Section 125 (FSA) Administration Guide
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GUIDE OVERVIEW

This “Section 125 Administration Guide” is designed to provide you with the administrative processes for implementing and maintaining your Section 125 plans with Flexible Spending Accounts and/or Alternate Premium plans throughout the plan year. This guide is broken into three sections for ease in locating the necessary information:

- Section I – Introduction to Section 125 Administration
- Section II – Implementation Process
- Section III – On-Going Administration

Each client is supported by the Client Services Team to assist with Section 125 administrative needs. Each team member is trained in Section 125 regulations and customer service protocols to provide you with the best service possible. Most of our team members are certified in Flexible Compensation (CFC) through the Employers Council on Flexible Compensation (ECFC), a nationally recognized industry group.

Our Client Services Team of Flex Consultants is located in Leawood, KS. Their primary responsibility is to understand the needs of the client, be responsive to HR staff calls and emails, research specific HR questions and issues, ensure HR satisfaction and interface with a client’s broker or consultant. The Client Services Team is assisted by the Technical Flex Consultant. The Technical Flex Consultant handles all incoming and outgoing client data files.

Participants are supported by Call Center Specialists. The role of Participant Call Center Specialist is to handle all participant calls and inquiries, as well as provide guidance and suggestions to participants to help them receive the highest level of service. The Claims operations team ensures that all claims are adjudicated and processed to quality standards and within the committed time frame.

The following resources are also available via the secure client website to support the administrative and communication needs of your program administered by us.

Additional Section 125 Resources Available

- Data Submission Guide – Provides details on the available methods of reporting data.
- Section 125 Client Communications and Reports Guide – Provides details and examples of available client communications and management reports.
- Section 125 Participant Communications Guide – Provides details and examples of all communications and enrollment materials available to participants.

Other Resources Available

- HIPAA Summary Guide – Provides details on HIPAA compliance.
SECTION I – INTRODUCTION TO SECTION 125 ADMINISTRATION

WHAT IS A SECTION 125 PLAN?

An IRS Code Section 125 plan acts like an “umbrella”, allowing employers to offer benefits on a pretax basis.

Premium Only Plan (POP)

A Premium Only Plan is the most common form of cafeteria plan. A premium only plan has only one purpose: to allow employees to pay for their share of premiums for insurance coverage with pretax dollars. (For example, an employer requires employees to pay the cost of dependent coverage). The employee elects to reduce his salary each month by an amount equal to his share of the insurance premium, and the employer in return agrees to provide the employee with health insurance.

Health Care Spending Account (or Health FSA)

A Health Care Spending Account (HCSA) is a non-interest bearing account funded with pretax payroll dollars contributed by the employee and is primarily used for medical, dental and vision expenses. Common examples of eligible expenses would be prescriptions, office visit co-pays, over-the-counter medications, glasses and orthodontia. The IRS has not set a maximum limit for the HCSA, so it is up to the employer to determine the maximum limit. The employee then makes his election for the year, funds are deposited on a pretax basis, in equal amounts over the remaining pay periods of the plan year, claims are submitted and reimbursements are then distributed. In addition, Limited Health Care Spending Accounts can be set-up according to your specific plan design of limiting or excluding certain eligible expenses.

Dependent Care Spending Account (or Dependent Care Assistance Plan)

Dependent Care Spending Accounts (DCSA) are employer-provided programs governed by Code Section 129 and are designed to reimburse an employee for day care expenses incurred to enable both the employee and spouse to be gainfully employed. A common example of an eligible expense would be the cost of a babysitter or a day care center while the parents are working. The IRS has set an annual election amount of $5,000 per household or $2,500 per year if married and filing separately.
Limited Purpose Health Care Spending Account (LPHCSA)
A LPHCSA are limited HCSA that only reimburse participants for dental and vision expenses and are typically used in conjunction with a Health Savings Account. The LPHCSA is administered in the same manor as a HCSA, just limiting what expenses can be reimbursed to the participants.

Health Savings Account (HSA)
An HSA is a tax-free savings account that must be used in conjunction with a high-deductible health insurance plan, the design of which is specified by statutes. No other access to coverage is allowed. The HSA allows for a rollover of unused funds in the account from one Plan Year to another. The employer, employee or combination of both can fund the HSA. Employee contributions can be made through a cafeteria plan if the plan allows it.

Alternate Premium (AltPrem)
An Alternate Premium account is set up for those Clients who offer individual insurance plan premiums with pretax dollars through their Cafeteria Plans. The employees sign up to deduct their individual insurance premiums from their paychecks, submit acceptable documentation (the insurance bill) and receive reimbursement through an Alternate Premium account. By including these policies under your Section 125 Plan, it may be enough to have them seen as an employer-provided benefit, subject to ERISA. When these Policies are subject to ERISA, they also are “group health plans” that may be subject to COBRA and other mandates.
DEFINITIONS

Within this guide, references to “the Client” are you, your, and Plan Administrator.

1.01 **Annual Maximums**: the plan year election limit set by the Plan Administrator for which a participant may elect to contribute to the spending accounts.

1.02 **Auto-Post**: we will post expected payroll deposits without receiving a payroll deduction report of actual deductions.

1.03 **Benefit Package Options**: the different benefits offered under your Section 125 plan such as medical, dental, vision, Health Care Spending Account, Dependent Care Spending Account, etc.

1.04 **Claim Adjudication**: the process during which we review, approve or deny claims based upon the IRS regulations and upon information submitted by the participant.

1.05 **Claim Run-Out Period**: the period of time a participant has to submit claims for expenses incurred prior to the end of the plan year or prior to termination of employment.

1.06 **COBRA**: the Consolidated Omnibus Budget Reconciliation Act of 1985. The Act imposed health care continuation requirements on group health plans, including the Health Care Spending Account.

1.07 **COBRA Administration**: the notification and management of COBRA rights to employees and Qualified Beneficiaries.

1.08 **ECFC**: the Employers Council on Flexible Compensation. This organization was “established to create and maintain the most favorable legislative, regulatory and public opinion environment for flexible compensation” as stated on their website www.ecfc.org.

1.09 ** Employer-Sponsored Group Insurance**: group insurance of medical, dental, vision, etc. offered to eligible employees under your Section 125 plan. Similar to Benefit Package Options.

1.10 **HIPAA Excepted Benefit**: if the employer contributes $500 or more in employer funds to a Health Care Spending Account on behalf of a participant.

1.11 **HIPAA Non-Excepted Benefit**: if the employer contributes less than $500 in employer funds to a Health Care Spending Account on behalf of a participant.

