Introduction
TO YOUR FLEX ACCOUNTS

A Flex Plan is an employee benefit that allows you to be reimbursed for certain expenses tax-free. You save federal, state, Social Security, and Medicare taxes on those dollar amounts, thus increasing your take-home pay. Flex Plans are part of the U.S. Internal Revenue Code Section 125, and are designed to give employees the opportunity to pay for certain eligible living expenses with tax-free dollars.

WHAT BENEFITS DOES THE PLAN OFFER ME?

Premium Only Plan (POP). Payroll-Deducted Health Insurance, includes any employer sponsored medical, HMO, dental, vision, and other health coverage premiums paid for by your employer or through payroll deductions. Any health or dental insurance premium deducted from your paycheck will automatically be paid pre-tax after the Plan Year begins.

Flexible Spending Arrangements (FSAs). There are six categories. A more comprehensive explanation of each category is included on the tabbed sheets provided in this packet.

1. Dependent Care FSA: Daycare for children under age 13 (note that special COVID-related age adjustments may apply), care for dependents that meet certain guidelines relating to disabilities, preschool, and other related expenses for care of dependents. The maximum allowed by the IRS is adjusted periodically. Please check with your employer or plan administrator for current, plan specific limits.

2. Full-Use Health FSA: Out-of-pocket costs for deductibles, co-payments, prescriptions, over the counter medication, certain feminine products, dental, optical, transportation, medical capital expenditures, etc., not reimbursed by your insurance.

3. Limited-Use Health FSA: Out-of-pocket costs for dental and vision expenses only. This is generally used if funding a Health Savings Account.

4. Limited Excepted Benefit Insurance Premiums : After tax premiums for personally-owned supplemental insurance limited to certain types.

5. Group Term Life Insurance: Employer-provided term life insurance for the employee tax-free up to $50,000 of coverage.

6. Health Savings Account: Tax free savings account to be used with a High Deductible Health Plan.

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HOW DO I PARTICIPATE?

To participate in the FSAs, you must complete and submit a Benefit Election Form or elect on-line before the beginning of the Plan Year. New employees have 30 days to submit an election form. If submitted within 30 days, expenses from first date of employment are eligible. To do this you should estimate the expenses you will have in each category during the Plan Year. It is important to predict your expenses as accurately as possible because the tax regulations that govern Flex Plans require you to use the money or you lose it at the end of the Plan Year. This is called the "use it or lose it" rule. Guessing is not recommended, nor is trying to increase your tax savings by electing more than you are fairly certain you will spend. Changes to your elections during the Plan Year may be allowed under very specific circumstances, please refer to the "Summary of Change Events" section.

EXAMPLE OF HOW A FLEX PLAN WORKS

	Sally Flexes	Tom Does Not Flex
Annual Compensation	$50,000	$50,000
Daycare	$5,250	
Medical/Dental Out-of-Pocket	$2,750	
Specific Illness Plan Insurance Premium	$1,500	
TAXABLE INCOME	$40,500	$50,000
FICA (7.65%)	$3,098	$3,825
Federal Tax (~20%)	$8,100	$10,000
State Tax (7%)	$2,835	$3,500
Daycare		$5,250
Medical/Dental Out-of-Pocket		$2,750
Specific Illness Plan Insurance Premium		$1,500
SPENDABLE INCOME	$26,467	$23,175
Tax Savings	$3,292	

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COBRA CONTINUATION RIGHTS UNDER YOUR FLEX PLAN

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives you the right to continue to participate in the 125 Flexible Benefits Plan (the Plan) under certain circumstances. Those rights may be extended to your dependents covered by the Plan as well, if their expenses are reimbursable under the Plan.

Some "life events" may cause you to lose your coverage. If you experience one of these life events, COBRA allows you to elect whether you want to remain in the Plan until the end of the Plan Year, or revoke participation in the Plan effective the date of the event. If you elect to continue in the Plan you must pay for that coverage. You will receive a "COBRA Qualifying Event Separation Form" from your employer upon notification of the life event. Your plan administration will counsel you on your options and disclose the cost associated with continuing in the Plan.

It is the employee's responsibility to notify the Plan administration of a life event. Keep your Plan administrator apprised of your status and contact information. You have 30 days from the date of the qualifying life event, or the date of loss of coverage to notify the Plan administrator. Do not wait that long to contact us. The sooner we know of your status change the better options you have to pay for your coverage. The notice must include name and address of the individuals that want continuation coverage, a description of the event and the date the event occurred. Please send the written notice to: Aviben, 1995 E. Rum River Dr. S, Cambridge, MN 55008. Questions regarding COBRA should be directed to an Aviben representative at 1-888-507-6053.

