

# BPC



## Health Care FSA

Want an easy way to save 30% or more on medical expenses for you and your family?

A Health FSA can save many people over **\$600** each year.\*

### Q. How does it save me money?

Eligible employees may elect up to \$2,850 in 2022, to set aside pre-tax for medical expenses. By avoiding taxes on those funds, many families may save 30% or more, which can easily save you over \$600 per year.

### Q. What expenses are eligible for reimbursement?

The account can be used for medical expenses for yourself, your spouse, or your children up to age 26. You can enroll whether you are on your employer's medical plan or not. NOTE: If you also have a Health Savings Account (HSA), your FSA will be limited to dental and vision expenses only.

### Examples of Commonly Eligible Expenses:

- Commonly Eligible – Doctor and hospital bills, prescription drugs, eye exams, glasses and contacts, dental checkups and procedures, many over-the-counter medical supplies, chiropractic care, and more!
- Not Eligible – Cosmetic products or procedures, expenses for services that occurred before the plan year starts, over-the-counter medications (unless prescribed)

### Q. How will I spend the funds or be reimbursed?

You'll receive a BPC Benefits Debit Card that can be used to pay directly for most expenses. You can also submit claims for fast reimbursement online, with our BPC Benefits Mobile App, or with paper. Direct deposit reimbursement will occur within 1 or 2 business days.

### Q. What happens to any leftover money?

This depends on the specifics of your plan. There is always some potential to forfeit unused funds from an FSA election, so it's always wise to elect carefully. Some plans do include features like a \$500 rollover or 2<sup>1/2</sup> month grace period that can lower the risk of losing funds. Check your plan SPD or contact BPC for details!

*\*Actual savings will vary depending on the amount you elect and your applicable federal and state tax rates*

*\*\* Certain plans utilize lower maximum elections.*

More questions? Visit [www.bpcinc.com](http://www.bpcinc.com) to learn more!

**AMERICAN BANK AND TRUST COMPANY, N.A.  
SECTION 125 PLAN**

**SUMMARY PLAN DESCRIPTION**

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**XI  
SUMMARY**

**AMERICAN BANK AND TRUST COMPANY, N.A.**  
**SECTION 125 PLAN**

**INTRODUCTION**

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

**I**  
**ELIGIBILITY**

**1. When can I become a participant in the Plan?**

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

**2. What are the eligibility requirements for our Plan?**

You will be eligible to join the Plan once you have completed 30 days of employment. Of course, if you were already a participant before this amendment, you will remain a participant.

**3. When is my entry date?**

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

**4. Are there any employees who are not eligible?**

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are part-time. A part-time employee is someone who works, or is expected to work, less than 30 hours a week.

**5. What must I do to enroll in the Plan?**

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for a portion of the benefits you have elected.

## II OPERATION

### 1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. Also, we will make additional Employer contributions to the Plan that you may use to increase the amounts used to pay benefits. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

## III CONTRIBUTIONS

### 1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan after application of the Employer Contribution. These amounts will be deducted from your pay over the course of the year.

### 2. How much will the Employer contribute each year?

We may contribute a discretionary amount which we will determine prior to the beginning of each Plan Year. This contribution can be used for the Health Savings Account and will be made on a pro rata basis during the year. If you elect not to participate, the Employer will not contribute to the Plan on your behalf.

### 3. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

### 4. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

### 5. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

### 6. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

#### **7. May I make new elections in future Plan Years?**

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

## **IV BENEFITS**

### **1. Health Flexible Spending Account**

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is \$2,600. After 2017, the dollar limit may increase for cost of living adjustments. In addition, you will be eligible to carryover amounts left in your Health Flexible Spending Account, up to \$500. This means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

## **2. Dependent Care Flexible Spending Account**

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- (a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- (b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- (c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

## **3. Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan.
- Dental insurance premiums.
- Vision insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

#### **4. May I direct Plan contributions to my Health Savings Account?**

Yes. Any monies that you do not apply toward available benefits can be contributed to your Health Savings Account, which enables you to pay for expenses which are not covered by our insured medical plan and save taxes at the same time. Please see your Plan Administrator for further details.

