

CAFETERIA PLAN ADMINISTRATION

Flexible Spending Account (FSA)

Dependent Care Account (DCA)

Transit & Parking (TRN)

Premium Only Plan (POP)

Watch our Video!



SIGN UP TO SAVE!



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Cafeteria Plans (including FSA, DCA, TRN and POP) are a tax-advantaged way for you to pay for expenses with “Pre-Tax” dollars. This means you may elect a reduction from your paychecks to pay for eligible expenses that are either medical in nature (including prescription) or related to dependent care. The pre-tax benefit creates a savings around 20-40% (based on your tax bracket) and to take advantage of this opportunity all you would need to do is create an election for the items that you already pay for out of your pocket.

HOW TO GET A PAY RAISE!

Without an FSA		With an FSA	
Monthly Gross Earnings	\$3500	Medical Gross Earnings	\$3500
		Medical Expenses	-\$100
		Prescription Expenses	-\$200
		Day Care Expenses	-\$400
Taxable Income	\$3500	Taxable Income	\$2800
Payroll Taxes @ 25%	-\$875	Payroll Taxes @ 25%	-\$700
Net Income	\$2625		
Medical Expenses	-\$100		
Prescription Expenses	-\$200		
Day Care Expenses	-\$400		
Take Home Pay	\$1925	Take Home Pay	\$2100

This example represents \$175 of monthly additional take home pay or \$2,100 per year for expenses that you already pay for!

An FSA allows you to pay for certain unreimbursed medical, dental and/or vision with pre-tax dollars.

The annual election for the FSA is available from the first day of the Plan Year.

Dependent Care Accounts only reimburses up to the amount contributed through payroll.

The “Use-It-Or-Lose-It Rule” requires any unreimbursed employee contributions be forfeited.



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EXAMPLE OF ELIGIBLE EXPENSES

Benefit Analysis Worksheet

Section A: Anticipated Medical Costs Per Year for You and Your Family

Health insurance deductibles, co-pays, etc. \$

Vision care (eye exams, contacts, eye glasses, etc) \$

OTC or Prescription drugs (including birth control) \$

Dental expenses (exams, orthodontia, etc) \$

ANNUAL ELECTION \$

Section B: Expected Dependent Care Expenses

How much do you pay for childcare? \$

How much do you pay for eldercare? \$

ANNUAL ELECTION \$

Section C: Expected Transit & Parking Expenses

How much do you pay for parking/transit? \$

MONTHLY ELECTION \$

If the amounts you have identified here is what you wish to be your Annual Election amounts, please add them to the Enrollment Form on the next page.

- Abdominal supports
- Acupuncture
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Birth Control (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Contact Lenses
- Convalescent home (for medical treatment only)
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Drug addiction therapy
- Drugs (prescription)
- Eyeglasses
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Insulin treatment
- Lab tests
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychologist
- Radium Therapy
- Registered nurse
- Surgeon
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment



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POLESTAR BENEFITS, INC. - EMPLOYEE ENROLLMENT FORM

SUBMIT FORMS TO: 412 Jefferson Parkway, Suite 202 - Lake Oswego, OR 97035 **OR Fax** (888) 539-9565 **OR Email** info@polestarbenefits.com