FILING YOUR TAX RETURNS

There is nothing extra to do at tax time unless you've elected dependent care expenses, which you must report on IRS Form 2441. You do not have to pay extra taxes because of the benefits that you used pre-tax dollars to pay for. Your W-2 should show a taxable wage reduced by the benefits elected. Thus, you don't have to "pay back" tax savings you enjoyed during the Plan Year. Also, since salary reductions are not included in your W-2 taxable wages, you do not enter them as a deduction on your tax return. The benefits may appear on Box 14 of yourW-2, but this is for informational purposes only.

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Plan GUIDELINES

DEPENDENT/DAYCARE FSA

The maximum amount you may elect in the Dependent /Daycare FSA may be changed by the IRS annually. Please ask your employer or check the Aviben website at www.aviben.com for the most updated maximum. Expenses must be incurred during the plan year, and you must be working or looking for work in order for the expense to be eligible. So, if you are a teacher and decide to take the summer months off, you may not flex for expenses incurred during the summer months. However, if you are taking classes during the summer to get our masters, doctorate, or teaching certifications your expenses are eligible.

An eligible dependent is defined by the IRS as follows:

- A child who is under age 13 for whom you claim as an exemption on tax forms
- A dependent who is physically or mentally not able to care for himself/herself and who relies on you for more than half of his/her total support in a year
- A spouse who is physically or mentally not able to care for himself/herself

CAN I BE REIMBURSED FOR PAYMENT TO A RELATIVE FOR DEPENDENT CARE?

You cannot be reimbursed for dependent care payments to (1) your child who is under age 19 at the end of the taxable year in which the payments are incurred or paid, or (2) anyone who could be claimed as a dependent on your federal income tax return for the taxable year in which the payments are incurred or paid.

You can be reimbursed for dependent care payment to other relatives. However, you can't modify your dependent care election based on a cost increase if the provider is a relative.

DEPENDENT CARE ELIGIBLE EXPENSES

- Adult daycare centers
- Summer day camp (overnight camp is not eligible)
- Child daycare
- Extended day/latch key
- Nursery/Preschool
- Kindergarten is not an eligible expense

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Plan GUIDELINES

Monies set aside for dependent or daycare may not be used for other purposes such as medical reimbursement or outside health insurance.

Monies that you flex for dependent care expenses may not be used for the dependent care tax credit on your federal income tax.

WHAT IS THE DEPENDENT CARE TAX CREDIT?

This is a credit against your taxes based on the amount of your dependent care expenses and your taxable income. The amount of the credit can vary from individual to individual.

IS IT BETTER TO FLEX FOR DEPENDENT CARE OR TAKE THE TAX CREDIT?

The answer to this question will depend on your tax bracket (for federal, state, FICA and Medicare taxes), on how much you pay for dependent care and on the amount of federal, state and local tax benefit you would receive for the dependent care expenses you expect to incur. You should project your taxes both ways, with the credit and without the credit before you make your decision. This is because the credit may be more or less than the value of the exclusion under this Plan. If you have only one qualifying child or dependent, the current ceiling for the tax credit is $6,000, compared to $5,000 ($2,500 if you are married filing separately) if your employer allows for flexing under the Plan. The amount you flex for, tax-free, under the Dependent Care Reimbursement Plan reduces the maximum tax credit on your tax return ($3,000 for one and $6,000 for two or more "qualifying individuals") but may be a better tax savings than the tax credit. Please consult your tax professional to determine which option(s) may be best for you and your family.

WHEN MAY I CHANGE MY ELECTION DURING THE PLAN YEAR?

You can change your election only if you have a "change event". A change event is an event that, under the law and the terms of the Plan, permits election changes. You can change your election by filing the "Change in Status Form" available through your employer. You may change your election, but only in a way that is consistent with the change event. For a more detailed listing and explanation of the change events allowed under this plan please refer to the Summary of Change Events in this packet.

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Plan GUIDELINES

TERMINATION OF EMPLOYMENT

Aviben's Flexible Benefits Plan provides that employees may continue to submit for eligible daycare expenses after termination of employment until deductions taken to date or daycare/dependent care are exhausted. The participant does not have to elect for COBRA continuation coverage for this benefit.