## **V BENEFIT PAYMENTS**

#### **1. When will I receive payments from my accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

#### **2. What happens if I don't spend all Plan contributions during the Plan Year?**

Any monies left at the end of the Plan Year will be forfeited, except for \$500 that can be carried over into the next Plan Year or, except for amounts contributed to your Health Savings Account. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

#### **3. Family and Medical Leave Act (FMLA)**

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

#### **4. Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

#### **5. What happens if I terminate employment?**

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- (a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- (b) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection and contributions will be made on your behalf after you terminate. You must submit claims within 90 days after termination.

(c) Your Health Savings Account amounts will remain yours even after your termination of employment.

(d) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection and contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

#### **6. Will my Social Security benefits be affected?**

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

#### **7. Qualified Reservist Distributions**

If you are a member of a reserve unit and if you are ordered or called to active duty, then you may request a Qualified Reservist Distribution (QRD). A Qualified Reservist Distribution is a distribution of all or a portion of the amounts remaining in your Health Flexible Spending Account. You can only request this distribution if you are called to active duty for a period of 180 days or more or for an indefinite period. The distribution must be made during the period beginning on the date of the call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of the call.

You can receive the amount you have actually contributed minus any reimbursements you have already received (or are in process). The amount you request may be adjusted if needed to conform with your actual account balance. You must request the QRD before the last day of the Plan Year. Any claims that you submit after the date you request the QRD will not be processed. You can only request one QRDs for a Plan Year.

### **VI HIGHLY COMPENSATED AND KEY EMPLOYEES**

#### **1. Do limitations apply to highly compensated employees?**

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

### **VII PLAN ACCOUNTING**

#### **1. Periodic Statements**

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

### **VIII GENERAL INFORMATION ABOUT OUR PLAN**

This Section contains certain general information which you may need to know about the Plan.

#### **1. General Plan Information**

American Bank and Trust Company, N.A. Section 125 Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on January 1, 2017. Your Plan was originally effective on January 1, 2014.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

## 2. Employer Information

Your Employer's name, address, and identification number are:

American Bank and Trust Company, N.A.  
4301 East 53rd Street  
Davenport, Iowa 52807  
36-4256335

## 3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

American Bank and Trust Company, N.A.  
4301 East 53rd Street  
Davenport, Iowa 52807  
563-441-6580

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

## 4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

American Bank and Trust Company, N.A.  
4301 East 53rd Street  
Davenport, Iowa 52807

## 5. Type of Administration

The type of Administration is Employer Administration.

## 6. Claims Submission

Claims for expenses should be submitted to:

Benefit Planning Consultants, Inc.  
P. O. Box 7500  
Champaign, IL 61826-7500

# IX ADDITIONAL PLAN INFORMATION

## 1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible employees and all other employees are entitled to:

- (a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- (b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;
- (c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and
- (d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## 2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account claims within 90 days after your termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Dependent Care Flexible Spending Account claims within 90 days after your termination of employment. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific Plan provisions on which the denial was based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

### **3. Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

## **X CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

## 1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## 2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- (a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

## 3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (a) The death of a covered Employee.
- (b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (d) A covered Employee's enrollment in any part of the Medicare program.
- (e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing

such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

#### 4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.
- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.
- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see [medicare.gov/sign-up-change-plan](http://medicare.gov/sign-up-change-plan).
- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

**Are there other coverage options besides COBRA Continuation Coverage?** Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

#### 5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

#### 6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

#### **7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) the end of employment or reduction of hours of employment,
- (b) death of the employee,
- (c) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (d) entitlement of the employee to any part of Medicare.

#### **IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.**

#### ***NOTICE PROCEDURES:***

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

American Bank and Trust Company, N.A.  
4301 East 53rd Street  
Davenport, Iowa 52807

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (a) The last day of the applicable maximum coverage period.
- (b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- (e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**11. What are the maximum coverage periods for COBRA continuation coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:
  - (1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
  - (2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**12. Under what circumstances can the maximum coverage period be expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

**13. How does a Qualified Beneficiary become entitled to a disability extension?**

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

**14. Does the Plan require payment for COBRA continuation coverage?**

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

Yes. The Plan is also permitted to allow for payment at other intervals.

**16. What is Timely Payment for COBRA continuation coverage?**

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**17. How is my participation in the Health Flexible Spending Account affected?**

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money including any carryover amounts than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

## **IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## **KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

## **XI SUMMARY**

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.



