VOLUNTARY BENEFITS ADMINISTRATORS, INC.

CAFETERIA PLAN ADMINISTRATION

LICOA

Contact: CASSIE CHAPMAN
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Toll Free Fax (866) 729-3539

Cafeteria Plans are the perfect solution for coping with the high cost of medical and dependent care. Whether you're an employer looking to offset benefit cut-backs, a consultant, or an insurer searching for that perfect solution to help bridge the gap, we can offer you an affordable Cafeteria Plan solution that benefits both employers and employees.

POPs are the simplest form of a Cafeteria Plan. POPs can be implemented quickly and easily with very little effort and ongoing administration.

Premium Only Plan (POP) Services

The Premium Only Plan (POP), provided under Section 125 of the Internal Revenue Code, allows your employees to pay their premiums for employer-sponsored insurance such as health, dental, vision, disability, accident, and group life ($50,000 maximum) on a pre-tax basis. Payroll tax savings give your employees more take-home pay, and your company gets a tax break. Both the employer and the employees profit!
VBA offers the following POP deluxe administration services:

» Up to date legal documents and administrative forms

» Initial benefitelectionforms

» Discrimination testing worksheet

» Legal documents and administrative forms

» Phone support concerning legal and administrative practices of a 125 plan

» Initial benefit election forms plus re -enrollment forms are personalized including election amounts

» Reports for payroll setup for employee deductions

» Pay cycle contribution billing reports for reconciliation with payroll

» Non-discrimination tests, with reports to employer as needed if the necessary information is provided

» Advice on any known plan compliance issues

» Change of Status election processing for easy re-enrollment

The Premium Only Plan (POP) permits employees to have their insurance premiums deducted from their paycheck on a pre-tax basis. The POP plan reduces taxes without reducing benefits.

Benefit Adminstration *you can* **Depend On**

Cafeteria Plan Administration

Flexible Spending Account (FSA)

A Cafeteria Plan allows employees to pay for their employer-sponsored insurance premiums with pre-tax dollars. The employer may also implement a Flexible Spending Account into the Cafeteria Plan, which allows employees to also pay for expenses like deductibles, coinsurance, co-pays, prescription drugs, vision expenses, dental expenses, day care services, and privately owned insurance policies with pre-tax dollars. Even the most comprehensive insurance policies have out-of-pocket expenses. FSAs can help your employees save on these expenses.

Flexible Spending Accounts encompass all the aspects of a POP plan with these additional value-added services:

» Case setup / employee communication

» Online / onsite enrollment

» Claims submission to VBA (not HR office)

» Claims adjudication tailored to employer schedule (daily reimbursement available)

» Payments via direct deposit, check, debit card, or credit card

» Online participant inquiry and reporting

» Online employer module and reporting

The following Benefits can be added to a Cafeteria Plan:

Health Savings Accounts
Employees can put pre-tax dollars into a interest-bearing account and use those funds tax--free for medical expenses.

Dependent Care Flexible Spending Accounts
Employees can use payroll withholding of pre-tax dollars to pay for work-related expenses associated with the care of a live-in dependent, such as a child or elderly relative.

Premium Reimbursement Accounts
Employees can set aside pre-tax dollars for the costs of insurance premiums. Premiums are only eligible if the insurance policy is an individual policy purchased by the employee.

By implementing an FSA into your Cafeteria Plan, you can reduce your employees' taxable compensation. You are also giving your employees a way to pay for out-of-pocket medical expenses, work-related daycare expenses, and privately owned insurance policies.

VBA Flex Plans are as simple as a payroll deduction

Medicine isn't old fashioned anymore...

why should your reimbursement methods be?

When you go to the doctor, you expect the best modern medical treatment of the day that science and medicine have to offer. When you go to pay, shouldn't you use the best modern method of payment and reimbursement your health plan administrators have to offer?

When seeking reimbursement from your group health plan you can:

Do things the old fashioned way and pay cash or write the provider a check, mail in your receipts with a claim form and wait for a reimbursement check in the mail

OR

Do things a newer, better way and swipe your mySourceCard® to have your medical bills paid instantly from your accounts.

Instant Access to Funds

The days of filing claims and waiting for reimbursement checks are drawing to a close. With your mySourceCard®, you will be able to have instant access to your Flexible Spending Account and Health Reimbursement Arrangement funds right when you need them. No more waiting!

IIAS

With the implementation of the new Inventory Information Approval Systems (IIAS) technology at major retailers and pharmacies, using the card is even easier! Your mySourceCard® will only be charged for items marked as eligible at the point of sale, eliminating the hassle of repaying your account over ineligible purchases. The IIAS also ensures that your "claim" is entered the moment you swipe the card. No worrying about submitting receipts and paperwork!

Ask today about how you can get a mySourceCard® of your own for instant easy access to your health plan dollars.

