TAX SOLUTIONS FOR PAYCHECK SAVINGS

Medical Flexible Spending Account

What is a Medical Flexible Spending Account (FSA)?

Medical FSAs are voluntary, employee-owned accounts that use pre-tax dollars to pay for out-of-pocket medical/dental/vision expenses for you and your family members including children up to age 27. The money elected for deposit into an FSA is automatically deducted tax-free from your paycheck in equal installments throughout the year.

A Medical FSA may be a good choice for you if:

- You and/or family members have regular out-of-pocket expenses, such as doctor or prescription drug co-pays, and vision expenses.
- You anticipate major dental work within the next year.

What does it cost to enroll in a Medical FSA?

There is no cost to participate, nor do you have to purchase anything. You also do not have to be covered under your company's medical plan to participate, and your spouse and children are automatically covered. The IRS requires that you forfeit any unused money, but there is a grace period for up to two and a half months after the end of the plan year in which you're allowed to incur expenses and draw upon your previous year's funds.

After determining the value of your FSA, you cannot change or discontinue that amount unless you experience a "life event," such as marriage, divorce, the birth or adoption of a child, or a change in your spouse's job status.

What are the tax savings?

Your tax savings can be anywhere from 25% - 35%, depending on your tax bracket and residence. For example, if you incur out-of-pocket expenses of $1,000, you will save $250 - $350 – a substantial savings.

Prepaid Debit Card

Each FSA participant receives a gente Prepaid Smart Card that allows you to access the allotted money in your FSA account in an easy and convenient manner. The gente card automatically deducts eligible expenses from your FSA every time you use it and the pre-tax dollars are electronically transferred to the vendor for payment.

A Summary Plan Description explaining all plan provisions and IRS requirements will be provided to each employee participating in the Medical FSA.

Dependent Care Flexible Spending Account

What is a Dependent Care Flexible Spending Account (FSA)?

A Dependent Care FSA is a voluntary, employee-owned account that uses pre-tax dollars to pay for daycare expenses for eligible dependents. The IRS determined that eligible dependents are dependent children under 13 years, a disabled child more than 13 years, or a parent/spouse who is physically or mentally unable to care for themselves and whom you can claim as a dependent on your income tax return. Also, if your spouse is employed, actively seeking employment or is a full-time student, you may participate in this program.

The IRS has specified the following as qualified expenses:

- The cost of day care at home or away, as long as not provided by someone you claim as a dependent
- After-school care
- Nursery school
- Day camp (not overnight)
- Elder care

What is the Dependent Care FSA Maximum Amount?

The maximum amount allowed must not exceed $5,000 if you're married and filing jointly, or $2,500 if you are filing separately.

It is important to note that when using a Dependent Care FSA to pay for child care expenses, you cannot claim the same expenses as a Federal tax credit since your deductions are taken on a pre-tax basis. Your estimates should be based on your current child care expenses for an eligible dependent.

A Summary Plan Description explaining all plan provisions and IRS requirements will be provided to each employee participating in the Dependent Care FSA.

IRS Eligible Medical Expenses

The IRS defines eligible health care expenses as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness. With this in mind, listed below are many of the medical expenses eligible for payment under a Flexible Spending Account that are not covered by your medical or dental insurance. This list is not meant to be all-inclusive.

DENTAL SERVICES

Crowns/Bridges
Dental X-Rays
Dentures
Exams/Teeth Cleaning
Extractions
Fillings
Gum Treatment Oral Surgery
Orthodontia/Braces

INSURANCE RELATED ITEMS

Co-pay and coinsurance amounts
Deductibles
Pre-existing condition expenses (medical)
Private hospital room differential

LAB EXAMS/TESTS

Blood Tests
Cardiographs
Diagnostic
Laboratory fees
Metabolism tests
Spinal fluid tests
Urine/stool analyses
X-rays

MEDICATION

Insulin
Prescribed birth control
Prescribed vitamins
Prescribed drugs

OBSTETRIC SERVICES

Lamaze class
Mid-wife expenses
OB/GYN exams
OB/GYN prepaid maternity fees (reimbursable after date of birth)
Post-natal treatment
Pre-natal treatment

PRACTITIONERS

Allergist
Chiropractor
Christian Science
Dermatologist
Homeopath
Naturopath
Osteopath
Physician
Psychiatrist
Psychologist

OTHER MEDICAL TREATMENTS/ PROCEDURES

Acupuncture
Alcoholism/Substance abuse
Bio-feedback therapy (in medically necessary situations)
Reconstructive surgery (if medically necessary due to a congenital defect or accident)
Drug addiction
Hearing exams
Hospital services
Infertility
In-vitro fertilization
Norplant insertion or removal
Patterning exercises
Physical examination (not employment related)
Physical therapy
Rolfing
Speech therapy
Sterilization
Transplants (including organ donor)
Vaccinations/immunizations
Vasectomy and vasectomy reversal
Weight loss program*
Well baby care

OTHER MEDICAL EQUIPMENT, SUPPLIES AND SERVICES

Abdominal/back supports
Ambulance services
Arches/orthopedic shoes
Bandages
Contraceptives, prescribed
Counseling
Crutches
Guide dog (for visually/hearing impaired person)
Hearing aids & batteries
Hospital bed
Learning Disability (special school/ teacher)
Lead Paint Removal (if not capital expense and incurred for a child poisoned)
Medic alert bracelet or necklace
Oxygen equipment
Prescribed medical and exercise equipment
Prosthesis
Splints/casts
Support hose (if medically necessary)
Syringes
Transportation expenses (essential to medical care)
Tuition fee at special school for disabled child
Weight loss drugs (to treat a specific disease)
Wheelchair
Wigs (hair loss due to disease)

VISION SERVICES

Artificial eyes
Contact lenses
Contact lens solution
Eye examinations
Eyeglasses
Laser eye surgeries
Ophthalmologist
Optometrist
Prescribed sunglasses
Radial keratotomy/LASIK

Ineligible Expenses

The following expenses are ineligible for reimbursement for a Medical FSA under IRS regulations. Expenses to promote general health are not eligible unless prescribed by a physician for a specific medical ailment. This list is not meant to be all-inclusive.