# HEALTH FSA GUIDE

Provided by Holmes Murphy



HOLMES  
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# HEALTH FSA GUIDE

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Paying for health expenses can be stressful, but planning ahead and putting money in a health flexible spending account (FSA) will help you save on taxes while keeping a reserve of money available for health care costs. Although FSAs are a great way to help you pay for medical expenses, they can be confusing if you haven't worked with one before. This guide will walk you through what health FSAs are, what they can pay for and how they work.

## What Are Health FSAs?

An FSA is an employer-sponsored savings account for health care expenses. You are not taxed on the money put into the FSA, and you can then use the account to pay for qualified out-of-pocket health care costs, such as your deductible and copays, but not your premium. However, you cannot stockpile money in the account from year to year, and you will lose leftover money in the account at the end of the plan year unless your employer offers an option that allows for either a short extension or a small carry-over into the next year.

FSAs were created in the 1970s to enable employees to use pre-tax dollars for health care expenses that were not otherwise covered by employer-sponsored health coverage. These accounts gained more popularity in the 2000s, and they underwent a few changes with the Affordable Care Act (ACA), including the addition of an annual contribution limit.

Health FSAs can save you money on taxes while helping you regularly put aside money for health care expenses. If carefully planned, using an FSA for health care costs can be an asset to your family's budget.

## Why Have a Health FSA?

Health FSAs offer an option for setting aside money to use for qualified medical expenses. These accounts offer a convenient way to prepare for out-of-pocket medical expenses while saving on taxes. In addition, you can use your health FSA to pay not only for your medical expenses, but also for the medical expenses of your spouse and dependents.

### Health FSA Advantages

Here are some of the advantages an FSA can provide:

*Tax reductions:* The amount you contribute to a health FSA is not subject to federal income tax or social security (FICA) tax—effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly.

- Your employer can also contribute to your FSA, and this amount is also not considered taxable income to you.
- You can withdraw money from your FSA to pay for qualified medical expenses (see Appendix) and your withdrawals are not taxed.
- You do not have to report FSA amounts on your income tax return.

*Convenience:* After the initial election at the beginning of the year, your employer will take care of transferring the allotted amount into your FSA through salary deferral.



# HEALTH FSA GUIDE

*Flexibility:* You can withdraw health FSA funds at any time (for qualified medical expenses), even if the amount has not yet been deposited into the account, as long as the amount is no more than your elected annual deferral amount less any amount already used.

## Is a Health FSA Right for You?

FSAs can save you money because you don't have to pay taxes on the amount deferred to the account. However, using an FSA does require careful planning in order to reap the financial benefits.

When you participate in an FSA, you have to decide at the beginning of the plan year how much to contribute for the year. Because you will generally lose what you don't use by the end of the year, determining how much to defer into an FSA can be challenging. While correctly estimating your health care expenses and using an FSA to pay for those expenses will save you money, incorrectly gauging your health costs could cause you to lose money.

How your employer manages the FSA may also affect how much you will benefit from using an FSA. If the employer provides a grace period or carry-over option (see "Grace periods and carry-overs" section), you will have a little more flexibility when using your FSA funds. The largest downside to using an FSA is that if you overfund your FSA and don't use the amount in there, you will lose what you've saved.

## How Do Health FSAs Work?

At the beginning of the year, you elect the total amount you want to have withdrawn from your paychecks to put into your FSA, and your employer will deposit the money into the account in equal allotments throughout the year. The IRS has outlined rules guiding eligibility, contributions and reimbursements.

### FSA Eligibility

FSAs are employer-sponsored benefit plans, and the employer can choose what other type of group health plan coverage to offer with the FSA. FSAs can be offered with any type of health plan—FSAs are not tied to a high deductible health plan (HDHP) like health savings accounts (HSAs) are. Self-employed individuals are not eligible for an FSA, and restrictions may apply for highly compensated individuals or key employees.

### Opening Your FSA

The FSA is sponsored by your employer as one of your employee benefits. You will need to choose how much you want to contribute to your FSA. The amount you elect will be for the entire plan year, and your employer will then deduct the corresponding amount from your paycheck with each pay cycle. This is sometimes referred to as a salary reduction arrangement.

### Contributions

After your initial contribution election, you ordinarily cannot change your election for a plan year during the year. Your elected contribution amount can only be changed if you experience a permitted election change event, such as a change in family status and your FSA permits you to change your election.

The amount you choose to transfer into your FSA should be based on the amount of qualifying medical expenses you anticipate your family incurring during the plan year. Start by looking at your family's medical expenses for the past year



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and then determine whether your family will likely have those same expenses again and whether there will likely be any new expenses. Use this estimate to help you choose what amount you would like to contribute to your FSA, remembering that it is typically best to underestimate by a little than to overestimate and lose that money at the end of the year.

