

FLEXIBLE BENEFIT PLAN INFORMATIONAL PACKET

Employer Sponsored Insurance Premiums
Health Flexible Spending Account
Dependent Care Flexible Spending Account



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INTRODUCTION

Take advantage of a benefit choice that can increase your spendable income - a flexible benefit plan. You can enhance your benefits package by participating in this valuable option available through your employer.

As a benefits eligible employee, you may be eligible to enroll in the Flexible Benefit Plan (refer to the SPD for eligibility rules). The Plan provides you an opportunity to set aside part of your pay on a pre-tax basis, thereby lowering your taxable income, reducing your social security and income taxes and increasing your spendable income.

The information contained in this packet describes the basic features of the Plan and how it operates in an effort to help you choose the benefits that best protect you and your family. This is your benefit, and it is important that you understand how it works and how it can help you.

Not all of the information contained in this packet may apply to your plan. The "Highlight Sheet", available through your employer, lists the plans available under your Flexible Benefits Plan and the maximum amounts you can contribute. Please refer to this sheet when making your elections.

Please note this packet addresses only the key components of the Flexible Benefit Plan. Consult the Plan Document or Summary Plan Description for more details.

EMPLOYER SPONSORED INSURANCE PREMIUMS

Any portion of an employee's premiums not paid for by the Employer for employer-sponsored health insurance will be paid with "pre-tax" dollars unless you instruct your Employer to deduct them on an after-tax basis. You should reference the materials specific to your Flexible Benefit Plan as to what benefit plan premiums are eligible to be paid with pre-tax dollars. The advantage of paying benefit plan premiums on a pre-tax basis is your contributions to the Plan are taken out of your paycheck before FICA, federal or state income taxes are calculated, which means you pay less in taxes. The contribution necessary to obtain the health benefits will be communicated by your Employer at the time you choose to enroll in the benefit plan(s).

FLEXIBLE SPENDING ACCOUNTS (FSAs)

***HEALTH CARE FLEXIBLE SPENDING ACCOUNT**

By enrolling in a Health Care Flexible Spending Account, employees are able to pay for eligible out-of-pocket medical and dental expenses on a pre-tax basis with deductions taken directly from salary. These deductions reduce an employee's gross income on his/her Form W-2 for federal, state and social security tax purposes. These deductions are spread out evenly over each payroll and allocated to your Health Care Flexible Spending Account for reimbursement of covered expenses. Participation in a Health Care Flexible Spending Account that includes medical expenses will disqualify you and your spouse from contributing to a Health Savings Account.

***DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

By enrolling in a Dependent Care Flexible Spending Account, employees are able to pay for eligible dependent care expenses on a pre-tax basis with deductions taken directly from salary. The maximum you may deposit to a Dependent Care Flexible Spending Account is \$7,500 per year (\$3,750 if married filing a separate tax return) or the lesser of you or your spouse's earned income.

Please refer to your "Highlight" sheet for accounts available and the maximum amounts you are eligible to set aside.

HOW DOES THE PLAN SAVE ME MONEY?

The following example illustrates how the Plan saves you money. Assume that your monthly share of the group medical insurance premium is \$250 per month, your monthly income is \$2,000, and you are in a 15-percent federal income tax bracket and a 7.5-percent state income tax bracket. Assume also that you expect to have \$2,400 in uninsured medical expenses during the year. If you pay your health insurance premiums using pre-tax dollars and your uninsured medical expenses using the Health Care Flexible Spending Account, you will save \$135 per month, or \$1,620 per year. These amounts are computed as follows:

	<u>With a Pre-tax Plan</u>	<u>Without a Pre-tax Plan</u>
Salary	\$2,000	\$2,000
LESS:		
Health Insurance Premium	(250)	0
Uninsured Medical Expenses	<u>(200)</u>	<u>0</u>
Taxable Income	\$1,550	\$2,000
LESS:		
Federal Income Tax (15%)	(233)	(300)
State Income Tax (7.5%)	(116)	(150)
Social Security FICA (7.65%)	(119)	(153)
Health Insurance Premium	0	(250)
Unreimbursed Medical Expenses	<u>0</u>	<u>(200)</u>
Net Take Home Pay	\$1,082	\$947
Monthly Tax Savings	\$ 135	
Annual Tax Savings	\$1,620	

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

WHAT IS A HEALTH CARE FLEXIBLE SPENDING ACCOUNT?

