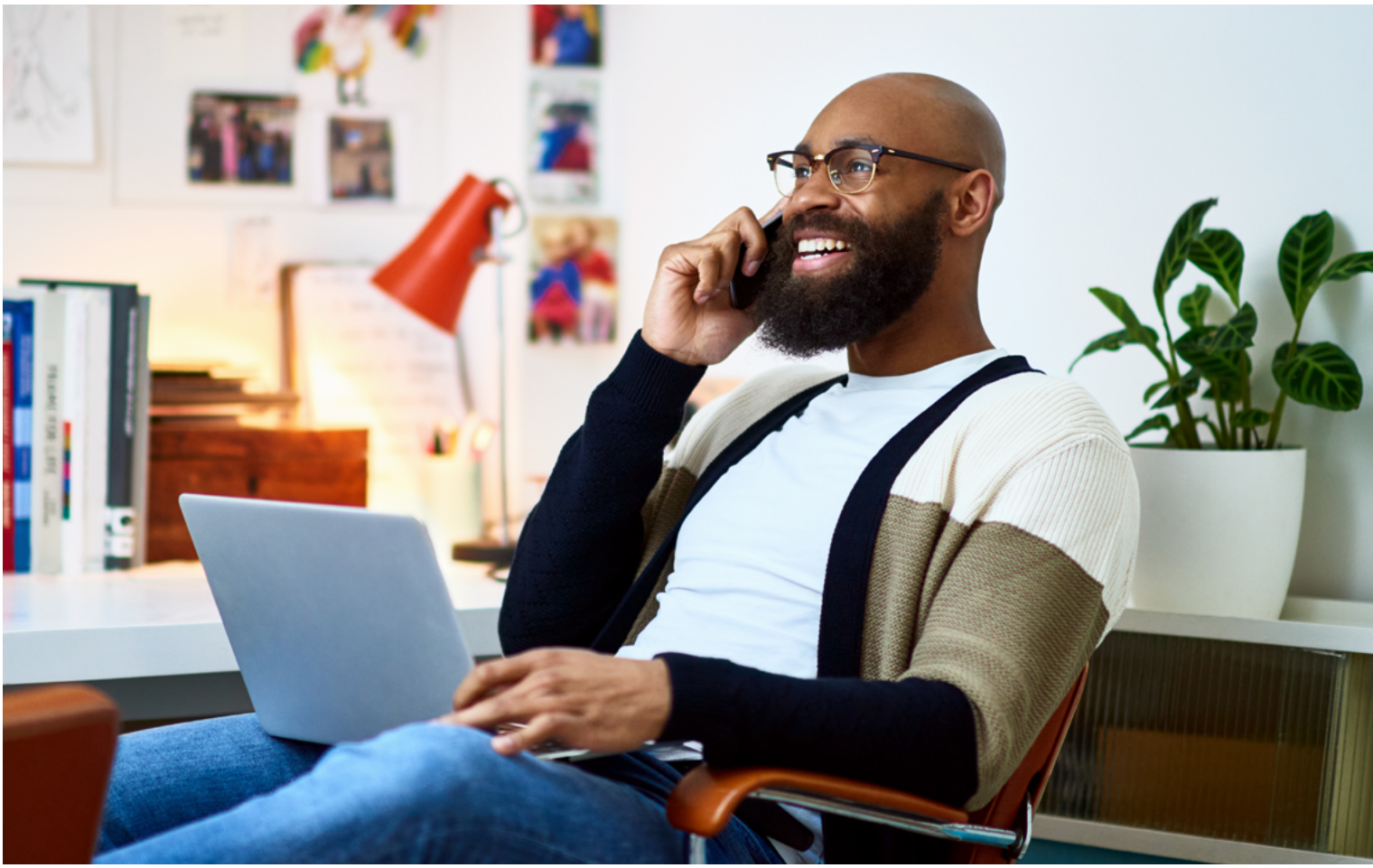
Section 125
Paychex Benefit Account Administrative Guidebook



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Welcome to the Paychex Section 125 Plan

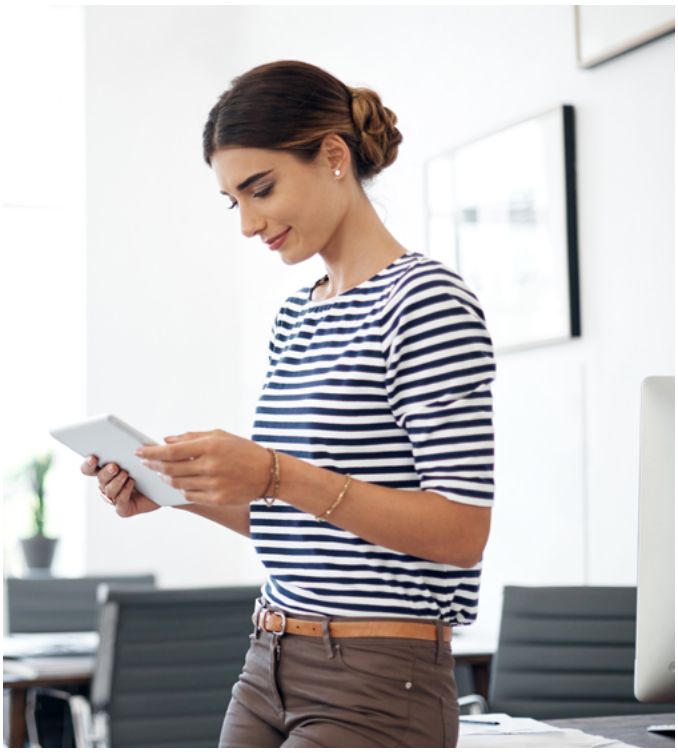
This Administrative Guidebook will help you manage your Paychex Section 125 Plan. It includes administrative requirements and documentation for the Paychex Premuim Only Plans (POP), Health Savings Accounts (HSAs), and Flexible Spending Accounts (FSAs). Your company may offer one or more of these benefits.

POPs offer participants a nontaxable benefit when paying a portion of an insurance premium through payroll salary deduction. Nontaxable benefits that may be included in the POPs are group health and accident insurance, group term life insurance up to $50,000, health savings account, and disability benefits. POPs are also referred to as premium conversion plans, salary reduction plans, and pretax premium plans.

HSAs use the Paychex Benefit Account (PBA) platform to offer pretax reimbursements to participants for eligible current/future out-of-pocket health expenses. This is an employer-funded and/or employee-funded account created in employees' names that requires enrollment in a High Deductible Health Plan (HDHP).

FSAs use the Paychex Benefit Account (PBA) platform to reimburse employees on a pretax basis for eligible out-of-pocket health expenses (excluding insurance premiums) and child care expenses that are not covered by an employer-provided benefit plan.

Limited Purpose Flexible Spending Account (LPFSAs) is a saving option for employees that are enrolled in a HSA. The LPFSA works the same way a standard FSA does. The difference is that a LPFSA limits what expenses are eligible for reimbursement, only allowing for the reimbursement of eligible preventive care, vision, and dental expenses.



Your Administrative Guidebook consists of five major components:

- **Plan Administration** defines Paychex' role as your plan recordkeeper and service provider, and your role as plan administrator
- **FSA** discusses plan administration
- **Internal Revenue Service (IRS) Regulations** concerning FSA plans are defined and explained
- **FSA Submittal and Reimbursement Processes** are outlined
- **Annual Enrollment Procedures**

Glossary: Common terms relating to your Section 125 Plan.

This *Section 125 Administrative Guidebook* is not intended to replace the *Paychex Section 125 Basic Plan Document* that employers are required to retain for their records. If any information in this guidebook conflicts with the Basic Plan Document, the Basic Plan Document controls the plan to the extent permitted by law.

This *Section 125 Administrative Guidebook* is to be used as a tool to assist the plan administrator and not as an authoritative plan document, or as a substitute for legal or other professional advice.

The Paychex Basics

Thank you for giving us the opportunity to provide this employee benefit for your company. If at any time, you or your employees have questions, issues, or comments, please do not hesitate to contact us.

The toll-free Paychex Human Resource Services number is 800-472-0072. Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET.

If your company offers a Paychex FSA or HSA to your employees, they can call Paychex Employee Services at 877-244-1771, or can visit the PBA Employee Portal at www.paychexflex.com.