*Limits* – In 2021, the maximum amount you can contribute to your FSA is \$2,750, which is indexed for inflation and therefore may change year to year. The employer may implement a lower annual limit than the federal maximum.

*Who can contribute* – Both you and your employer may contribute to your FSA. However, your employer is not obligated to contribute to the account.

## **Grace Periods and Carry-overs**

The FSA operates with a use-or-lose rule, meaning if you don't use the money in your FSA by the end of the plan year, you will lose it. However, the use-or-lose rule was relaxed with two options that employers may choose to offer: a grace period or a carry-over. The grace period can last up to 2 ½ months into the next year, typically March 15 for a calendar year plan. Generally, only expenses you incur during the plan year can be reimbursed from the funds in your FSA, but if your FSA has a grace period, you can use those unused funds in your FSA for expenses incurred during the grace period.

Under the carry-over option, an FSA may allow employers the option of allowing employees to carry over up to \$550 of unused funds from one year to the next beginning in 2021. Through 2020, this limit had been \$500. The carry-over does not count toward the annual maximum allowable contribution. Employers are not required to offer either of these options, and they may only offer one of the two options, not both.

If you have funds in your FSA at the end of the year, you might consider scheduling a checkup, dental cleaning or similar appointment before the end of the year in order to use up the leftover funds before they are lost.

## **Using Your Health FSA**

FSAs must comply with a uniform coverage rule. The uniform coverage rule provides that an employee's entire annual FSA election amount, less any amount already used, must be available at any time of the plan year—even if that full amount has yet to be contributed to the account. This means that the entire amount of your election is available for your use at any time of the year. For example, if you elect \$1,000 for your annual contribution, and you incur qualified medical expenses of \$800 in January, your FSA will reimburse you for the \$800 even though that amount has not yet been deducted from your salary.

When you are paying for a qualified medical expense that you would like to use your FSA funds for, you typically have two choices: using a health payment card or requesting reimbursement.

### ***Health Payment Card***

Some employers may provide you with a health care payment card, which is very similar to a debit or credit card, and you can pay for eligible medical services or products by swiping the card as you would a debit or credit card. The money will then be deducted from your FSA account.

Health care payment cards may be used only on eligible medical expenses that are not reimbursed or covered by another source. Over-the-counter (OTC) medications are only eligible for reimbursement if they are prescribed to you, and you present the prescription at the time of purchase. The only OTC medication that can be reimbursed without a prescription is insulin. Health care payment cards may not be used to cover more than the maximum dollar amount of coverage available in your FSA.



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As a general rule, every claim paid with a health care payment card must be reviewed and substantiated. The IRS guidance allows automatic adjudication for certain card transactions, meaning that receipts do not need to be submitted for verification of expenses for which a health care payment card is used. This applies in three situations at medical providers and 90-percent pharmacies (drug stores and pharmacies where at least 90 percent of the store's gross receipts during the prior taxable year consisted of medical expenses):

- When the total cost of the transaction is equal to the standard copayment for the service(s) received
- When the transaction is for recurring expenses that have previously been approved
- When the merchant provides expense verification to the employer when the transaction takes place

## **Reimbursement**

Another way to pay for eligible medical expenses with your FSA funds is to pay out-of-pocket and then submit receipts for reimbursement. Your account will have specific instructions for how to do this. When submitting for reimbursement, you will need your receipts and proof that what you paid for was an eligible medical expense; this is one of the reasons it is important to keep all receipts and related paperwork from your health care provider.

## **Qualified Expenses**

Employees may use their health FSAs to pay for or reimburse themselves for their own eligible medical expenses, as well as their spouses' and dependents' eligible medical expenses. Eligible medical expenses are unreimbursed medical care expenses, as defined under Section 213(d) of the Internal Revenue Code. An employer can more narrowly define the expenses that can be reimbursed from an FSA. Health FSAs cannot be used to pay for non-medical expenses. Your FSA cannot be used to pay for health insurance premiums, long-term care coverage or expenses, or amounts already covered under another health plan. See Appendix for a list of qualified medical expenses.

## **Life Events**

Certain life events may affect your FSA.