How the mySourceCard® will work for you:

- Gives flexible access to your money
- Eliminates wait for reimbursements
- Never submit a paper claim again
- Account information available 24/7 on the secure myRSC.com web portal

VBA Inc. Cafeteria Plan Services & Minimum Charges

Premium Only Plan (POP)

FEES

- Annually $150 (this fee is waived if LICOA products are implemented)

Implement Services Include:

- Plan Document, Adoption Agreement and Corporate Resolution
- Summary Plan Description and Plan Information Summary
- Administrator's Guide
- Benefit Election Forms

Administrative Assistance Services Include:

- Processing Employee Additions, Terminations and Changes
- Advising Plan Administration of Any Known Plan Compliance Issues
- Providing Monthly, Quarterly and Annual Administrative Reports if necessary
- Re-Enrollment packages with pre-printed election forms for every employee

Annual Compliance and Reporting Services Include:

- Testing for Non-Discrimination if necessary information is provided to VBA, Inc.
- Reviewing and Updating Plan and Other Documents As Needed

Flexible Spending Accounts (FSA)

FEES:

- $150.00 Annually (this fee is waived if LICOA products are implemented)
- $3.00 Monthly Fee PER FSA Participant
- $2.00 Fee for Replacement Debit Cards whether lost or stolen

Implement Services Include:

- Plan Document, Adoption Agreement and Corporate Resolution
- Summary Plan Description and Plan Information Summary
- Administrator's Guide
- Benefit Election Forms

Administrative Assistance Services Include:

- Processing Employee Additions, Terminations and Changes
- Advising Plan Administration of Any Known Plan Compliance Issues
- Providing Monthly, Quarterly and Annual Administrative Reports if necessary
- Re-Enrollment packages with pre-printed election forms for every employee

Annual Compliance and Reporting Services Include:

- Testing for Non-Discrimination if necessary information is provided to VBA, Inc.
- Reviewing and Updating Plan and Other Documents As Needed

FSA's are the way to go and give your clients more tax savings. POP Plans are only ½ a plan!

Cafeteria Installation Checklist

1) **Discuss cafeteria plan with management.**

2) **Point out the information in the brochure, stress the compliance issues and tax savings.**

3) **Point out that POP Plans are only ½ a plan and VBA has simplified the process to take advantage of ALL the potential tax savings. Discuss reimbursement options and how flexible our plans can be set up.**

4) **For a formal proposal, complete the requested information in the brochure and forward to VBA. We will mail or email you the proposal. Call VBA for clarification of any issues.**

5) **Complete Data Gathering Form and Discrimination Questionnaire and forward to VBA for document preparation.**

6) **Be sure to include the contact person or payroll manager in the discussions. It is important that these people are comfortable with the process especially when FSA's are implemented.**

7) **Deliver and review documents with management. Get the documents signed and arrange the enrollment schedule.**

8) **At this point it is important to include Dept. Heads / Supervisors in the planning. If they are made to feel as part of the decision process, you will have much better co-operation from them. Go over the introductory material with them and find out what is the best way to get the same information to their people. Schedule the enrollment time and place and how it will be accomplished.**

9) **VBA will set up the plan, perform the discrimination testing and advise of any necessary adjustments if necessary information is provided to VBA, Inc.**

Sample Company
P.O. Box 132 607 Broad St.
Gadsden, AL 35902-0132

Date: June 16, 2021

To: All Employees

Do you want to get more spendable dollars out of your paycheck—and give less money to Uncle Sam? If so, you will love our new Cafeteria Plan.

This exciting program lets you take advantage of current tax laws by permitting you to pay for your health insurance *before-taxes are figured.* Why is this so exciting? It's simple—*it saves you money!* Look at how this benefit gave one employee more money to spend.

	Without this Plan	**With this Plan**
Gross Salary	$1500	$1500
Insurance Premiums	0	-173
Taxable Salary	1500	1327
Less Taxes (Federal, State, FICA)	-375	332
Less Insurance Premiums	-173	0
SPENDABLE PAY	**$952**	**$995**

This employee received $43 more to spend each month ($516 annually) through their Cafeteria Plan.

Your Plan goes into effect soon. You will receive further details on the Plan and how to sign up for this new benefit. ***Watch for it.***

Sincerely,

Bookkeeper

Sample Company Cafeteria Plan

Is Right For You

Whether you're a single person, single parent, part of a dual-income household, or a family person with a non-working spouse, DPI125 will provide you with additional benefits, more take home pay, and even allow you to establish an additional retirement plan with your tax-free dollars.

Single Parents

In the illustration below, the single parent earns $19,200 and has two children. She uses DPI125 to pay the premium for dependent medical coverage and to pay for the cost of medical deductibles and dental care this year. In addition, she has opted to pay her child care expenses out of her pre-tax dollars. In this way, she increases her take home pay by $109 each month … or $1,308 this year. That's an additional 15% take home pay

Working Couples

This man and wife both work. They have two children. The husband makes $27,500 and his wife earns $14,500 per year. They use DPI125 to help pay the premium for dependent medical coverage and pay for the orthodontist bills for the children. With both of them working, they also utilize the plan to pay for necessary childcare expenses. The chart shows that this couple increases their monthly take-home by $220 … or $2,640 this year. That gives them additional money for the emergency expenses every family has … and allows them to set some money aside to fund an additional retirement plan!

Family Person with Non-Working Spouse

With grown children, and only one spouse working, this couple has no childcare expenses. The annual salary of the working spouse is $48,000. They use DPI125 to pay the premium for dependent medical coverage, meet their medical deductibles, and pay dental expenses. DPI125 gives this couple an additional $134 monthly take-home, or $1,608 this year … a nice raise for the family budget!