All correspondence should be sent to:

FSA Email: PaychexBenefitAccount@paychex.com
HSA Email: PaychexHSA@Paychex.com

Paychex Section 125 Department
1175 John Street
West Henrietta, New York 14586

Note: Your local Paychex office and the Paychex Section 125 Department are at different locations. Throughout this guidebook, we request that you notify Paychex of certain information. Unless we specifically request that you contact your payroll service representative, or your payroll office, please notify the Section 125 Department.

Section 125 Plan Basics

What Is a Section 125 Plan?

The term Section 125 refers to the section within the Internal Revenue Code that pertains to cafeteria plans. A Section 125 Plan is a written benefit plan maintained by a company for the benefit of its employees. The plan participants are allowed to choose among two or more benefits consisting of cash or nontaxable benefits.

In the this context, "cash" is considered to be an employee's gross income prior to a Section 125 contribution. Therefore, employees who waive participation in the Section 125 plan, but participate in a health care plan, will have payroll taxes calculated before the health care deduction is made. You may also need to refer to your employer organization and plan service provider payroll processor to learn more about state and local laws pertaining to a Section 125 plan.

Nontaxable benefits may include group health or accident insurance (including health care FSAs), group term life insurance up to $50,000, HSAs, disability benefits, and child and dependent care reimbursement accounts.

What Is the Benefit of a Pretax Plan?

With a Section 125 election, employee and employer payroll taxes are calculated after Section 125 contributions are deducted from the gross salary. Without a Section 125 election employees are taxed on their full salary, even if there is participation in the health care plan. Refer to the example below, which outlines a participant without a Section 125 plan versus a participant with both POP and FSA deductions:

Example:	**Without Section 125**	**With Section 125**
Gross Income Each Month	$2,500.00	$2,500.00
Less: POP Benefit	0.00	-80.00
Less: FSA Contribution	0.00	-200.00
Gross Taxable Wages	$2,500.00	$2,220.00
Less: Federal, State Income, and Social Security Tax (37.65%)	-941.25	-835.83
Less: Insurance Premium Contribution	-80.00	0.00
Less: Unreimbursed Medical Expenses or Child Care	-200.00	0.00
Net Check	$1,278.75	$1,384.17
Gross Tax Savings Each Month		$105.42
Annual Gross Tax Savings ($105.42 x 12 months)		$1,265.04
Employer Gross Tax Savings Each Month (Social Security Tax @7.65%) ($2,500 x .0765) - ($2,220 x .0765)		$21.42
Employer Annual Gross Tax Savings ($21.42 x 12 months)		$257.04

This example illustrates potential tax savings. Tax savings will vary depending on an individual's tax bracket and the elected Section 125 contribution amounts.

Services Supplied by Paychex, the Plan Service Provider

Preparation of the Adoption Agreement and Basic Plan Document

The *Adoption Agreement* is executed by the employer to adopt the Paychex Section 125 Plan. This document formally adopts the Basic Plan Document into your company's Section 125 Plan document.

The *Adoption Agreement* designates the employer's options under the plan and includes:

- plan effective dates,
- eligibility requirements,
- plan contacts,
- benefit plans offered by the employer to the employees, and
- FSA minimum and maximum elections.

Your *Adoption Agreement* should be retained with this Administrative Guidebook.

The *Basic Plan Document* describes the operating rules outlined under Internal Revenue Code Section 125 and other regulations pertaining to the plan. The Basic Plan Document includes:

- benefit descriptions,
- eligibility requirements,
- funding,
- plan election requirements, and
- other plan and regulatory requirements.

Preparation of the Summary Plan Description (SPD)

The Summary Plan Description is a document required under the Employee Retirement Income Security Act of 1974 (ERISA). This document is written in an easy-to-understand manner and provides participants with a brief outline of the benefits, plan effective dates, and eligibility requirements of the employer-sponsored Section 125 Plan. Refer to Providing a Summary Plan Description, section, for information regarding the distribution of this document.

Nondiscrimination Testing

Compliance testing is prepared in accordance with IRC Section 125 regulations to ensure that the plan is maintained as an employee benefit. The testing calculates the total pretax benefits being withheld for your company's Section 125 Plan and compares this to the amount contributed by key or highly compensated employees (HCEs) and owners. The plan cannot discriminate in favor of the key employees, HCEs, or owners. Refer to Nondiscrimination Testing Information, section, for information regarding your responsibility.

Paychex Human Resource Services

Representatives are available to answer your administrative questions regarding the Section 125 Plan benefit. Call 800-472-0072, Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET. If your employees have questions regarding their plan, have them call Paychex Employee Services at 877-244-1771.

Paychex Benefit Account (PBA) Website

The PBA website enables employees to manage their FSAs and HSAs online. The website has a number of helpful resources that are readily available to help employees with all aspects of their FSAs or HSAs, such as:

- enrollment,
- account balances, and
- submitting and tracking claims or distributions.

Employees can visit www.paychexflex.com to view their online account. If they have any questions, they can call Paychex Employee Services at 877-244-1771.

Paychex Employee Services

Your employees can enroll in the FSA or HSA plan using one of the following options:

1. Online (Only during Open Enrollment)

- Log in to www.paychexflex.com and select which plan they would like to enroll in.
- If your employees have not already registered, they should select Register for a New Account and follow the prompts.

2. Paper Form

- This form can be found under the Resources tab on the PBA website.

Employee Reporting Tools

Paychex makes reports available to the employer via the PBA Employer Portal access through www.paychexflex.com to assist with tracking employee enrollment and verification.

Your Company's Role as the Plan Sponsor

As the plan sponsor, your company is responsible for the following tasks associated with beginning and maintaining the Section 125 Plan.

Enrolling Employees

It is your company's responsibility to notify Paychex when participants will begin a pretax deduction. The enrollment eligibility date should correspond to the plan entry date listed on the Adoption Agreement. The pretax contributions for the participants begins with the first check date following the Section 125 Plan effective date.

Note: Sole proprietors, partners in a partnership, and greater than 2% owners of an S-Corporation and their family members are ineligible to participate in a Section 125 Plan.

	Premium Only Plan	Flexible Spending Account
Eligibility requirements	All employees must satisfy a service period requirement before they are eligible to enroll in the POP. The employer-established eligibility requirement is indicated in the *Adoption Agreement* and *Summary Plan Description*.	All employees must satisfy a service period requirement before they are eligible to enroll in the FSA. The employer-established eligibility requirement is indicated in the *Adoption Agreement* and *Summary Plan Description*.
When can the pretax deduction begin?	Enrollment in a POP can begin the first check date following the plan entry date, as specified in your company's *Adoption Agreement*.	Employees may enroll in the FSA the first day of the month following the date they become eligible for the plan. If employees choose not to participate during the month in which they initially become eligible, these employees must wait until the open enrollment period for the next plan year to enroll in the plan unless they experience qualifying event.
Enrolling the plan	An Enrollment/Waiver Form should be completed by all employees eligible for insurance benefits. If employees decide not to participate in the POP, the "I elect not to participate in the Premium Only Plan" information box should be selected. This form is evidence that the employees were offered participation in the benefit plan on a pretax basis, and a copy should be kept in the employees' personnel files.	If employees choose to participate in the FSA, the employees may enroll online by visiting www.paychexflex.com, or by calling Paychex Employee Services at 877-244-1771. If employees complete the Election Form/ Compensation Reduction Agreement (Enrollment Form), a copy should be kept in the employees' personnel files.
How do my employees enroll?	If Paychex processes your payroll, the deduction amount indicated on the Enrollment/ Waiver Form can be given to your payroll service representative when you call in in your payroll information. If Paychex does not process your payroll, the deduction information must be sent by fax or mail to the Section 125 department. The address and fax number are listed in the Welcome section in this guidebook.	If employees use the PBA website or call Paychex Employee Services to enroll, an enrollment form is not required. Please do not send duplicate information to the Section 125 department. If employees complete the Election Form/Compensation Reduction Agreement (Enrolment Form), the form should be sent to the Section 125 department. Your Paychex service representative cannot make changes to the FSA deductions.
How do I re-enroll in the plan after a plan year ends?	Employees will be re-enrolled automatically in the Premium Only Plan and will remain enrolled until an Enrollment Change Form is completed and mailed to the Section 125 department or your payroll service representative is notified.	Employees will be re-enrolled automatically in the FSA plan each subsequent January 1 at their current annual election amounts. Employees will remain enrolled until they modify their annual elections or terminate participation based on annual enrollment, termination of employment, or a qualifying event. Employees may submit new annual election amounts by visiting the PBA at www.paychexflex.com calling Paychex Employee Services at 877-244-1771, or completing the Election Form/ Compensation Reduction Agreement (Enrollment Form). Refer to the FSA section of this guidebook for additional information on the FSA Annual Enrollment process.

