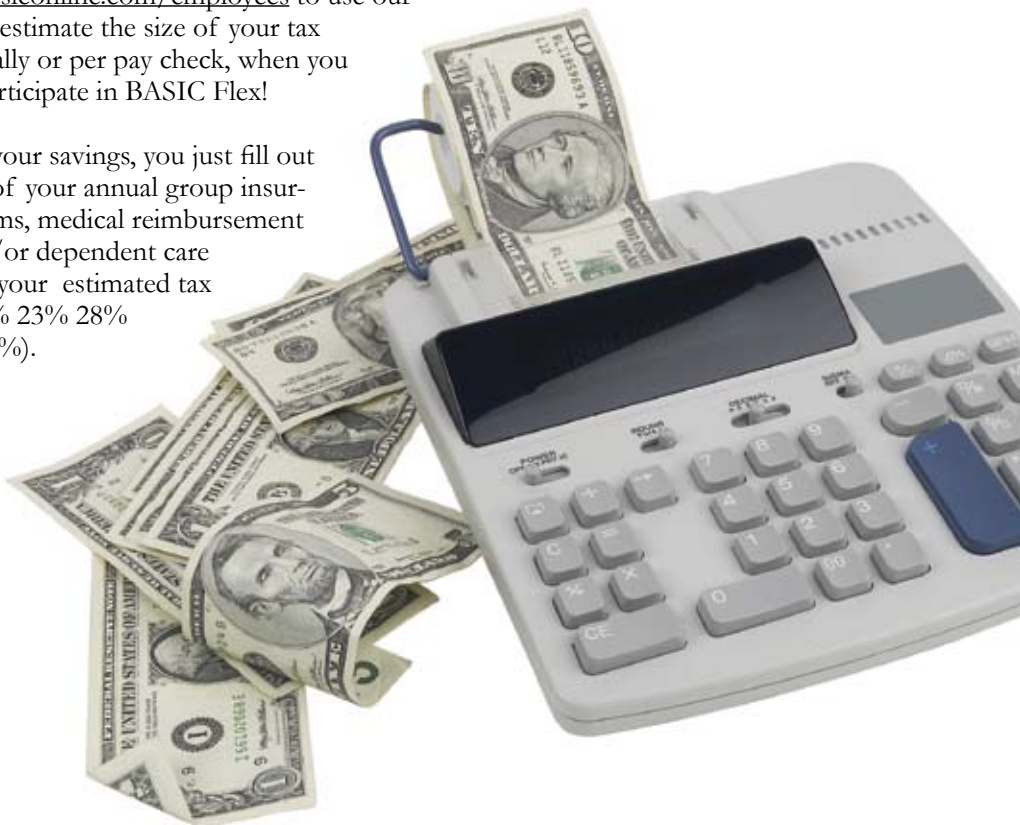
Use the list on the opposite page to estimate your predictable medical, dental, vision and over-the-counter (OTC) expenses for your plan year. These pages list commonly reimbursed eligible expenses as well as examples of ineligible items.

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. If you have a question regarding a specific item or treatment call a BASIC Flex Customer Service representative at 269.327.1922 ext. 1 or 800.FSA.FLEX.

TAX SAVINGS CALCULATOR

Visit www.basiconline.com/employees 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!

To estimate your savings, you just fill out the amount of your annual group insurance premiums, medical reimbursement election and/or dependent care election and your estimated tax bracket (15% 23% 28% 32% 40% 45%).



| EXAMPLES OF INELIGIBLE EXPENSES |
|---|
| The IRS does not allow reimbursement for the following: |
| Cosmetic surgery |
| Insurance premiums |
| Marriage counseling |
| Eyeglass sun clips |
| Eyeglass or contact warranty |
| Prepayment of services |
| Special (dietary) foods |
| Personal care items |
| Sanitary products |
| Diapers |
| Deodorant |
| Chapstick |
| Face cream or moisturizers |
| Teeth bleaching/whitening |
| Tooth brushes/toothpaste |
| Floss/flossing devices |

| EXPENSE | ESTIMATED COST |
|-----------------------------|----------------|
| MEDICAL* | |
| Acupuncture | \$ |
| Chiropractor | \$ |
| Podiatrist | \$ |
| Deductible | \$ |
| Co-pays | \$ |
| Doctor fees | \$ |
| Office visit | \$ |
| Prescriptions | \$ |
| Hospital bills | \$ |
| Laboratory fees | \$ |
| Medic alert bracelet | \$ |
| Dermatologist | \$ |
| Immunizations | \$ |
| Obstetrical expenses | \$ |
| Routine physicals | \$ |
| X-rays | \$ |
| Well baby check-ups | \$ |
| HEARING* | |
| Hearing exam | \$ |
| Hearing aids | \$ |
| Special batteries | \$ |
| VISION* | |
| Glasses | \$ |
| Eye exam | \$ |
| Contact lenses | \$ |
| Contact lens solution | \$ |
| Prescription sunglasses | \$ |
| LASIK surgery | \$ |
| Visine and eye drops | \$ |
| DENTAL* | |
| Orthodontic | \$ |
| Dentures/bridge/crowns | \$ |
| Fluoride treatments & seals | \$ |
| Cleanings and fillings | \$ |
| Root canals | \$ |
| Extractions | \$ |
| COLUMN #1 TOTAL | \$ |