1.12 **Grace Period**: the “extended period” according to IRS regulations of a participant incurring expenses past the plan year-end date but before the end of the accepted grace period.

1.13 **IRC**: Internal Revenue Code monitored and enforced by the Internal Revenue Service. Website: www.irs.gov.

1.14 **IVR**: Interactive Voice Response system by which the telephone line is tied to an automated voice data source and accessed by the participant, using a touch-tone phone.
1.15 **Participants:** are the employees of a Client who elect to contribute to a HCSA, DCSA, HRA, HSA, Limited HCSA or Alternate Premium plan.

1.16 **Pay Cycles:** the number of times an employee gets paid during the plan year.

1.17 **Payroll Process:** the Client’s and our maintenance of pretax payroll deductions in the spending accounts.

1.18 **Plan Year:** the period of coverage (usually a 12 month period) set forth in your Plan Information Appendix.

1.19 **Flexible Benefits Card:** a card pre-loaded with election amount (similar to a gift card) used for paying eligible health care and/or dependent care spending account expenses without any out-of-pocket cash.

1.20 **Reimbursement:** the process by which a participant will be repaid for eligible expenses.

1.21 **Webinar:** the ability to conduct presentations in which the audience calls into a dedicated conference call and connects into our web presentation session.
SECTION II – IMPLEMENTATION PROCESS

IMPLEMENTING YOUR ACCOUNT

The implementation process begins when we receive a completed application including the set-up fee. This provides us with the information we need to begin our set-up process. Our Flex Consultants begin by conducting a welcome call and also to let them know that your materials have been shipped to the designated contact. These materials include:

- Getting Your Flexible Benefit Plan Up and Running packet, including tips to increase enrollment, the Administrative Services Agreement, and information / authorization forms
- Plan Document, HIPPA kit, etc.

Implementation Calls

We will conduct a series of implementation calls to discuss the implementation materials provided and the implementation process along with answering any questions. Each call will focus on a particular aspect of the process to facilitate a successful implementation. The three scheduled calls are: Materials Review, Web site training and Debit card.

1. Materials Review Call
   This is the first of the three-implementation calls that will be conducted. The primary focus of this call is to discuss in detail the materials received, including the banking arrangements necessary for funding the accounts and Administrative Service Agreements as well as answer any questions. We also schedule the Web Site training call at this time.

2. Web Site Training Call
   This is the second of the three-implementation calls that will be conducted. The primary focus of this call is to take the employer through a step by step introduction to the functionality and advantages of the employer web site, including both initial enrollment and on-going eligibility maintenance.

3. Payment Card Call
   Following the necessary paperwork arrives, the employer plan ready to activate. This is the third call is answer any remaining questions and cover the debit card functionality and management.
## Implementation Task List

### Documents Signed and Returned
- Set-up Fee (new clients only)
- Administrative Services Agreement
- Fee Schedule “A”
- Payroll calendar
- Insurance Plan(s) Information form
- New Year Setup & Enrollment checklist

### Banking Arrangement Items Needed
- Authorization for Electronic Funds Transfer
- If Weekly Account Service option selected. MICR Encoding Form. (This form shows the character placement of the numbers at the bottom of your check. Request this form from your bank.) Also, Signature sample of check signer (check signer to write signature three times on company letterhead.) .tif or .jpg of signature

### Enrollment Process
- Distributed enrollment materials
- Conducted meetings/benefit fairs
- Gathered enrollment data
- Enrollment data entered online or file sent

### Takeover Administration (If Applicable)
- Set cut-off dates with prior TPA for claims and final deposit
- Held and submitted claims to us after takeover date
- Determined a claims “black out” period of 2 weeks before takeover date
- Transferred year-to-date (YTD) data to us
- Distributed transfer letter to participants
BANKING ARRANGEMENTS – FUNDING YOUR PLAN

One of the most important pieces of the implementation is to establish the funding arrangements for claim reimbursements and Flexible Benefits payment card transactions. The Administrative Services Agreement includes a description of Banking options.

Direct Deposit

We strongly encourage the use of direct deposit for reimbursement of participant claims. It is safer in that the check cannot be lost in the mail or on the participant’s desk at home. It is faster in that it goes directly to the bank account within three business days. It is easier in that your accounting department never has to account for un-cashed checks.

Select your Service/Funding Option

Rapid Claims Account Service

This option allows us to make claim reimbursements and card payments (on your behalf) from a single client account managed thru the National Flex Trust (NFT) which is managed by WageWorks. Under this banking arrangement, your funds are deposited by the NFT in a designated client account, with sub or book accounts maintained for each client. Employer and/or employee contributions are withdrawn from an employer-specified account no later than each payroll date. Both claim reimbursements and payment card transactions are paid on a daily basis with your funds on deposit with the National Flex Trust. We will perform all bank reconciliations and refund unused amounts to you after the year-end-grace period.
Weekly Account Service

The Weekly Account Service provides for claim reimbursement checks to be written off a checking account designated by you. Reimbursements from the designated checking account to participants are processed weekly and distributed by EFT to a participant specified bank account or by printing a check. All checks are signed with a facsimile signature you designate and account reconciliation is your responsibility. In order to have the reimbursement checks signed with your digital signature, simply fax the signature to us. We will digitize and electronically secure the file. Payment card transactions are processed daily from your designated funding account via EFT, and the daily information is available at our secure employer web site.

Establishing your Flex Benefits Payment Card

The Flex Benefits Debit card is a very convenient way for participants to access their Section 125 plan account funds. The card is free and allows participants instant access to their funds through the use of the take care debit card.

New “Drug Store Only” Payment Card Option

On July 1, 2009, a new IRS ruling went into affect that greatly enhances the convenience of suing the flex payment card at drug stores. The new rule eliminates the hassle of requesting receipts (for further verification) when employees use the card at retail drug stores, grocers, and superstores*. As a result, now you have two Payment Card options:

- **Card Option1**: The take care Pharmacy+OTC Card (new for 2009) may be your most convenient choice. That’s because about 60% of all flex plan purchases are made at the drug store. The take care Pharmacy+OTC Card is only accepted at drug stores, grocers and superstores (40,000 certified locations nationwide). The card knows which items in your market basket are IRS-qualified and ONLY pays for those items. That’s why we won’t ask for a receipt when this card is used at a drug store*.

- **Card Option 2**: The take care Total Flex Card is still available if you prefer a card that works at all qualified providers. In addition to drug stores, the Total Flex Card works at doctors, hospitals, optical shops, and dentists. Like the take care Pharmacy+OTC card,
when used at the drug store, we won’t ask for a receipt for further verification. In addition, we won’t ask for a receipt when a card swipe matches one of your health plan’s co-pays (if we have your plan’s co-pays on file). However, if we are unable to electronically substantiate a card payment, the IRS requires that we review a copy of the receipt. We’ll contact your employee if we need to review a receipt.

