ONEDIGITAL | BENEMAX

Your Flexible Spending Account Participant Handbook

Effective 1/1/23

INTRODUCTION

Benemax is pleased to be your Flexible Spending Account (HFSA) administrator. We are committed to providing you with superior service. Benemax is available 8:30 to 5PM EST at 800-528-1530 or via email at benemax.service@onedigital.com.

You have two types of HFSAs available to you: A **Healthcare HFSA (HFSA)** and a **Dependent Care HFSA (DCA).** You may participate in one or both HFSAs. At the beginning of each plan year, you elect a specific dollar amount from your paycheck that you wish to direct to each HFSA. You may not transfer money between your healthcare and your dependent care accounts. Participation in one or both HFSAs reduces your taxable income because taxes (state, local, federal & FICA) are calculated *after* the elected amount is deducted from your salary. Please note that your taxable income will be reduced for Social Security purposes as well; therefore, it is possible that there could be a slight reduction in your Social Security benefits.

Any person with two percent or more ownership in an S corporation, LLC, LLP, PC, sole proprietorship, or partnership may **NOT** participate. C corporation owners and their families are eligible to participate in FSAs.

To meet the qualifications for tax-favored status, an FSA plan cannot discriminate in favor of key or highly compensated employees. These employees are defined as:

· Any employee with more than 5% ownership in the business in the current or prior plan year
· A 1% owner with a salary of $150,000 or more
· Any officer of the company in the prior plan year and/or any officer earning $185,000 or more annually
· Any employee with gross annual compensation of $130,000 or more in the prior plan year
· Any employee whose salary is in the top 20% of all employees in the current plan year.

If the percent of benefits elected by key and or highly compensated employees is more than 25% of the total benefits, those elections must be reduced pro-rata to meet the 25% test.

A **HFSA** allows you to use pre-tax dollars to pay for insurance deductibles, co-insurance and co-payments; you also may use these funds to pay for other qualified healthcare expenses such as eye glasses, contact lenses, orthodontia and complementary alternative medicine. Funds from your healthcare account are available up to your election amount throughout the year. This means you can use funds for an eligible expense as soon as it has been incurred, even if that is before you have deposited sufficient funds to cover that expense. You may elect up to **$3,050.00** per HFSA plan year.

HFSA Maximum

$3,050

A **DCA** assists employees who need to provide custodial care (i.e., “daycare”) for a qualified dependent (child under the age of 13, disabled adult or elderly parent) in order for you or your spouse to be able to work. You set aside pre-tax dollars to help fund the cost of such care. Dependent care funds are available only as the funds are deposited in your account. However, you can claim up to your full election, and you will be paid automatically each time a payroll deduction reaches your account. If using a debit card, you will need to make sure there are enough funds in the account for the card to process the payment.

DCA Maximum

$5,000

The DCA contributions during a single calendar year may not exceed the lesser of the following:

- **$5,000.00** or **$2,500.00**, if married but filing separate tax returns, or
- Participant’s earned income (after participant’s pre-tax contributions have been deducted under the Plan), or if married, the lesser of the participant’s earned income and the spouse’s earned income (after pre-tax contributions have been deducted) unless that spouse is disabled, in school or actively looking for work.