FULL-USE MEDICAL FSA

You may flex for most health care expenses not covered by your insurance. These expenses can be incurred by you, your spouse and dependents. These expenses are referred to as your out-of-pocket medical expenses. These expenses must be incurred as a result of an illness, treatment, diagnosis or injury. The treatment may also be as a result of preventing or treating a physical or mental defect or illness. Expenses incurred solely for cosmetic purposes, such as cosmetic botox, are not eligible. Some cosmetic surgeries may be eligible provided they are the result of a disfiguring disease, accident, trauma or birth defect: in these circumstances a letter of medical necessity is required. Co-pays and deductibles under any medical, dental, or vision plan are also eligible. Some over-the-counter items may also be eligible. Items purchased for your general well-being or for purposes of personal hygiene (e.g., toothbrushes, toothpaste, etc.) are not generally eligible. The maximum amount an employee can contribute to a medical FSA is set by the employer as long as it does not exceed the Internal Revenue Service (IRS) maximum. The IRS maximum will be reflected on an Election Form or on your Consumer Portal during Open Enrollment.

LIMITED-USE MEDICAL FSA

Only to be used with a Health Savings Account (HSA) for vision and dental out-of-pocket expenses.

OVER-THE-COUNTER ITEMS (OTC)

As of January 1, 2020, over-the-counter ("OTC") medications are eligible expenses, even without a prescription. Menstrual care products are also reimbursable as eligible expenses, including tampons and pads. Other OTC items, such as: gauze pads, thermometers, bandages, blood-pressure monitors, contact lenses, contact lens solution and first aid kits are also still eligible expenses. The dual purpose items (e.g., nasal strips, herbal supplements, massage, gym memberships, exercise equipment and vitamins) will continue to require a Letter of Medical Necessity which must be updated annually.

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Plan GUIDELINES

ELIGIBLE EXPENSES

For more information on eligible expenses please download the Aviben app and use the expense scanner or refer to the Aviben website, www.aviben.com, and search through the FSA/HRA Store or the HealthShopper Store under the "For Participants" link.

PREPAID AVIBEN HEALTH BENEFIT CARD

Not all employers will offer this prepaid benefits card. If your employer is offering the Aviben Health Benefit Card, it can be used to pay for eligible Medical FSA items at qualified merchants.

There are two types of qualified merchants:

1) Merchants that use the Inventory Information Approval System (IIAS). Transactions at these merchants are fully substantiated and no paper follow-up is needed. A list of IIAS Merchants is available on our website at www.aviben.com. Click on Services, Benny Card, and then click on the List of Participating Merchants link.

2) 90% Merchants. This means 90% of the merchants' sales are for eligible medical expenses. These merchants use other methods to auto substantiate claims. See below:

- **Co-pay matching** – Entered in our system from information given to us from your employer
- **Recurring expense logic** – Pattern is noticed by the system for same payment amounts, ie, monthly orthodontia payments
- **After-the-fact substantiation** – Letters are sent out to participant requesting receipts to verify the expense

The IRS requires that 100% of card transactions be substantiated, so in some cases, further substantiated is required by the participant.

IMPORTANT – ALWAYS SAVE ITEMIZED RECEIPTS!

If you receive a letter/email from Aviben requesting receipts or more information on your purchase with the card, please comply with the letter by the date specified. If transaction is not eligible or documentation is not sent in, Aviben shall suspend the card and request refund from the card holder. You will receive two receipt requests before the card is suspended. Cards will be reinstated when receipts are received or overpayment is returned to the account.

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Flexing
INSURANCE

LIMITED EXCEPTED BENEFIT INSURANCE PREMIUMS

Employees may flex for the cost of a personally owned limited excepted benefit insurance policy. This was previously referred to as Outside Health Insurance, but the name was causing confusion on what was actually covered. To be eligible for this benefit, the policy must belong to you, your spouse or dependent(s), and the premium must be paid with after-tax dollars. This does NOT include individually owned health insurance policies, an individually owned supplemental policy, or any policy that is currently being paid on a pre-tax basis through a payroll deduction. The Affordable Care Act (ACA) precludes the use of 125 Plan pre-tax dollars to be used to purchase or reimburse the cost of an individual to purchase an individual health insurance policy through a Public Health Insurance Marketplace commonly referred to as the "Exchange". This includes state and federally run Exchanges. Please refer to your summary plan description for more details.

The following are eligible premium expenses under this category:

- Accident Insurance
- Cancer Insurance
- Vision Insurance
- Dental Insurance
- Disability Insurance
- Hospitalization Insurance

The following are NOT eligible expenses under this category:

- Long Term Care Insurance is NOT an eligible expense.
- Individual Health Insurance Coverage Premiums are NOT an eligible expense.
- Medicare Supplement plans are NOT an eligible expense.
- If a plan is purchased through a public health insurance marketplace commonly referred to as the "exchange," this would also make it an ineligible expense.
- If a plan is paid for with pre-tax dollars (i.e., as a salary reduction), it would NOT be eligible.

DISABILITY BENEFITS

If you have the disability insurance premiums reimbursed through your Flex Plan, and you become disabled, you must report the proceeds of the policy as taxable income. If you have never had the premiums reimbursed, the proceeds of the policy will be tax-free.