*The IRS provides an exception for specialty pharmacies who attest that over 90% of their sales are for IRS qualified items. Receipts will be needed for transactions at these locations.

Setup Items Needed
In order to activate the Flex Benefits debit card option, we will need you to sign and return the employer card service agreement. There are no initial deposit requirements.

Payment Card Process
The payment card process is as follows:

1. Inform your participants of the Flex Benefits card by distributing our take care communication materials.
2. As participants swipe the card, funds will be taken directly out of the funding bank account.
3. If additional substantiation is required, the participant will be notified.

Requesting debit cards
*Who requests the Flexible Benefits card?*

- Participants can request a card, or order extra cards at the secure participant web site after their enrollment has been posted.
- Employers can order cards for participants (including spouse/dependent cards) at the secure employer web site. Cards can be ordered as part of the enrollment process, or during the plan year.
- As your administrator, we will be glad to order cards for all your participants.
DEBIT CARD AUTO-ADJUDICATION METHODS

Overview of Auto-Adjudication Methods
We provide three methods for auto-adjudicating your participants debit card transactions, as allowed by the IRS.

- Recurring Transactions
- Merchants with an Inventory Information Approval System (IIAS)
- Copayment Matching

Recurring Transactions
This method of auto-adjudication will occur automatically for all participants with no additional setup requirements from you. There is no additional charge for the setup or administration of this method.

This method will occur after a participant has used their payment card at a vendor and has submitted the proper documentation to verify the expense was for eligible services. If the participant goes to the exact same vendor again and has the exact dollar amount for the transaction again, this transaction will auto-adjudicate based on the prior approved claim.

If the dollar amount or the vendor number with the new transaction is different in anyway, the transaction will not auto-adjudicate and the participant will need to submit the required documentation to us for review and approval.

Merchants with an Inventory Information Approval System (IIAS)
This method of auto-adjudication will occur automatically for all participants with no additional setup requirements from you. There is no additional charge for the setup or administration of this method.

Under this method, merchants who implement an IIAS system are able to distinguish which items in their stores are eligible expenses allowed under the plans, based on IRS Code Section 213(d) expenses. The merchant will use the product’s barcodes to distinguish these expenses and only allow the payment card
to be used for those eligible expenses. All non-eligible items will need to be paid with another form of payment.

Please note: We do not control the items the merchant has identified as eligible per the IRS regulations. In some cases an eligible product may not be on the merchants IIAS system as eligible, therefore the participant may need to pay out-of-pocket for the product and submit a claim to us for processing.

**Copayment Matching**

This method of auto-adjudication will require additional setup information in order for your participants to take advantage of it. There is no additional charge for the setup or administration of this method.

Under this method, you will need to establish with us a listing of all your health plans and the various copayment amounts associated with each plan, by entering this information on the secure employer website or completing the form included in your initial setup and returning to us. You will need to assign the participants to their health plan and notify us via fax/email or file transfer. Then as your participants incur expenses at eligible merchants for amounts that match your co-payment amounts, we will auto-adjudicate these transactions.

**IMPORTANT:** On a yearly basis you will need to update your established health plans, copayment amounts as well as participant’s accounts based on your health plan design changes.
DOCUMENTS AND COMPLIANCE

Each client will be provided with the following documents necessary to implement and administer your Section 125: Administrative Services Agreement, Draft Plan Document, Draft Summary Plan Description and HIPAA Agreement and Summary Guide. Each document and the effect it has on the administration of your plan are explained below.

Administrative Agreement

The Administrative Services Agreement is sent to you at the beginning of implementation.

This agreement describes our services and responsibilities as your responsibilities as well as the fees for services (schedule A). We require that you sign and return the Administrative Agreement and Schedule A, prior to services commencing.

At the anniversary of your plan year, you will not receive a Renewal Administrative Agreement unless there has been a change within the agreement.

Plan Document

Section 125 of the IRC requires that a Cafeteria Plan be maintained by a governing written Plan Document. You must adopt the Plan before reducing your employees’ salaries on a pretax basis. Therefore, the Plan Document must be signed by an Officer of the Company prior to taking payroll deductions from employees who are participating in the Section 125 (pretax premiums and/or Flexible Spending Account) Plan. At your request, we will provide documents and/or amendments at no additional charge.

Summary Plan Description

The Summary Plan Description (SPD) is an additional document to be reproduced and distributed to each plan participant no later than 90 days after the participant is enrolled in the plan. The Summary Plan Description describes the basic operation of the Section 125 plans, including the spending accounts.

The Plan Information Appendix attached to the SPD lists all the plan provisions (your plan design). If the provisions of the SPD differ from the Plan Document, the Plan Document has legal precedence. Therefore, it is critical that the Plan Information Appendix is reviewed carefully for accuracy prior to distribution. It is best to keep all these documents in a binder for quick reference (provided).

We’re not licensed to practice law, so a legal opinion regarding the sufficiency of the documents should be obtained. Therefore, have your Corporate Counsel review the Plan Document and associated Summary Plan Description prior to signing the Plan Document.

If, during the plan year or at the renewal of a plan year, you have a change in your plan details, such as adding an employer-sponsored group insurance to the pretax option, increasing annual maximums in the Spending Accounts, changing plan years or eligibility requirements, you will need to request an Amendment to your Plan Document and the associated Summary Plan Description. Contact your Client Services Team to discuss preparing an Amendment to your plan. There is no cost to amend your plan.
HIPAA Privacy and Security Rules

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996.

What are HIPAA Privacy Rules? Generally, the HIPAA privacy rules regulate the use and disclosure of protected health information (PHI) by defining who is authorized to access PHI created or maintained by “covered entities”, as well as the scope of permissible uses and disclosures. The HIPAA privacy rules also give individuals certain rights regarding their PHI.

What are HIPAA Security Rules? HIPAA’s security rules require “covered entities” (e.g. health plans and health care providers) that maintain or transmit electronic protected health information (“PHI”) to maintain reasonable and appropriate safeguards to ensure the integrity and confidentiality of health information, to protect against threats to security or unauthorized uses or disclosures of information, and to otherwise ensure their officers’ and employees’ compliance with the security standards.

A “HIPAA Agreement” is sent with your Administrative Agreement. The HIPAA Agreement includes the Designated Person Contact form to whom we may provide PHI and it must be signed and returned to us.