A Health Care Flexible Spending Account allows you to set aside tax-free money to cover eligible health care expenses you incur for you and your dependents during the plan year. Eligible dependents include your spouse and your adult child who as of the end of the taxable year has not attained age 27 and regardless of whether or not this individual is a full-time student, disabled or married. **By participating in a Health Care Flexible Spending Account that includes reimbursement of medical expenses, you and/or your spouse are disqualified from contributing to a Health Savings Account.**

ELIGIBLE HEALTH CARE EXPENSES

Eligible health care (medical/dental/vision) expenses are expenses that are “medically or dentally necessary.” This means the expense must be for the diagnosis, treatment or prevention of disease and for treatment affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness. In addition, to qualify as a reimbursable health care expense the expense must:

- be incurred (received) during your eligible period of coverage; and
- not be reimbursable from any other health insurance or reimbursement program.

Expenses incurred prior to your effective date are not eligible for reimbursement. Special plan provisions such as a grace period or a rollover provision will determine whether expenses incurred after the plan year end date are eligible for reimbursement. Refer to your specific plan documents.

The IRS imposes certain restrictions on Health Care Flexible Spending Accounts, including the following:

- Under the “use or lose” rule, participants who submit claims that are less than the participant’s annual election are required to forfeit the unused funds.
- In 2005, the IRS modified the “use or lose” rule allowing an employer to include a grace period option. Under the grace period, an employee with an account balance remaining at the end of a plan year may continue to use that balance to reimburse claims incurred during the 2 ½ months following the end of the plan year. The grace period is optional and must be formally adopted by the employer to apply. You should review the materials specific to your Flexible Benefit Plan to see if the grace period is included under your Plan.

- In October of 2013, the IRS modified the “use or lose” rule allowing an Employer to include a rollover provision of a year-end account balance into the next plan year that is equal to 20% of the maximum salary reduction contribution allowed under Section 125(i) of the Internal Revenue Code, following the end of the run-out period. The rollover provision is optional and must be formally adopted by the employer to apply. You should review the materials specific to your Flexible Benefit Plan to see if the rollover provision is included under your Plan.
- Employers are not allowed to offer the grace period and the rollover provision during the same plan year. It is important that you review the documents specific to your Flexible Benefit Plan to determine if and how these provisions may apply to your Plan. If your plan does not include either the grace period or the rollover provision, all unused funds in your Health Care Flexible Spending Account will be forfeited under the “use or lose” rule following the end of the run-out period. For this reason, you should estimate your anticipated expenses for the plan year conservatively.
- You will receive a statement shortly after the start of the plan year. The statement will provide information as to how to log onto our website and view your account information. Under the run-out provision you may continue to submit eligible expenses incurred during the plan year for up to 90 days after the Plan Year ends. Employees who terminate employment during the Plan Year will be given **90** days from their date of termination in which to submit expenses incurred prior to their termination.

ONCE ENROLLED, YOU MAY NOT CHANGE YOUR ELECTION

To comply with IRS regulations, you may only make a change in your election at the beginning of each plan year. This means you may not make a change in your elections after the open enrollment period unless you experience a family status change. Examples include - marriage, divorce, birth, adoption, death, loss of spouse's employment, etc.

Be sure to contact your employer if any of these changes apply to you so that you can complete a change form. The completed change form must be received within 30 days of the change to make a new election.

SOCIAL SECURITY BENEFITS

Any reduction in your taxable pay for Social Security purposes may also lead to a reduction in your Social Security benefits. For most employees, the reduction in Social Security benefits will be insignificant compared to the value of paying lower taxes today.

SEPARATE ACCOUNTS

Under IRS regulations, each flexible spending account (FSA) is separate and is not interchangeable. Dependent (Day) care may only be reimbursed under the Dependent (Day) Care FSA and unreimbursed medical expenses may only be reimbursed through the Health Care FSA.

