



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

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 **1** \$ _____
 25% and 40% on
 FICA, federal & **2** \$ _____
 state income tax
 (in applicable states) = \$ _____

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
<p>No Substantiation Required</p> <p>The FSA Card will work without anything further from you!</p> <p>Please keep a copy of documentation just in case.</p>	<p>Healthcare Providers with Copays:</p> <p>Hospitals Pharmacy Physician's Office Vision Care Providers Urgent Care Outpatient Surgery Centers</p> <p>Prescriptions that can be purchased at participating retailers.</p>	<p>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.</p> <p>You will receive a letter if IRS guidelines require supporting documentation.</p> <p>It's important that you keep all of your supporting documentation.</p>
<p>May require supporting documentation</p>	<p>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:</p> <ul style="list-style-type: none"> ■ Deductibles or Coinsurance ■ Spouse's insurance out-of-pocket expenses ■ Caregivers for Dependents (Dependent Care) 	<p>You will receive a letter if more information is required.</p> <p>Please submit requested documentation* no later than 30 days after the reminder letter is sent to your home to avoid having your card suspended.</p> <p>*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.</p>
<p>Cannot use the FSA Card</p>	<ul style="list-style-type: none"> ■ 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. 	<p>Expenses for OTC medications may be eligible for reimbursement from your FSA plan as long as you have a doctor's prescription.</p> <p>A doctor's prescription must be submitted with any claim for Over-the-Counter medications.</p> <p>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.</p>

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

Using Custom Flex

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



Custom Flex Login
Qualified FSA Expenses
FSA Savings Calculator
How It Works
Forms & FAQs

- Go to www.CustomDesignBenefits.com and Login to the Custom Design Benefits FSA portal.
- Click on **Custom Flex Login**.
- Follow prompts to complete your claim electronically.
User Name: First initialLastNameLast4SSN ... example: jsmith9999
Password: Customflex
- You may file a claim, check account balances, and review claims history.
- Upload documentation and submit.
- Retain a copy for your records.

MOBILE



Mobile App available for Android and Apple devices.
FREE download from the App Store (Search for "CustomFlex").



EMAIL

Complete the FSA Claim Form & attach scanned documentation to the email.

You may also use this email address for all other questions and forms.

CustomFlex@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 Cincinnati
800.598.2929 Toll-Free

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 Custom Flex.
- **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 Custom Flex Login (see image at right).



FSA - HRA

Custom Flex Login

Qualified FSA Expenses

FSA Savings Calculator

How It Works

Forms & FAQs



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
customflex@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.



Custom Design Benefits
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
CustomFlex@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
 Due to Health Care Reform any Over the Counter medications require a prescription from your physician. Prescriptions are valid for **1 Year from the date they are written**. Prescriptions submitted will be kept on file for faster claims processing, and will not need to be submitted again until the prescription has expired.

DEPENDENT CARE REIMBURSEMENT				
Name and Date of Birth of Dependent(s)	Period Covered		Name, Address & Taxpayer Identification Number of Service Provider	Claim Amount
	From	To		
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 <i>Take Care</i> FSA Card				
Patient Name and Relationship	Date of Service		Name of Service Provider and Description of Expense	Claim Amount
	From	To		
			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

To view claims and other account information visit www.CustomDesignBenefits.com and click 'Custom Flex Login'