*Employment status changes* – Your employer owns the FSA. Typically, if you leave your job before you've used the FSA funds, the employer will keep the amount left in the account. However, you may be eligible to elect COBRA and continue your FSA until the end of the year.

*Death* – If you die, the contributions to your FSA will stop, but your survivors can file claims until the filing deadline for any remaining eligible expenses that you or your family members incurred.

## **FSA Recordkeeping**

In most cases, you will have to submit receipts and other proof that you purchased an eligible medical service or product in order to receive reimbursement. Make sure you retain all receipts, Explanation of Benefits (EOBs) and other documents to ensure that you have the necessary proof to obtain reimbursement from your FSA.

# HEALTH FSA GUIDE



## FSA Case Studies

### Example of tax savings in a year

Flexible spending accounts provide you with an important tax advantage that can help you pay for health care expenses on a pretax basis. As a result of the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money.

*Bob and Jane's combined gross income is \$30,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend \$3,000 in medical expenses in the next plan year, they decide to direct a total of \$2,750 (the maximum allowed amount per individual, for that taxable year) into their FSAs. (See table)*

	Without FSA	With FSA
<b>Gross income</b>	<b>\$30,000</b>	<b>\$30,000</b>
FSA contributions	\$0	-\$2,750
Gross income	\$30,000	\$27,250
<b>Estimated taxes</b>		
Federal	-\$2,550*	-\$1,776*
State	-\$900**	-\$750**
FICA	-\$2,295	-\$1,913
<b>After-tax earnings</b>	<b>\$24,255</b>	<b>\$22,811</b>
Eligible out-of-pocket medical expenses	-\$3,000	-\$300
<b>Remaining spendable income</b>	<b>\$21,255</b>	<b>\$22,511</b>
<b>Spendable income increase</b>	<b>--</b>	<b>\$1,256</b>

\* Assumes standard deductions and four exemptions

\*\* Varies, assumes 3 percent

*This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.*

# HEALTH FSA GUIDE



## Example of a carry-over

Jill elected \$2,000 for her FSA for the first year. She used \$1,200 for qualified medical expenses, but at the end of the year had \$800 left. Her employer offers the option of a \$500 carry-over into the next year. She will lose \$300 from that first year, but can carry over \$500 to her FSA for the next plan year. She is expecting to have an expensive surgery and decides to elect the maximum allowable contribution of \$2,750 for that taxable year. The \$500 carry-over is added to this, so she has \$3,200 in her FSA for her out-of-pocket medical expenses in the second plan year.

Year One Activity	FSA Balance
Elected \$2,000	\$2,000
Used \$1,200	\$800
<b>Carries over \$500 (loses the extra \$300)</b>	<b>\$500</b>
Year Two Activity	
Elects \$2,750	\$3,250

## Appendix—Qualified Medical Expenses

The qualified medical expenses that can be reimbursed by an FSA on a tax-free basis are limited to expenses for medical care (as defined in the federal tax code) for the employee and his or her spouse and dependents, to the extent those expenses are not reimbursed by any other health coverage. The federal tax code defines medical care expenses as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

The products and services listed below are examples of medical expenses that may be eligible for payment under your Flexible Spending Account, when such services are not covered by your health plan. This list is not exhaustive; additional expenses may qualify as medical expenses, and the items listed below are subject to change. Also, your FSA plan may have additional restrictions on the types of expenses it will reimburse.

- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical exam
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Breast pumps and supplies
- Breast reconstruction surgery following mastectomy for cancer
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment installed for a person with a disability
- Chiropractor
- Contact lenses
- Crutches
- Dental treatment (not including teeth whitening)
- Diagnostic devices
- Disabled dependent care expenses (medical care of the disabled dependent)
- Drug addiction treatment
- Eye exam
- Eye glasses
- Eye surgery
- Fertility enhancement (for example, in vitro fertilization or surgery)

# HEALTH FSA GUIDE

- Guide dog or other service animal
- Hospital services
- Laboratory fees
- Lactation expenses
- Lodging at a hospital or similar institution
- Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent
- Medical information plan
- Medications, if prescribed
- Nursing services
- Operations
- Optometrist
- Osteopath
- Oxygen
- Physical exam
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychoanalysis
- Psychologist
- Sterilization
- Stop-smoking programs
- Surgery
- Special telephone for hearing-impaired individual
- Television for hearing-impaired individuals
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Vasectomy
- Vision correction surgery
- Weight-loss program if it is a treatment for a specific disease
- Wheelchair
- X-rays

Take advantage of pre-tax savings by participating in Flexible Spending Accounts (FSAs) and save on out-of-pocket healthcare expenses. With an FSA, you can pay for eligible expenses such as doctor's office co-pays, prescription drugs, eyeglasses, over-the-counter supplies, and much more with your pre-tax income. By taking advantage of your FSA, you can increase your take-home pay!