EMPLOYER		EFFECTIVE DATE		ENROLLMENT TYPE <input type="radio"/> Open Enrollment / New Hire <input type="radio"/> Add / Change Reason: _____			
EMPLOYEE INFORMATION							
LAST NAME		FIRST NAME		MI	SSN	DATE OF HIRE	DATE OF BIRTH
MAILING ADDRESS		APT	CITY		STATE	ZIP	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE
EMAIL ADDRESS (REQUIRED)					PHONE	ALT. PHONE	
DEPENDENT INFORMATION							
<i>Special Request: If a Benefit Card is offered, would you like an additional card for your spouse?</i> <input type="radio"/> YES <input type="radio"/> NO							
SPOUSE NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE	CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE
CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE	CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE
CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE	CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE
SECTION 125 - FLEXIBLE (FSA), DEPENDENT CARE (DCA) SPENDING ACCOUNT, TRANSIT ACCOUNT & PREMIUM ONLY PLAN				DIRECT DEPOSIT AUTHORIZATION			
Flexible Spending Account Election			ACKNOWLEDGEMENT AND AUTHORIZATION: I hereby request coverage as outlined above under the Polestar Benefits, Inc. plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.*** 125/FSA and HRA Acknowledgement ***The dependents for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for support. I am aware the premium and other contributions made under this plan are the property of my employer and will be used to purchase the elected coverage and cannot be refunded. Reimbursement account claims must be accompanied by proper documentation (i.e. a reimbursement request and related receipt(s) or Explanation of Benefits) of the out-of-pocket expense and be incurred within the plan year. This agreement cannot be revoked or changed, unless I experience a qualified change in status. WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud, which is a crime.				
PAY PERIOD ELECTION \$	# OF PAY PERIODS	ANNUAL ELECTION \$					
Dependent Care Account Election							
PAY PERIOD ELECTION \$	# OF PAY PERIODS	ANNUAL ELECTION \$					
Transit Spending Account Election							
PAY PERIOD ELECTION \$	# OF PAY PERIODS	MONTHLY ELECTION \$					
Premium Only Plan Election			BANK ACCOUNT INFORMATION <input type="radio"/> CHECKING <input type="radio"/> SAVINGS Routing # _____ Account # _____				
ENTER THE TOTAL AMOUNT PER MONTH	MONTHLY ELECTION \$	EMPLOYEE SIGNATURE					DATE
DECLINATION OF PARTICIPATION My Employer's Cafeteria Plan has been explained to me; I have been given the opportunity to participate and have elected not to do so in: <input type="radio"/> Flexible Spending Account <input type="radio"/> Dependent Care Account <input type="radio"/> Transit Account				<i>I have read and understand the statements above. I hereby authorize Polestar Benefits, Inc. to initiate direct deposits to the bank account listed above. It is my responsibility to notify Polestar Benefits, Inc of any changes relating to my account. I may cancel the direct deposit option at any time.</i>			
EMPLOYEE SIGNATURE		DATE					

Q: How do I fill out the reimbursement form?

A: Select HRA, FSA, or Dependent Care on the matching line. Place subtotals in corresponding rows.

Q: What are these emails I keep getting from Polestar Benefits about “Pending Transactions”?

A: Most transactions made with your Benefits Card must be confirmed, due to federal guidelines. Emails are sent every 15 days to request the proof of expense(s), up to 45days after the transaction. If we have not received the requested information, the Benefits Card will be temporarily inactivated and any manual claims will be offset by the pending amount.

Your Benefits Card can be reactivated with 1 business day after receipt of the requested information.

Q: Did you get my claim request/fax?

A: If you have not received a reimbursement within 15 business days from when you submitted your claim, please contact us and we will provide information of any pending status and when you should expect to receive your reimbursement.

Q: Why do I have to submit proof or validation of why I used my Benefits Card?

A: The IRS’ federal guidelines mandate that all expenses must be adjudicated. We are the responsible party to confirm service dates, services provided, merchant and dollar amount are eligible for the pre-tax dollars being spent in accordance with the rules of the Plan(s).

Q: What is an Explanation of Benefits (EOB)?

A: EOB’s are supplied from your medical insurance company stating deductible, co-pay, coinsurance & YTD expenses. It is sent to your mailing address and it generally states at the top “THIS IS NOT A BILL.”

Q: I submitted a claim, where is my money/check?

A: If you have not received reimbursement within 15 business days from when you submitted your claim, please contact us and we will provide information of any pending status and when you should expect to receive your reimbursement.