GENERAL

Baby-sitting & child care
Canceled appointment fees
Contact lens insurance
Cosmetic surgery/procedures
Dancing/exercise programs
Diaper service
Discounts/write-offs
Electrolysis
Exercise equipment
Eyeglass insurance
Fitness programs
Hair loss medication
Hair transplant
Health club dues
Illegal operation or treatment
Insurance premium interest charge
Insurance premiums
Marriage counseling
Massage therapy*
Maternity clothes
Nutritional supplements
Personal trainer*
Prescription drug discount program premiums
Rogaine
Student health fee
Swimming lessons
Teeth whitening/bleaching
Vision discount program premiums
Vitamins (for general health)

OVER-THE-COUNTER MEDICATIONS

Over the counter medications are covered with a doctor's prescription.

* Eligible only with a doctor's certification identifying the physical nature of the medical condition and length of treatment program. Massage therapy for the sole purpose of tension/stress relief does not qualify as an eligible expense.

FSA Worksheet

Your FSA allows you to pay for eligible medical and day care expenses on a pre-tax basis. The money elected for deposit into an FSA is automatically deducted in equal installments from your gross pay before federal, state (except NJ), local and Social Security taxes are withheld. You will have the option to participate in the medical or daycare FSA, or both, each plan year. This worksheet will help you calculate how much to deposit for your expenses for you and your family members. The IRS requires that you forfeit any unused money but there is a grace period for up to two and a half months after the end of the plan year in which you're allowed to incur expenses and draw upon your previous year's funds.

MEDICAL CARE FSA

Medical/Dental/Vision Expenses* List the amount you spend for:	**Prior Year Actual Expenses***	**Projected Expenses***
Co-payments\Co-insurance	$	$
Deductibles	$	$
Prescription drug co-pays	$	$
Vision care (eye exams, glasses contact lenses & supplies)	$	$
Well-child care	$	$
Maintenance for chronic medical conditions (e.g. diabetic supplies)	$	$
Dental & orthodontic services	$	$
Other (any approved IRS expense)	$	$
Total	$	$

*Not covered or partially covered under any group insurance plan.

DAY CARE FSA

List the amount you spend for:	**Prior Year Actual Expenses**	**Projected Expenses**
In-Home day care	$	$
Day care center	$	$
Nursery school	$	$
Summer day camp (e.g. YMCA, sports camps, etc.)	$	$
After-school care	$	$
Total	$	$

Check out our website at: www.gente.solutions. A Health Care Expense Table can be accessed by clicking on "Tax Favored Accounts" then at the bottom clicking on "Health Care Expense Table". You will be redirected to My FSA Store where you can access a full listing of eligible expenses.

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FSA/DCAP ELECTION FORM

122 Parish Drive, Wayne, NJ 07470

Employer Name:			
Employee Last Name, First Name:			**Social Security #:**
Home Address (include apt #):			**Date of Birth:**
City	**State:**	**Zip:**	**Date of Hire:**
Email Address:	**Phone #:**	**Gender M/F:**	**Marital Status S/M/D/W:**

DEPENDENTS TO BE COVERED UNDER THE FSA

Last Name	First Name	Relationship	Date of Birth

AUTHORIZATION OR WAIVER OF PARTICIPATION

Medical Care Spending Account

☐ **I elect to participate in the Medical Care *FSA*. I direct my employer to reduce my annual salary for the current Plan Year by $_____($2,700 maximum)**

☐ **I *do not* elect to participate in the *Medical Care FSA***

Dependent Care Spending Account

☐ **I elect to participate in the Dependent Care FSA. I direct and authorize my Employer to reduce my annual salary for the current Plan Year by $_____**

☐ **I do not elect to participate in the Dependent Care Spending Account**

I hereby apply for the options listed above. I authorize my employer to adjust my pay as required by my election. I acknowledge that my election is irrevocable and will remain in force throughout the plan year unless there is a change in my family status. A change in family status includes: marriage; divorce; death of the spouse or dependent; birth or adoption of a child; a change in the spouse's employment status; or termination. I WILL FORFEIT ANY UNUSED MONEY REMAINING IN MY ACCOUNT AS OF THE END OF THE PLAN YEAR OR WHEN MY PARTICIPATION IN THE PLAN ENDS.

Employee Signature: _____Date: _____

Please return this form to your Benefits/Human Resources Administrator

---------- **FOR EMPLOYER USE ONLY** ----------

*** Required Fields / Must be completed for enrollment to be processed**

Pay Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly	**Plan Effective Date: ___/___/_____**
Salary Reduction Will Begin: ___/___/_____	**Pay Cycle Deduction Amount $_____**
Employer Representative Signature:	**Date: ___/___/_____**

Note: Partners, Sole Proprietors, Owners of an LLC and 2% or more owners of a sub-chapter S Corporation are not permitted to participate in a Medical FSA program.

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