ELIGIBLE EXPENSES

The following list gives examples of the types of health care expenses that may be eligible. Only expenses that are not reimbursed by insurance or another reimbursement program can be claimed. Expenses for cosmetic procedures that are not medically necessary are not eligible for reimbursement. This list is compiled from IRS Publication 502, which you may obtain from the Internal Revenue Service. For a comprehensive list visit our Health Care Expense Table at www.benefitextras.com
Password: HCET2022

- | | | |
|--|--|--|
| ✓ Alcoholism Treatment | ✓ Eyeglasses and Eye Exams | ✓ Stop Smoking Programs |
| ✓ Ambulance | ✓ Expenses in Excess of Medical/Dental Plan Limits | ✓ Surgical Fees |
| ✓ Artificial Limb | ✓ Hearing Aids | ✓ Telephone (Special for the Deaf) |
| ✓ Birth Control Pills | ✓ Hospital Services | ✓ Therapy Programs |
| ✓ Braille Books and Magazines | ✓ Insulin | ✓ Tuition at Special School for the Challenged |
| ✓ Breast Pumps | ✓ Laboratory Fees | ✓ Weight Loss Programs |
| ✓ Chiropractor | ✓ Laser Eye Surgery | ✓ Vision Care |
| ✓ Co-payments or Co-insurance (Amounts you pay) | ✓ Orthodontia | ✓ Wheelchair |
| ✓ Crutches | ✓ Orthopedic Drugs | ✓ X-rays |
| ✓ Deductibles under Medical/Dental Plans (Amounts you pay) | ✓ Over the Counter Items (see following page) | |
| ✓ Dental Treatment | ✓ Prescription Drugs | |
| | ✓ Routine Physicals | |
| | ✓ Sterilization Fees | |

INELIGIBLE EXPENSES

The IRS specifically disallows reimbursement for expenses that benefit or maintain overall good health or that is as a result of a personal decision where no disease or defect is present. This is a partial list of medical care expenses not eligible for reimbursement.

- | | | |
|----------------------|---------------------------------|---|
| ✓ Clip-on Sunglasses | ✓ Health Club Membership | ✓ Meals |
| ✓ Cosmetic Surgery | ✓ Herbal Remedies | ✓ Over-the-Counter Drugs (see following page) |
| ✓ Custodial Care | ✓ Illegal Drugs | ✓ Personal Use Items |
| ✓ Diaper Service | ✓ Insurance Premiums | ✓ Non Prescription Safety Glasses |
| ✓ Divorce Expenses | ✓ Late Fees or Interest Charges | ✓ Teeth Bleaching |
| ✓ Ear Piercing | ✓ Liposuction | ✓ Teeth Guards |
| ✓ Electrolysis | ✓ Marriage Counseling | ✓ Tooth Bonding |
| ✓ Exercise Program | ✓ Maternity Clothes | ✓ Union Dues |
| ✓ Face Lift | | |
| ✓ Fitness Program | | |
| ✓ Funeral Expenses | | |

Eligible Over-the-Counter items - Items used for “medical care” (to alleviate or treat personal injuries) are reimbursable under the health care flexible spending account. Some examples of eligible over-the-counter items that can be reimbursed are:

- ✓Feminine menstrual products
- ✓Contact lens solutions/cases
- ✓Insoles
- ✓Wrist/ankle braces/supports
- ✓Pregnancy tests
- ✓Reading glasses
- ✓Test strips
- ✓Blood pressure monitors
- ✓Crutches
- ✓Acid controllers
- ✓Antibiotic products
- ✓Anti-gas
- ✓First aid supplies (i.e. thermometers, ace bandages)
- ✓Allergy & sinus
- ✓Anti-diarrheal
- ✓Sleep aids
- ✓Medicated ointment/creams
- ✓Cough, cold & flu
- ✓Anti-fungal / anti-itch
- ✓Laxatives
- ✓Aspirin / pain relief
- ✓Cold sore remedies
- ✓Digestive aids
- ✓Hemorrhoid preps

Ineligible Over-the-Counter Drugs (these products are not considered medical care and therefore are NOT reimbursable through the plan):

