YOUR FLEXIBLE BENEFITS PLAN

Questions & Answers

1. *What is the Flexible Benefits Plan?*

The Flexible Benefits Plan is an Employer-sponsored plan that allows you to set aside a portion of your salary before taxes are calculated for the reimbursement of IRS-approved health and dependent care expenses that would otherwise have to be paid with after-tax dollars. The Plan is unique because it changes the way you pay for certain expenses so that you're left with more spending money. By participating in the Plan, you are able to pay these expenses with pre-tax (or before-tax) dollars—dollars that Uncle Sam would otherwise take.

2. *What are the advantages of enrolling in the Flexible Benefits Plan?*

We understand that your benefit needs are as unique as you are. Those needs may change from time to time—if you are single and have no children, your needs are different than for someone who is married, has several children, and whose spouse may also work. It's an approach that makes sense because it lets you tailor a benefit to meet your individual needs from year to year.

One of the greatest advantages is the tax savings generated by participating in the Plan. When you enroll in the Plan, you are reducing your taxable income as well as saving tax-free money for health care and/or dependent care expenses. Without participating, you would still pay for these expenses, but you would use dollars remaining in your paycheck after taxes are withheld. The dollars set aside from your salary are not subject to Federal, State and FICA taxes. As a general rule of thumb, you will save approximately $30 in taxes for every $100 you contribute to the Plan.

Another advantage is the opportunity it gives you to budget for out-of-pocket health care expenses due to the fact that you can access the full amount you elect for the Plan Year from the beginning of the Plan Year. Your contributions, however, are deducted by payroll deduction in equal amounts from your paychecks throughout the Plan Year. This is especially advantageous if you are anticipating a surgery, birth of a child, or if you do not have insurance coverage for dental and vision expenses.

3. *What types of expenses can be paid on a pre-tax basis?*

You may pay the following categories of expenses with pre-tax dollars. Separate "bookkeeping accounts" are set up to track your elections each Plan Year. You may choose to participate in one, two or all three accounts depending on your needs from year to year. The accounts are:

Premium Account – Contributions to the Employer-sponsored Benefit Plan(s). If you are required to share in the cost of an Employer-sponsored Benefit Plan such as the medical or dental plan, you may have this deduction taken on a pre-tax basis, automatically giving you more money in your paycheck.

Health Flexible Spending Account (FSA). This account covers eligible health care expenses incurred for you and your family that are not reimbursed by any medical, dental or vision care plan you or your dependents may have. If you or your spouse plan to contribute to a Health Savings Account during the Plan Year, please contact Arcadia or your HR Department for additional information.

Dependent Care Flexible Spending Account (FSA). This account covers eligible dependent care expenses incurred so you can work. If you are married, your spouse must also work or attend school full-time. Childcare, pre-school and before/after school expenses fall into this category.

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4. *How does it work?*

When you enroll in the Plan, you decide on an amount that will cover your expected out-of-pocket health and dependent care costs for the upcoming Plan Year. The total amount you choose to set aside for the Plan Year is divided by the number of paychecks you receive in the Plan Year. Your deductions are taken out of your paycheck before taxes are calculated and will begin with the first pay period after the Plan Year starts, or after you become eligible if you are hired during the Plan Year.

5. *How do I know how much to contribute?*

A Worksheet is available to help you estimate these expenses for you and your family. Examples of eligible and ineligible expenses are included on the back of the Worksheet.

6. *Do I need to be covered under my employer's group health plan in order to be eligible to participate in the FSAs?*

No, it is not a requirement that you are covered under the group health plan to be eligible for the FSAs. It could be that your spouse has coverage for your family under his or her employer's group health plan. Your family out-of-pocket health and dependent care expenses can still be paid on a pre-tax basis through the Plan, as long as you meet eligibility requirements.

7. *When and how do I request reimbursement from the FSAs?*

When you incur expenses eligible for reimbursement, complete a Request for Reimbursement form or submit a claim online. Attach required documentation of the expense and submit the claim to our Benefits Administrator, Arcadia Benefits Group. Claims can be submitted at any time by mail, fax or via Arcadia's online claims submission and reimbursements will generally be processed within two (2) business days of receipt. You may elect to have your reimbursements direct deposited (by electronic funds transfer) into your checking or savings account vs. receiving a check in the mail.

8. *When is the expense incurred and what documentation is required when my claim is submitted?*

"Incurred" means when the service is provided, not when you are billed for or pay for the expense. Expenses must be incurred during the Plan Year or prior to your termination date if you terminate from the Plan mid-year.

