

Health

Child Care

Premiums

Dental

Vision



Who Should Choose Your Benefits?
The Choice Account Says ***You Should!***

The Choice
ACCOUNT



A Benefit That Gives You A Choice!

Design Your Own Benefit Program

Your Choice Account Flexible Spending plan is firmly based on the concept of CHOICE. It is designed to allow you to pay for the benefits of your choice with before tax dollars. By offering The Choice Account, your employer is giving you the opportunity to "shop" for your benefits and design the program that best meets your individual needs.

Make your paycheck more valuable

With The Choice Account, you contribute enough money from your income, before tax, to the program to pay for the benefits you have selected. No Federal income taxes or, in most states, state income taxes are withheld from the money you contribute for benefits. This is called the "payroll reduction" method of paying for benefits.

Through the payroll reduction method, you can *STRETCH* your earnings and actually increase your spendable income. The amount of the increase will depend on your income tax bracket and on the amount of benefits you are able to pay through the program.

SAVE TAX DOLLARS

The Choice Account helps you take advantage of tax breaks available only through payroll reduction programs. Without it, you would need to earn enough to pay your taxes *and then* pay for your benefits with the money left over. With The Choice Account, you will be paying for your benefits **before taxes**, and then you will only pay taxes on the money that is left. You will end up with **more spendable money after paying for the same benefits**.

Why Do You Need To Choose Your Benefits?

Today's workforce is made up of single people, married couples, families, single parents and various other household situations that are presenting new challenges to employers. No longer can any employer be expected to select a single benefit program that adequately addresses the needs of his entire workforce. The Choice Account puts important benefit decisions into *your* hands, rather than having your employer make choices for you that may or may not fit your needs.

Three Flexible Spending Accounts Have Been Set Up For You

The Choice Account gives you three separate Flexible Spending Accounts to use to reimburse yourself for certain medical and dependent care expenses with money that you have had deducted from your paycheck before taxes. Without these Flexible Spending Accounts, you would need to earn enough to pay your taxes and then pay your medical and dependent day care expenses with the money left over. But with them, you will be using money taken from your paycheck before taxes to pay these expenses, and then you will only pay taxes on the money that is left. You'll end up with more spendable income after paying the same expenses!

ACCOUNT #1

Tax-Free Health Premiums

ACCOUNT #1A - PAYROLL DEDUCTION HEALTH PREMIUM PAYMENT

The employee-paid portion of your premiums for your company health plan(s) will continue to be automatically deducted from your paycheck, but these deductions will now go through your Choice Account on a tax-free basis. This will save you money on income taxes and increase your spendable income. If you **do not** want this to occur automatically, you must inform your employer, your enroller, or LFS Benefit Services.

ACCOUNT #1B - PRIVATE HEALTH PLAN PREMIUM REIMBURSEMENT

Private health premiums can be paid on a tax-free reimbursement basis through your Tax-Free Private Health Premium Account. Eligible private premiums can include any health premiums you pay directly for the benefit of yourself, your spouse or any of your dependents. You simply submit a **Choice Account** Claim Form each time you pay an eligible private health premium for the amount of your payment and return it to LFS with a copy of your receipt. You will then be reimbursed for the expense with the money you contributed to your Private Health Premium Account. This **cannot** include your spouse's payroll deduction premiums paid through their employer. Reimbursement claims must be for private premiums paid for covered periods that fall during the plan year, regardless of when the premiums are actually paid. For example - if your plan year is January 1 through December 31, then January through December premiums are eligible for reimbursement even if the January premium was actually paid in December of the previous year.

ACCOUNT #2

Tax-Free Health Expense

The Tax-Free Health Expense Reimbursement Account allows you to reduce your taxable earnings by using tax-free dollars to purchase health care goods and services that you would normally buy with post-tax dollars. The money paid into this special account will go toward paying any of your health care expenses (medical, dental, & vision) that are allowed by the IRS. Any deductibles or out-of-pocket expenses reimbursed from your account can also be applied toward satisfying the deductibles under your medical plan. "*Out-of-pocket*" expenses are any amounts that are your responsibility, such as deductibles, co-payments and eligible expenses for medicines, before the insurance company will pay 100% of the remaining covered charges. Your health care reimbursement account can also be used to pay all eligible deductibles, co-payments and eligible medicine expenses for your spouse and your dependents.