A “HIPAA Summary Guide” is available on our client website. The Summary Guide contains important information concerning your compliance obligations under the Health Insurance Portability and Accountability Act. HIPAA’s privacy and security rules that affect health plans, (which include Health Care Flexible Spending Account), health care providers and health care clearinghouses.
SECTION III – ON-GOING ADMINISTRATION

FLOW OF ADMINISTRATIVE PROCESS

Enrollment Process
The flow chart begins with the employee making an annual election to the Health Care and/or Dependent Day Care Account(s) by completing an Enrollment Form. Once the participant makes an election, enrollment information is forwarded to us, or entered directly online through our secure employer website. Of course, card requests can be included as part of the enrollment process.

Payroll Process
In the standard payroll process, we will automatically post the payroll deductions based on the election amount and payroll schedule. Actual deductions can be posted if you prefer to send a file.

Claim Adjudication
The participant will begin to incur expenses for health or dependent care services. The participant will pay for the expense with out-of-pocket money (or swipe the Flexible Benefits Card) for the services rendered. The participant will then submit a claim to us. All claim forms must be accompanied by supporting documentation (receipts) and faxed, emailed or mailed to us for adjudication. Once a claim has been adjudicated the participant can view the in process claim on the secure participant web site.

If the claim is approved, then the participant will receive reimbursement on the next scheduled reimbursement date or if they used the Payment Card, the process is complete. If the claim is denied, the participant will receive a Claim Follow Up Letter stating the reason for the denial and if applicable, the necessary corrective action.

Reimbursement Process
Based on the chosen reimbursement method, participants will receive a Live Check or a Direct Deposit payment. Management reports are then available for review and downloading at the secure employer client website.
ON-GOING ENROLLMENT PROCESSING

Communicate your Plan Design

To successfully administer your Section 125 Plan, you must effectively communicate the plan specifics to your employees. You will need to communicate the plan design in addition to their contributions to the Flexible Spending Account, the employee’s contribution to any component benefit plan premiums, such as Medical and Dental, will typically be taken from their paycheck on a pretax basis.

Distribute communication materials such as enrollment form, newsletters and promotional materials to employees. Information about these participant communication materials can be found in our “Section 125 Participant Communications Guide”. During enrollment meetings it is important to stress that the only reason to participate in the Flexible Spending Account is to save money on taxes. By setting money aside on a pretax basis, participants save anywhere from 25-40% of every dollar they set aside and use for eligible expenses.

Some general plan features to communicate to employees are:

- The positive effects on tax savings by participating.
- The possible impact on Social Security wages, worker’s compensation or unemployment insurance benefits by participating.
- The irrevocable election rule and the circumstances by which they could change their elections, that is, status change rules for Section 125.
- Plan carefully and estimate conservatively. The “Use it or Lose It” rule does apply. However, “don’t be so afraid to lose it that you don’t use it.” The whole purpose of the plan is to save money on taxes.

The following specifics of your plan design should be communicated, as well:

- Plan Year (Full or short year) – Services must be rendered during the plan year.
- Grace Period – Decide if you will be implementing the Grace Period. There are a few options for designing this optional period to make it better fit your organization’s needs and purposes: length of extension (75 day maximum), amount to be carried over and accounts to be included.
- Benefits offered under Section 125 that will be taken as a pretax contribution (e.g. medical, dental, Health Care Spending Account, Dependent Care Spending Account, etc.).
- Annual maximum contribution limits for the Health Care Spending Account (your plan establishes a maximum, no IRS regulated maximum) and Dependent Care Spending Account ($5,000 limit per IRS Regulations).
- Claim submission Run-Out Period after the end of the plan year and after termination of employment.
- Eligibility requirements for participation and effective date of benefits.
- Claim Submission Process (enter claims online or send claims directly to us via fax, email or mail).
- Reimbursements will be paid out as scheduled by direct deposit to participant’s checking account or by live check.
- Any specific eligible expenses, such as over-the-counter items or expenses you may not want your plan to reimburse.
- Orthodontia reimbursements – what option did you offer to reimburse a participant for Orthodontia (monthly payments, lump sum payment, or payments over plan years)
If you are including the Flex Benefit card, you will need to prepare the participants for the issues that can arise with the use of the payment card. See our “Payment Card” section for more information.

**Submitting your Enrollment Data**

At the beginning of the plan year, submit the Initial Enrollment Data of those participating in the spending accounts. This is done by entering new elections online or using our electronic data file and sending to our secure FTP site. We will import the elections and participant information. See our “Data Submission Guide” for further details on submitting your enrollment and participant information. Once enrollment is submitted to us, you will be asked to verify the accuracy of the enrollment information by reviewing the Enrollment Payroll Deduction Report from our secure employer website. We will then release an enrollment confirmation mailing to each participant confirming their enrollment.

**Open Enrollment**

Three months prior to the beginning of the next plan year, you will receive information on your upcoming Open Enrollment. The Open Enrollment Package that you will need to access via the secure client website will include:

- Open Enrollment Client Letter
- Open Enrollment Check List
- Enrollment Materials

Some of the items you will be asked in this Open Enrollment Package will be:

- Confirm your open enrollment period
- Do you have any changes to your Plan?
- How many benefit eligible employees do you currently have?

Once your annual open enrollment period is complete, simply submit the enrollment data to us (via the secure employer web site or data file).

**Enrollment Meetings**

We offer the Webinar sessions (“Benefit Fair In-A-Box”) at no charge to be used in place of or in addition to the on-site enrollment meetings. Our PowerPoint presentation, “Introducing Flexible Spending Accounts”, can be a very effective tool in an employee meeting and is available to download from our website. It takes the presenter through the key issues, reinforcing the fact that participation saves money on taxes.
PAYROLL DATA PROCESSING

In order to begin the payroll deduction process, review your existing payroll system to ensure its capability to withhold pretax elections.

Some elections need to be adjusted to accommodate rounding. For example, if an employee elects an annual election of $500 and there are 24 pay cycles in the plan year, his pay cycle deduction will be $20.83, for a total annual deduction of $499.92.

We offer two methods for us to process your participant’s payroll deduction information. You can select the option that best fits your needs:

- Auto-Posting Deductions Amount - See subsection “Payroll Deposit Posting Options”
- Manual Reporting/Notification of Deduction Amounts - See subsection “Payroll Deduction Reporting Option”

Payroll Deposit Posting Options (Auto-Posting)

Auto-posting your payroll deposits is a way to automatically load the pay-period deductions for each participant on the scheduled day without sending a deduction file. You will need to make sure that our system is kept up-to-date by going on the secure employer web site and making any needed changes to your participant’s information before 5:00 P.M. Central Time on the day prior to the scheduled payroll date. You may update the information at the secure employer web site, sending a data file or email/fax changes to us. It is always a good practice to audit the YTD deductions on the YTD Report (available at our secure employer web site) against your payroll reports in order to keep the two systems in synchronization. This auto-post service is optional. You may send in the electronic file each pay-period to report participant deductions if this will better serve your needs (see Manual Reporting section).