	The Single Parent		Working Couples		Family Person	
	Without DPI125	**With DPI125**	Without DPI125	**With DPI125**	Without DPI125	**With DPI125**
Total Monthly Pay	$1,600	**$1,600**	$3,500	**$3,500**	$4,000	**$4,000**
Less Non-Taxable Benefits						
Insurance Premiums	0	**$187**	0	**$291**	0	**$379**
Medical/Dental Expenses	0	**$60**	0	**$100**	0	**$75**
Childcare Expenses	0	**$175**	0	**$350**	0	**0**
Total Pay Subject To Tax	$1,600	**$1,178**	$3,500	**$2,759**	$4,000	**$3,546**
Less Deductions						
Federal & State Taxes*	$192	**$115**	$487	**$324**	$667	**$568**
Social Security Tax	$122	**$90**	$268	**$211**	$306	**$271**
After Tax Income	$1,286	**$973**	$2,745	**$2,224**	$3,027	**$2,707**
After Tax Expenses						
Insurance Premiums	$187	**0**	$291	**0**	$379	**0**
Medical/Dental Expenses	$60	**0**	$100	**0**	$75	**0**
Child-Care Expenses**	$175	**0**	$350	**0**		
Spendable Income	$864	**$973**	$2,004	**$2,224**	$2,573	**$2,707**
Annual Increase In Take-Home Pay		**$1,308**		**$2,640**		**$1,608**

*Federal and State taxes reflect 2000 Federal Tax rates and typical state taxes

**Does not include any available tax credit for child care expenses

VOLUNTARY BENEFITS ADMINISTRATORS, INC.

PREMIUM REDUCTION OPTION

DATA GATHERING FORM

Name of Organization: _____

(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Federal Employer ID No: _____ Date Incorporated/Organized: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address: _____ Zip: _____

Organization Type:

- ☐ Corporation
- ☐ Professional Corporation
- ☐ Partnership
- ☐ Government Agency
- ☐ Other _____
- ☐ Sub-chapter "S" Corporation
- ☐ Professional Association
- ☐ Sole Proprietorship
- ☐ LLC Limited Liability Company

NOTE: Only employees can participate in a cafeteria plan. Thus, while partnerships, sole proprietorships and Sub-chapter "S" corporations may sponsor cafeteria plans, the following cannot participate: sole proprietors, partners, and greater than 2% shareholders in Sub-chapter "S" corporations.

The Employer/Organization entity is operating pursuant to the laws of the State of _____

Principal Business Activity Code: __ __ __ __ __ __

Nature of Business: _____

PLAN ELECTIONS SECTION 125 CAFETERIA PLAN

Original Plan Begin Date: ___/___/___ Amended Plan New Year Begins: ___/___/___

Current Plan Effective Date: ___/___/___ Amended Plan New Year End Date: ___/___/___

Current Plan End Date: ___/___/___

ELIGIBILITY REQUIREMENTS

1. Number of eligible employees: _____
2. The following class of employees is eligible to participate
   ___ All ___ Salaried Employees Only ___ Hourly Employees Only
   ___ Other _____
   Tax penalties may be imposed if the Plan contains eligibility requirements that have the effect of favoring highly compensated employees. Consult your tax advisor before limiting participation in the Plan.
3. The following employees are excluded from participation:
   - ☐ No Exclusions.
   - ☐ Part-time employees normally expected to work less than _____ hours a week.
   - ☐ Employees under the age of _____.
   - ☐ Union employees (unless the bargaining agreement provides for coverage).
   - ☐ Non-resident aliens.
   - ☐ Other:_____

   Section 125 does not specifically provide for election exclusions. Consult your tax advisor before excluding any classification(s) of employees.
4. The service period employees must complete before being eligible to participate is as follows:
   - ☐ As of date of hire or Plan effective date.
   - ☐ Number of days after date of hire: _____
   - ☐ Number of months after date of hire: _____

   Employees must be in service or on the job as one of the requirements.

5. Once the employees are eligible, they can begin participating in the plan:
   - ☐ First day of pay period following the date employee becomes eligible.
   - ☐ First day of month following the date employee becomes eligible.
   - ☐ First day of quarter following the date employee becomes eligible.
   - ☐ First day of Plan Year following the date employee becomes eligible.
6. Payroll Frequency

   ___ Weekly ___ Bi-weekly ___ Semi-monthly ___ Monthly

BENEFITS

Check the benefits to be offered under this Plan:

- ☐ Core Health Benefits (Group Health)
- ☐ Non-Core Supplemental Health Benefits (Dental, Accident, Cancer, Heart, & Vision)
- ☐ Group Term Life Benefits (50,000 Maximum Employee Only)
- ☐ Short Term Disability Benefits
- ☐ Long Term Disability Benefits
- ☐ Health Savings Accounts

BENEFIT COORDINATOR

The Benefit Coordinator is the individual at the Employer with whom Employees should communicate.

Name: _____ Title: _____

Telephone: _____ Fax: _____

E-mail: _____ Website: _____

OWNER, MANAGER, OR OFFICER AUTHORIZED TO ESTABLISH OR CHANGE CAFETERIA PLAN

Name: _____ Telephone: _____

Title: _____ E-mail: _____

ENROLLMENT & SERVICING AGENT

Name: _____ Telephone: _____

Title: _____ E-mail _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Fees:

Free if LICOA products are being offered.

If no LICOA products are being offered, fee will be $150.

Sec. 125 Cafeteria Plan Premium Reduction Option
Benefit Election Form and Salary Reduction Agreement

Employer Name

Employee Name (Last, First, MI) Social Security No.

Employee Street Address City, State, Zip Code

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown under the Premium Conversion and Reimbursement Accounts headings shown below and to deduct from after-tax income the post-tax items shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date the Plan. I further authorize future adjustments in the amount of the salary reduction in the even the cost of coverage in any problem selected below under the heading PREMIUM CONVERSION is changed by the carrier during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction or after-tax deduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit (All amounts paid should be per deduction period) **Salary Reduction per Pay Period**

Premium Conversion

Medical ..... $_____

Dental ..... $_____

Vision ..... $_____

Cancer ..... $_____

Term Life (up to $50,000 including company contribution) ..... $_____

Other: _____ $_____

Pretax Deduction for Insurance Premiums ..... $_____

Total Deductions ..... $_____

I have read the Summary Plan Description and the attached Plan Information Summary that has been given to me.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as listed on the Status Change Matrix I received with the Summary Plan Description.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate.**

Signature_____ Date_____

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate.**

Signature_____ Date_____

VOLUNTARY BENEFITS ADMINISTRATORS, INC.