Your plan's Tax-Free Health Expense Reimbursement Account may have a maximum contribution limitation. Please check your plan's "*Just The Facts*" sheet for your specific limitations. If you should terminate your employment during the plan year you can continue to withdraw from your Tax-Free Health Expense Account to the end of the plan year, **but only to pay expenses incurred prior to your date of termination of participation** (the end of the month in which you made your last contribution) unless you choose COBRA Continuation of your Health Expense Reimbursement Account participation. See page 9 of this booklet for more information about COBRA.

ACCOUNT #3

Tax-Free Dependent Day Care Expense

This account allows you to pay your dependent day care expenses, including child day care and babysitting, with tax-free dollars. The care must be given for the purpose of allowing you, if single, or if married, you **and** your spouse to be gainfully employed. Also, your contributions may not exceed the lesser of:

- if single, your earned income for the year,
- if married, your or your spouse's earned income for the year,
- \$5,000 (or \$2,500 if married and filing a separate return).

"*Dependent*" is defined as anyone included as a dependent on your income tax return including an unmarried child under the age of 13, a disabled or handicapped child, or a disabled spouse or parent.

Day care for dependents can be given anywhere (inside the employee's home, in a center, someone else's home or other licensed or unlicensed facility) as long as the care is given for the purpose of allowing the employee and spouse to be gainfully employed.

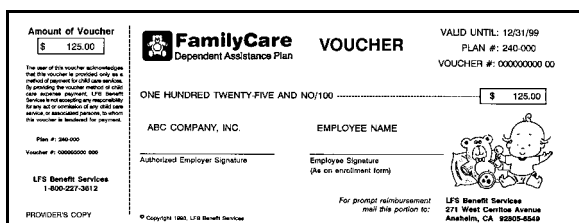
At the time you enroll in the Dependent Day Care Reimbursement Account, you will need to fill out a "*Dependent Care Authorization Form*". This provides LFS, the plan administrator, with IRS required information for their files including the dependent's name and the name and Social Security or Tax I.D. number of the care provider.

1 Direct Reimbursement

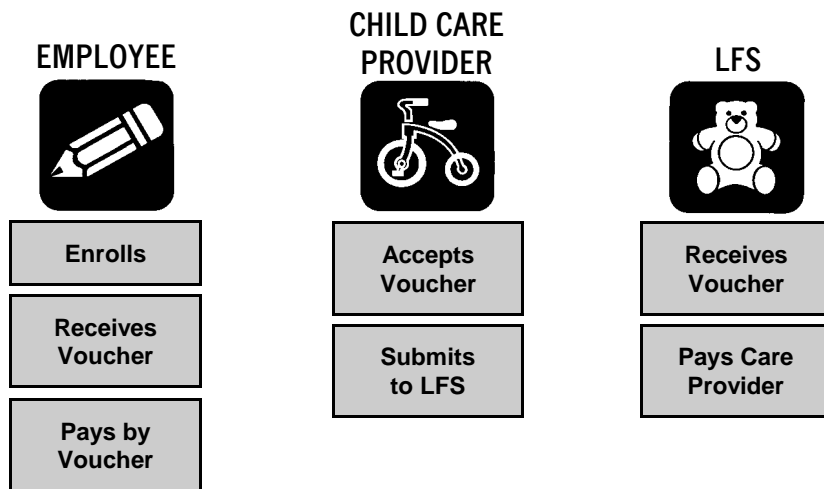
With direct reimbursement, you pay your child care provider as usual and retain a receipt or invoice. Then, submit a **Choice Account Claim Form** with a copy of your receipt or invoice to LFS Benefit Services by the last day of the month. Claims are processed by LFS Benefit Services once each month. Remember, the first month of your participation, this program will effect your cashflow as if you are paying your child care twice. At the same time you are paying your child care provider, your before tax deduction will be taken from your paycheck to be available to reimburse you for your expenses the beginning of the next month.