IMPORTANT: When setting up the spending accounts with your payroll system or payroll administrator, be aware that the Dependent Care deductions should be set up with a calendar year accumulator, as this amount will have to be reported in Box 10 of the employee’s W-2 Form at year end.

Caution: If you are a Client who has a fiscal plan year, take into consideration the impact of previous DCSA payroll deductions within that calendar year when calculating the remaining DCSA deductions. The IRS limit is a calendar or tax-year limit. Participants will be taxed on amounts in excess of $5,000 (or $2,500 if married and filing separately).

Payroll Deduction Reporting Option (Manual Reporting)

Each payroll cycle, deduct the scheduled amount from each participant’s paycheck and forward the electronic payroll deduction file via the secure employer website or transmitting to our secure FTP (see “Data Submission Guide”) site for posting into participant’s accounts prior to paying claims. The payroll deduction file should be sent no later than 2:00 P.M. Central Time the day prior to your actual payday. This file confirms the deductions actually taken. If the file is not received by the scheduled reimbursement date, we will hold the reimbursement of claims until it is received. If you would like to make other arrangements, contact your Client Services Team. Remember, the Dependent Care Spending Account must have a posted deposit before paying a participant’s claim.
CLAIMS PROCESSING

Claims are processed within 48 hours of receipt. Participants have the option of entering claims online or submitting a manual paper claim.

Entering Claims Online

Entering claims begins by logging into the participants secure web site and clicking on the “Request Payment” tab. To enter a claim, the participant just follows the detailed instructions on the page to enter their claim in the fields provided.

When finished, the participant clicks “View Form” to review their claim, then “continue” to print the claim form. The system automatically saves the information in the participant’s account.

After the participant prints claim form, they sign and fax, mail or scan & email, along with supporting documentation to us for final processing.

Note: if you offer the debit card to your employees, they will also have a “Flex Debit Card” tab on the secure participant web site, with a “Review Card Payments” section. This section will show any payment card transactions that are waiting for documentation.

Manual Claims Submission

Participants can email, fax or mail a signed claim form with supporting documentation that includes the service provider name, date of services provided, type of service or product, cost of service or product. All claims require substantiation, although some payment card claims can be automatically substantiated, based on safe harbors outlined in IRS Revenue Ruling 2003-43. Our claim operators review, enter all receipts and process the claim for payment. After a claim is reviewed and posted, they are visible in as pending payments at the participant secure web site.

If the payment card was used to pay the expense, the claim will show as “pending payments” until the payment clears through the credit card system and then will switch to “completed payments”. Card payments requiring receipts will be displayed in the “Review card payments” section. The participant is notified monthly if they have card transactions which require receipts.
REIMBURSEMENT PROCESSING

Based upon the chosen reimbursement cycle, a participant receives a reimbursement check or direct deposit. The lower portion of the reimbursement check stub lists account details. In addition to the details, the stub will show account year-to-date totals for each account.
PARTICIPANT OVERPAYMENTS

Occasionally, there are times when a participant's account may become overpaid and we would request a participant to make a repayment to the plan or if needed, assess a lien on the account. Overpayments can occur for a variety of reasons, however the most typical are:

- A payment card transaction used for ineligible services or expenses (called Non-Qualified Expenses or NQE's)
- Participants were reimbursed based on available funds at that time, then having a payroll deduction removed from our system.

When an overpayment occurs on a participant’s accounts, we will communicate with the participant the need to repay the plan and the amount due. The total amount due is highlighted and clearly displayed on the secure employee web site. The participant can satisfy the amount due by providing the necessary documentation or by repaying the plan online by credit card or echeck, or mailing in a check for the amount due.

There are three methods that they can use in order to repay an overpayment.

- Use other out-of-pocket eligible expenses that they have incurred to offset the overpayment.
- Send a personal check or money order (made payable to National Flex Trust) to repay the overpayment.
- Make a repayment by credit card online at the secure employee web site.

There are times when a participant does not make the necessary repayment to the plan. In these events, the IRS has made provisions for you, as the Plan Sponsor, to be able to retrieve these repayments directly from the participants. These methods include:

- You as their employer request that they repay the plan for the overpayment amount.
- If after the request for repayment is not met, you may withhold the amount of the repayment from the employees pay, as allowed by law.
HANDLING MID-YEAR ENROLLMENT EVENTS

New Hires

During the year, as you have new hires, you will need to distribute the Enrollment Form and applicable take care program communication pieces to each newly eligible employee with sufficient lead time for the employee to carefully consider his participation.

Be sure to describe the plan details, such as irrevocable election, annual maximums, Social Security impact and the tax advantages of enrolling in the spending account plan.

There are several steps to enrolling the new hire:

- Have the employee complete the Enrollment Form based on the plans eligibility requirements. An employee must sign and return the form prior to participation. No monies can be deducted, nor savings realized, from such deductions until the enrollment form is completed, signed and returned to you.
- Review the enrollment form for completeness. Incomplete forms may delay or prevent the participant’s enrollment.
- Calculate the amount to be deducted per pay cycle by dividing the annual election by the number of remaining pay cycles in the plan year. For example, a $1,500 annual election divided by 13 remaining pay cycles, equals a per pay cycle deduction amount of $115.38. Again, if your plan is a fiscal plan year, be aware of the DCSA participant’s annual “calendar” maximum deduction.
- Forward the participant’s pretax elections to your internal payroll department or payroll provider.
- Enter the enrollment information online through our secure employer client website, or forward the enrollment information on the eligibility file, or email/fax the enrollment to us.

Terminated Employees

Notify us of a participant’s date of termination of employment by:

- Entering the termination online at our secure employer website;
- Forward the termination on your eligibility file to us; or
- Email us detailing the participant name, termination date and the benefits termination date.

It is very important that you send us information on terminated participants immediately to prevent reimbursement of claims for expenses incurred past the termination date or if you offer the payment card, cards can be closed. Remember, participants can be reimbursed amounts up to their annual election for Health Care Spending Account or only what has been deposited into their Dependent Care Spending Account.

The Plan Information Appendix will specify the exact date that termination is effective for benefits (which could be as of the date the employee terminates or the last day of the month during which termination takes place).