Special note concerning rehired employees: If employees are rehired within 30 days of their original termination date, they may return to their prior enrollment status for the POP, HSA, and FSA plans.

For example, if an employee participated in the POP at $30.00 per pay period, the employee can continue with this election as if he/she never stopped participating. If an employee needs to be reinstated in the FSA Plan, the plan administrator will need to contact us at 800-472-0072. If an employee needs to be reinstated in the HSA plan, the employee will need to contact us at 877-244-1771.

An employee rehired after 30 days will not be eligible to enroll in the HSA, FSA, or POP plan until he/she have met the Service Period indicated in the Eligibility Requirements of the Adoption Agreement or Summary Plan Description.

Change of Elections

According to IRS regulations, employees may start, stop, or change HSA contributions at any time during the plan year.

Employees do not have the option to voluntarily cancel or change participation in an FSA or POP plan until the end of the plan year. However, if there is a qualifying event, the participant may revoke or change their election. These occurrences are outlined below.

a. **End of the plan year:** Each year, employees will have an annual enrollment period when they can voluntarily elect not to participate in the FSA Plan or change their plan election and amounts.

- POP - employees can do this by completing a Premium Only Plan Enrollment Change Form; you can give this form to your payroll service representative.
- FSA plan - employees can enroll or change their FSA plan election amounts by:
  - visiting the Paychex Benefit Account website at www.paychexflex.com, or
  - submitting a new Election Form/Compensation Reduction Agreement (Enrollment Form) to the Paychex Section 125 Department.

Note: Enrollment in these plans continue at the same election amount for the following plan year, unless the participants complete a change on the website or submit a new enrollment form.

b. Significant cost or coverage change (POP/ Dependent Care FSA only): These changes must be caused by an outside third-party, such as an insurance carrier or daycare provider.

For the POP, a cost change is considered significant when the premiums of the health plan greatly increase, and employees are required to make a corresponding change in premium contribution. In this situation, employees have the right to revoke their current election and receive coverage under another health plan with similar coverage.

A coverage change is also significant when the benefits under the current policy are modified.

The policy changes are significant when the value to employees is reduced. In this situation, all participants may revoke their elections in the health plan and elect to receive coverage under another health plan with similar coverage.

For the Dependent Care FSA, if the daycare provider increases the cost, or if there is a change in coverage by the provider, participants may make a corresponding change in the Dependent Care FSA.

Note: A change in the cost of participants' health plan or health coverage is not considered a Qualifying Event.

c) Change in status: Changes to current plan elections for both the POP and FSA plan may be made after a plan year has started if, during the plan year, participants experience a qualifying event. Status changes due to qualifying events include:

- significant change in health coverage of employees or spouses* attributable to the spouses' employment (POP only),
- employees, spouses*, or dependents become eligible or ineligible for Medicare/ Medicaid,
- change in residence or work site of employees, spouses*, or dependents,**

- dependent care cost motivated change or provider change (Dependent Care FSA only),
- change in legal marital status, separation, or divorce,
- change in number of dependents (birth, adoption, or death),
- termination or commencement of employment or benefits by the employees' spouses* or the employees' dependents,
- change in work schedule (full-time to part-time or vice versa),**
- dependents satisfy (or ceases to satisfy) dependent eligibility requirements,
- unpaid leave of absence by the employees or the employees' spouses,*or
- return from unpaid leave of absence by the employees or the employees spouses*.

*As defined under federal law.

**Allowable only if eligibility is affected.

d) Cessation of contributions: A benefit will cease to be provided to employees if they fail to make the required payments.

e) Employee termination: Upon termination of employment, employees are no longer eligible for the Section 125 Plan. Participation in the Section 125 Plan will end on the same day, and further pretax contributions to the plan cannot be made. You should notify your payroll service representative about employee terminations. If you are not a Paychex payroll client, you can email, fax, or mail the termination notices to the Paychex Section 125 Department. If employees participated in the FSA, you must complete the *Section 125 Information Transmittal Form (For Non-Payroll Clients)*, indicating termination as the type of change.

Send this form, by mail, fax, or email to the Paychex Section 125 Department within 30 days of the termination.

Employees will have 90 calendar days from the date of termination to submit claims for services incurred prior to the termination date. Services that occur after their date of termination are ineligible for reimbursement. Any remaining funds left in their FSA balance after the 90-day claim submission time frame, will be forfeited.

Terminated employees can't have FSA contributions deducted from severance or excess vacation pay, etc. Refer to the Basic Plan Document for more information. Employers can't force terminated employees to withhold more than their normal contribution or pay any remaining contributions toward their FSA plan.

Notification of Insurance Policy or Rate Changes

If the policies covered by the Section 125 Plan change, your company must notify the Paychex Section 125 Department of the new policy name, policy number, insurance plan contact, and telephone number. Changes will then be made to your company's Adoption Agreement and a copy of the revised Summary Plan Description will be forwarded to you for distribution to your employees. An insurance policy change occurs when any policy identified in the Summary Plan Description is added to or is replaced with a new policy. For example, an insurance policy change occurs if a local Health Maintenance Organization (HMO) plan is added to or replaces the existing Blue Cross/Blue Shield traditional indemnity plan. New documentation is not needed when the insurance carrier changes the benefits under an existing plan (for example, the employee deductible increases from $250 to $550).

If you are a Paychex payroll client and the insurance premium rate changes, notify your payroll service representative of the new contribution amounts.

If you are not a Paychex payroll client, please complete the Non-Payroll Transmittal form, including a list of employee names, their social security numbers, the new per-pay-period contribution amounts, and the effective date of the new amount to the Paychex Section 125 Department. Most insurance carriers will increase their premium rates on an annual basis. This increase most often occurs on January 1. For your convenience, refer to the *Section 125 Information Transmittal Form* in the Forms section of this guidebook.

Providing a Summary Plan Description

ERISA requires plan administrators to provide plan participants with a copy of the *Summary Plan Description* (and related material modifications) within 90 days of becoming a participant in the plan.

If a regulatory material change to the plan occurs, Paychex will send a Summary Material Modification (SMM), which must be distributed to participants within 210 days after the plan year in which the change became effective. In the event of a reduction in plan benefits, a revised Summary Plan Description or Summary Material Modification must be distributed within 60 days of the change.

ERISA requires that updated *Summary Plan Descriptions* be distributed to all plan participants every five years if a change occurs within those five years, or every 10 years if no change occurs. Paychex will provide these updated documents to you, for distribution to plan participants. A copy of your plan's *Summary Plan Description* and any related *Summary Material Modification* are available at any time, upon request. If your company offers the FSA, **this plan document is also made available on the Paychex Benefit Account administrative web portal**.

Nondiscrimination Testing Information

Paychex provides nondiscrimination testing information and an instructional packet semiannually. The information indicates whether your plan is in compliance for the non-discrimination testing performed by Paychex. As the plan service provider, Paychex will complete the 25% Concentration Test (Key Employee Test) for all POP, HSA, and FSA clients. The 55% Average Benefits Test and 25% Owner's Test will also be completed for all FSA clients with a dependent care plan component. A plan is out of compliance when the key employees, Highly Compensated Employees (HCEs), and/or owners' pretax contribution are greater than the IRS established thresholds.

- **25% Key Employee Test:** This test requires identifying all key employees. Section 125 of the Internal Revenue Code requires that benefits provided to all key employees may not exceed 25%t of the total benefit provided to all employees under the plan.
- **55% Average Benefits Test:** This test determines the average Dependent Care benefit percentage by dividing the total contributions by the total number of employees in each category (HCEs/ non-highly compensated employees). Section 129 of the IRC requires that the average dependent care benefits provided to all non-highly compensated employees must be at least 55% of the average dependent care benefits provided to all HCEs.
- **25% Owner's Test:** This test compares the total dependent care benefits of non-owner participants to the total dependent care contributions of owners. Section 129 of the IRC considers a plan out of compliance if the owner(s) receives more than 25% of the plan's total dependent care benefits.

It is your company's responsibility to review the test and verify employees are accurately classified as key employees, HCEs, and owners, and all participating employees are listed.

Notes:

- Sole proprietors, partners in a partnership, greater than 2% owners of an S-Corporation, and their family members are ineligible to participate in a Section 125 Plan; if they contribute post-tax, these amounts are not included in the testing.
- HCE and owner designations are only necessary only for FSA and HSA plans.
- Notify Paychex of any updates to the information.
- If your plan is not in compliance, initiate steps to put the plan into compliance. All plans must be in compliance by December 31 of the current plan year.
- Retain a copy for your records.