| EXPENSE | ESTIMATED COST |
|--|----------------|
| DIABETIC SUPPLIES* | |
| Insulin | \$ |
| Glucometer | \$ |
| Syringes/Needles | \$ |
| Test Strips | \$ |
| BIRTH CONTROL DEVICES* | |
| Condoms | \$ |
| Prescriptions | \$ |
| Sterilization | \$ |
| Spermicidal foam | \$ |
| THERAPY* | |
| Physical therapy | \$ |
| Learning disability | \$ |
| Psychologist fees for medical care | \$ |
| Psychiatric care | \$ |
| PHYSICAL IMPAIRMENTS* | |
| Wheelchair | \$ |
| Crutches | \$ |
| Walker | \$ |
| Custom made orthopedic shoes and inserts | \$ |
| SPECIAL NEEDS* | |
| Stop smoking programs | \$ |
| Transportation to and from doctor/hospital (call for current rates and guidelines) | \$ |
| OVER-THE-COUNTER DRUGS* | |
| Allergy medicine | \$ |
| Antacids | \$ |
| Anti-diarrhea medicine | \$ |
| Bactine | \$ |
| Band-aids | \$ |
| Bug bite medication (not bug spray) | \$ |
| Calamine lotion | \$ |
| Carpal tunnel wrist supports | \$ |
| Cold medicines | \$ |
| COLUMN #2 TOTAL | \$ |

| EXPENSE | ESTIMATED COST |
|--|----------------|
| OVER-THE-COUNTER DRUGS CONT.* | |
| Cold/hot packs for injuries | \$ |
| Cough drops | \$ |
| Diaper rash ointments | \$ |
| Fiber supplements | \$ |
| First aid cream | \$ |
| Glucosamin/chondroitin | \$ |
| Hemorrhoid medication | \$ |
| Home pregnancy tests | \$ |
| Incontinence supplies | \$ |
| Laxatives | \$ |
| Liquid adhesive for small cuts | \$ |
| Menstrual cycle products for pain and cramp relief | \$ |
| Motion sickness pills | \$ |
| Nasal sinus sprays | \$ |
| Nasal strips | \$ |
| Nicotine gum or patches | \$ |
| Pain reliever | \$ |
| Pills for persons who are lactose intolerant | \$ |
| Products for muscle pain i.e., Bengay | \$ |
| Reading glasses | \$ |
| Rubbing alcohol | \$ |
| Sinus medications | \$ |
| Sleeping aids used to treat occasional insomnia | \$ |
| Special ointment/cream for sunburn | \$ |
| Wart remover treatments | \$ |
| COLUMN #3 TOTAL | \$ |

| 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 length and frequency of treatment. 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 obtained at the beginning of each plan year. | |
| EXPENSE | ESTIMATED COST |
| Health club fees/gym memberships | \$ |
| Nutritional supplements/vitamins | \$ |
| Massage therapy | \$ |
| Acne medication | \$ |
| Sunscreen/Suntan lotion | |
| Weight loss programs (i.e. Weight Watchers and Jenny Craig) Program fees are eligible but food portions are not. | \$ |
| COLUMN #4 TOTAL | \$ |

| ESTIMATED EXPENSES | |
|---------------------------------|----|
| COLUMN 1 | \$ |
| COLUMN 2 | \$ |
| COLUMN 3 | \$ |
| COLUMN 4 | \$ |
| TOTAL ESTIMATED EXPENSES | \$ |

***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 to confirm eligibility.



DEPENDENT CARE REIMBURSEMENT

If you're one of the many people who spend money on child care while at work, a Dependent Care Reimbursement Account is a logical choice. Using BASIC Flex is like getting child care on sale. The money is deducted before taxes so you don't pay federal, state, Social Security and Medicare taxes on that amount. The savings range from 15% to 40% depending upon your tax bracket.

Determine the amount to put into your Dependent Care Account and start saving. 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 (It's \$2,500 for that person but still \$5,000 for the family). Unlike the Medical Reimbursement Account, this is a pay-as-you-go account. Reimbursements are not made until funds are available. Remember, left-over money is forfeited, so elect only what you know you'll spend.

Here is an illustration of someone in a 15% tax bracket with the maximum \$5,000 election. They would save \$1,132 in one year using BASIC Flex.