PREMIUM REDUCTION OPTION PLUS FSAs

DATA GATHERING FORM

Name of Organization: _____
(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Federal Employer ID No: _____ Date Incorporated/Organized: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address: _____ Zip: _____

Organization Type:

- ☐ Corporation
- ☐ Professional Corporation
- ☐ Partnership
- ☐ Government Agency
- ☐ Other _____
- ☐ Sub-chapter "S" Corporation
- ☐ Professional Association
- ☐ Sole Proprietorship
- ☐ LLC Limited Liability Company

NOTE: Only employees can participate in a cafeteria plan. Thus, while partnerships, sole proprietorships and Sub-chapter "S" corporations may sponsor cafeteria plans, the following cannot participate: sole proprietors, partners, and greater than 2% shareholders in Sub-chapter "S" corporations.

The Employer/Organization entity is operating pursuant to the laws of the State of _____
Principal Business Activity Code: __ __ __ __ __ __

Nature of Business: _____

PLAN ELECTIONS SECTION 125 CAFETERIA PLAN

Current Plan Effective Date: ___/___/___ New or Amended Plan Year Begins: ___/___/___

Current Plan End Date: ___/___/___ New or Amended Plan End Date: ___/___/____

Grace Period 2.5 Months ____ OR Rollover $500 _____

ELIGIBILITY REQUIREMENTS

1. Number of eligible employees: _____
2. The following class of employees is eligible to participate
   ___ All ___ Salaried Employees Only ___ Hourly Employees Only
   ___ Other _____
   Tax penalties may be imposed if the Plan contains eligibility requirements that have the effect of favoring highly compensated employees. Consult your tax advisor before limiting participation in the Plan.
3. The following employees are excluded from participation:

- ☐ No Exclusions.
- ☐ Part-time employees normally expected to work less than _____ hours a week.
- ☐ Employees under the age of _____.
- ☐ Union employees (unless the bargaining agreement provides for coverage).
- ☐ Non-resident aliens.
- ☐ Other:_____

Section 125 does not specifically provide for election exclusions. Consult your tax advisor before excluding any classification(s) of employees.

4. The service period employees must complete before being eligible to participate is as follows:
   - ☐ As of date of hire or Plan effective date.
   - ☐ Number of days after date of hire: _____
   - ☐ Number of months after date of hire: _____

   Employees must be in service or on the job as one of the requirements.

5. Once the employees are eligible, they can begin participating in the plan:
   - ☐ First day of pay period following the date employee becomes eligible.
   - ☐ First day of month following the date employee becomes eligible.
   - ☐ First day of quarter following the date employee becomes eligible.
   - ☐ First day of Plan Year following the date employee becomes eligible.

6. Payroll Frequency
   - ☐ Weekly 52 beginning (date)_____
   - ☐ Bi-Weekly beginning (date)_____
   - ☐ Semi-Monthly _____
   - ☐ Monthly beginning _____
   - ☐ Any Omitted weeks _____

Include information on any exceptions_____
_____
_____
_____

BENEFITS

Check the benefits to be offered under this Plan:

- ☐ Core Health Benefits (Group Health)
- ☐ Non-Core Supplemental Health Benefits (Dental, Accident, Cancer, Heart, & Vision)
- ☐ Group Term Life Benefits (50,000 Maximum Employee Only)
- ☐ Short Term Disability Benefits
- ☐ Long Term Disability Benefits
- ☐ Health Savings Accounts
- ☐ Dependent Care FSA
- ☐ Health FSA
- ☐ Health Premium Reimbursement
- ☐ Cash Benefits

7. _____ Election must be made every year OR _____ Election rolls over by default (Evergreen)

CONTRIBUTIONS

Medical FSA Minimum: _____ Maximum: ($2750.00 for 2021) $_____
(Subject to changes by IRS)

Dependent Assistance: Minimum: $_____ Maximum: ($5000.00) $_____

BENEFIT COORDINATOR
THE BENEFIT COORDINATOR IS THE INDIVIDUAL AT THE EMPLOYER WITH WHOM EMPLOYEES SHOULD COMMUNICATE.

Name: _____ Title: _____

Telephone: _____ Fax: _____

E-mail: _____ Website: _____

OWNER, MANAGER, OR OFFICER AUTHORIZED TO ESTABLISH OR CHANGE CAFETERIA PLAN

Name: _____ Telephone: _____

Title: _____ E-mail: _____

ENROLLMENT & SERVICING AGENT

Name: _____ Telephone: _____

Title: _____ E-mail _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

BANK ACCOUNT ATTACH VOID CHECK (DO NOT COMPLETE IF VBA ACCOUNT IS USED)

(Fill the information below out only if the employer will be using their own bank account to fund accounts)

Name of Bank: _____

Bank Address:_____

Bank City:_____ Bank State:_____ Bank Zip Code:_____

Name on Account:_____

Account Number:_____

Bank Routing No. (MICR) (ex: 123456789):_____

Bank Routing No. (Bank Info) (ex: 111-42/348):_____

Person Signing check:_____

Standard Fees:

- ☐ Monthly Participant Admin Fees:$ 3.00 per employee, includes 2 debit cards
- ☐ Annual Fee of: $ 150.00 initially and for each subsequent plan year.
- ☐ Annual Fees waived for LICOA clients offering LICOA products exclusively.
  Please note that employers will still have a monthly participant fee.