ELIGIBLE AND INELIGIBLE EXPENSES

Eligible Expenses	Ineligible Expenses
Artificial limbs and reconstructive breast implants	Counseling that is not medically related (counseling, etc,)
Counseling, if related to a medical condition	Dietary supplements that are beneficial to general health
Dental care (examinations, cleanings, fillings, crowns, etc.)	Drugs, prescribed OTC for cosmetic reasons without script
Diabetic supplies (blood sugar monitor, syringes, etc.)	Elective cosmetic surgery/procedure
Drugs, legally obtained by prescription (insulin or medicines)	Anti-aging treatments (chemical peels, laser therapy, etc.)
Fertility Enhancement (in vitro fertilization, reverse vasectomy)	Breast implants (non-reconstructive)
Guide/leader or hearing-assisting animal	Cosmetic dental veneers/teeth whitening
Hearing devices (hearing aids, batteries and repair)	Electrolysis/hair transplants
Insurance co-payments and deductibles	Funeral expenses
Menstrual products, includes tampons, pads, etc.	Health club membership fees
Nursing care	Household help
Orthodontia	Maternity clothing
Over-the-counter drugs (antacids, allergy, cold medicine)	Medical insurance premiums
Oxygen equipment	Toiletries and person care items (shampoo, deodorant, etc.)
Rental if medical equipment	Weight loss foods that substitute for nutritional needs
Service fees for medical care (consultations, lab work)	*This list is merely a brief summary of eligible and ineligible expenses. Please visit your VBM site at:* **www.mybenemax.com, enter your company keyword** *for a more descriptive list.*
Smoking cessation programs, aids, devices and medications	
Support or corrective devices (crutches, braces, etc.)	
Medically prescribed therapy treatments	
Vision care (eye exams, prescription eyeglasses, contacts)	
Vision corrective surgery (including RK and Lasik)	
Weight loss programs (when prescribed by a physician)	

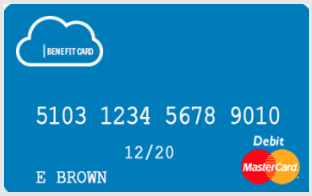
ELIGIBLE DCA EXPENSES & QUALIFYING INDIVIDUALS

- **Daycare center:** Expenses incurred for services provided by a licensed daycare center (i.e., a facility providing care for more than six individuals not residing at the facility).
- **Home daycare providers:** Expenses incurred for services provided by home daycare providers. Provider must supply SS# for claim purposes and claim compensation as income.
- **Payments to relatives:** Expenses incurred for services provided by a relative who is not your dependent (even if he or she lives in your household). However, you may not claim any amounts paid to:
  - An individual for whom you/your spouse is entitled to receive a personal tax exemption as a dependent, or
  - Any of your children who are under age 19 at the end of the year in which the expenses were incurred (even if he or she is not your dependent).
- **Summer day camp:** Expenses incurred for a day camp that is primarily custodial in nature rather than educational. However, expenses for overnight camps are not considered work-related and are ineligible.

Note that full day kindergarten **is not** a covered expense under the HFSA daycare assistance program.

YOUR FSA DEBIT CARD

A FSA Debit card is provided for your convenience for FSA-eligible items and service purchases. You'll have no claim forms to complete, and you won't have to wait for a reimbursement check.



Present your FSA Debit card at participating locations that accept Debit MasterCard®, and the amount for eligible purchases will be deducted automatically from your account. You may check your FSA Debit card balances or account details anytime – online or with a quick phone call to Benemax.

Please save all your receipts; ask your dental and vision providers for detailed receipts that show the member's name, date of service and services provided. When necessary, you will receive a letter or e-mail from Benemax requesting this additional information.

Once your election amount has been exhausted, the card will reject any further charges. Do not discard the HFSA Debit card at that time. It will be used for the next year's FSA plan; the card is good for 5 years.

BENEFIT PERIOD & INCURRED EXPENSES

The benefit period is shown on your HFSA election form. Any money that you elect to set aside in the benefit period may only be used for eligible expenses you or your eligible dependents incur within that benefit period or grace period if applicable. You may only claim reimbursement from the HFSA account after the covered service has been performed. Eligible expenses are based on the dates the service was incurred, not when you pay for the service. Therefore you may submit your claims before you have paid them in full. IRS regulations require a date of service on all documentation submitted for reimbursement. Cancelled checks or bills that do not indicate a date of service or only show balance forward information are insufficient.

Orthodontia exception: You may submit and be reimbursed up to your annual election amount if you pre-pay orthodontia expenses, and the services are incurred within the benefit period. Proof of payment and a completed claim form are required. Initial evaluation fees for orthodontia, such as molding, diagnostic records fees, or appliances are reimbursable when incurred if the expenses are separated from the contracted treatment. A down payment is not eligible for reimbursement as it does not represent any incurred services.