Employers may request a compliance test at any time by calling our Client Service Center at 800-472-0072. Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET. For clients offering the FSA plan, the Section 125 Compliance Test is available on the Paychex Benefit Account employer web portal.

New Plan Year Administration

All plan years for clients participating in a Paychex Section 125 Plan begin on January 1.

Each year, all employees participating in the POP or FSA plan must be given an opportunity to change their current plan elections. HSA contributions can be changed at any time.

During Open Enrollment, participants should be allowed to start, stop, or make changes to existing pretax elections. This is also the time when newly-eligible employees are able to enroll in the FSA plan. Employees must submit any elections to enroll or change current elections before the new plan year begins. For participants currently enrolled in the plan who don't want to make any contribution changes, no additional enrollment or change forms need to be completed. They will automatically be enrolled in the new year's plan. It is the employer's responsibility to notify employees of the opportunity to make election changes and distribute the necessary information to them. Employer contributions need to be submitted each year. Employer contributions don't roll over. Paychex must receive new enrollments or changes by current participants before January 1.

Note: For FSA clients, Paychex will specify a deadline for FSA enrollments. Refer to *FSA Annual Enrollment*, the section, for additional information. There is no deadline for HSA enrollments.

Refer to Enrolling Employees, section, for additional information.

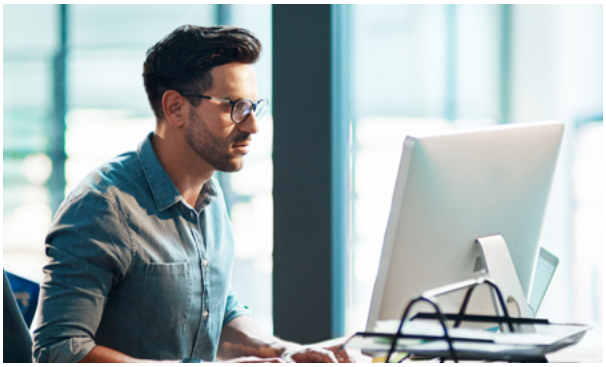
Summary of Plan Administration Roles and Responsibilities

Beginning Your Section 125 Plan

Paychex	Your Company
• Prepare reports: Adoption Agreement Basic Plan Document Summary Plan Description Employee Deduction Report FSA Employee Account Balance Report Initial nondiscrimination testing • Provide client toll-free Paychex Human Resource Services telephone number	• Review accuracy of all reports prepared by Paychex. • Distribute Summary Plan Description to plan participants. • Enroll employees (refer to the Enrolling Employees section, for additional information). • Retain copies of this documentation for your records.

Ongoing Section 125 Plan Maintenance

Paychex	Your Company
• Provide client support on the toll- free Paychex Human Resource Services telephone number as well as access to the PBA website. • Provide employees access to the PBA website and Paychex Employee Services telephone number. • Calculate nondiscrimination testing results. • Update plan documentation upon request. • Send section 125 plan administration supplies upon request. • Send annual enrollment materials and confirmation packages.	• Enroll employees (refer to the Enrolling Employees chart, Page 1-3, for additional information). • Make Annual Election updates for employees who experience qualifying events. • Verify nondiscrimination information, request and approve adjustments to bring plan into compliance (if applicable). • Notify Paychex of changes affecting your plan documentation.



Paychex Benefit Account Website and Paychex Employee Services

Paychex Benefit Account and Paychex Employee Services provide easy access to information about the FSA and HSA plan. With these automated features, your employees may:

- enroll in the FSA and/or HSA plan during open enrollment,
- enroll or revise their FSA plan elections during open enrollment,
- update their HSA per pay amounts,
- review their account balances, year-to-date contributions, annual elections, per-pay-period deduction amounts, and reimbursement information,
- submit claims online; including uploading receipts,
- submit distribution requests,
- update and maintain their account information, including dependent information,
- request replacement debit cards,
- use a mobile app on their smartphone to take pictures of receipts with smartphones and upload them to the website,
- submit new claims and check claim statuses,
- receive important account status alerts,
- request FSA-related forms and information,
- and manage HSA investments.

In addition, the website offers a variety of tools, including a glossary, Frequently Asked Questions (FAQs), and an Education Center where employees can learn more about FSAs and HSAs.

Follow these steps to access the PBA website:

1. To access your account on the PBA website, visit www.paychex.com/login.
2. As a new user, you must register and create a password upon logging on to the website.
   - To register, click Register for a new
   - Enter and submit the requested information
   - Follow the instructions to create a password.

   Note: Existing users of Paychex Online Services will use the same password they previously created.
3. Enter your username and password at the log on screen. Once logged in, select Paychex Benefit account from the left menu.

Follow these steps to use Paychex Employee Services

1. Using a touch-tone telephone, dial 877-244-1771, Flexible Spending Account option.
2. Enter your social security number (SSN). If you don't want to use your SSN, you may create a user ID.
3. Enter your Personal Identification Number (PIN). If you don't have a PIN, the system will prompt you to create one. If you forget your PIN, the system can generate a new one for you.

   Note: If you have previously used Paychex Employee Services for Retirement Services, your PIN will be the same.
4. Any changes made using Paychex Employee Services will be confirmed by mail or fax (if you select the fax confirmation option).

Health Savings Account Rules and Regulations

In addition to the information discussed in the Plan Administration section of this guidebook, HSAs have additional administration requirements that don't apply to the FSAs and POPs. This section addresses those additional requirements established by Paychex and the Internal Revenue Service.

Employee HSA Participation

To have an HSA, individuals must have coverage under an HSA-qualified High-Deductible Health Plan (HDHP), can't be claimed as a dependent on someone else's tax return, and can't be entitled to Medicare.

Employees with a HDHP are eligible for an HSA in any month that they have insurance coverage as of the first of that month.

If individuals with HSAs are no longer covered by a qualified HDHP, they can't make additional contributions.

While individuals enrolled in Medicare can't open an HSA, they can maintain an existing account when they enroll, but they can't make any more contributions into their account.

HSA Contributions

Each HSA participant may contribute to the HSA on a per-pay-period basis, up to the annual maximum contributions itemized below: HSA Enrollments

	2022
Individual Coverage	$3,650
Family Coverage	$7,300

When the account holders reach age 55, they can make up to $1,000 in additional catch-up contributions per year.

Employers may also make contributions to employees' HSAs. When this occurs, the combination of both employee and employer contributions cannot exceed the statutory maximum for HSA for that year.

HSA Enrollments

All employees must satisfy a service period requirement before they are eligible to enroll in the HSA plan. The employer-established eligibility requirement is indicated in the Adoption Agreement and Summary Plan Description. After completing the service period requirement, employees who qualify may enroll in the HSA on the first day of the month following the eligibility date. Employees may enroll by going to the PBA website at www.paychex.com/login. They can elect to enroll for any month that they have coverage under a HDHP.

Employees will continue to contribute until they choose to update their contribution amount or close their HSA account.

Distribution Reimbursements

Distribution checks are mailed to employees' home addresses.

Direct Deposit

HSA Direct Deposit provides an electronic distribution reimbursement delivery option. This option allows Section 125 Plan participants to receive reimbursements through direct deposit to their bank accounts.

PBA Debit Card

Paychex automatically sends participants PBA Debit Cards that are linked to your employees' reimbursement accounts. Participants may use PBA Debit Cards to pay for HSA-eligible items and services at the point-of-sale, instead of submitting a distributions for reimbursement.

Eligible Expenses

The following is a brief list of the most common medical expenses that are eligible under a medical HSA plan. For more information, participants can access a common expense list on the PBA website at www.paychex.com/login.

Note: If your employees have an FSA in conjunction with a HSA, they may only submit medical expenses under the Unreimbursed Medical portion of their FSA for dental, vision, and preventative care. Their HSA may be used to pay for any remaining HSA-qualified medical expenses. For more information regarding preventative care, refer to IRS Notice 2004-23 at http://www.irs.gov./irb/2004-15_IRB/ar10.html.

Eligible Expenses with a Doctor's Prescription (Effective 01/01/2011)

Flexible Spending Account Rules and Regulations

In addition to the information discussed in the Plan Administration section of this guidebook, FSAs have additional administration requirements that do not apply to POPs and HSAs. This section addresses those additional requirements set forth by Paychex and the Internal Revenue Service.

