FLEX 125

Contact Us Today!
www.myflexinfo.com

How Much Can I Save?

The following example illustrates the savings of a typical employee who chooses Flex125.

	Without Flex125	With Flex125
Gross Monthly Compensation	$1,000.00	$1,000.00
Less Pre-Taxed Expenses		
FSA Expense		$25.00
Dependent Child Care		$200.00
Group Medical Insurance Premium		$50.00
Group Dental Premium		$2.00
Gross Taxable Income	$1,000.00	$723.00
Less Taxes and After-Tax Expenses		
Federal Income Tax at 20%	$200.00	$144.60
State Income Tax at 10%	$100.00	$72.30
Social Security Tax at 7.65%	$76.50	$55.31
Group Medical Insurance Premium	$50.00	
Group Dental Premium	$2.00	
Net Paycheck	$571.50	$490.79
Plus Flex125 Plan Reimbursements		
FSA Reimbursement		$25.00
Dependent Care Spending Account Reimbursement		$200.00
Disposable Income	$571.50	$675.79
Estimated Increase in Spendable Income per Month		**$104.29**
Estimated Increase in Spendable Income per Year		**$1,251.48**

These savings represent an increase of 18% in this employee's disposable income —a substantial pay increase.

FLEX 125

Estimated Expenses Worksheet

Contact Us Today!
www.myflexinfo.com

Use the **FSA Worksheet** to estimate your FSA expenses.

Eligible Expenses:	**Estimated Expenses**
Healthcare Expenses-	
Deductibles	_____
Copayments	_____
Routine physical exams	_____
Well-baby care	_____
Chiropractic care	_____
Other medical expenses not reimbursed by your health plan	_____
Other FSA Expenses-	
Dental Expenses	_____
Orthodontia	_____
Eye exams, glasses & contacts	_____
Hearing Aids	_____
Other/OTC Drugs/Items*	_____
Total Annual FSA Expenses:	_____

Use the **Dependent Care Spending Account Worksheet** to estimate your dependent care expenses.

Eligible Expenses:	**Estimated Expenses**
Babysitter	_____
Daycare Center	_____
Nursery School	_____
After School Care	_____
Home Health Care Worker	_____
Care for Eligible Adult	_____
Summer Camp	_____
Total (weekly expenses):	_____
Number of Weeks Care is Needed (Multiply number of weeks by total weekly expenses on above line to compute total annual dependent care expense)	X _____
Total Annual Dependent Care Expenses:	_____

*__Effective January 1, 2011__, as part of the Healthcare Reform changes, Over-the-Counter (OTC) medicine and drugs will require a prescription in order to be considered an eligible expense for the FSA.

FSA Election Form

Contact Us Today!
www.myflexinfo.com

Date: _____
Fax- # of Pages: _____

Please follow the steps below to thoroughly and accurately complete this form.

Step 1: Personal Information

Company Name: _____

Effective Date of Election: _____ Date of Hire: _____

Employee Name: _____ SSN: _____ Date of Birth: _____

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

Phone Number: _____ Fax Number: _____ Email Address: _____

Step 2: Enter Deductions Per Pay Period

Employee Health Insurance Premium Account		Pre-Tax Amount Per Pay Period	Pay Period Frequency *(W, B, S or M*)*	First Payroll Date Affected
• Health		$		
• Dental		$		
• Vision		$		
• Other		$		
Flexible Spending Account (FSA)**	$ Annual election	$		
Limited Scope Flexible Spending Account**	$ Annual election	$		
Dependent Care Spending Account	$ Annual election	$		

Remember, when your needs change, Flex125 does too! You can change your premium elections any time you have a qualifying event that would change the status and/or premium amount of your employee insurance (i.e. marriage, divorce, birth or death of a child, death of a spouse, adoption or change of employment by spouse).

***Pay Period Frequency: W = Weekly; B = Biweekly; S = Semi-monthly; M = Monthly**

****If you have a HSA account, you are only eligible to participate in a limited scope FSA if offered by your employer**

Step 3: Acknowledgement and Signature

☐ I acknowledge that I am authorizing the company to deduct equal amounts from my paychecks to collect the designated pre-tax column above. I recognize that these selections constitute a deliberate binding decision on my part that may not be changed until the enrollment period for the next plan year or if I experience a change in status

Employee Signature: _____ Date: _____

OR

☐ I elect **NOT** to participate in any portion of the Flex125 plan. (i.e. Premium, FSA, Dependent Care, Limited Scope).

Employee Signature: _____ Date: _____

FLEX 125

myFlexInfo.com & FSA Enrollment Video

Contact Us Today!
www.myflexinfo.com

myFlexInfo.com is a password-protected online resource for all your Flex account needs.

Information and status can be viewed at the plan administrator level, and individually at the employee level 24 hours a day. Whether your employer has established a FlexHRA® Health Reimbursement Arrangement, Flex125 Flexible Spending Account (FSA), FlexMRP™ Medical Reimbursement Plan or FlexTRANSIT® Reimbursement Account, myFlexInfo.com serves as a channel of communication through which everyone can be kept informed without the necessity of making phone calls.

Through myFlexInfo.com, for example, employees can learn how their benefit plans work, check account history and current balances, download forms and much more.