USE-IT-OR-LOSE-IT RULE

It is important for you carefully to estimate your out-of-pocket healthcare and dependent care expenses for the upcoming year due to the IRS Use-It-or-Lose-It Rule. This rule requires that any amount of money remaining in your **HFSA** or **DCA** after the end of the grace period and run-out period will be forfeited.

GRACE PERIODS

The IRS allows FSAs a *grace period* of two and one-half months after the end of the plan year, during which time participants may incur and submit claims for reimbursement against their prior year's account balances. During this grace period, participants can draw from either the prior year's balance, the current year's balance or both. For example, if you have a $200 balance at the end of one plan year and you incur $300 of expenses during the grace period, $200 will be paid from the prior year's account balance and $100 will be paid from the current year's balance.). This grace period applies to both **HFSA** and **DCA** plans.

Grace Period

2 1/2 Months

RUN-OUT

Runout
90 Days

In addition, your plan allows a *run-out period* of 90 days from the end of the grace period for you to submit claims for **FSA** and **DCA** expenses that were incurred during the prior plan year and/or grace period. These rules apply to both Health Care and Dependent Day Care accounts. Note that during the run-out period, claims are quired to be sent in via Benemax Claims Connection™ or with a paper claim form.

ELECTION IRREVOCABILITY

Once you have elected the plan year dollar amount that you wish to direct into your HFSA(s), you may not change that election unless there is a qualifying change in your status that affects eligibility. Even if a change in status occurs, you only may make changes that are consistent with the qualifying event (or as otherwise specified by your Plan Document).

Qualified changes in status may include:

- Change in employee's legal marital status
- Change in number of tax dependents
- Change in employment status that affects eligibility
- Dependent ceases to satisfy eligibility requirements
- Judgment, decree or court order dictating provision of coverage
- Entitlement to Medicare or Medicaid (healthcare only)
- Change in cost of the benefit (dependent care only)
- Change in coverage (dependent care only)
    - ♦ Addition or elimination of benefit option
    - ♦ Change in coverage of spouse or dependent under his/her employer's plan
    - ♦ Significant curtailment of coverage.

TERMINATION OF EMPLOYMENT

HFSA: Unless you elect COBRA, your participation in the plan ends when you terminate employment. You no longer will be able to incur expenses for reimbursement. Your contributions also will cease; however, you will have a 90-day runout period to file claims for services incurred before your termination.

DCA: If, upon termination of employment, you have not yet claimed 100% of the contributions made to your account, you have a 90-day runout period to submit claims incurred from the beginning of the plan up to your termination date. Any funds remaining in your account after the run-out period will be subject to the Use-It-or-Lose-It rule.

COBRA: COBRA, if elected, allows you to continue to participate in your healthcare account and receive reimbursement for medical expenses incurred after the termination of your employment. COBRA does not apply to dependent care accounts. Under COBRA, you must continue to submit contributions (now with after-tax dollars) to your employer. COBRA eligibility terminates at the end of the plan year in which your employment terminated.

If you are terminated, you may elect COBRA if (and only if):

- The plan sponsor (your employer) is subject to COBRA, and
- You have contributed more into your healthcare account than you have received in healthcare benefits as of your termination date.

NEED HELP?