2 FamilyCare Vouchers

When you elect to use the voucher system, in two of your paychecks each month you will receive a **FamilyCare** voucher for the cost of your dependent care for that period. You then give the voucher to your child care provider and they submit it to LFS Benefit Services for payment. It works like a money order and keeps you from having to pay first and then wait for a reimbursement from your **FamilyCare** account. You can also submit the voucher, along with a bill or invoice from your child care provider, for direct payment to you. LFS will process the voucher and mail a reimbursement check to the submitting party, you or your child care provider, within 5 days of LFS' receipt of the voucher. Your **FamilyCare** account will be charged \$4.00 for each voucher issued (\$8 for the month), but this cost will be considerably less than your tax savings resulting from your participation.



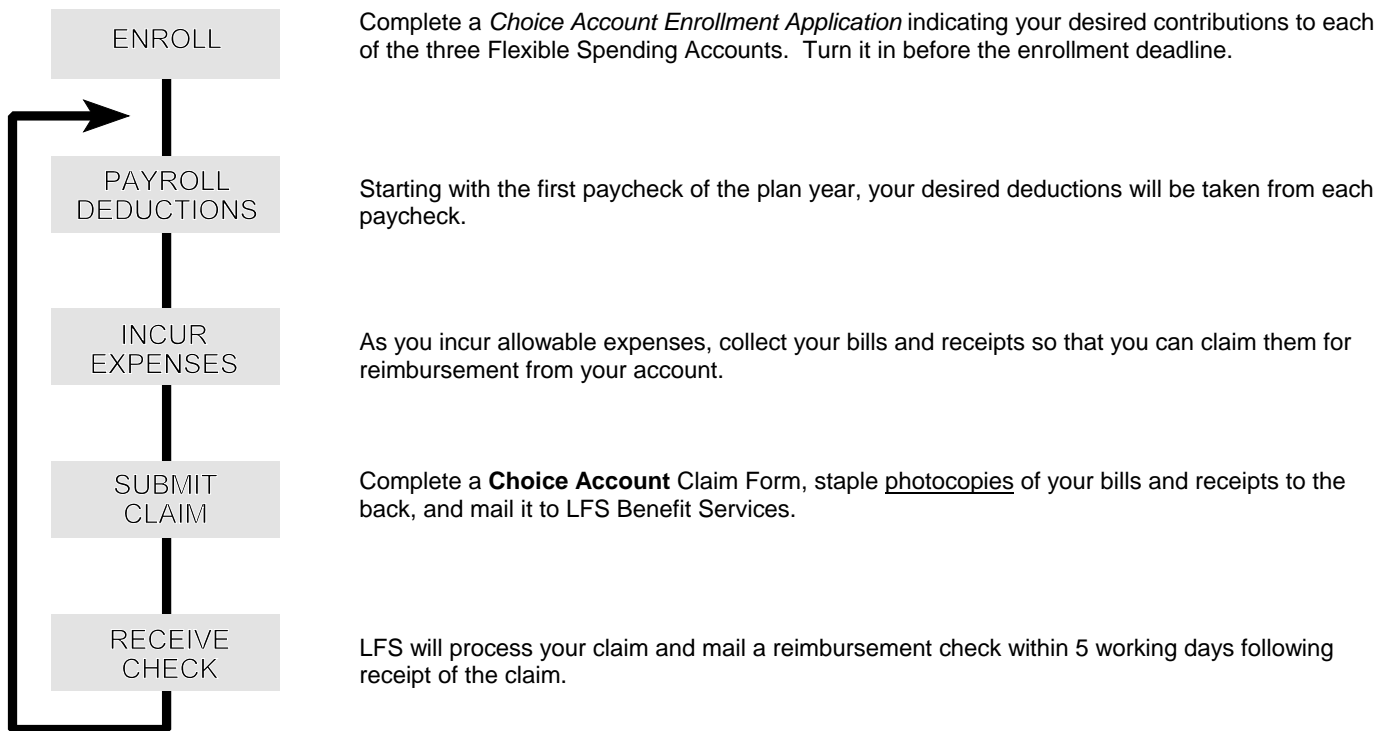
The Voucher Process:



REMEMBER: Your Flex Accounts Are Each Separate Pools of Money

Each of your three Flexible Spending Accounts is a separate pool of money. Money needed to pay child care expenses must be contributed to your Tax-Free Dependent Day Care Account, and money needed for health care expenses, such as medical plan deductibles, must be contributed to your Tax-Free Health Expense Account. Under no circumstances can money contributed to one account be used to pay expenses in another. Be sure to calculate your expenses carefully and specify them correctly on your *Choice Account Enrollment Application*.