Complete this statement to waive fees:

We will offer LICOA payroll deductions insurance plans exclusively to our employees during the plan year. Employees with other carriers will not be required to change their deductions. LICOA will offer limited underwriting on certain plans for employees desiring to make a change. Our representatives will provide you with the guidelines.

_____ _____

Signature of authorized person Date

Sec. 125 Cafeteria Plan Premium Reduction Option *Plus* FSAs
Benefit Election Form and Salary Reduction Agreement

Employer Name

Employee Name (Last, First, MI) Social Security No.

Employee Street Address City, State, Zip Code

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown under the Premium Conversion and Reimbursement Accounts headings shown below and to deduct from after-tax income the post-tax items shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date the Plan. I further authorize future adjustments in the amount of the salary reduction in the event the cost of coverage in any program selected below under the heading PREMIUM CONVERSION is changed by the carrier during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction or after-tax deduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit (All amounts paid should be per deduction period)	**Salary Reduction per Pay Period**
Premium Conversion	
Medical	$_____
Dental	$_____
Vision	$_____
Cancer	$_____
Term Life (up to $50,000 including company contribution)	$_____
Other: _____	$_____
Pretax Deduction for Insurance Premiums	$_____
Reimbursement Accounts	
FSA Medical Expenses	$_____
FSA Dependent Care	$_____
Pretax Deduction for Reimbursement Accounts	$_____
Post Tax Deductions	
Employee Life exceeding $50,000	$_____
Spouse Life	$_____
Dependent Life	$_____
Post Tax Deduction (Non-Section 125 Benefits)	$_____
Total Deductions	$_____

I have read the Summary Plan Description and the attached Plan Information Summary that has been given to me.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as listed on the Status Change Matrix I received with the Summary Plan Description.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate.**

Signature_____ Date_____

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate.**

Signature_____ Date_____

How Much Can I Save?

Annual Tax Savings Calculator

Example Based on Arkansas Resident
Married Filing Jointly

Without a Section 125 Cafeteria Plan

Gross Taxable Income	$38,000
Federal Income Tax	$ 3,490
Social Security/Medicare Taxes	$ 2,907
State Income Tax	$ 1,534
Spendable Income	$30,069
Less Dependent Day Care Expense	$ 5,000
Less Out-of-Pocket Medical/Dental/Vision	$ 2,000
Net Take-Home Pay	**$23,069**

With a Section 125 Cafeteria Plan

Gross Taxable Income	$38,000
Less Dependent Day Care Expense	$ 5,000
Less Out-of-Pocket Medical/Dental/Vision	$ 2,000
Taxable Income	$31,000
Federal Income Tax	$ 2,440
Social Security/Medicare Taxes	$ 2,372
State Income Tax	$ 1,112
Net Take-Home Pay	**$25,076**

Increase In Annual Spendable Income Through Section 125 Plan For This Sample Participant

$2,007

FSA Worksheet

Use this to estimate the amount you want to set aside in your flexible spending accounts

Insurance Deductibles	$_____
Insurance Co-Pays	$_____
Dental Deductibles	$_____
Dental Expenses	$_____
Vision Deductibles	$_____
Vision Expenses	$_____
Hearing Expenses	$_____
Prescriptions	$_____
Medical Equipment	$_____
Chiropractor	$_____
Other Medical Expenses	$_____
Total Out-of-Pocket Medical Expenses	$_____
Divide by No. of Pay Periods Per Year	÷_____
= Per-Payroll Deduction For Health FSA	$_____

Dependent Care for Children under 13 years of age

Cost Per Week	$_____
Multiply by 52 weeks	X_____
Total Annual Cost (Maximum $5,000)	$_____
Divide by No. of Pay Periods Per Year	÷_____
= Per-Payroll Deduction For DCAP	$_____

Get Reimbursed with the Swipe of a Card

Get Connected to Your:

- Flexible Spending Account
- Cafeteria Plan
- Dependent Care Reimbursement
- Parking/Transit Reimbursement Account
- Health Reimbursement Arrangement
- Health Savings Account

This MasterCard® Debit Card Reduces...

- Out-of-Pocket Expenses
- Claim Forms
- Reimbursement Checks

Advantages of the mySourceCard®

- Get instant reimbursement for goods and services at the point of sale
- Payment comes directly from your reimbursement account — no more paying cash out of your pocket
- Reduces the need for those lengthy claim forms and the long wait for reimbursement checks
- Online access to real-time account information — allowing you to review transactions and check your balance at any time — at **www.myrsc.com**

Important Things to Remember When Using the mySourceCard®:

- Keep all your receipts. Your plan administrator may request them to verify expense eligibility
- You can only use the card for qualified purchases at authorized merchants
- You can only use the card up to the amount available in your account. Any charge above this amount may cause the entire transaction to be denied
- You have 24/7 access to account information at **www.myrsc.com**

Simplify your life with the swipe of a card!

For more information on how to get connected to your employee benefits, visit www.mysourcecard.com.

mySourceCard® FAQs:

Where can I use the card?

You receive hassle-free reimbursement for goods and services at qualified locations, such as:

- Hospitals and Surgery Centers
- Physician and Dentist Offices
- Vision Service Locations
- Pharmacies
- Daycare Facilities
- Transit and Parking Facilities

How do I use the card?

Simply present the mySourceCard® as payment for qualified goods and services. Qualified purchases will be paid directly from your reimbursement account.