How to Register on myFlexInfo.com:

Step 1: Logon to www.myflexinfo.com and click the "Employee Login" button.

Step 2: Click the register link.

Step 3: You will need to provide certain details, including your Access Code. Please contact your employer for this information.

Step 4: You will create a user name and password along with a security question/answer should you happen to forget your password. Then click "Next"

Step 5: Your registration is now complete and you can click "confirm" to login to your account.

Find out more about your plan using our interactive **FSA Enrollment Video**!

Looking for more information on your FSA?
Our FSA video—available at **www.myflexinfo.com**—provides a comprehensive overview of the Flex125 product and the tax advantages available to you. It also provides valuable information on how to enroll in the program and where to locate the necessary forms. You will also find interactive tools that help you calculate savings potential and election amounts.

Visit **www.myflexinfo.com** and click on FSA Video today to learn more!

FLEX 125

Submit Your Flex Claims Automatically with CrossTech!

Tired of looking for receipts, claim forms and stamps? What if you could eliminate the manual effort and streamline the process of submitting medical claims for reimbursement?

Don't ponder that question any longer. Flexible Benefit Service Corporation (Flex) has CrossTech®, which is the automatic, paperless submission of FlexFSA, HRA and MRP medical, prescription, and dental claims through Blue Cross® and Blue Shield® of Illinois (BCBSIL)-PPO plans only.

In order to take advantage of this claim submission process, you must have a PPO Plan through BCBSIL, and complete the Single Claim Submission Authorization Form that follows this page.

If you elect to participate in this technology and confirm your eligibility based on the criteria listed above, you must complete the Single Claim Submission Authorization Form.

Once you elect CrossTech, you will remain on CrossTech for each new plan year that you have a qualifying PPO plan. If you decide to cancel your CrossTech, there is a cancellation form which will need to be submitted.

Attached is the CrossTech election form and if you have questions, please feel free to call your Flex representative at (866) 472-0882.

Note: Paperless claim submission is only available to PPO participants. Adjusted claims are not processed through CrossTech and need to be submitted manually.

Contact Us Today!

www.myflexinfo.com

Sign up today and take advantage of the following benefits:

- Claims are submitted automatically; no need to wait for the EOB from the carrier
- Margin of error in processing a claim is decreased because the claims come directly from the carrier and are submitted to our system electronically
- Information is transferred over a secure line; not viewable by others
- The hassle of submitting claim forms has been eliminated
- Available to BCBSIL PPO Plan members (HMO Plan members, secondary coverage and domestic partner coverage are not eligible to participate in CrossTech)

CrossTech is not available under the conditions listed below:

- You are on a HMO Plan or any other plan which is not a BCBSIL PPO plan.
- You or your dependents have coverage under another health plan with coordination of benefits. For example, Medicare or secondary coverage with your spouse's plan.
- You are covering a domestic partner under your medical plan that is not your dependent for federal income tax purposes. The medical expenses of the domestic partner who is not your tax-qualified dependent are not eligible for reimbursement under a FSA, HRA or MRP plan.

PLEASE NOTE: This a Blue Cross® and Blue Shield® of Illinois (BCBSIL) requirement. Please complete form in full.

Contact Us Today!
www.myflexinfo.com

CrossTech® Single Claim Submission Authorization Form

Please Sign and Return this Form Immediately for FSA/HRA/MRP Single Claim Submission Authorization Form

For BCBSIL Medical and Dental Participants Only (NON-HMO)

Employer Name: _____

NOTE: ALL INFORMATION MUST BE COMPLETED FOR PROCESSING

Please print information.

First Name: _____ M.I. _____ Last Name: _____

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

Email Address: _____ Date of Birth: _____

SSN: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

If you have **BCBSIL Medical and Dental**, you can elect to have *expenses that may or may not be covered by Blue Cross and Blue Shield automatically submitted to your FSA, MRP and/or HRA for reimbursement*. This is called Single Claim Submission. In order to activate Single Claim Submission, please sign this Single Claim Submission Authorization Form confirming you are eligible per the qualifications listed below and return it to Flexible Benefit Service Corporation (Flex).

If you do not have coverage under **BCBSIL Medical and Dental**, you have a HMO or other non PPO plan, secondary coverage (for example – Medicare) or have coverage for a domestic partner, you are not eligible for automatic Single Claim Submission for your health care flexible spending account.

AUTHORIZATION

In electing to have claims for reimbursement from my health care spending account automatically submitted, I authorize Blue Cross and Blue Shield of Illinois to disclose information about the medical care, diagnosis, treatment or advice provided to me and/or my dependents including, without limitation, information about AIDS or HIV, mental illness, and/or the use of drugs or alcohol. I understand that this authorization is valid for the plan year to which this waiver applies and may be revoked at any time. I also understand that any information disclosed under this authorization will be made available to me upon request. I further understand that without this authorization my claims and claims for my dependents cannot be automatically submitted by Blue Cross and Blue Shield of Illinois for reimbursement from my health care spending account.

SIGNATURE REQUIRED FOR PROCESSING

I certify that I am claiming reimbursement only for eligible expenses that have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Participant Signature: _____ Date: _____

Thank you for choosing the Single Claim Submission option.
Please send completed form to Flex.