- ✓Mouthwash
- ✓Chap stick / lip balm
- ✓Shaving cream / razors
- ✓Soap / shampoo
- ✓Teeth whitening kits
- ✓Toothpaste
- ✓Q-tips
- ✓Lotions, anti aging creams
- ✓Cosmetics
- ✓Cotton balls
- ✓Deodorants
- ✓Vitamins taken for your general health

Claim Substantiation As with any claim submitted under the health care flexible spending account, Benefit Extras requires an itemized bill from a third-party substantiating the expense. In the case of an eligible over-the-counter item, the eligible itemized bill will commonly be the cash register receipt. If the cash register receipt does not clearly indicate the item(s) purchased, please provide this information either on the front of the claim form or directly on the cash register receipt. If this information is not provided at the time you submit your claim, your claim will be returned requesting the additional information.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

One of the most important issues to a working parent is childcare. Not only is it difficult to find and arrange for good childcare, it can be very expensive. Also, with our aging population, many people are caring for elderly or disabled dependents that are unable to care for themselves.

WHAT IS A DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT?

The Dependent Care Flexible Spending Account is designed to give you a tax saving way to pay for these expenses. It is important to remember that the dependent care expenses must meet certain IRS requirements. The expenses must be necessary for you to continue working. If married, you and your spouse must both be working, or your spouse must be a full-time student or disabled.

To be considered a “dependent,” the person receiving care must be eligible to be claimed as your dependent on your federal income tax return and be either:

- under the age of 13; or
- your spouse or other dependent who is physically or mentally incapable of self-support, and who spends at least 8 hours per day in your home.

USING TAX-FREE DOLLARS TO PAY FOR EXPENSES

With a Dependent Care Flexible Spending Account you can set aside money to cover dependent care expenses on a tax-free basis. This way you save money because you never have to pay taxes on the money you set aside in the account. For example, if you incur \$2,000 of eligible dependent (day) care expenses in a year, you could save about \$600 in income taxes:

With a Flexible Spending Account		Without a Flexible Spending Account
\$24,000	Salary	\$24,000
-2,000	Pretax Child Care	0
-----		-----
\$22,000	Taxable Income	\$24,000
-6,600	Taxes (30%)	-7,200
-----		-----
\$15,400	After-Tax Income	\$16,800
0	After-Tax Child Care	-2,000
-----		-----
\$15,400	Take-Home Pay	\$14,800

REIMBURSABLE DEPENDENT CARE EXPENSES

To qualify as a reimbursable dependent care expense, the expense must be incurred during the plan year. Any dependent care expenses incurred *prior* to the plan year are not reimbursable.

SETTING UP AN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

To set up a Dependent Care Flexible Spending Account, you must first decide how much money to set aside for the plan year. You may deposit any amount up to \$625 a month (\$7,500 annually for a full plan year). Your maximum amount is \$312.50 a month if you are married filing a separate income tax return.

The IRS limits the amount of money you may contribute into a Dependent Care Flexible Spending Account to the smallest of:

- your income,
- your spouse's income, or
- \$7,500 per family (\$3,750 if married filing separate returns).

There are special IRS provisions if your spouse is a full-time student or is disabled.

SPECIAL NOTICE CONCERNING DEPENDENT CARE EXPENSES

Under current law, a tax credit is available for dependent day care expenses of the same type eligible for reimbursement through the Plan. The amount of the credit depends on the taxpayer's adjusted gross income and ranges from 35% to 50% of eligible expenses up to a limit of \$3,000 of expenses if there is one eligible Dependent and \$6,000 of expenses if there are two or more eligible Dependents. You will not be eligible to take the tax credit for any expenses reimbursed through the Plan. In addition, the maximum amount of expenses eligible for the credit will be reduced on a dollar-for-dollar basis for each dollar of dependent day care reimbursements you receive under the Plan.

Determining whether taking the credit or reimbursement under the Plan is more beneficial involves complex calculations. Because each individual's situation is different, the Employer cannot predict whether or not it would be more beneficial for you to take the tax credit for dependent day care expenses or to have your expenses reimbursed under the Plan. You may want to consult your tax advisor to determine whether the tax credit or Dependent Care Flexible Spending Account is more beneficial to your personal situation.