How is this card different?

For the most part, your card works just like any other debit card, with two important differences:

1. It is limited to specific merchants and eligible expenses, which are determined by the benefit account you have selected.
2. You can't use it at an ATM or for "cash back" when making a purchase.

What's an Eligible Expense?

Depending on the benefits plan you have selected from your employer, it can include anything from hospital stays and doctor visits to prescription drugs, eyeglasses, daycare services, transit and parking passes.

What's an Ineligible Expense?

Anything that's not listed in your benefit plan documents. It's important to note that you are responsible for how you use the card. If you are not sure if something is eligible, check with your administrator.

What if there's not enough money in my account?

The transaction may be denied. If that occurs, you'll have to pay for the expense yourself and submit a receipt and a claim form to your administrator for reimbursement.

What if my doctor or daycare doesn't accept MasterCard®?

You'll need to pay with cash or check and submit a receipt to your plan administrator for reimbursement.

What exactly is this card for?

mySourceCard® is a MasterCard® debit card designed to reduce your out-of-pocket expenses and speed up your reimbursement. This card allows you to pay for qualified expenses — at authorized locations that accept MasterCard® — without having to file a claim and wait for reimbursement.

mySOURCE® CARD

www.mysourcecard.com

The mySourceCard® MasterCard®
Debit Card is issued by

Armstrong BANK

Issued by Armstrong Bank, the mySourceCard® can be used only for qualified purchases as set forth in your plan document(s) and only at authorized MasterCard® acceptance locations. No cash access.

*my*SourceCard® Enrollment Kit

Dear Employer:

Welcome to the *my*SourceCard® program, the MasterCard debit card that will empower your employees with a convenient way to pay for health care with no out-of-pocket expenses.

Enclosed in this Enrollment Kit you will find everything you need to get you and your employees signed up and using the *my*SourceCard®:

- Employee Brochures
- Enrollment Agreement between the Employer and Employees
- Settlement Account Agreement between the Employer and DataPath Card Services Inc. (DCSI)
- Settlement Account Application between the Employer and DCSI
- Card Parameter Setup Form
- Implementation Checklist

Getting started is as easy as 1-2-3:

1. You fill out and return the forms and required documents.
2. Your employees fill out and return the enrollment materials.
3. The bank mails the cards to your employees.

On the next page, you will find detailed instructions for you and your employees.

I am honored that you have chosen to join me in this exciting partnership, and I am dedicated to your complete satisfaction. If you have any questions or need assistance, please feel free to contact me personally.

Thank you,

Application Process for Employers and Employees

Step 1 – You sign up for the program.

In order for the bank to approve your company and for me (your Plan Service Provider) to enroll your company in the program, you and your employees must fill out a few simple forms (see the enclosed checklist).

Here are the steps that you (the **Employer**) should follow:

- Give your employees the enclosed **Employee Brochures** and **Enrollment Agreements**.
- Review the enclosed **Settlement Account Agreement**.
- Fill out the enclosed **Settlement Account Application**, **Card Parameter Setup**, and **Implementation Checklist**.
- Return **all documents**, along with your **Initial Deposit Check** (if applicable) and the **Employee Enrollment Agreements**, to your Plan Service Provider (see address below).

Step 2 – Your employees sign up for the card.

Your **Employees** only need to follow two simple steps:

- Fill out the enclosed **Enrollment Agreements,** keep a copy for their records, and give a copy to you.
- Once they receive their cards in the mail, they will need to activate their cards by visiting **www.myRSC.com** or calling 1-888-523-4308.

Once I receive the documents back from you, I will upload the information for card creation. At any time, you and your employees may update this information via **www.myRSC.com**.

Step 3 – Card Services mails the cards to your employees.

I will forward the documents to Card Services, where they will be compared against the information I uploaded. Once the files are reviewed for accuracy, they are released to the card processing company, which will emboss the cards and mail them to the individual cardholder's home address.

Thank you again for participating in the *my*SourceCard® program. If you have any questions, please feel free to contact me for assistance.

Best Regards,

Your Plan Service Provider

DEBIT CARD SETTLEMENT (Secure)
ACCOUNT APPLICATION

EMPLOYER INFORMATION

Company Name: _____ Tax Id Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

P.O. Box: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____ Email: _____

Preferred Mailing Address: ☐ Street Address ☐ P.O. Box

Primary Contact: _____ Email Address: _____

SETTLEMENT ACCOUNT INFORMATION

Initial Deposit Method:

_____TPA Secured Funding

NOTE: *Suggested Initial Funding Method is Company Check but a wire transfer or EFT from the account indicated below is acceptable. If Check, enclose with this form, payable to DCSI.*

REPLENISHMENT INFORMATION

Replenishment Method:

_____ EFT *(only)*

NOTE: *See Article VI of the Agreement for associated fees for Check & Wire replenishments.*

FOR EFT REPLENISHMENTS, COMPLETE THE FOLLOWING INFORMATION:

Bank Name: _____ Bank Phone Number: _____ ☐ Mark this box if the "*Other Bank*" option is selected in CMS.

Routing Number: _____ Account Number: _____

Account Owner:
_____ PSP _____ Employer

NOTE: *See Article II of the Agreement for an explanation of the Settlement Account Replenishment process.*

PLAN SERVICE PROVIDER INFORMATION

PSP Name: _____ Serial Number: _____

Phone Number: _____ Fax Number: _____

Primary Contact: _____ Email Address: _____

PLEASE NOTE:

By signing below, you authorize DataPath Card Services, Inc. to create a general asset account ("Settlement Account") at Benefit Bank for the purpose of facilitating transactions made by your employees with *my*SourceCard® MasterCard® Debit Cards. This account will be created, funded and replenished as indicated on this Application, and according to the terms of the Settlement Account Agreement. Furthermore, by signing below you acknowledge your receipt and acceptance of the Settlement Account Agreement and the terms and conditions contained therein.