You will need to inform the participant of the Claim Run-Out Period. For example, a participant may continue to submit claims for expenses incurred while an active participant up to 90 days after his
termination date. Again, refer to the Plan Information Appendix attached to the Summary Plan Description for your Plan’s specific Run-Out Period or additional plan details.

Rehired Employees

Former participants who are rehired within the same Plan Year, except as otherwise provided in the Benefit Package Options or Policies, and are eligible for the Plan (or they become eligible again), may make a new election provided that they are rehired or become eligible again more than 30 days after termination of employment or lost eligibility. If they are rehired or again become eligible within 30 days or less, their prior elections will be reinstated and remain in effect for the remainder of the Plan Year.

Information regarding rehired employees can also be found in your Summary Plan Description.

- If the employee is rehired before the 30 days, the participant's prior election must be reinstated unless a Qualifying Event has occurred.
- If the employee is rehired after the 30 days, the employee can make a new election. Supply the employee with the Enrollment Form to make a new election.

Enter the participant's election (new election or stepping back into their previous election, pay cycle deduction amount and the new effective date) information online or forward the election information on your eligibility file to us.

You will also need to inform your payroll department or payroll administrator of the new or existing election and per pay cycle deduction amount for the rehired employee.

Change in Status Elections

A participant may not change his/her benefit election during the Plan Year unless there is a qualifying change in status event. These qualifying “Change in Status” events are outlined in your Summary Plan Description.

You will need to give the participant an Enrollment/Change Form and have them complete, with the appropriate box marked on the form to indicate which status change situation occurred and the date of the occurrence. You may want to obtain other documentation from the participant to substantiate the Change in Status Event. The participant must complete, sign and return this form to you within 30 days of the qualifying Change in Status Event. If the change form is signed and returned prior to the change, the benefits change will be effective on the date of the status change. If the form is signed and returned following the Change in Status, then benefits will change on the date signed, or with the first payroll cycle following the date of the signature. You as the Plan Administrator or the agent of the Plan Administrator, such as us, determines under the IRS code guidelines, if the event is a qualified Change in Status. Once approved, enter online or send the information on your eligibility file to us.

Important Note – Please refer to the Data Submission Guide for information on the methods of providing on-going participant account data to us.
COBRA HEALTH CARE SPENDING ACCOUNT

If the terminating employee is a participant in the Health Care Spending Account and you are an employer with more than 20 employees, COBRA continuation rules will generally apply.

Certain Health Care Spending Account participants as well as their dependents will be eligible for COBRA Continuation Coverage if they have a positive Health Care Spending Account balance (taking into account all submitted and approved claims) at the time of a Qualifying Event. This is known as the “under-spent HCSA”. The qualified beneficiary could elect to continue his Health Care Spending Account.

Taking into account all claims submitted and approved on or before the date of the Qualifying Event, if the Qualified Beneficiary’s remaining Health Care Spending Account balance for the Plan Year is in a deficit position, COBRA is unavailable to the qualified beneficiary. This is known as the “over-spent HCSA”.

The length of time that you will need to offer COBRA on the participant’s Health Care Spending Account depends on the type of benefit that you offer. If you have a HIPAA Excepted Benefit, you will need to offer COBRA for the full 18 or 36 months from the date of the Qualifying Event. If you offer a HIPAA Non-Exempt Benefit, you will only offer COBRA on the account until the end of the plan year during which the Qualifying Event occurred.

Refer to the COBRA Continuation Coverage information in your Plan Document and Summary Plan Description for the Health Care Spending Account. An example of a COBRA continuation notice to be given to the terminating participant is shown here.

Example COBRA Continuation Notice
(Newly eligible HCSA COBRA Participant)

Date
Dear Employee, Spouse or Dependent:
As a part of your continuation of benefits under COBRA, you have the opportunity to extend your participation to the Health Care Spending Account. You can use this account to pay for out-of-pocket health care expenses. We are not encouraging or endorsing your participation in this account, as there are few, if any, advantages to you. In making your decision, consider that:

- If you choose to enroll in the Health Care Spending Account, you will be billed for the amount of your monthly election plus a two percent administrative fee per month.
- Since you are receiving no pay from the company, there is no tax benefit to this election.

If you have a significant amount on deposit with little or no eligible expenses at this point, it may make sense to continue your Health Care Spending Account. Consider carefully your decision to continue this benefit.

If you think that continuation may be beneficial to you, contact Human Resources for the forms you will need to fill out.

If you self-administer your COBRA Administration, you must send the employee/beneficiary his Qualifying Event notice within 44 days of the qualifying event (i.e. termination). If there is a choice of coverage under the plan, the notice sent to participants by the employer should include explanations of the choices, their costs and the form should allow for election of the type of coverage preferred.

If another Third Party Administrator, handles your COBRA Administration; you have 30 days to notify the TPA of the qualifying event. Be sure to inform us of the termination or enter the information online at our secure employer website.
USING THE PAYMENT CARD

The payment card can enhance your Section 125 Flexible Spending Account plan with the following advantages:

- The card can be used at qualifying vendors nationwide where major credit cards are accepted.
- No out-of-pocket money at the time of service.
- No more waiting for reimbursement check or direct deposit to arrive.
- Easier access and more efficient use of funds decrease participants’ risk of losing unused funds at the end of the year.
- Increases participation.

The Flex Benefits Card is a great tool in the hands of your employees. Like any tool, learning to use it properly will result in the greatest benefit. We want to help you and those in your HR department to be familiar with the Card and some of the common issues that arise.

How Does the Payment Card Work?

Order the Card

The participant will receive a single card for all accounts in which they are enrolled. Once the card is ordered, it will take 10 – 14 business days for the card to arrive at the home of the participant. Two cards can be requested on the initial order. After that, the participant can order additional cards at the secure participant web site. There is no charge for payment cards.

Use the Card - DCSA

Given the complexity of the process required by the IRS, the card may not be used for Dependent Care spending accounts.

(For the Dependent Care Spending Account, the IRS requires that participants must have a “placeholder” claim in place with us in order to use the payment card for dependent care expenses. A participant must pay up front with another form of payment such as cash or check for the expenses he is about to incur. The participant would then submit a DCSA Placeholder Claim form with the day care provider’s signature or attach supporting documentation. Only after the placeholder claim’s services have been fully rendered, the amount of the services designated on the DCSA Placeholder Claim Form or available year-to-date payroll deduction amounts whichever is less, could be made available on the card.)