ONCE ENROLLED, YOU MAY NOT CHANGE YOUR ELECTION

To comply with IRS regulations, you may only make a change in your election at the beginning of each plan year. This means you may not make a change in your elections after the open enrollment period unless you experience a family status change. Examples include - marriage, divorce, birth, adoption, death, loss of spouse's employment, etc. **Please Note:** Regulations enacted as of January 1, 2001 may allow you to change your dependent care election as your day care needs change during the plan year. Consult the Plan Document or Summary Plan Description for more details.

Be sure to contact your employer if any of these changes apply to you so that you can complete a change form. The completed change form must be received within 30 days of the change to make a new election.

SOCIAL SECURITY BENEFITS

Any reduction in your taxable pay for Social Security purposes may also lead to a reduction in your Social Security benefits. For most employees, the reduction in Social Security benefits will be insignificant compared to the value of paying lower taxes today.

SEPARATE ACCOUNTS

Under IRS regulations, each flexible spending account (FSA) is separate and is not interchangeable. Dependent (Day) care may only be reimbursed under the Dependent (Day) Care Flexible Spending Account and unreimbursed medical expenses may only be reimbursed through the Health Care Flexible Spending Account.

HEALTH CARE AND DEPENDENT CARE ACCOUNT WORKSHEET

The purpose of this worksheet is to determine the medical, dental, vision or dependent care (day care) expenses for which you are not reimbursed from any other benefit plan. Be conservative and estimate only those expenses you are reasonably certain you will incur during the plan year to avoid any use or lose rules that may apply. Certain plans include a grace period or rollover provision which may minimize the use or lose rules. Refer to the materials specific to your plan for details.

ESTIMATED UNREIMBURSED HEALTH CARE EXPENSES

	Annual Amount
Medical Deductibles/Co-payments	_____
Medical Supplies	_____
Other Medical Providers (Chiropractic, podiatrists, etc.)	_____
Annual Physical Exam	_____
Dental Deductibles/Co-payments	_____
Dental Expenses (Exams, cleaning, fillings, etc.)	_____
Prescription Drug Deductibles/Co-payments	_____
Vision Care (Eye exams, contacts, eye glasses)	_____
Orthodontia	_____
Any Other Eligible Expenses	_____
TOTAL PROJECTED EXPENSES FOR THE PLAN YEAR	_____

NUMBER OF PAY PERIODS IN THE PLAN YEAR (or partial year, if applicable) _____

DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS _____ *

*Enter result on the enrollment form under Health Care Flexible Spending Account Elections PER PAY PERIOD amount.

ESTIMATED DEPENDENT CARE (DAY CARE) EXPENSES

	Annual Amount
Day Care for Eligible Dependents	_____
Pre-School Educational Programs	_____
TOTAL PROJECTED EXPENSES FOR THE PLAN YEAR	_____

NUMBER OF PAY PERIODS IN THE PLAN YEAR (or partial year, if applicable) _____

DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS _____ **

**Enter result on the enrollment form under Dependent Care Flexible Spending Account Elections PER PAY PERIOD amount.

ENROLLMENT INSTRUCTIONS

As a benefit eligible employee, you are required to complete an election form prior to the date you first become eligible for the plan or prior to the first day of each plan year.

The election form has the following Sections you need to complete.

- **Section I: Employee Information** – Please print all the requested data.
- **Section II: Account Elections** – This section is subdivided to reflect the three accounts under the plan. Please refer to the “Highlight” sheet for available accounts and maximums specific to your Employer’s Flexible Benefit Plan.
 - 1. Pre-tax Premium Election** – If you are currently paying a portion of your group benefit plan premiums, this amount may be paid on a pre-tax basis.
 - 2. Health Care Flexible Spending Account** – Use the Health Care Expense Worksheet to calculate the amount of health care expenses you will have to pay out of your pocket during the plan year. Decide how much of this amount you wish to contribute, up to the plan maximum. Your annual election will be divided equally by the number of payrolls in the plan year.
 - 3. Dependent Care Flexible Spending Account** – Using the Dependent (Day) Care Worksheet, calculate the amount of eligible day care expenses you will have during the year. Decide how much of this amount you wish to contribute annually up to the plan maximum. Your annual election will be divided equally by the number of payrolls in the plan year.