Signature: _____ **Effective Date:** _____

Signature of a company officer only

For Official Use Only		
DCSI Rep Initials:	Receive Date:	Process Date:

mySourceCard® Enrollment Agreement

As a participant in one or more of your Employer Plans or as an account holder under the HSAtoday™ program, you will receive a mySourceCard® MasterCard® Debit Card issued by Armstrong Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used ***exclusively*** for Qualified Expenses as defined by the plan(s) in which you participate. If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

Please Note: Additional terms and conditions would apply if you use the Card to access your funds in your HSA under the HSAtoday™ program. In such event, these additional terms and conditions would be set forth in an HSA Addendum to your HSA custodial account agreement.

For proper Cardholder Identification, please complete the following information.
Your Card will not be issued until this form is received by your Plan Service Provider.

Name on Card: (Please Print)_____
21 characters maximum including spaces

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Home Phone: _____

E-mail Address: _____

Name on 2nd Card: (Please Print) _____
21 characters maximum including spaces

Mother's Maiden Name (Security purposes only): _____

Signature: _____ Date:_____

ALL FIELDS ARE REQUIRED

For Official Use Only		
Plan Service Provider Initials:	Receive Date:	Process Date:

*Includes up to 2 debit cards…replacement cards cost $2.00

Voluntary Benefits Administrators, Inc.

P.O. Box 349 Gadsden, AL 35902
Phone (866) 730-3539 Fax (866)729-3539

Eligible FSA Medical Expense Examples:

This list in non-inclusive and does not represent all allowable or non-allowable charges. You may refer any further questions regarding allowable and non-allowable charges to your service provider.

- ✓ Medical expenses for Child (incurred before adoption is finalized)
- ✓ Alcoholism Treatment
- ✓ Ambulance
- ✓ Artificial Limbs
- ✓ Artificial Teeth
- ✓ Braille books/magazines (only the difference between regular books/magazines and Braille books/magazines)
- ✓ Car Controls for Handicapped
- ✓ Chiropractic Services
- ✓ Christian Science Practitioners (payments for medical care)
- ✓ Coinsurance Amounts and Deductibles
- ✓ Contact Lenses and Solution
- ✓ Crutches
- ✓ Dental Treatment
- ✓ Diagnostic Tests
- ✓ Drug Addiction Treatment
- ✓ Eye Examinations and Eyeglasses
- ✓ Guide dog or other animal (Purchase, training, And care of animal)
- ✓ Hearing Aids and Examinations
- ✓ Hospital Services
- ✓ Injections
- ✓ Insulin
- ✓ Laboratory Fees
- ✓ Lasik Eye Surgery
- ✓ Medical Monitoring and Testing Devices (If Prescribed by a physician)
- ✓ Medicines (If prescribed by a physician to treat specific ailment and if only by prescription)
- ✓ Occlusal Guards (To prevent teeth grinding)
- ✓ Operations (Legal operations which treat a specific ailment)
- ✓ Optometrist
- ✓ Orthodontia (unless for cosmetic purposes)
- ✓ Osteopath
- ✓ Oxygen
- ✓ Periodontal Fees
- ✓ Physical Exams (except for employment related physicals)
- ✓ Physical Therapy (for specified medical purpose)
- ✓ Prescription sunglasses
- ✓ Private hospital room
- ✓ Psychiatric care
- ✓ Psychologist
- ✓ Radial Keratotomy
- ✓ Surgery
- ✓ Telephone for the deaf
- ✓ Transplants
- ✓ Transportation to attend seminar on Medical condition of employee, spouse or dependent
- ✓ Cost of seminar on medical condition of employee, spouse or dependent
- ✓ Vaccinations
- ✓ X-Rays

Non-Eligible FSA Medical Expense Examples:

*** This list in non-inclusive and does not represent all allowable or non-allowable charges. You may refer any further questions regarding allowable and non-allowable charges to your service.***

- Body Piercing
- Breast Pump
- Chauffeur Services
- Controlled Substances
- Cosmetic Surgery directed only at improving appearance
- Cosmetic products
- Dancing Lessons
- Diapers for infants
- Diaper service
- Ear Piercing
- Electrolysis
- Fees written off by a provider
- Food supplements
- Funeral Expenses
- Hair transplant
- Health club dues
- Herbs
- Household and domestic help
- Illegal operations and treatments
- Insurance premiums
- Liposuction
- Long-term care services
- Maternity clothes
- Medical savings accounts
- Over the counter drugs
- Personal hygiene products
- Personal items
- Preferred provider discounts'
- Pregnancy kits
- Salary expense of a nurse to care for a healthy newborn at home
- Tattoos/tattoo removal
- Teeth whitening
- Transportation expenses to and from work
- Trip or vacation for well being
- Weight Loss Program
- Uniforms
- Vitamins without prescription

Also visit fsastore.com for more eligible items.

Request for Reimbursement
CLAIM FORM

EMPLOYER			
NAME:	Last First MI	**SS#**	
ADDRESS:	Street City State ZIP	**PHONE**	( )

☐ **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

* Information below must be completed

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
					Total:	$

DEPENDENT CARE CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
							$
							$
							$
							$
						Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____ /_____ /_____

FOR FASTEST REIMBURSEMENT, FAX TO (866) 729-3539.