How Do The Flexible Spending Accounts Work?



Submitting a Claim For Reimbursement

Choice Account Claim forms are available from your employer or LFS Benefit Services. You will also receive a new claim form with each reimbursement check sent to you. The following are instructions for correctly completing your claim form.

- 1 Complete Part A** - Always provide your name, social security number & company name.
- 2 Read ALL instructions and information in Part B**
- 3 List ALL expenses being claimed on the back of form** - Also provide dates of service (date incurred) for each expense listed. Expenses must be listed under the appropriate account to ensure proper payment.
- 4 Total the expenses listed for each of the three accounts** - Place totals in the appropriate total boxes ([1], [2], & [3]) provided.
- 5 Carry totals [1], [2] & [3] forward to Part B**
- 6 Sign & date Part C** - Due to strict IRS regulations, it is important that you read the statement presented in Part C and always sign and date your claim form. Unsigned forms must be returned for signature, delaying the payment of your claim.
- 7 Provide a daytime phone number in Part C** - Please give us your daytime phone number so that a customer service representative can call you should we have any questions regarding your claim. This may prevent a delay in the payment of your claim.

Questions?

If you have any questions regarding completing or submitting a claim form, please call our toll-free Customer Service Helpline at 800-662-5970.

Claims Processing Schedule

Your Flexible Spending Account payroll deductions are withheld from your paychecks according to your elections and then forwarded by your employer to LFS Benefit Services at the end of the month in which they are deducted. During the first week of the following month, these contributions are credited to your account. LFS will process claims received during the month within 5 working days of their receipt of your claim. Reimbursement account statements will be processed each month following the crediting of contributions and will be mailed to you by the 10th of the month, whether or not you have a current claim pending.

Remember, claim requests for dependent care and private premium expenses can only be processed to the extent of your account balance at the time of the request. If your claim exceeds the balance in your account, a reimbursement check will be processed in the amount of your current balance and the unpaid remainder of your claim will be paid after the month's contributions have been credited with the next regular monthly processing cycle.

Enrolling In The Flexible Spending Accounts

To enroll, fill out the *Choice Account Enrollment Application* completely giving your desired monthly contributions for each of the three accounts. Also, be sure to initial the appropriate boxes for your participation choices.

This is your **only opportunity** to enroll or make any changes to your contribution amounts for this plan year, unless you experience a "family status change". A family status change is defined as the occurrence of one of the following events:

- Marriage
- Divorce, legal separation or annulment
- Death of a spouse or dependent child
- Birth or adoption of a dependent child
- Certain employment changes: Commencement of employment (when previously unemployed) of a spouse or covered dependent, loss of employment of the employee, spouse or covered dependent, or significant job change (e.g. significant reduction or increase in work hours). Also, strike, lockout or change in work site for the employee, spouse or covered dependent.
- Change in place of Residence of the employee, spouse or covered dependent: Enrollment change can be made only to the extent that the change of residence **directly results** in a situation that would significantly affect the participant's current benefit elections.

If a family status change makes you eligible to make a change to your enrollment you must do so in writing by completing a new enrollment form on or before the 31st day after the occurrence of the family status change. Your changes then take effect with the first payroll following the later of:

- the date of the family status change, or
- the date you make written application for the changes.

You may change your contribution amount and how your contribution is split between your three accounts **ONLY** at annual plan enrollment periods or upon the occurrence of a family status change. Otherwise, the amount you choose to contribute will be effective for the entire year. Therefore, it is important to determine your contribution carefully and accurately.