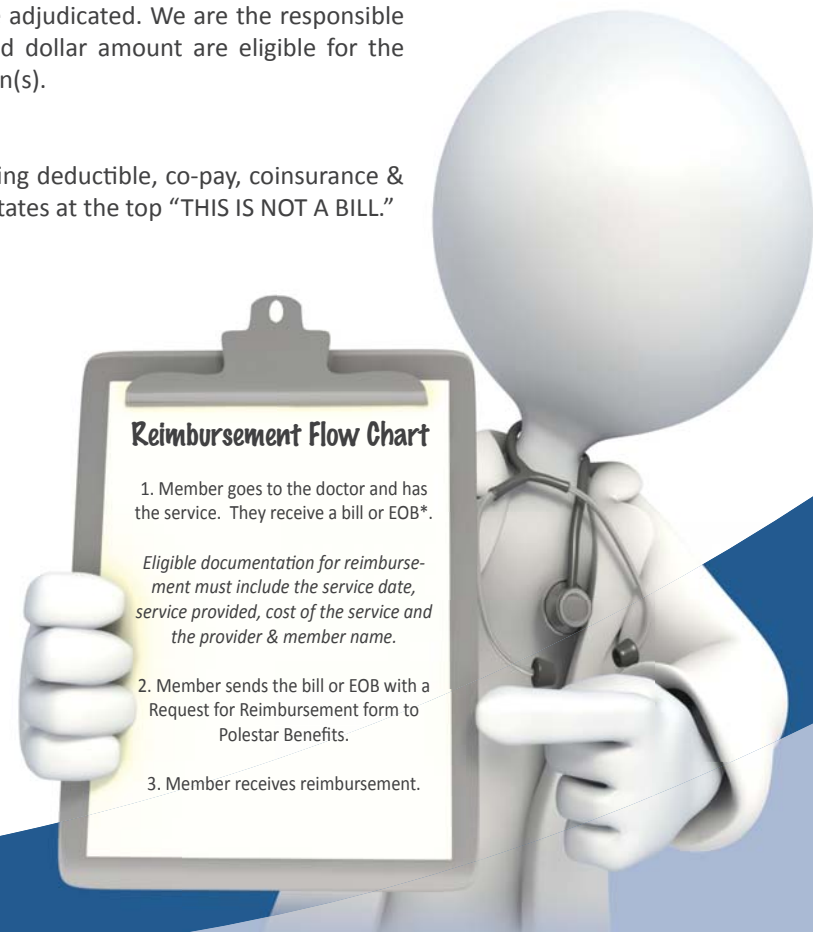
Q: How do I submit a claim?

A: Send in the Polestar Benefits “Request for Reimbursement” form and your proof of expense to 412 Jefferson Parkway, Suite 202 - Lake Oswego, OR 97035 or Fax to (888) 539-9565, or by email to claims@polestarbenefits.com.

The proof of service/product(s) covering can either be a bill or invoice that illustrates service date, service provided, expense to the member and provider.

Q: How do I log into my account?

A: Your HR manager will have user guide to provide directions of how create your online benefits account. Your Employee ID# is your Social Security Number (no dashes).



POLESTAR BENEFITS, INC. - REQUEST FOR REIMBURSEMENT

MEMBER INFORMATION

SEND CLAIMS TO

Company Name		Comments	Fax	(888) 539-9565
Employee Name			Email	claims@polestarbenefits.com
Employee Phone #			Mailing Address	412 Jefferson Parkway, Suite 202
Employee Email				Lake Oswego, OR 97035

Please visit www.polestarbenefits.com for additional forms and information.

REIMBURSEMENT REQUESTED

Please list eligible medical, dental, vision services and/or expenses for you and your family that you have not already claimed through Polestar Benefits, Inc. in the appropriate boxes below. Only list the amount of the expense you are eligible for and is not being reimbursed through another Plan, by another Administrator/Carrier.

Services for Reimbursement	Reimburse from HRA, FSA, Transit or DCA	Estimated Amount to Reimburse
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
IF ANY EXPENSES WERE COVERED BY INSURANCE, PLEASE SEND THE EXPLANATION OF BENEFITS (EOB)	EXPLANATION OF BENEFITS THIS IS NOT A BILL	

4 KEYS TO A QUICK REIMBURSEMENT

- 
- Service Date**
 - Service Provided**
 - Cost of Service**
 - Provider / Member Name**

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS FORM. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. **IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED (see above), YOUR REIMBURSEMENT WILL BE DELAYED.**

I certify that these statements are true and that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my tax dependents, and/or spouse (if filing taxes jointly). I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed by Polestar Benefits, Inc. may not be claimed on my individual tax return at the end of the year.

Employee Signature	Date
IF YOUR ADDRESS HAS CHANGED, PLEASE LIST BELOW.	
Street/PO Box	
City	State Zip

**If you have questions about filing claims,
please contact us!**
Toll Free: (855) 222-3358
Email: claims@polestarbenefits.com