### Common Flex Uses

- Doctor Visits
- Copayments, Coinsurance, and Deductible Expenses
- Eyeglasses, Contact Lenses, Contact Lens Cleaner\*
- Dental Expenses (excluding whitening)\*
- Prescriptions
- Orthodontia\*
- Mileage for Medical Services
- Drug or Substance Abuse Treatments
- Acupuncture
- Arch Supports
- Breast Pumps
- Chiropractor Fees
- Durable Medical Equipment
- Hearing Aids Diabetic Supplies
- Cancer Screenings
- CPAP Machines
- Bandages
- First Aid Kits
- Neck, Wrist, Knee Braces
- Thermometers
- Blood Pressure Monitoring Device
- Pregnancy Test Kits
- Wheelchairs
- Massage Therapy (prescribed by a physician for medical treatment)
- Psychiatric Care
- Lasik Surgery\*
- Dentures\*
- And More! Please check your BPC Employer Specific Website or [www.bpcinc.com/fsa-extras](http://www.bpcinc.com/fsa-extras) for more eligible expenses.

*\*If you are enrolled in a Health Savings Account (HSA) in addition to your FSA, then your FSA may be treated as a Limited-Purpose FSA, restricted to covering dental and vision expenses. By electing both, you can save your HSA dollars for other medical expenses, or even for retirement, and use your Limited-Purpose FSA election to cover your annual dental and vision expenses.*



Maximize Your Income And Save Tax Dollars  
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## Limited-purpose FSAs

Have you considered adding a limited-purpose flexible spending account (FSA) option to your company's health care coverage options? Before your employees start contributing to a limited-purpose FSA, they need to know how this type of health plan works and how it can be advantageous for them. A limited-purpose FSA is similar to a general-purpose health FSA—the difference being that there are fewer eligible expenses. The main advantage of FSA funds is that employees can pay for qualifying expenses tax-free while reducing their taxable income.

### FSA Rules

Employees are not allowed to contribute to both a health savings account (HSA) as well as a standard (non-limited) health flexible spending account (FSA). They are, however, eligible for an HSA if they use a limited-purpose FSA for their dental and vision care needs. This will allow your employees to maximize their savings and tax benefits.

As an employer, you have the option of incentivizing a limited-purpose FSA by reimbursing standard FSA-qualified health care expenses as your employees meet their deductible. This would cause your employees' limited health care FSA to work like a standard health care FSA and will not limit it to dental, vision or preventive care. Employees would remain eligible for an HSA once meeting their limited-purpose FSA deductible.

FSAs employ a "use-it-or-lose-it" model. If you do not use the funds that you contribute to your limited-purpose FSA within the end of the year, you will have to forfeit those funds. However, for plan years beginning on or after Jan. 1, 2023, employers also have the option of allowing employees to carry over up to \$610 of unused funds from one year to the next. In addition, any amount that is carried over does not count toward the maximum contribution limit. However, due to the COVID-19 pandemic, the IRS provides flexibility to

employers offering FSAs to allow employees to carry-over unused amounts from 2020 and 2021 plan years.

In a limited-purpose FSA, covered health care procedures are limited to dental, vision and preventive care. Over-the-counter medicines are not covered under an FSA without a doctor's prescription (except for insulin).

There are contribution limits to FSAs. The contribution limit for 2023 is \$3,050. There is also no "double-dipping," meaning that employees are unable to pay for a medical procedure using their FSA as well as an additional plan or program, such as an HSA.

### Typical eligible limited FSA expenses:

- Cleaning
- Fillings
- Crowns
- Orthodontia
- Contact lenses
- Eyeglasses
- Refractions
- Vision correction procedures

### Typical ineligible limited FSA expenses:

- Insurance premiums
- Medical expenses (deductibles, coinsurance and copays)
- Alcohol and drug rehab expenses
- Prescription medicine
- Medical equipment
- Contraceptives



# BPC



## Dependent Care FSA

Are you paying childcare expenses for your children or disabled dependents while you work?