The only clear guide to determining your contribution is your past expense history. In the beginning, use your Flexible Spending Accounts with caution and for those items of which you are most sure. After gaining experience using your Flexible Spending Accounts this year, your needs will be more clear and you will be able to make even greater use of your account in the future.

Important Points To Remember

- ❑ **"Use It or Lose It"** - The IRS regulations require that any balances left in your Flexible Spending Accounts at the end of the plan year must be **FORFEITED**. (If your employer offers a claims grace period, you may have some additional time to incur and submit expenses. Please refer to your enrollment "Just the Facts" information sheet for specific details.) Therefore, it is very important to estimate your eligible expenses carefully! LFS will provide statements with each reimbursement check and year-end notices to help ensure that you use all of your money.
- ❑ All reimbursement expenses must be incurred in the same plan year in which you contributed to your account (with the exception of your grace period, if applicable - see your "Just the Facts" sheet for more info). You may request reimbursement for these expenses for two months following the end of the plan year.
- ❑ A terminated employee can continue to withdraw from his Tax-Free Health Expense Account to the end of the plan year, **but only to pay expenses incurred prior to the employee's date of termination of participation** (the end of the month in which the last contribution was made). COBRA Continuation can be elected by any qualifying employee or covered dependent, but such after-tax contributions offer no tax benefit and are of little advantage. Please refer to the COBRA Rights Notice found on page 9 for more information regarding your COBRA Continuation Rights.
- ❑ Reimbursements from your account will always be paid directly to you - not to the provider of services. The only exception is reimbursements for **FamilyCare** vouchers, which will be processed and mailed within 5 working days to the party submitting the voucher for reimbursement.
- ❑ You, the participant, will be responsible for answering to the IRS if you are audited. To help you prove the eligibility of your claims, be sure to keep good records and contact your tax advisor if you have any questions about tax deductibility or tax matters.

Examples of Expenses Eligible For Reimbursement

This is only intended to be a partial list of some of the categories of expenses allowed by the IRS to be paid before tax through Section 125 Flexible Spending Accounts. For information on the eligibility of any specific expense, call the IRS at 1-800-TAX-FORM for a copy of their Publication 502 or consult your tax advisor. Please note that Publication 502 is not exclusively meant as a Section 125 Flexible Spending plan reference. It contains references to insurance/insured products that are not eligible for reimbursement through The Choice Account Flexible Spending Plan.

Acupuncture

Alcoholism - the amount you pay to a treatment center for alcohol or drug addiction (can include meals and lodging provided by the center during treatment)

Ambulance - amounts you pay for ambulance service

Artificial Limbs, Teeth

Birth Control Pills and legal abortions

Braille books and magazines - the portion in excess of price for regular editions

Chiropractic - medical expense fees you pay to a Chiropractor for medical care

Christian Science Practitioners (CSP) - medical expense fees you pay to a CSP

Crutches, Wheelchair

Deductibles and copayments for Medical and Dental services

Dental Expenses, Dentures - non-cosmetic

Diagnostic fees

Eye Examinations, Eyeglasses, Prescription Sunglasses, Contact Lenses - needed for medical reasons

Hearing Aids

Hospital Services - including meals and lodging

Laboratory, X-Ray Fees

Medical Services - amounts you pay for medical services provided by Physicians, Surgeons, Specialists, or other medical practitioners

Over-the-Counter and Prescription Medicines - amounts paid for prescription drugs and insulin, and well-documented amounts paid for over-the-counter medicines for the treatment of specific ailments or conditions.

Obstetrical Expenses, Midwife fees

Orthopedic Shoes

Oxygen

Psychiatric Care, Psychoanalysis, Psychologist - medical expenses paid to a psychiatrist, psychoanalyst, or psychologist for medical care

Radical Keratotomy

Special Schools - payments to a special school for a mentally or physically impaired person if the main reason for using the school is its resources for relieving the disability

Surgery, Operations

Therapy - amounts you pay for therapy you receive as medical treatment

Weight Loss or Smoking Cessation Program - **ONLY IF** prescribed by your doctor for the treatment of a particular ailment (**NOT** for improvement of your general health)

NOTICE TO ALL COVERED EMPLOYEES AND DEPENDENTS CONCERNING HEALTH EXPENSE REIMBURSEMENT CONTINUATION COVERAGE (COBRA)

Both you and your spouse should take the time to read this notice carefully before initially the appropriate boxes in Notification Acknowledgment section of your enrollment form.