Employee FSA Contributions

FSA or LPFSA participants may contribute to the FSA on a per-pay-period basis, up to the annual maximum contributions itemized below:

	Maximum Contribution
FSA or Limited Purpose FSA (LPFSA)	$2,850 per employee (IRS Maximum) or lesser amount as outlined under the plan
Dependent Care Account (DCA)	$5,000 per household (IRS Maximum)

Your company's plan maximum contribution is located in the Cafeteria Plan Benefits section of the Adoption Agreement. To determine the per-pay deduction for an FSA election, use the following equation:

Annual election ÷ number of pay periods in a year = per-pay-period deduction amount

For example, assume an employee is paid biweekly and chooses an election of $1,200 for UME. The per-pay-period deduction would be calculated as follows: $1,200.00 ÷ 26 = $46.15

FSA Enrollments

Employees must satisfy a service period requirement before they are eligible to enroll in the FSA plan. The employer-established eligibility requirement is indicated in the Adoption Agreement and Summary Plan Description. After completing the service period requirement, employees may enroll in the FSA on the first day of the month following the eligibility date. Monthly enrollment is for new employees only.

Employees may enroll by going to the PBA website at www.paychex.com/login, or by calling Paychex Employee Services at 877-244-1771. If employees choose not to participate during the month in which they are eligible, employees must wait until the next plan year to enroll.

Employees will continue to participate until they choose to change or cease participation during the annual enrollment period, or until they're no longer employed by the company. The annual enrollment period will be the 60-day period immediately preceding the plan year start date of January 1.

Note: It is important to remember that any leftover contributions from the previous plan year can't be carried forward unless you have chosen to offer the FSA Grace Period or Carryover Option. Refer to FSA Grace Period/Carryover section for more information.

Employees can't participate in an HSA and FSA concurrently unless their FSA is a Limited Purpose FSA (LPFSA). To have a LPFSA, participants must be enrolled in both a HDHP and an HSA. Participants can't use funds from the LPFSA and HSA to cover the same eligible expense.

Claim Reimbursements

Claim reimbursement checks are mailed to the employer ready to be signed and distributed to employees. All claim reimbursement requests submitted are processed upon receipt of the completed claim form and all approved supporting documentation, or upon upload to the PBA website within a 48-hour timeframe.

Check Signing and Insertion Service

Paychex offers a check signing and insertion service for FSA reimbursement checks. The checks are signed with your signature and mailed to the employees' home addresses. Employers or plan administrators will receive the account balance and check register reports.

FSA Direct Deposit

FSA Direct Deposit provides an electronic claims reimbursement delivery option. This option allows Section 125 Plan participants to receive medical and dependent care account reimbursements through direct deposit to their bank accounts.

FSA Debit Card

Paychex automatically sends participants FSA Debit Cards that are linked to your employees' reimbursement accounts. Participants may use FSA Debit Cards to pay for FSA-eligible items and services at the point-of-sale, instead of submitting paper claim forms for reimbursement. Refer to FSA Debit Card, section, for additional information.

Eligible Expenses

The following is a brief list of the most common medical expenses that are eligible under a medical FSA plan.

- A.E.D. for home use
- Alcoholism treatment
- Ambulance services
- Blood pressure monitors
- Clinic charges
- Contact lenses/solution
- Co-pays and deductible
- Crutches
- Dentist/doctor fees (not cosmetic)
- Diabetic supplies and test strips
- Drug addiction treatment facilities
- Eye exams/prescribe eyeglasses
- Fertility treatments
- Hearing aids/batteries/repairs
- Nursing care
- Orthodontia (contract required)
- Over-the-counter medicines and drugs – these types of expenses were reinstated during COVID-19
- Physical exams
- Prescription medications
- Prosthesis
- Smoking cessation prescriptions
- Surgery/treatments
- Wheelchairs
- X-ray fees

A non-exhaustive list of eligible expenses can be found on the FSA Store website, at https://fsastore.com/FSA-Eligibility-List.aspx.

Ineligible Expenses

The following are examples of medical expenses that are not covered under a medical FSA plan:

- Clip-on eyeglasses
- Cosmetic procedures/products
- Dental bleaching
- Dental floss
- Deodorants
- Diaper service
- Funeral expenses
- Illegal treatments or drugs
- Insurance premiums
- Marital therapy
- Medications imported from outside U.S.

- Mouthwash
- Remedial reading classes
- Shampoo
- Skin moisturizers/lotions
- Soaps
- Teeth whitening products
- Toiletries
- Toothbrushes
- Toothpaste
- Toothache/teething pain relievers
- Vitamins used for general health
- Warranties for eyeglasses

If employees are enrolled in the LPFSA in conjunction with a HSA, they may only submit medical expenses under the Unreimbursed Medical portion of their LPFSA for dental, vision, and preventative care. Their HSA may be used to pay for any remaining HSA-qualified medical expenses. For more information regarding preventative care, refer to IRS Notice 2004-23 at http://www.irs.gov./irb/2004-15_IRB/ar10.html.

PBA Debit Card

Participants can use PBA Debit Cards to pay for FSA eligible items and services at the point-of-sale, instead of submitting a claim for reimbursement. However, depending on the items purchased, participants may be required to submit documentation to validate the expense as eligible under the plan.

The FSA Debit Card may be used only at locations that sell FSA-eligible items and services. Each point-of-sale terminal contains an embedded code confirming the merchant as selling FSA-eligible items and services. This helps to safeguard you, as the employer, for cards being used at locations that do not sell FSA-eligible items.

All other FSA-eligible expenses can still be reimbursed by using the FSA Reimbursement Claim Form and submitting by mail or fax, or by uploading to www.paychex.com/login or through the mobile app.

Your organization is automatically enrolled to receive PBA Debit Cards unless otherwise specified.

If your employees have questions about the FSA Debit Card after they have enrolled, they can visit the PBA website at www.paychex.com/login, or can call Paychex Employee Services at 877-244-1771.

For additional information regarding the PBA Debit Card, please contact Paychex Human Resource Services at 800-472-0072. Representatives are available to help you Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET.

Limited Purpose Flexible Spending Account Rules and Regulations

The additional requirements set forth by Paychex and the Internal Revenue Service for the FSA also apply to the LPFSA, except for the limited number of eligible expenses.

Employees can't participate in an HSA and FSA concurrently unless their FSA is a LPFSA. To have a LPFSA, participants must be enrolled in both a HDHP and an HSA. Participants can't use funds from the LPFSA and HSA to cover the same eligible expense.

Participants may only submit medical expenses under the Unreimbursed Medical portion of their LPFSA for dental, vision, and preventative care. For more information regarding preventative care, refer to IRS Notice 2004-23 at http://www.irs.gov./irb/2004-15_IRB/ar10.html.

PBA Debit Card

Participants can use PBA Debit Cards to pay for LPFSA eligible items and services at the point-of-sale, instead of submitting a claim form for reimbursement.

Internal Revenue Service Regulations

The following information explains the rules for FSAs as mandated by the Internal Revenue Service.

Uniform Coverage

The Uniform Coverage Rule pertains to the availability of funds contributed only under the Unreimbursed Medical Expense portion of the FSA plan. The maximum annual contribution elected by participants must be available to participants at all times during the plan year, regardless of their year-to-date contributions. The Uniform Coverage requirement is best explained in an example:

An employee elects to contribute $40 each paycheck to a medical FSA plan. If the employee is paid biweekly, the contributions will equal $1,040 at the end of the plan year ($40 x 26 paychecks = $1,040).

As of February 10, the participant has contributed $120 to the FSA account and has not submitted any claims. On February 15, the participant submits an eligible medical claim in the amount of $250. The participant would receive a reimbursement of $250, not $120.

Uniform Coverage regulations don't apply to the Dependent Care Assistance (DCA) portion of the FSA. Under DCA regulations, employees can be reimbursed only amounts already contributed.

12-Month Period of Coverage Requirement

With the exception of the initial and final plan years, plan elections to an FSA plan must last for a 12-month period. The Paychex Section 125 Plan operates on a calendar year basis, so all plan year elections will end December 31 and will renew automatically as of January 1 of the following plan year. Current participants will have an annual enrollment period to make any changes for the following plan year. Therefore, requests received by Paychex to cancel or change employees' FSA contributions for any reason other than a qualified event can't be processed, except during the annual open enrollment period. In the event of a status change due to a qualified event, employees may be allowed to adjust the remaining portion of the 12-month period only within the given deadlines.