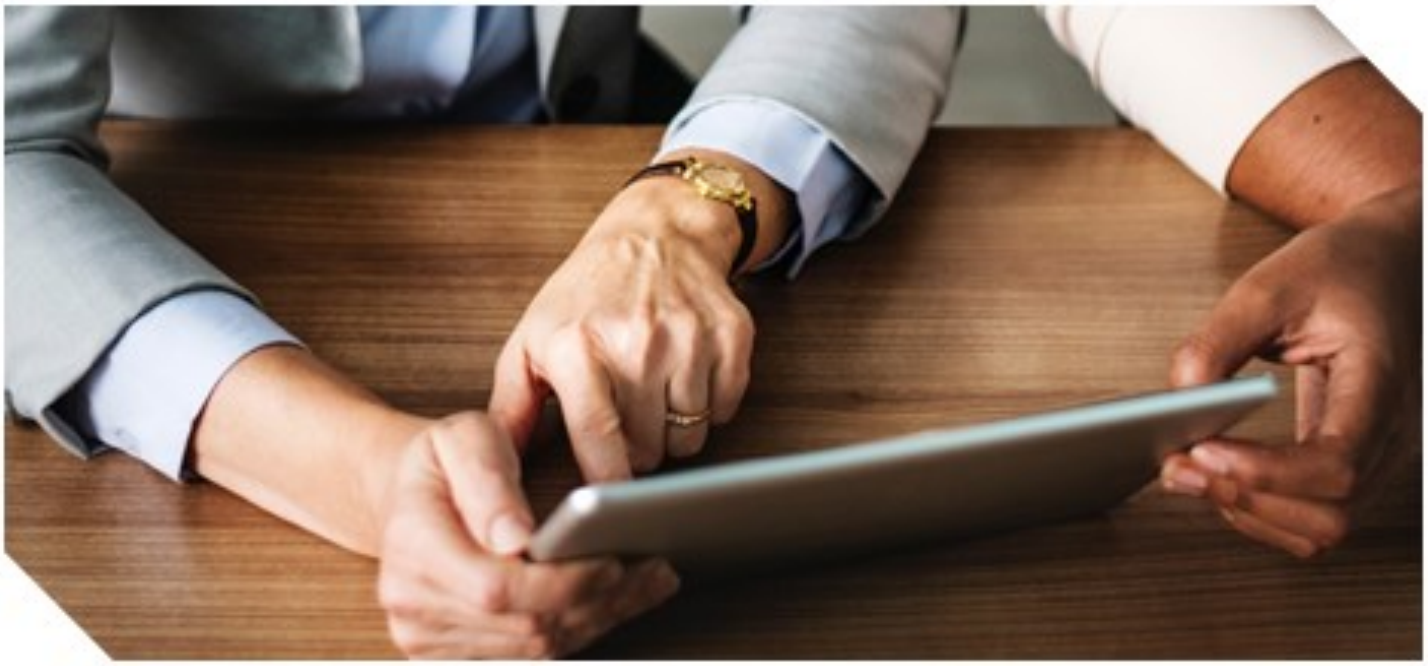
Call a Benemax IMA at 800-528-1530, prompt 3

Visit Virtual Benefit Manager®
www.mybenemax.com
Enter your company keyword

In VBM, the Claims Connection™ link will allow you to view elections, balances and claim information.

A Letter of Medical Necessity (LOMN) or written prescription is required for reimbursement for certain services. A LOMN is available on VBM, under your company's HFSA page.

HOW TO FILE A CLAIM



OBTAIN A CLAIM FORM

- Go to www.mybenemax.com, and enter your company's keyword. Click on Flexible Spending Account (FSA), then select claim form, and download or print the form.
- Or, call us at 800-528-1530, prompt 3.
- Benemax also provides a electronic claim form through Benemax Claims Connection™.

COMPLETE THE CLAIM FORM

- Attach legible receipt (s) from the service provider or an explanation of benefits from your insurance showing:
    - A description of the service or a list of supplies furnished
    - The charge (s) for each service
    - The date (s) of service
    - The name of the person (s) receiving the service.
- For prescriptions, submit non-register receipts that show the patient's name, date of service and amount paid.
- For OTC drugs, submit a register receipt showing the date of purchase.
- DCAP receipts should include dependent's name, dates of service, and provider's TIN or social security number. Cancelled checks can be accepted if this information is included.

SUBMIT YOUR CLAIMS

- Upload on Benemax Claims Connection™; fill out the electronic claim form and attach the receipts you have scanned and saved to your computer.
- Email scanned forms and receipts to **benemax.claims@onedigital.com**
- Fax to 508-242-6198 or 508-359-3601 Attn: FSA
- Mail to Benemax, PO Box 950, Medfield, MA 02052, Attn: FSA

Presented by:

ONEDIGITAL | BENEMAX