Availability of a Health Expense Reimbursement Continuation Under COBRA

Effective January 1, 1987 it is mandatory that your employer provide a Medical Benefits Continuation Plan for covered employees, their spouses and children. The purpose of the Plan is to provide employees, spouses and children who are currently covered by the group health plan the opportunity to continue such coverage after the occurrence of an event that would otherwise have terminated or limited the coverage. These events are known as "qualifying events" and if an employee, spouse or child is covered by the group health plan the day before the qualifying event, he or she can elect to continue such coverage, **provided that he or she pays the premium necessary to retain the coverage.**

What is a Qualifying Event?

If you are covered by the company's Health Expense Reimbursement plan and you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part), then you have the right to choose this continuation of coverage for a period of up to 18 months.

If you are the spouse of an employee who is covered by such a plan, you have the right to choose continuation coverage for yourself for a period of up to 3 years (36 months) if you lose coverage under the plan for any of the following "qualifying events":

- Death of your spouse;
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by such a plan, he or she has the right to continuation coverage for up to 3 years (36 months) if coverage under the plan is lost for any of the following "qualifying events":

- The death of the parent;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in your parent's hours of employment;
- Parents' divorce or legal separation;
- A parent becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the plan.

Notifying Your Employer of the Occurrence of a Qualifying Event

Under this Plan, **the employee or a family member has the responsibility to inform the plan administrator** of a divorce, legal separation, or a child losing dependent status under the plan **within 60 days of the change in status**. The company has the responsibility to notify the administrator of the employee's death, termination of employment or reduction in hours, or Medicare entitlement within 30 days of the change in status. Similar rights may apply to certain retirees, spouses, and dependent children if the company commences a bankruptcy proceeding and these individuals lose coverage.

When the administrator has been notified of the change in status, the administrator has 14 days in which to send notification to you of the details of the right to choose continuation coverage. You then have 60 days from the date the administrator sends the notification information to inform the plan administrator that you want continuation coverage.

If you do not choose continuation coverage, your Health Expense Reimbursement account will become inactive on the last day of the month in which the "qualifying event" occurs.

If you choose continuation coverage, the company is required to give you the coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

How Long May I Be Covered Under COBRA Continuation Benefits?

The law requires that you be afforded the opportunity to maintain continuation of coverage for 3 years, unless you lost coverage because of termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18 month period.

The 18 months may be extended to 29 months if an individual is determined to be disabled (for Social Security disability purposes) and **the administrator is notified of that determination within 60 days. The affected individual must also notify the administrator within 30 days of any final determination that the individual is no longer disabled.** In no event will continuation coverage last beyond 3 years from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

However, the law also provides that your continuation coverage may be cut short for any of the following five reasons:

- (1) The company no longer provides group health benefits to any of its employees;
- (2) The premium for continuation coverage is not paid when due;
- (3) You become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have;
- (4) You become entitled to Medicare;
- (5) You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

You do not have to show that you are insurable to choose and obtain continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage: the administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you must pay all of the cost of coverage for your continuation coverage, including an administrative fee of up to 2% of the cost of coverage.

This plan may be changed or terminated at any time with or without further notice.

Since 1974, LFS Benefit Services...



has been taking care of the growing benefit needs of numerous client companies. Over the years, we have developed a service philosophy that is characterized by individual attention and custom service. LFS has a sound reputation for honesty, integrity and thoroughness. Our emphasis on customer service goes a long way to meet our clients' needs. From coast to coast. From the present into the future.

If you have any questions or need assistance in enrolling in
The Choice Account, please contact LFS.



BENEFIT PLANNERS & ADMINISTRATORS

Toll-free Customer Service Helpline: 800-662-5970
Toll-free General Line: 800-227-3612 ○ Local Line: 714-774-8051
Email: helpline@lfsc.com

Online Account Information: www.thechoiceaccount.com