REQUIREMENTS

- You and your spouse must be employed or actively seeking employment or attending school full time.
- Child care provider must claim payments as income.
- Child must be under 13 years old and considered a dependent for income tax purposes. If 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).
- Provider may not be a minor child or dependent for income tax purposes (i.e. an older child).
- If the services are provided by a day care facility, that facility must comply with state day care regulations.
- Services must be for the physical care of the child, not for education, meals, etc.
- Overnight camps are not eligible for reimbursement
- This is a pay-as-you-go account. Your employer will not advance any money.
- Expenses paid for Kindergarten are not eligible.

WEEKLY PAYROLL CHECK

Without a Flexible Spending Plan

| | |
|---|----------|
| Gross taxable wage | \$500.00 |
| Federal, FICA & State Tax | -113.25 |
| Take home pay | \$386.75 |
| Dependent care election (<i>\$5,000 divided by 52 weeks</i>) | -96.15 |
| Amount left to spend | \$290.60 |

With a Flexible Spending Plan

| | |
|---|----------|
| Gross taxable wage | \$500.00 |
| Dependent care election (<i>\$5,000 divided by 52 weeks</i>) | -96.15 |
| Taxable wage | \$403.85 |
| Federal, FICA & State Tax | -91.47 |
| Amount left to spend | \$312.38 |

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

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

ACQUAINT YOURSELF WITH THE FACTS.



WWW.BASICONLINE.COM
P 800.FSA.FLEX
F 800.391.6562

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PORTAGE, MI 49024

WHEN IN DOUBT, JUST ASK.

We realize that the IRS regulations can be confusing at times. Please call BASIC Flex, prior to election, if you have any questions about the eligibility of any item, event, service or treatment. One of our Customer Service Representatives will be happy to listen to your exact situation and advise you on the regulations that apply. Better safe than sorry.

We want your BASIC Flex plan to benefit you in every way possible.

Each plan can differ slightly. The list below applies to most plans; however, for specifics on your plan please refer to your Summary Plan Description, contact your Benefits Coordinator or BASIC Flex at 800.444.1922 x 1.

- Flex Benefits end upon termination of employment and/or participation.
- Services must be rendered during your current plan year. For new employees entering the plan during the plan year, services must be rendered after eligibility or election date.
- Refer to the Summary Plan Description booklet to find out how long you have to submit remaining claims after your plan year or coverage has ended.
- 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.
- Your pre-tax contributions through your BASIC Flex plan could reduce your future social security benefits; however studies show it is usually less than 1%.
- According to the IRS, any money left in your account becomes the property of your employer and cannot be returned to you. Most people use their remaining money by good planning . . . such as getting a physical or dental checkup, new glasses or purchase over-the-counter products. Rarely is there ever more than 5% left in the account. Your tax savings will more than outweigh this amount.

BASIC LIMITED PURPOSE FLEX

BASIC Limited Purpose Flex is a reimbursement account specifically designed for individuals with a Health Savings Account (HSA). IRS regulations state that an individual with an HSA may not simultaneously have a general purpose flex plan, but they are allowed a limited purpose flex plan. **If you or your spouse are currently enrolled or plan to enroll in an HSA during your flex plan year, a limited purpose flex plan might be just what you need.** The difference between BASIC Flex and BASIC Limited Purpose Flex is the eligible expenses. A BASIC Limited Purpose Flex plan only allows for reimbursements of dental, vision and post deductible expenses (co-insurance and co-pay expenses after your deductible has been met). With a limited purpose flex, you may still sign up for a dependent care account.



PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: _____

Participant First Name: _____ Last Name: _____

Social Security #: [] [] [] - [] [] - [] [] [] [] Date of Birth: _____ / _____ / _____

Address: _____

City, State, Zip: _____ Phone Number: _____

E-mail Address: _____ (Notification of direct deposit payment is 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
 Health Savings Account (HSA) Contributions Other _____

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 (not to exceed employer limit of \$ _____)
\$ _____ per pay x _____ (# of pays in plan year) = \$ _____ Annually (do not round)
 Is this Medical Reimbursement Account a Limited Purpose Account (see page 6)
 I elect NOT to participate

DEPENDENT CARE ACCOUNT

- I elect to participate (not to exceed \$5000 or \$2500 if married filing separately)
\$ _____ per pay x _____ (# of pays in plan year) = \$ _____ Annually (do not round)
 I elect NOT to participate

DIRECT DEPOSIT (not all employers allow direct deposit as a reimbursement option)

- I elect to participate (there is no need to complete this section, unless you are changing accounts)
 checking account OR savings account

CHECK EXAMPLE

Routing number account number check number

Financial Institution (name of bank): _____

Routing Number (always 9 digits): [] [] [] [] [] [] [] [] [] Account Number: _____

If you would prefer, you can attach a voided check.

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 will 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