OR MAIL TO: VOLUNTARY BENEFITS ADMINISTRATORS, INC.
P.O. BOX 349 , GADSDEN, AL 35902

Account Rules and Claim Filing Instructions

Rules for Both Dependent and Medical Accounts

1. You cannot submit a claim unless you are participating in the Cafeteria Plan.
2. You can be reimbursed only for eligible expenses occurring during the coverage period in which your contributions are made.
3. You can submit a claim at any time during the plan year and for a specified period after the plan year as described in the Summary Plan Description.
4. If you terminate employment, you can submit a claim for a specified period after the date of termination if so stated in the Summary Plan Description as long as the service occurred before your date of termination.
5. IRS rules stipulate that any money left in the your account(s) after all reimbursements for the plan year have been processed cannot be carried forward or returned. Money in one account can not be used for expenses incurred in another account. For instance, any unused amounts left in the medical account can not be used to reimburse dependent care expenses.
6. You cannot receive payment from any other source for expenses reimbursed by claim, and you certify that you are not eligible to bill any other source for the reimbursed expenses.
7. If you have received reimbursement for expenses, you cannot claim the expenses for income tax purposes.
8. You cannot bill for a service period that begins in one plan year and ends in the next plan year. File two reimbursement claims, one for each plan year covering the period during that plan year.
9. Complete ALL the information on the claim form for each amount claimed for reimbursement.
10. Attach copies of receipts from service providers or the Explanation of Benefits Form from Insurance Carriers to the claim.
11. Sign and date the claim.
12. Make a photocopy of the claim for your records.
13. Submit the Claim with attached receipts to Voluntary Benefits Administrators, Inc. according to the procedures provided. Additional Claims are available from your employer.

Dependent Care Expenses

1. You can use a Dependent Care Spending Account only if you pay dependent day care expenses to be able to work. Your day care services can take place either inside or outside of your home. If you are married, your spouse must also work, go to school full time, or be incapable of self-care for you to be eligible.
2. Only (a) dependents under the age of thirteen or (b) dependent adults or children thirteen years or older who are mentally or physically incapable of self-care are covered.
3. Your Maximum Contribution Amount can not be more than the smaller of (a) or (b).
   - Your income or your spouse's income, whichever is smaller. If your spouse is a full-time student or incapable of self-care, your spouse is considered to earn $2,400 per year with one dependent or $4,800 per year with two or more dependents.
   - $5,000 per year if your tax filing status is married filing jointly and or single head of household or $2,500 per year if your tax filing status is 'married filing separately'.
4. You cannot claim expenses if the service provider is your child or stepchild and are under age 19 or if you claim the service provider as a dependent for Federal income tax purposes.
5. To be reimbursed, you must include the facility's name, address, and tax identification number or the Social Security number of the individual providing the dependent day care service.
6. The maximum amount you can be reimbursed during the time you are covered in the Plan Year can not exceed the salary reduction amounts you have elected and made under the Dependent Care Assistance Plan less any previous reimbursements paid.

Unreimbursed Medical Expenses

1. The total annual election for eligible medical expenses (less any previous reimbursements paid) is available when requested for covered expenses.
2. Refer to the provisions in the Unreimbursed Medical Expense Spending Account Plan document for the maximum annual election amount.
3. To be reimbursed, you must include the dependent's name, date expenditure incurred, name of Service Provider, description of the expense, and the amount of the claim less any amounts that have been or will be paid by insurance or other sources.

Internal Revenue Service Publication 502 lists the eligible tax-free expenses. An Eligible expense means any item for which you could have claimed a medical expense deduction on an itemized Federal income tax return (except insurance premiums, long-term care and other similar charges) and is not eligible under your medical or any other source. You or your dependents while participating in the plan must incur the expenses.

Call our automated phone line to check card balances anytime 888-523-4308.

Get 24 hour access to your Flexible Spending Account anytime through the website www.myrsc.com. You can check your account balance, see claims submitted and see your reimbursements. Contact us today at 866-730-3539 to get your login information!

Download the free mobile app, myRSC, from your app store.

Get the same account information at your convenience on your phone!

VOLUNTARY BENEFITS ADMINISTRATORS, INC.

P.O. Box 349 Gadsden, AL 35902

Phone (866) 730-3539 Fax (866) 729-3539

Flexible Spending Account Worksheet

Pay Check Deductions:

Group Medical Insurance	**$_____**
Group Term Life Insurance	**$_____**
Group Dental, Vision Insurance	**$_____**
Cancer, Intensive Care, Accident	**$_____**
TOTAL COST:	**$_____**

Dependent Care Assistance: $_____ x _____ = _____

(How much do you pay for dependent care for children under 13 years.)

Weekly Expense **# of Weeks** **Total Cost**

Medical Expenses:

(Estimate your uninsured medical costs per year)

	Projected Expenses
Insurance Deductibles	**$_____**
Insurance Co-payments	**$_____**
Dental Deductibles	**$_____**
Dental Expenses	**$_____**
Vision Deductibles	**$_____**
Vision Expenses	**$_____**
Hearing Expenses	**$_____**
Prescriptions	**$_____**
Medically required equipment	**$_____**
Chiropractic	**$_____**
Other Medical Expenses	**$_____**
Over the Counter Drugs	**$_____**
TOTAL COST:	**$_____**

Total Deductions: $_____

You may meet with your benefits counselor to answer any questions and adjust your estimates according to your personal needs. You have 14 ½ months to incur these expenses, which includes the 2 ½ month grace period.

Voluntary Benefits Administrators,
P.O. Box 349
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