To waive participation in the Flexible Benefit Plan

- Account Elections – Indicate your desire not to participate by checking the applicable box(es). Except for a change in status, you will not be able to elect pre-tax benefits until the next anniversary date and any after-tax coverage will be outside the plan.

Sign and date the form.

- **Section III: Election Changes** – This section only needs to be completed if you are eligible to enroll mid-year or change your previous election due to a family status change. Mid-year enrollments and election changes must be requested within 30 days of the change. If elections are changed because of birth, adoption, or placement for adoption, the changes are effective as of the date of the event. In all other cases, the changes are effective as of the date the election form is signed.
- **Section IV:** To be completed by the Employer prior to submitting the form to Benefit Extras.

Enrollment/Change Form Flexible Spending Accounts

Instructions:

Check one box, complete the sections, New Plan Year Election (New hires) (Complete sections I and II)
Sign and date the form Change for the Plan Year (Complete sections I, II and III)

Section I – Employee Information (Please print)

Social Security #	Location/Division
Participant Name (Last, First, MI)	Date of Birth
Home Address	City State Zip

Section II- Account Elections (Please complete items 1, 2, 3 & 4)

1. Pre-tax Premium Election: I elect to have my required employee contributions withheld on a pre-tax basis for these coverages. (Availability of plans and contributions necessary to obtain coverage will be communicated by your employer prior to participation.)

Check the box for the coverage premium(s) you are electing Medical Dental

I do not wish to make a pre-tax premium election.

2. Health Care Flexible Spending Account: I elect \$_____ per payroll or \$_____ for the plan year to be contributed on a pre-tax basis to my Health Care Flexible Spending Account or, if an election change the amount elected is for the remainder of the Plan Year. *I understand that by participating in the health care flexible spending account I (and my spouse) am disqualified from having a Health Savings Account ("HSA").*

I do not wish to participate in the Health Care Flexible Spending Account.

3. Dependent Care Flexible Spending Account: I elect \$_____ per payroll or \$_____ for the plan year to be contributed on a pre-tax basis to my Dependent Care Flexible Spending Account or, if an election change the amount elected is for the remainder of the Plan Year.

I do not wish to participate in the Dependent Care Flexible Spending Account.

I hereby authorize my employer to deduct from my pay on a pre-tax basis the amounts elected above for the Plan Year. I understand that the payroll deducted amount will be available for the reimbursement of my qualifying expenses incurred during the Plan Year (or grace period, if part of the plan) and/or for the payment of my premiums in accordance with the terms of the formal Plan Documents and while I am a participating employee.

Employee Signature _____ Date _____

Section III – Election Changes (Check the proper box, indicate the date of the change, sign & date the section)

Complete this section only if you are eligible to enroll mid-year or change your previous election due to a family status change. Mid-year enrollments and election changes MUST be requested within 30 days of the change.

- | | |
|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Birth or Adoption of Child | <input type="checkbox"/> Commencement or Termination of Employment of Spouse |
| <input type="checkbox"/> Change from Full-Time to Part-Time or Part-Time to Full-Time status by employee or employee's spouse | |
| <input type="checkbox"/> Significant Change in Health Coverage due to Spouse's Employment | |
| <input type="checkbox"/> Change in Cost/Coverage to Daycare | <input type="checkbox"/> Death of Spouse or Child |
| <input type="checkbox"/> Termination of Employment | <input type="checkbox"/> Other: _____ |

I hereby revoke my previous deduction authorization for the current Plan Year and authorize my employer to make the payroll deductions indicated above for the remainder of the Plan Year.

Employee Signature _____ Date _____

Section IV for Employer Use Only (Employer Must Complete This Section For Any Changes)

Plan Sponsor / Employer Name _____ Location _____
Effective Date _____ 1st Payroll Change _____
Signature of Plan Administrator _____

REIMBURSEMENT PROCEDURES

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

To receive reimbursement you must complete a Flexible Spending Accounts claim form and attach the required substantiation. Once approved, you will be reimbursed the full amount of your eligible expenses up to your elected Health Care Flexible Spending Account limit.