Employees are automatically re-enrolled in the FSA plan every January 1 for their current election amounts. Employees will remain enrolled until they submit enrollment changes through the web, automated phone line (IVR), by using an Election Form/ Compensation Reduction Agreement (Enrollment Form), or by terminating participation based on annual enrollment.

Prohibited Reimbursements

Only certain expenses may be reimbursed from each FSA benefit elected. A list of common expenses is located on Paychex Online FSA at www.paychex.com/login. Two primary requirements for FSAs are (1) insurance premiums are not reimbursable under the FSA, and (2) funds can't be intermingled between FSA accounts. For example, a medical claim may never be paid with dependent care contributions, and vice versa. Such payments are called "prohibited reimbursements." Due to the separated funds requirement, a separate employee "account" is established for each FSA benefit selected. The term "account" for the FSA plan is a descriptive term only. An "account" is of a memorandum or bookkeeping nature only and is recorded by Paychex based on employee payroll contribution information provided. A bank checking account is maintained by the employer, from which claim reimbursements are drawn. Additionally, no interest will be credited or paid to amounts contributed to participants' accounts.

Note: Paychex HR Solutions clients must contact their Human Resource Generalist (HRG) for assistance with questions about how claim reimbursements are drawn. Employers may access a summary of each participants' FSA activity in an Employee Account Balances Report.

Claims Substantiation

Claims for reimbursement can be submitted through the PBA website at www.paychex.com/login, or by completing the appropriate Paychex claim form (Reimbursement Claim or Monthly Dependent Care Claim). The form must be completed, signed, and submitted with an itemized

bill from the service provider. The itemized bill must include the name of the service provider, date of service, description of service, and the amount of the expense. The receipt must state the actual product name purchased and not a general description such as "pharmacy." A receipt with "pharmacy" listed as the purchased product won't be eligible for reimbursement. An Explanation of Benefits statement may satisfy all of the above requirements.

Note: The claims reimbursement process may differ for FSA Debit Card participants. Refer to FSA Debit Card, section, for additional information.

Orthodontia

Paychex requires a copy of an orthodontia contract (or a written statement from the orthodontist) indicating the length of treatment and schedule of payments. This information is required since treatment of orthodontia is ongoing and reimbursement of medical expenses prior to services being rendered is not permitted. Once Paychex receives a contract, it remains on file. It is the employee's responsibility to notify Paychex if any provisions of the contract change and to provide an updated contract, if necessary. Paychex may request a copy of the contract at the beginning of each plan year.

Employees will be reimbursed based on the length of treatment and schedule of payments provided on the required orthodontia contract during the plan year in which they are enrolled. Employees won't be reimbursed in full if the orthodontia bill is paid up front. Once Paychex receives the required contract, employees must submit a claim form and itemized document from the service provider in order to be reimbursed. The claim form and receipt must match the amount listed on the payment schedule of the orthodontia contract.

Claims Incurred

For a claim to be reimbursed, the service must have been incurred when employees were actively enrolled and covered by the FSA plan. Expenses are treated as having been incurred when participants are provided with medical care that give rise to medical expenses, and not when participants are formally billed, charged for, or have paid for the medical care.

FSA Grace Period/Carryover/Forfeitures

Closeout Period

Participants have up to 90 days after the end of the plan year (December 31), or termination of employment, to submit claims for reimbursement of incurred expenses. Eligible expenses must be incurred during the plan year (or prior to the participant's termination date) while an active participant.

Grace Period

You may offer a grace period following the end of the plan year (two and a half months after the end of the plan year, or March 15), which allows participants to incur expenses that may be reimbursed from the previous year's account. This applies only if employees are active participants on the last day of the plan year (December 31), including participants who are active through COBRA coverage for health FSA and have a balance remaining in their FSA.

Carryover

If clients choose to allow a carryover option, participants can carry over up to $570 of unreimbursed medical expense funds from the current year to the following year. The carryover amount will be added to any salary reduction election by the participants for the following year. This allows participants to incur expenses up to and including December 31 of the following year that can be reimbursed from the remaining balance in their previous year's account. This applies only if employees are active participants on the last day of the plan year (December 31) and have a balance remaining in their previous year's account. A lesser amount can be allowed by the plan and would be outlined in the Adoption Agreement.

Note: For grace period and carryover options, reimbursement requests will be processed in the order they are received and deducted from the prior year's account. Participants should submit reimbursement requests for services from the previous plan year first to ensure they receive the maximum benefit. The client can't choose both the carryover option and the grace period option.

Forfeitures

Any unused funds remaining in the prior year's account will be forfeited to the plan. The IRS limits the employer's decision as to the use of the forfeited funds. ERISA requires that any forfeiture from the benefit plan be returned to the plan based on certain recommended options. The funds must never be refunded to participants based on the amount that participants forfeited. This type of cash reimbursement is a direct violation of Section 125 regulations. The funds may be allocated to the participants in the form of a premium or contribution refund. This allocation must be done on a uniform basis and must never be distributed based on an individual's claims experience. Some IRS recommended uses of experience gains are:

- Funds may be used to help pay the administrative costs of the plan.
- plan year which generated the excess.
- Funds may be allocated, as taxable income, equally among all FSA participants enrolled in the
- Funds may be used to reduce required premiums for the plan year following the year in which the excess was generated.

Note: This is not an exhaustive list, and clients should consult with their tax advisors.

Health Savings Account (HSA) Interaction with FSA

Employees can use an HSA in conjunction with an FSA; however, there are some restrictions. Employees may submit claims only for medical expenses under the Unreimbursed Medical Expenses portion of the FSA for dental, vision, and preventative care. The HSA may be used to pay for any remaining HSA-qualified medical expenses.

Rules Pertaining to Dependent Care Assistance (DCA) Plans Only

Dependent Defined

A dependent is any individual claimed by an employee as a dependent on the employee's personal income tax return.

*A qualifying person is:

a) the employee's dependent under the age of 13 when the care was provided and for whom the employee can claim an exemption,

b) an immediate family member (as defined under IRS Code section 152) requiring full-time care because of a physical or mental incapacity (for example, a disabled parent), or

c) the employee's spouse who is physically or mentally incapable of self-care.

*For additional information about the definition of a dependent, refer to IRS Publication 503 on the IRS website at www.irs.gov.

Reimbursements

For an expense to be reimbursed through a dependent care plan, the expense must:

a) allow the employee (or the spouse, if married) to work, actively look for work, or be a full- time student,

and

b) be incurred for a qualifying person's care.

Dependent care reimbursements are limited to the lesser of:

a) $5,000 (or $2,500 for married individuals filing separate tax returns)

b) the employee's earned income, or

c) the spouse's earned income.

Child care services provided by dependents of the employee (including children under the age of 19), or the employee's spouse, are not eligible for reimbursement.

A dependent care claim must contain the name and address of the person providing the dependent care services. It is the responsibility of the employee to provide the taxpayer ID number or social security number when filing personal income tax returns (IRS Form 2441), since all pretax dependent care contributions will appear on Form W-2.

In contrast to an unreimbursed medical expense account, dependent care expenses can be reimbursed only up to the payroll contribution amount.

Claims Processing

FSA claims must be submitted for eligible expenses incurred during the plan year and/or grace period, if applicable. Claims for services incurred during the plan year and/or grace period, if applicable, may be submitted up to 90 days after the end of the plan year. If employees terminate participation in the plan, they have 90 days from the date they cease participating in the plan to submit expenses for services incurred prior to the date of plan termination.

If the grace period is applicable and employees are active and participating on the last day of the plan year (including active FSA COBRA participation), regardless of their employment status during the 2½ months immediately following the end of the plan year, participants will still be able to incur and be reimbursed for eligible expenses incurred during the entire grace period.

Refer to the following example regarding an employee who terminates participation in the plan when a grace period is applicable:

> An employee is a participant for the entire 2021 FSA plan provided by his employer. The participant is terminated from employment on February 15, 2022. Since the participant was active and participating on the last day of the 2021 plan year, they are able to continue to incur eligible expenses until March 15, 2022 (Grace Period) and submit claims for reimbursement against their remaining account balance for the 2021 plan year until March 31, 2022 (Closing Period).

There are three possible scenarios for terminating participation in the plan:

- employee experiences a qualifying event,
- employee terminates employment, or
- an employer terminates the plan.

