Cafeteria Plan

SHAFFER INSURANCE SERVICES, INC.

BENEFITS DIVISION

Information Package

CAFETERIA 125 PLANS

Shaffer Insurance Services, Inc. Benefits Division 902 E. Ave Q-9 Palmdale Ca. 93550
Toll Free (866) 412-5872 Office Tel (661) 575 9331 Fax (661) 280 2016

Section 125 Cafeteria Plans or also know as **Flexible Spending Accounts (FSA)**

"Tax Benefit You Can't Afford To Ignore!"

You can **reduce your taxable income** and avoid paying Social Security and Medicare Tax (7.65%) and Federal Income Tax (15% to 40%) by enrolling in your company sponsored Flexible Benefits Plan. These tax savings can apply to one or more of the following options:

1. **Premium Conversion Account (Employer/Employee)** allows for YOUR SHARE of qualifying group insurance premiums to automatically be deducted from your pay with TAX-FREE dollars.
2. **Health Care Flexible Spending Account (FSA Medical Expenses)** allows you to pay for health care expenses for yourself and your family which are not covered by health insurance including dental, vision, orthodontia, etc. (and even those deductibles or "co-pays" which are the patient's responsibility) with TAX-FREE dollars.
3. **Dependent Care Flexible Spending Account (FSA Child Care)** allows you to pay for child day care or dependent care expenses up to $5,000 per year TAX-FREE.

How you save taxes...

When you participate in a flexible spending account via salary reduction, you reduce your federal, FICA, Social Security, Medicare (and in some cases, state) taxes and increase your take-home pay. The money that is deposited into your Flexible Spending Account comes straight out of your gross pay, therefore avoiding taxes.

The following example shows how a single person making $30,000 per year can save$2,777.60 in taxes annually by contributing $403 per month to a spending account. As you can see, with only $403 in monthly-qualified expenses, by enrolling in the Plan, you would have an extra $241.43/month ($2,777.60/year) of spendable income, the amount you would otherwise be paying in taxes.

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EXAMPLE FOR SINGLE PERSON MAKING $30,000 a YEAR

Tax Savings Illustration					
		Without Flexible Benefits Plan		**With Flexible Benefits Plan**	
Gross Monthly Salary		$2,500.00		$2,500.00	
	Qualifying Insurance Premiums	$0.00		$100.00	
	Qualifying Health Care Expenses	$0.00		$100.00	
	Qualifying Dependent Care Expenses	$0.00		$203.00	
Total Qualifying Expense		$0.00		$403.00	
Gross Taxable Income		$2,500		$2,097.00	
Income Tax @ 13.3% plus F.I.C.A. @ 7.65%		$523.75		$439.32	
Net Spendable Income		$1,976.25		$1,657.68	
	Post-tax Insurance Premiums	$100.00		$0.00	
	Post-tax Health Care Expenses	$100.00		$0.00	
	Post-tax Dependent Care Expenses	$350.00		$0.00	
Total Post-tax Expenses		$550.00		$0.00	
Net Spendable Income		$1,426.25		$1,657.68	
Increase in Monthly Spendable Income		N/A		$231.43	
Increase in Annual Spendable Income		N/A		$2,777.60	

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Premium Conversion Accounts (Group Health)

Questions and Answers

What is it?

Premium Conversion under Section 125 allows you to avoid Social Security and Federal Income (withholding) Tax on your monthly deduction for group insurance premiums.

How does it work?

If you elect to participate, payroll will adjust your monthly deduction for qualifying insurance premiums from an "after-tax" to a "pre-tax" basis. There are no forms or claims for you to file.

What insurance premiums qualify?

- Premiums for group medical, dental, vision, accident and/or disability insurance (Section 106).
- Qualified premiums you pay for yourself, spouse and/or dependents.

(Please note that any policy that builds cash value or allows for a refund of premium is not a qualified plan and any disability or salary insurance premium paid pre-tax has a taxable benefit.)

Why should I participate?

Your withholding taxes will decrease and your net take-home pay (Spendable income) will increase.

Are there any negatives?

Because Social Security tax will not be deducted from the amount used to pay for qualifying insurance premiums, your Social Security benefits may be slightly reduced.

Can I revoke my premium conversion amount?

Only if you have a change in family status during the plan year. If your group insurance premiums change, your deduction will be adjusted automatically.

How do I participate?

Your share of out-of-pocket premiums will automatically be deducted pre-tax unless you notify your employer to the contrary.

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EXAMPLE FOR "PREMIUM CONVERSION" also known as GROUP HEALTH INSURANCE

Jack earns $30,000 annually and his employer deducts $200/month ($2,400/yr) from his paycheck to pay the premiums for covering his wife and Child under the company's group insurance plan.