Claim Reimbursement Documentation Required:

- A completed (and signed) Flexible Spending Accounts claim form; and
- If the expense is covered by insurance, an Explanation of Benefits (EOB). An EOB is a statement from the insurance carrier that explains how much of the health care charges will be paid by insurance.
- If the expense is not covered by insurance, an itemized bill or an invoice that clearly identifies the name of the service provider, the date of service, the service rendered and the cost of service.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A completed (and signed) Flexible Spending Accounts claim form, which shows the name of the provider, the dates of service, the cost of service, the amount incurred and the TIN or SSN for that provider. Section Three must be completed, signed and dated by the service provider.

Dependent (day) care claims are reimbursed in an amount equal to the balance in your account. Any unpaid requests will be automatically considered for reimbursement as more dollars are contributed from your pay to your Dependent Care Flexible Spending Account.

Incomplete or incorrect documentation will delay processing of claims.
Instructions for completing the claim form are also provided on the form.

Mail or Fax Claim To: **Benefit Extras, Inc.**
P.O. Box 1815
Burnsville, MN 55337
Phone: (952) 435-6858

Flex Spending
Accounts Claim Form
Fax: (952) 435-8435

1. Employer/Employee Information
(Must be completed)

Employer
Employee Name

Complete address below ONLY
if it has changed

Street		
City	State	Zip
Soc. Sec. #	Date of Birth	

2. Instructions for Completion

- Fill out the date, description and amount of expense, attach itemized bill, **sign** and date the form. If applicable, indicate whether the claim is to be paid under the Grace Period provision of the Plan (not available with all Plans).
- Itemized bills **must** include provider name, date of service, service provided and cost.
- **Note:** Canceled checks, copies of checks, credit card statements and credit card slips are not eligible documentation.
- Claims will be processed upon receipt, compliant with the sufficient balance requirement for dependent care spending accounts.
- The summary plan description provides eligibility rules for unreimbursed medical and dependent care expenses.

3. List of Expenses

Health:	*Date Expense Incurred	Description of Expenses	Amount
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
		Total \$	_____

GRACE PERIOD (does not apply to all employer groups – consult your employer for details)
 By checking this box, I am requesting the attached claim(s) be reimbursed out of my last year's Health Care Flexible Spending Account. I understand that by not checking the box, my claim will be processed under the plan year in which the expense(s) was incurred and that I may not request the claim be re-processed at a later date. The Grace Period provision does not apply to the Dependent Care Account.

Dependent Care:						
Name Of Provider	Provider Tax ID#	Dependent Name	Age	Dates of Service	Amount	
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
						Total \$ _____

Dependent Care Provider Signature (Required unless submitting a receipt)	_____	Date	_____
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4. Employee Certification

I, the undersigned, certify that the above expenses were incurred by me (and/or my spouse/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and to the best of my knowledge and belief are eligible for reimbursement under my account. I have attached WRITTEN PROOF (itemized bills) of these expenses and I (or we) will not use the expenses reimbursed through this account as deductions or credits when filing my (our) individual income tax return. If audited, I understand that it is my responsibility (not my employer's) to provide written proof that these expenses were actually incurred and eligible for reimbursement. In the event that any reimbursement that I may claim and receive under this plan is later determined by the IRS to be unsubstantiated, I hereby acknowledge and accept responsibility for any adverse tax consequences that may result to me. I understand the employer does not accept responsibility for direct payment to any individuals other than the employee.

X _____
Employee Signature (Required)

Date

Questions about the Plan?

The Summary Plan Description (SPD) is designed to explain the plan in detail and answer your questions.

A Summary Plan Description is to be provided to you at the time of enrollment.

If you have questions regarding a particular reimbursement request, you should contact the Benefit Extras, Inc.'s Flexible Benefit Department:

Benefit Extras, Inc.

P.O. Box 1815

Burnsville, MN 55337

Phone: (952) 435-6858; Toll-free 1-866-435-6858

Fax: (952) 435-8435; Toll-free 1-800-886-8793

Email: flex@benefitextras.com

Visit us on the web @ www.benefitextras.com

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