Use the Card - HCSA

The participant may begin using or “swiping” the card at qualified participating merchants. For example, the participant swipes his card at “The ABC Pharmacy” for his prescription. The participant has now purchased the prescription without any out-of-pocket cash or check, and keeps the receipt. In this example, the card swipe will debit the appropriate Health Care Spending Account for the transaction and checks for real-time balances. This transaction is available real time at the participant secure web site.
The participant must submit the receipt(s) from the payment card transaction to us if requested. We will adjudicate or review the claim to determine if the expense is eligible. IRS requires 100% substantiation of the expense, even when the payment card is used. If receipts are requested, the participant will need to attach the receipt or supporting documentation to a Receipt Verification form (available at the secure employee web site or monthly statement) and fax or mail the form and receipts for verification to us.

If a participant does not provide the required documentation and we are unable to auto-adjudicate the transaction, we will provide follow up requests to the participant:

- Monthly receipt request statement
- If not received after the receipt due date, the card will be suspended. If the receipt is received, or the transaction is repaid or if offsetting claim is received, the card will be reactivated.
- If a swipe is still pending documentation after the card is suspended the swipe will be turned into a “balance due” to the plan at the end of the quarter.

If the expense is ineligible or the documentation does not support the payment card transaction, we will respond with the claims denial process and notify the participant to resubmit supporting documentation or repay the expense.

In accordance with IRS guidelines, we also have available an auto-adjudication (auto-approve) process for:
- reoccurring expenses that match expenses previously submitted as to amount, provider, same benefit type such as Health Care and time period (e.g. the participant refills a prescription drug on a regular basis at the same provider, same amount, etc.
- matching co-pay amount, up to a multiple of five times
- real time point of sale substantiation (IIAS)

It's that easy! However, if a participant experiences difficulty with the Flex Benefits card, we suggest that the participant contact our Participant Call Center to research the situation.

A new card with a new expiration date will be issued for each new plan year, provided that the participant has active elections for each plan year and that the participant's card has not canceled due to ineligible/unsubstantiated transactions or non-activation of card.

Card Issues
There are times when card swipes fail. Most of the time there is a simple explanation for the failure. Below are some of the most common card issues.

- Occasionally, the merchant bank, transaction provider or the phone company is having computer or line down time.
- The swipe box has an improper Merchant Category Code (MCC) – for example, the pharmacy has a box that had been previously used at an auto repair shop and still holds that MCC code.
- The participant may be trying to swipe a $500 charge, but only has $490 left in his account.

If card issues arise, the participant may contact our Participant Call Center. Our toll-free number is embossed on the front of the card below the participant's name. If the card issue is during our business hours, we can typically address it immediately. In any event, we will identify the problem and implement a
solution or provide additional education. Card swipes can take 7-10 days to fully settle in the payment card system. During that time, money is held and considered spent as of the date of the swipe and our system treats the swipe as completed.
GRACE PERIOD – EXTENDING THE PERIOD TO INCUR CLAIMS

The client has the choice of establishing a grace period (maximum of two and a half months) following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse eligible medical expenses incurred during this grace period. The client then has the option of establishing a Run-Out Period following the end of the grace period. Our system is designed to add this grace period and will establish the rule for determining the order that available funds will be applied to claim payments based upon your plan design chosen.

For example, assume a participant has a $250 balance remaining in his HCSA at the end of the plan year. He has also elected $2,000 for the new plan year. After the new plan year begins, he has a $2,000 expense and submits the claim promptly. This claim would pay $250 from the prior plan year and $1,750 from the new plan year. If later he discovers and submits other HCSA expenses incurred during the prior plan year, the earlier claim will be “moved” to the current plan year, assuming the participant has funds available, and the later claim will not be paid under the prior plan year. This assures that the participant will have the maximum reimbursement (and least forfeitures) from his account. Claims are initially always paid on a first in, first out basis regardless of the incurred date. However, during the remainder of the Run-Out Period, each claim he submits will be evaluated against other claims paid during the same period of time to see if we can further maximize the payout.

Communication materials are available to describe the plan design to your participants.
ON-GOING PLAN COMPLIANCE

Plan Design Changes
If during the course of your plan, the IRS regulations change or you wish to make any changes to how your plan is established, you will need to have an amendment or possibly a full amendment and restatement of your Plan Document and Summary Plan Description. Some examples of plan design changes can include:

- Changes to your annual maximums.
- Changes to your plan run-out periods.
- Adding the Grace Period option.
- Changes to your eligibility or waiting periods.

When IRS regulations occur that may affect your plan, we will notify you and request authorization for your Plan Documents to be updated. If you wish to make changes to your plan, contact your Client Services Team. Additional fees are billed for amendments and restatements, therefore, refer to your Administrative Agreement for the costs associated.

Once your documents are amended or restated, you will need to provide the updated Summary Plan Description to all participants under the plan.

Non-Discrimination Testing
It is the responsibility of the plan sponsor to make sure that the plan is non-discriminatory and is in compliance with IRS Section 125 regulations at all times throughout the plan year. To ensure your plan complies with applicable Section 125 non-discrimination rules, you will receive a notification to access the Non-Discrimination Testing Workbook and worksheet on the client secure website at the beginning of the plan year. This workbook informs you of the testing requirements, as well as what employee information is needed to perform the testing. Once you return the employee information to us, we will conduct the testing at a “point-in-time” that you choose and return the results to you. Do not be surprised if your plan fails one or two tests; this is common. We will assist you with compliance efforts.

During the year, as you hire additional highly compensated employees or change employee demographics, it is highly recommended that you request subsequent testing to ensure your plan remains in compliance with the regulations.

Be sure to inform the highly compensated employees as they are making their elections during annual open enrollment or mid-year new hires, that the non-discrimination testing may affect their election or participation.

IRS 5500 Form
According to IRS Notice 2002-24, the requirements to file a 5500 Form for the Section 125 plan (which is Schedule F) have been rescinded, pending further guidance from the IRS. This means that, at this time, you do not have to file a Schedule F for your pretax premiums or flexible spending account deductions. However, please read below regarding the 5500 filing requirements for your component Health & Welfare plans. If required by IRS notice in the future, and upon request, we can complete the IRS Form 5500 filing for the Section 125 Plan. There is no charge for this service.
For Health & Welfare component plans (with more than 100 participants in medical, dental, vision, HCSA, Life or Disability or if you have a “Funded HCSA”) requiring filing Schedules A and/or C, we will prepare the filing upon request. The filing of IRS 5500 is due within seven months of the close of the plan year.
REGISTERING FOR CLIENT WEB ACCESS

We have a secure website dedicated to assist your plan’s administration. The website gives you the ability to log in to a secure site and view/download information based upon your designated web access authorization from a menu of reports, as well as add, terminate or update participant information such as election, address and name changes.