In the event of a plan termination, employees will have 90 days to submit claims for reimbursement. You have the option of electing Paychex to continue processing claims after the plan termination date up to a 90-day closing period. If a qualifying event causes employees to lose eligibility to participate in the plan, then participants will have 90 days from the date of the loss of eligibility to submit claims for services incurred prior to the event date. After 90 days, any money for which employees have not submitted claims will be forfeited to the plan and will not be returned. At the time the FSA plan was sold, the employer provided Paychex with the company checking account number to which the FSA funds are deposited. It is this funding account through which claims are reimbursed.

Note: Paychex HR Solutions clients must contact their Human Resource Generalist for help with questions about how claim reimbursements are drawn.

On a per-check-run basis, employers can review the Employee Account Balance Report highlighting individual accounts. Paychex is at no time responsible for verifying that the FSA funding account has a sufficient balance to cover all reimbursements processed.

Note: Claims processing may differ for FSA Debit Card participants. Refer to FSA Debit Card, section, for additional information.

Employee Claim Responsibilities

a) Participant requests for reimbursement from the FSA account(s) must be made at www.paychex.com/login, along with the uploaded receipt or on the claim form, and the supporting documentation can either be mailed or faxed to the Paychex Section 125 Department.

b) By signing the claim form or by submitting the form online, employees certify that the expenses are not eligible for, or already reimbursed under, any other insurance or FSA plan. For this reason, claim forms with no signature will be placed on hold and employees will be notified in writing. Claim forms submitted online don't require a signature since the login is considered an electronic signature.

c) A copy of an itemized bill or statement must accompany the claim form. The itemized bill or statement must include date of service, type of service performed, amount to be reimbursed, and the provider of the service. An insurance carrier's Explanation of Benefits statement may satisfy all of the above requirements.

Paychex Claim Responsibilities

a) Upon receipt of a claim form, Paychex will verify that:

• the employee is enrolled, and

• the expense is reimbursable under the plan.

b) Paychex will notify participants, in writing or electronically, if any (or all) of the claim is placed on hold or denied.

c) Paychex will process all claim reimbursements upon receipt of the completed claim form and all supporting documentation.

d) Paychex will mail reimbursement checks to the employer. If the check signing option is selected, the reimbursement checks will be sent directly to the employees' home address. If the direct deposit option is selected, the reimbursement amount will be deposited into the employee's bank account.

Employer Claim Responsibilities (if FSA Check Signing, Direct Deposit, or Debit Card is not used)

a) Upon receipt of the claim check, employers must sign the check.

b) After signing the check, employers must distribute it to employees.

c) Employers must ensure sufficient funds are available to cover the claim reimbursement check(s).

Additional Claim Information

Employees should keep copies of all claims submitted. This may be required for future verification if, for example, a claim is lost in the mail or there is an IRS audit of the plan. The backup copies can be re-mailed for payment.

The minimum reimbursement amount that will be processed is $1. Employees with claim(s) that total less than $1 won't be reimbursed until future claim requests equal or exceed $1. When an account balance is below $1 and claims are submitted, the payment won't be processed until the close of the plan year.

Nonpayment of Claims

If a claim requires more information or can't be paid because it is for an ineligible service, participants will receive notification, including the necessary steps to resolve. If multiple services are submitted on the same claim form, the item(s) on hold or denied won't delay the rest of the claims. The held service will be paid upon receipt of the additional documentation.

Note: Additional information regarding the process of submitting and adjudicating claims is located in the Basic Plan Document, Article IX and the Summary Plan Description, Section B.

Voiding of FSA reimbursement checks issued by Paychex is possible. If a check was processed, but not received by your company, Paychex will generate a replacement check. For replacement checks to be processed, a waiting period of 7 to 10 days is required. Employers or designated individuals can submit a written request to have a check voided and replaced. It is the employer's responsibility to contact the financial institution and initiate the stop payment process unless the client is a Paychex HR Solutions client, in which case the stop payment is initiated by Paychex when the void request is received by Paychex Human Resource Services.

FSA Reminder Letters are provided for FSA participants. This letter recaps employee's FSA activity, claims paid, and the remaining credit available for reimbursement.

Participants can retrieve account balances and account status on the PBA website at www.paychex.com/login or by calling Paychex Employee Services at 877-244-1771.

FSA COBRA Regulations

Health FSA plans must comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Federal regulations require all companies with 20 or more employees to provide their employees and qualified beneficiaries the ability to continue their health FSA coverage if coverage is lost due to a COBRA "qualifying event." However, COBRA is not required if participants have a zero or negative account balance. These qualifying events are:

a) death of employees,

b) voluntary or involuntary termination (other than gross misconduct) or reduction in hours of the covered employees' employment,

c) the divorce or legal separation of the covered employees,

d) the covered employees becoming eligible for benefits under Title XVIII of the Social Security Act, and

e) a dependent child ceasing to be a dependent.

It is your company's responsibility to provide COBRA notification to qualified health FSA participants. Federal law requires that this notice be sent within 14 days of the plan administrator's receipt of notification of a qualifying event. Employees have 60 days from the date of the notice to choose COBRA coverage for health FSA. To assist you in being compliant with federal regulations, you may request an electronic version of a sample *COBRA Election Notification and Flexible Spending Account Continuation Form* at any time.

If participants choose to continue FSA coverage through COBRA, you must notify the Paychex Section 125 Department, in writing, for Paychex to continue claim processing and claim reimbursement. Continuation of coverage can be maintained only through December 31 of the current plan year.

COBRA contributions toward a health FSA are made by employees on a post-tax basis. It is the employer's responsibility to collect the funds from COBRA participants. All provisions of the plan (such as uniform coverage, expense and services incurred, etc.) apply to FSA COBRA participants as they do to any other participants in the plan. As with any change in status due to a qualifying event, Paychex must be notified within 30 days of the event. If the qualifying event is termination of employment, participants will have 90 days after the date of termination to submit a claim for any eligible expenses incurred before termination, unless they decide to continue coverage. For additional details refer to the *Basic Plan Document*.

FSA Leaves

FSA FMLA

The Family Medical Leave Act of 1993 (FMLA) provides certain employees with up to 12 weeks of unpaid, job-protected leave each year. It requires group health benefits be maintained during the leave as if the qualified employee continued to work. This requirement also applies to health FSA. The following options are available to FSA participants on FMLA leave. These options may also apply to participants on non-FMLA leave.

1. **Option 1:** Participants wish to revoke or cancel FSA election. An FSA election form must be completed and signed by participants and plan administrators. Such individuals will not be reimbursed for claims for services incurred during the leave period. If individuals return from leave prior to the end of the current plan year, they may continue to contribute the original per-pay amount for the remainder of the year. To do so, individuals must submit a completed FSA election form to re-enroll in the plan.

2. **Option 2:** Participants wish to continue coverage. Continuation of coverage applies only to reimbursement of medical claims during the leave of absence. Dependent Care claims are not eligible for reimbursement during a leave of absence. Plan administrators must notify Paychex, in writing (by mail or fax), if individuals elect this option and what method of payment is being used. This is to ensure continued claim reimbursement for services incurred during the leave of absence. Failure to notify Paychex will result in denial of claims.

Individuals must choose one of the following options for making FSA contributions while on leave:

- **Pre-pay:** Prior to the leave, participants will pay (pretax or post-tax) all contributions that will be due during the leave period.
- **Pay-as-due:** Participants will pay contributions (post-tax) as each is due during the leave of absence.
- **Catch-up:** After returning to work, participants will pay in full (pretax or post-tax) all contributions due during the leave or increase their per-pay-period deductions to meet the original election amount.

Note: FMLA requires that participants eligible for FMLA leave be offered the same options as participants on non-FMLA leave. If participants are on leave during open enrollment, or if a benefit enhancement is made while participants are on leave, FMLA requires that participants be offered the same options as active employees. The regulations don't allow participants to pre-pay contributions for periods of leave that occur in a subsequent Plan Year. Likewise, participants can't make catch-up contributions for periods of leave that occurred in the prior Plan Year.

NOT ALL EMPLOYERS ARE BOUND BY FMLA. Consult with your legal counsel or contact your state Department of Labor for details regarding your specific company.

Military Leave

If your employees are participating in the FSA, are in the uniformed services, and are called to active duty, they may be entitled to benefit continuation rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Participants must provide, in advance, a copy of orders or other notification that indicates they have been called to duty for uniformed services. If advance notice is not feasible, arrangements should be made to provide this information as soon as possible. Benefits may be suspended or canceled until notice is received.