The expenses eligible for reimbursement vary according to the Health FSA option that is elected. The General-Purpose Health FSA option covers most medical, dental, Rx drugs, and vision expenses. For individuals who are contributing to a Health Savings Account (HSA), or if your spouse is making contributions to an HSA, federal regulations require the use of a Limited-Purpose Health FSA, that only reimburses vision and dental expenses allowing you to save money in your HSA for medical expenses.

If you have partial coverage under your group health plan for the expense, submit your claims to your Insurance Carrier(s) first. After your Insurance Carrier processes the claim, you will receive an Explanation of Benefits (EOB) showing the amount covered by the group health plan and the patient responsibility. Submit a copy of this EOB to be reimbursed from your Health FSA. Proof of payment of the expense is not required.

If the expense is not covered under your group health plan (for example, if you incur an expense for vision expenses and you have no vision coverage), submit an itemized receipt or statement from your health care provider.

To be reimbursed for your prescription drug co-payments, submit the co-payment receipt that shows the patient name, drug name, date the Rx was filled and amount of the co-payment. You may also submit a printout from your pharmacy containing the same information.

For dependent care reimbursement, submit an itemized statement or receipt from your day care provider, or have your provider sign the reverse side of the Request for Reimbursement form in lieu of a separate receipt. Please note that the services must actually be rendered in order to be reimbursed.

Canceled checks, credit card receipts or balance due statements cannot be accepted as documentation of your expense as all of the information required by the IRS is not shown.

9. What happens if I have money left in my account at the end of the Plan Year?

The IRS requires that balances remaining in your FSAs are forfeited. However, your plan includes a $500 Health FSA carryover provision. This means that you can carry over up to $500 of unused funds into the next Plan Year. Keep this feature in mind when estimating your Health FSA election and be aware that the limited $500 carryover only applies to the Health FSA and not to the Dependent Care FSA.

Keep in mind that you have 3 months following the end of the Plan Year to submit your claims. You may also check your balances and submit your claims via Arcadia's secure website.

10. Can I change the amount of my payroll deduction in the middle of the Plan Year? What happens if I don't set aside enough money to cover my expenses?

After the Plan Year begins, you cannot change your election during the Plan Year unless you have an IRS "change in status" and the change in your election is consistent with the change in status event. Also, you must make your election change within 30 days of the event. The IRS defines a change in status as:

- Change in employee's legal marital status—including marriage, divorce, death of spouse, legal separation and annulment.
- Change in number of dependents—including birth, adoption, placement for adoption and death.
- Change in employment status (if there is a change in eligibility for insurance coverage or Health FSA coverage), including termination or commencement of your spouse's employment or a commencement of or return from an unpaid leave of absence. For example, if your spouse terminates employment, but has insurance coverage and a flex plan through your employer, there is no loss of eligibility for insurance coverage and no changes may be made to the FSA.
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements—an event that causes the dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, or any similar circumstance.
- Residence change—a change in the place of residence of an employee, spouse or dependent (if the residence change affects the employee's eligibility for coverage, e.g., moving outside of the HMO service area).

- Other events that would allow a mid-year election change under the Dependent Care FSA are:
- Child's attainment of age 13;
- Change in day care provider's rates (as long as the provider is not a relative);
- Switching to a new day care provider; and,
- Enrollment in school decreases the necessary hours of dependent care (or ceasing to be enrolled in school increases the necessary hours of dependent care).

11. My child may start orthodontia treatment this year. Can I be reimbursed for the full cost of the orthodontia expenses?

The level of reimbursement for orthodontia expenses depends on how the orthodontia treatment contract is initially written. If your contract specifies monthly payments over the period of the orthodontia treatment, then the Plan cannot reimburse for monthly payments in advance of the treatment.

If you choose to prepay orthodontia expenses in a lump sum at the beginning of treatment, you may be reimbursed in full for the lump sum payment (up to a maximum of your annual Plan Year election or the available balance in your account).

12. How do I enroll in the Plan?

To enroll, you must make an election each Plan Year. First, complete the Worksheet included with your enrollment materials. This is a valuable tool to help calculate your projected expenses for the upcoming Plan Year. Also, please review the list of eligible and ineligible expenses shown on the reverse side of the Worksheet. Then transfer the totals of your health and/or dependent care expenses to the Enrollment Form (or enroll via online enrollment if available) and divide by the number of paychecks in the Plan Year to arrive at the amount of your pre-tax payroll deduction.

If you have any questions concerning eligible expenses, or need any assistance, please don't hesitate to call a Client Services Representative at the number below, or email your questions to Arcadia at: info@arcadiabenefits.com.

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