Without Premium Conversion	
Gross (taxable) Pay	$30,000
Taxes @ 25%	(7,500)
Insurance Deduction	(2,400)
Net Take home	**$20,100**

With Premium Conversion	
Gross Pay	$30,000
Pre-Tax Insurance Deduction	(2,400)
Taxable Pay	$27,600
Taxes @ 25%	(6,900)
Net Take Home	**$20,700**

Jack has ***increased*** his take home pay by ***$600 per year ($50 per month)*** by participating in his employer's Section 125 Premium Conversion Plan.

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HOW SPENDING ACCOUNTS WORK:

Each year during the Open Enrollment period, usually January 1st of a new year, you are given the opportunity to participate in a variety of voluntary benefits programs. The FSA (Flexible Spending Account) also known as Medical Expenses and the FSA Child Care Programs may be included. If you decide to participate in one or all benefits, you will need to:

1. Complete a ***Benefit Election and Salary Reduction Agreement form,*** identifying the amount of Pre Taxed dollars you would like to set aside each pay period. This amount is placed in your spending account each pay period during the plan year.

2. When you incur eligible expenses, you will submit a claim form to Shaffer Insurance Services Inc. – Benefits Division to request reimbursement of the expense(s) from your spending account. The claim form must be accompanied by documentation (i.e., receipts or EOB's (Explanation of Benefits) that identifies your providers name, the date of service and a description of the service or name of the medication and the total amount of your claim. Claims are usually handled before a pay period.

3. Upon receiving your claim for reimbursement we will produce a check or an automatic deposit into your bank account if this has been offered, using your TAX FREE money in your spending account. Your employer may have stipulated a minimum reimbursement amount (usually is $10.00), and will not issue checks under that amount.

HOW DOES "DAY CARE"; DEPENDENT CARE WORK:

What is it and who is eligible to participate?

The Dependent Care flexible spending account (FSA Child Care), under IRC Section 125 allows you to avoid both FICA (7.76%) and Federal Income Tax (11%, 13%, 14%) on qualifying child and dependent care expenses. In order to participate in this plan, you and your spouse must meet the following:

1. The care for which you are paying must be for one or more qualifying dependents.
2. You must keep up a home that you reside in with the dependent(s).
3. You must have earned income during the year, unless your spouse is a full time student.
4. Your expenses for dependent care must be incurred so that you can work or look for work.
5. Your dependent care payments must be to someone that you or your spouse will not be claiming as a dependent on your taxes.
6. Your day care provider must be identified on your tax return, when you file your federal income tax.
7. The maximum for this benefit is $5000.00 a year for married couples and $2500.00 a year for singles.

Flexible Spending Account Worksheet

FOR EMPLOYEE

Pay Check Deductions:

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	$_____
TOTAL COST:	$_____

(Enter the annual premium amount of any of the following insurance plans That you or your dependents individually own)

Dental Insurance	$_____
Vision Insurance	$_____
Cancer Insurance	$_____
Accident Insurance	$_____
TOTAL COST:	$_____

Total Deductions: $_____

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BENEFIT ELECTIONS FORM AND SALARY REDUCTION AGREEMENT
EMPLOYER NAME:__ _____

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

Employee Street Address City, State, Zip Code

Email address_____ Day Time Phone #_____

I hereby authorize and direct my employer to reduce my salary by pay period in the amount specified to pay for the coverage's shown under the Premium Conversion and Reimbursement Accounts headings shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date of the Plan. I further authorize future adjustments in the amount of the salary reduction in the event that the cost of coverage in any program selected below under the heading PREMIUM 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 reduction per pay period cost. These selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Salary Reduction Amount ***per*** Pay Period

Premium (Health Insurance) (Employee portion) **not reimbursed**

(Such as: Blue Cross, Health Net, Kaiser, Delta Dental)

Medical ..... $_____

Dental ..... $_____

Vision ..... $_____

Other- AFLAC_____ $_____

Per pay period Pretax Deduction for Insurance Premiums $_____

Reimbursement Accounts

FSA Medical Expenses $ 2600.00 CAP Limit ..... $_____

FSA Child Care $ 5000.00 CAP LIMIT ..... $_____

Per pay period Pretax Deduction for Reimbursement Accounts $_____

Total Deductions per pay period ..... $_____

Starting Pay Date: _____

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.

Attach a VOIDED Check if you want Direct Deposit: DIRECT DEPOSITS MUST HAVE PERMISSION TO DO SO BY HUMAN RESOURCE

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

Signature_____ Date_____

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

Signature_____ Date_____

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