If so, this account could save you over **\$1,000** per year!\*

### Q. How does it save me money?

Working parents may elect up to \$5,000 each year to set aside on a pre-tax basis for childcare expenses. By avoiding taxes on those funds, many families may save 30% or more, which can easily save you over \$1,000 per year.

### Q. What expenses are eligible for reimbursement?

The account can be used for childcare expenses you incur, while working, for your children under age 13 or an older dependent (e.g. an older child or parent) if he or she is physically or mentally incapable of self-care.

### Examples of Commonly Eligible Expenses:

- Commonly Eligible – Day Care Center, Preschool, Before and After School Care, Day Camp, Babysitter, Nanny, Au Pair. These expenses have to be primarily for the care of the child.
- Not Eligible – Overnight camp, Kindergarten, Housekeeper, Educational services, Summer School, Tutoring Programs, Boarding School, and Care provided by any individual who is your child under age 19, or anyone you claim as a dependent for federal tax purposes.

### Q. How will I be reimbursed?

You can submit claims throughout the plan year online, from the BPC Benefits mobile app, or on paper, and receive direct deposit reimbursement within 1 or 2 business days. When you submit your claims, you'll need to provide documentation showing the provider name, dates and type of service, as well as the amount you were charged.

Throughout the year, you'll only be reimbursed up to the amount you've contributed at any given point. However, if your claims exceed that amount at any point, you can still submit the full claim. BPC will simply hold the excess claims and automatically reimburse you when your next contribution occurs.

*\*Actual savings will vary depending on the amount you elect and your applicable federal and state tax rates*

More questions? Reach us at [www.bpcinc.com/contact](http://www.bpcinc.com/contact) to learn more!



## Employee FAQ: Dependent Care FSA

### **What is a dependent care FSA (DCA)?**

A DCA is a flexible spending account that allows you to contribute a portion of your paycheck before taxes are taken out to pay for qualified dependent care expenses so that you can work or look for work.

### **Why should I participate?**

Since contributions to the account are deducted from your paycheck before income taxes are assessed, your taxable income is reduced. Participants enjoy a 30% average tax savings on the total amount they contribute to the account.

### **How do I contribute money to my DCA?**

Once you make your annual election during open enrollment, your employer will deduct this amount from your paycheck before taxes are assessed in equal amounts throughout the year.

### **How much can I contribute?**

The IRS limits annual contributions to \$5,000 on income tax returns for single or married filing jointly, and \$2,500 for married filing separately.

### **Who qualifies as a dependent?**

You can use your DCA to pay for care for children under age 13 that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves (if you provide more than 50% of their support).

### **What type of care is eligible?**

Eligible expenses must be for the purpose of allowing you to work or look for work. Services may be provided at a child or adult care center, nursery, preschool, after-school, summer day camp, or a nanny in your home.

### **What type of care is not eligible?**

Care expenses that are not eligible to be paid with DCA funds include care for a child over age 13, overnight camp, babysitting that is not work related, school fees for kindergarten and higher grades, and long-term care services.

### **Do I have access to my entire DCA election amount at the beginning of the year?**

No, you will only have access to DCA funds that have already been deducted from your paycheck.

### **Are there any rules about who can care for my dependents?**

Yes. You can not use funds to pay for care provided by a spouse, a person you list as a dependent for income tax purposes, or one of your children under the age of 19.

### **How do I use the funds in my account?**

If you have a benefits debit card and your care provider accepts credit cards, you may pay directly from your account. Otherwise, pay out-of-pocket and then file a reimbursement claim with your expense documentation.

### **What happens if I don't spend all of my DCA funds by the end of the plan year?**

It is essential to estimate conservatively during elections. Any unused funds at the end of the plan year are forfeited, also called the use-it-or-lose-it rule.

### **Can I change my election amount mid-year?**

Typically, you cannot change your contribution mid-year. However, if you experience a qualifying event, such as the birth of a new child, or if your child care provider significantly increases their rates, you may be eligible to adjust your contribution.

### **What happens to my account if my employment is terminated?**

Participation in the plan is also terminated. This means that only expenses that were incurred prior to your termination date are eligible for reimbursement.

### **Can I still deduct dependent care expenses on my tax return?**

Yes, but not the same expenses for which you have already been reimbursed. If your total expenses were \$7,000 and you were reimbursed \$5,000 from your DCA, you may only claim the \$2,000 difference.