Accessing the Site

1. There are two levels of access rights:
   a. Web Access – administrative – access to all reports and resources plus participant data.
   b. Web Access – Reports Only – access to reports and resources only.

2. Go to [www.takecarewageworks.com](http://www.takecarewageworks.com), click on “Express Login”, select “employer”, then click on “New User.”

3. At the login screen, click the “Register” button.

4. Enter your Federal Identification Number, company code, company zip and business email address. Assign a password and hint question/answer of your choosing and click continue.

5. After registering as a new user, you are able to login to the secure website and begin using the site.

Utilizing the Site

Once you have access to the site, there are many options available to assist you in monitoring your plan administration. View your management reports, add or update participant data or read through the resources available to you.

**Manage Eligibility** – where you can add, change, terminate employee information and also update their election amount and pay cycle during the plan year.

**Manage Your Debit Card** – where you can view a participants debit card status, request cards, suspend cards or reactivate cards.

**New Year Enrollment** – Where you can enter your new plan year enrollments, including adding participants, request a card and second card with your enrollment submission.

**Information** – our contact information when you need to reach us.

**Forms** – one location for forms you may need, including paper claim form, change in status forms, employee direct deposit, Cobra and request additional materials forms.

**Reports** – where you access a variety of client reports. For more details on reports available, please see our Section 125 Client Communications and Reports Guide.

**Employer Information** – where you can maintain client and participant login information, view other plan setup information and manage the assignment of participants to insurance plans and their copay amounts.

**Logout** – Will log you out of the system.
PARTICIPANT ACCOUNT ACCESS

Participant account information is available in several different ways. Account information is accessed through our secure participant web site, our Interactive Voice Response (IVR) phone system, or speaking to a live Participant Call Center Specialist or emailing our customer support center.

In addition to the access options, a 60 day letter is sent to the participant to let them know their account balance as they near the end of the plan year.

Participant Online web site

The most widely used option available to participants for account access is our secure online web site. The participant simply follows the login instructions. At the login page, the participant will need to register as a “New User” for the site upon his first login and create a personalized login. Once in his account, a participant has access to detailed information regarding his account(s), claims status, payment status, account balances, deposit status, request a payment, request debit cards, review card transactions and submit receipts, repay non-qualified expenses, view rejected card swipes and more.

Interactive Voice Response (IVR)

Participants can also access information through our Interactive Voice Response (IVR) system – a phone tree – by calling 913-789-4600 from any touch-tone telephone in the U.S. to receive information about his accounts. The line is available 24 hours per day, 7 days per week. Calling this number allows the participant access to:

- Current account balances for all accounts.
- Annual election amount for all accounts
- Contribution total for all accounts
- Claims total for all accounts
- Disbursement total for all accounts
- Pending claim total for all accounts
- Last Claim processed (date and amount) to confirm whether we have received a claim.
- Last Payment amount
- Instructions for reporting a lost/stolen card.

The system is easy to use. After hearing a welcome message, a caller enters their Security Number followed by a 4 digit secure access code (which they establish when they initially access the system). The system then verifies the Social Security number and access code and prompts summary information about employee accounts.

Participant Emailing Questions

We have established a support center general questions email queue at flexhelp@wageworks.com. A Participant Support Specialist will respond to the questions within one business day.

YEAR END PROCESSING & REPORTING

At the end of the plan year, there are several processes to remember.
Plan Year Reconciliation

We reconcile your account if you use the rapid claim service and provide an end of plan year summary at the end of the grace/claim run out period. With the final reconciliation, any funds forfeited by the participants will be returned to your account.

If you selected the Weekly account service, you are responsible for reconciling your account. Using the Year-to-Date Report available on the secure employer web site, you will need to reconcile the funding of your Flexible Spending Accounts. You will need to do this after the plan year claim Run-Out Period (stated in your Plan Information Appendix). This reconciliation of the plan year balances will assist you in determining forfeitures, losses, or unclaimed amounts.

DCSA W-2 Reporting

At the end of the calendar year, your payroll department or payroll administrator will prepare W-2’s for your employees. For those who are participants in the Dependent Care Spending Account, the annual deductions should be recorded in Box 10 of the W-2 Form. Employees participating in the Health Care Spending Account will not see these deductions specifically listed on the W-2.

DCSA IRS Form 2441

Participants in the Dependent Care Spending Account (DCSA) are required to file IRS Form 2441 with their personal tax returns. This form will assist the participant to calculate the amount, if any, of the benefits that may be excluded from income. The IRS Form 2441 is available at www.irs.gov under “Forms and Publications”, along with an explanation on how to complete the form.
GENERAL ADMINISTRATIVE PROCESSES

This section informs you of other general processes that effect the administration of your plan.

Administrative Forms

Administrative forms are those that you, the Plan Administrator, will use to gather information from your employees and then transmit to us. In our Section 125 Participant Communications Guide, administrative forms are described.

Client Management Reports

A variety of reports are available. These reports are available on our secure employer client secure website 24x7. Each report is described in our “Section 125 Client Communications and Reports Guide”.

Privacy Notice

The Gramm-Leach Bliley Act of 1999 requires “financial institutions” to safeguard client information and to provide notice of privacy practices to their customers. We provide you with a Privacy Notice upon implementation. We have always and will continue to treat our client’s data with the utmost care and integrity.

Billing of Administrative Fees

Your total monthly fees for administration is based on the number of participants enrolled at the beginning of each Plan year, divided by twelve, and invoiced monthly. The monthly fee will remain constant for the year unless there is a 10% or greater increase in the number of participants. Invoices are sent each month and fees are collected via EFT on the 15th day of each month.
CONTACTING WAGEWORKS

Employer Services

<table>
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<th>Service</th>
<th>Phone Number</th>
<th>Email/Website</th>
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<tbody>
<tr>
<td>Toll-free Line</td>
<td>888-342-3532</td>
<td><a href="mailto:ClientServices@takecareWageWorks.com">ClientServices@takecareWageWorks.com</a></td>
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<td>Website 24x7</td>
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<tr>
<td>Employer fax</td>
<td>877-220-3251</td>
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**Mailing Address:**
take care by WageWorks
4200 W. 115th Street, Suite 300
Leawood, KS 66211

Participant Services

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<tr>
<th>Service</th>
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<td>Account Balance Phone 24x7</td>
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<tr>
<td>Claims Fax</td>
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**Claims Mailing Address:**
WageWorks
Attn: Flex Claims Group
P.O. Box 14054
Lexington, KY 40512