Paychex Benefit Account Annual Enrollment

Annual Enrollment Roles of the Plan Service Provider and Plan Sponsor

Paychex' Annual Enrollment Role as the Plan Service Provider	Your Company's Annual Enrollment Role as the Plan Sponsor
• Paychex will send your company information regarding the annual enrollment process six to eight weeks before the enrollment deadline. This information will include any changes relevant to your Section 125 Plan and a deadline for your participants to enroll, modify, or cease participation in the FSA plan for the new plan year. • Prior to the new plan year (January 1), Paychex will send a Confirmation Package to you detailing the plan(s) in which participants are currently enrolled and the contribution amount that will be made each pay period.	• Notify employees of the upcoming open enrollment periods when you receive this information from Paychex so they have time to prepare for the upcoming plan year. • Notify your employees of the new FSA information and inform them of the enrollment deadline. • Notify current plan year participants that they will continue to participate in the same benefits at the same annual amount unless they choose to change or cease participation during the annual enrollment period. • Distribute the participant account balance information for the new plan year. • Upon receipt of the Confirmation Package, verify that employee elections are correct and report any discrepancies or changes to Paychex Human Resource Services at 800-472-0072.

Resources to Help Facilitate the FSA Annual Enrollment Process

The PBA website at www.paychexflex.com is an online tool that provides valuable resources for your employees.

The Section 125 Flexible Spending Account Employer Information Booklet is designed to help employers answer questions that their employees may have before enrolling in the Paychex FSA plan.

The Section 125 Flexible Spending Account Employee Information Booklet is designed to give employees additional insight into the benefit questions they may have when making the decision regarding FSAs. It also provides a guide to help employees make an accurate election.

You have access to Paychex Human Resource Services at 800-472-0072. Representatives are available to help you Monday through Friday, from 8:00 a.m. to 8:00 p.m.

Glossary

55% Average Benefits Test: This test determines the average benefit percentage by dividing the total contributions by the total number of employees in each category (highly compensated employees [HCE]/non-highly compensated employees [NHCE]). Section 129 of the Internal Revenue Code requires that the average dependent care benefits provided to all non-highly compensated employees must be at least 55"% of the average dependent care benefits provided to all HCEs.

25% Key Employee Test: This test requires identifying all key employees. Section 125 of the Internal Revenue Code requires that benefits provided to all key employees may not exceed 25"% of the total pretax benefit provided to all employees under the plan.

25% Owner's Test: This test compares the total dependent care benefits of non-owner participants to the total dependent care contributions of owners. Section 129 of the Internal Revenue Code considers a plan out of compliance if the owner(s) receives more than 25"% of the plan's total dependent care benefits.

Administrator: The employer, or other person or committee, who has been designated by the employer in the Adoption Agreement.

Adoption Agreement: An agreement, executed by the employer, adopting the Section 125 plan and designating the employer's options under the plan.

Basic Plan Document: A generic document that describes the operating rules outlined under Internal Revenue Code section 125 and other regulations pertaining to the plan. The plan document must include such items as benefit descriptions, eligibility, funding, plan year, and plan election requirements.

Cafeteria Plan: A fringe benefit plan under which (1) all participants are employees, and (2) the participants may choose among two or more benefits consisting of cash and qualified benefits.

Carryover: If clients choose to allow a carryover option, participants can carry over up to $500 of unreimbursed medical expense funds from the current year to the following year. The carryover amount will be added to any salary reduction election by the participants for the following year. This allows participants to incur expenses up to and including December 31 of the following year that can be reimbursed from the remaining balance in their previous year's account. This applies only if employees are an active participant on the last day of the plan year (December 31) and have a balance remaining in their previous year's account. A lesser amount can be allowed by the plan and would be outlined in the Adoption Agreement.

Closing Period: The number of days after the end of the plan year that the administrator holds the books and records open to allow participants time to submit claims arising from services rendered during the plan year, and/or during the grace period, if applicable, while the supporting documents and receipts become available. The number of days allowed for the Closing Period is specified in the Basic Plan Document and Summary Plan Description.

Company Maximum: The maximum amount, determined by the employer, that employees are allowed to elect for the unreimbursed medical and dependent care expenses under the Flexible Spending Account plan.

Compliance Test: A test that determines whether or not the key employees, highly compensated employees, or owners are withholding more than the thresholds allowed by the IRS.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): A law that allows certain individuals and their beneficiaries (of companies bound by COBRA) to continue their health benefit coverage (including health FSA), that would otherwise cease, based on certain qualifying events.

Effective Date: The effective date of the Section 125 Plan is the date specified in the Adoption Agreement and Summary Plan Description. The effective date of the insurance policy is the date the coverage under the insurance plan begins.

Eligible Employee: Any employee meeting the eligibility requirements as stated in the Adoption Agreement and Summary Plan Description.

Eligibility Requirements: Requirements stating the minimum conditions necessary to be able to participate in the Section 125 Plan as specified in the Adoption Agreement and Summary Plan Description.

Employee Retirement Income Security Act of 1974 (ERISA): ERISA applies to Section 125 Plans with rules concerning participants' rights and communication. ERISA states that the Section 125 Plan must be in writing and the plan must be communicated to all participants. Each participant must be supplied with a Summary Plan Description.

Family Medical Leave Act of 1993 (FMLA) A law that provides that certain employees (of companies bound by FMLA) be allowed a specific amount of unpaid, job-protected leave each year and requires that their health benefits (including health FSA) be maintained while on leave.

Grace Period: An extension of two and one-half months from the end of the Plan Year to allow participants to incur eligible expenses and submit them for reimbursement from any remaining balance in their FSA for that year.

Note: The participant must have a positive balance and be an active participant in the Plan (or be covered by COBRA continuation coverage for the Unreimbursed Medical/Dental benefit) on the last day of the Plan Year to qualify for the grace period extension.

Health Savings Account (HSA): The HSA is a funded account, similar to an IRA, to which individuals under age 65 and/or employers may make annual contributions within specific limits. The earnings in the account grow on a tax-free basis, and, if used for "qualified medical expenses," may be withdrawn on a tax-free basis. Earnings may also be carried over from one year to the next and HSAs also allow catch-up contributions.

Note: In order to participate in an HSA, an individual must be covered under a "high deductible health plan" and may not participate in any other non-high deductible health plan, subject to certain restrictions.

Insurance Plan: Any employer-sponsored insurance benefit including, but not limited to, group health insurance, dental, vision, cancer, accidental dismemberment, group term life insurance, and disability insurance. The plans offered by the employer are listed in the Adoption Agreement and Summary Plan Description.

Participant: Any eligible employee participating in the plan in accordance with the Adoption Agreement.

Plan Service Provider: Paychex, Inc. is the plan service provider. Paychex, in conjunction with the administrator, will perform the recordkeeping functions of the plan such as preparation of plan documentation, compliance testing, and claims processing (FSA only).

Plan Sponsor: The plan sponsor is the employer. As plan sponsor, the employer provides a plan of benefits that affords uniform types and, with certain exceptions, amounts of benefits to its employees.

Plan Year: The period commencing and ending on the dates indicated in the Summary Plan Description and each anniversary thereafter. The plan year shall be a 12-month period; however, a period of less than 12 months may be a plan year for the first or final plan year.

Section 125: The section of the Internal Revenue Code pertaining to pretax benefits under a cafeteria plan.

Summary Material Modifications (SMM): A summary of plan or Summary Plan Description changes that must be provided to participants when there is a material modification to the plan or a change in the information required to be in the Summary Plan Description.

Summary Plan Description (SPD): A summary of the benefits provided under the plan. The SPD must be distributed to plan participants and written in a manner that participants will understand. The SPD must include such items as a description of benefits offered, eligibility requirements, funding, claims procedures, and participants' rights under ERISA.

Trustee: The person, persons, or institution (and their successors) named in the Adoption Agreement, who have consented to being so named by their signature thereon and to abide by the terms and provisions of the Trust hereby created in order to hold and disburse the funds that are used by the employer's cafeteria plan.

Enrolling Employees: HSA

Eligibility Requirements: Same as other plans with additional requirements including employees must have coverage under a HSA-qualified HDHP, cannot be claimed as a dependent on someone else's tax return, and cannot be enrolled in Medicare.

When can pretax deduction begin? Employees may enroll in the HSA any time after satisfying the eligibility requirements.

Enrolling in the plan: If an employee chooses to enroll in the HSA, the employee may enroll online by visiting www.paychexflex.com.

How do my employees re-enroll in the HSA plan year after a plan year ends? Employees will be re-enrolled automatically in the HSA plan and will remain enrolled until they close their HSA account.

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