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Flexing INSURANCE

GROUP TERM LIFE INSURANCE

The premium for the first $50,000 of an employer-sponsored group term life policy may be paid for on a pre-tax basis through the Flex Plan. Any death benefits from the insurance are also income tax-free. Insurance coverage above $50,000 is taxed based on IRS tables. Even then, the amount taxed may be less than the actual premium cost. Again, any death benefits your family receives under the insurance are income tax-free.

WHAT OTHER EFFECTS MAY THERE BE IF MY TAXABLE INCOME IS REDUCED?

With reduced taxable pay, you may have a lower base for unemployment compensation and workers' compensation benefits.

HEALTH SAVINGS ACCOUNT (HSA)

If your employer has implemented a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) option you may be able to contribute to your HSA on a pre-tax basis through your 125 Flexible Benefits Plan. When you make an election to contribute to your HSA through the Flex Plan, your election amount will be pro-rated based on the number of pay periods you have in the Flex Plan Year. It is your responsibility to stay within the tax year HSA contribution limits. All contributions into your HSA count toward the limit (e.g., employee and employer). When you contribute to your HSA through your employer's 125 Flexible Benefits Plan your contribution amount will be disclosed every year on your W-2. HSA contribution limits are set by the IRS and may change from year-to-year. If you exceed your contribution limit for the tax year the overage is included in your gross income and an excise tax of 6% is charged on the overage.

CHANGING YOUR ELECTION

You may change your election amount to your HSA, at least once a month. The IRS does not require you to experience a "change event" in order to make a change to your election amount.

DISTRIBUTIONS

Distributions from your HSA are tax-free when used for eligible medical expenses. You are responsible for determining whether expenses are eligible or not. HSA distributions for nonmedical

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expenses are included in gross income and an additional 20% tax penalty is imposed. However, if you are age 65 or older, disabled, or die, no penalty is assessed. Individuals are responsible for maintaining receipts of purchase in case they are personally audited by the IRS.

ELIGIBLE EXPENSES

HSAs cover many of the same expenses as the Medical FSA category. However, unlike the Medical FSA, HSA funds can be used to pay for COBRA premiums, and long term care premiums (subject to the age based cap). If age 65 and older, you may also use HSA funds to pay for Cobra health care coverage while receiving unemployment and Medicare Part B and D. Otherwise, health insurance premiums are not an eligible HSA expense.

Summary
OF CHANGE EVENTS

WHEN MAY I CHANGE MY ELECTION DURING A PLAN YEAR?

You can change your election only if you have a qualifying "Change Event." A Change Event is an event that, under the law and the terms of the Plan, permits election changes. Upon the happening of a Change Event, you can change your election, but only in a way that is consistent with the Change Event. This is sometimes referred to as the "Consistency Rule." Some examples follow:

1. Your dependent dies or loses or gains eligibility for coverage under your spouse's health insurance. While you may change your election to adjust for that dependent's situation, you may not modify your election to add or remove coverage under the Plan for another dependent.
2. You get married during the Plan Year. You may change your election to: (a) add coverage for your spouse; (b) elect Health FSA coverage for your spouse; or (c) drop coverage for yourself under the Plan if you will be covered under your spouse's insurance.
3. Your child reaches age 26 and loses eligibility for your health insurance under your Insurance Plan. You may change your Plan election to switch from family to individual health coverage or drop health insurance coverage for your child.

Summary
OF CHANGE EVENTS

WHAT ARE "CHANGE EVENTS"?

The first two change events below (the cost and coverage changes) do not apply to the Medical FSA category. They only apply to the Premium Only Plan, Outside Health Insurance, Dependent/Daycare FSA, and Group Term Life categories.

Cost Change. A significant cost increase or decrease in a premium for health coverage provided by an independent third-party provider, or a significant increase or decrease in cost imposed by a dependent care provider if the dependent care provider is not your relative, or **Coverage Change**. A significant curtailment or cessation of coverage under a health plan provided by an independent, third-party provider during a period of coverage, or a significant change in health coverage of you or your spouse attributable to your spouse's employment, or a change in a provider of dependent care assistance or the dependent being enrolled in school during the Plan Year, or **Change in Status**:

- Change in marital status, including marriage, death of spouse, divorce, legal separation or annulment.
- Change in number of tax dependents, including birth, adoption, placement for adoption, or death.
- Change of employment status, including termination or commencement of employment by you, your spouse or dependent.
- Change of work schedule, including any of the following that affect the employment status of you, your spouse or dependent: a reduction or increase in hours of employment, a switch between part-time and fulltime, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite.
- Change in dependency, dependent satisfies or ceases to satisfy health plan requirements, including attainment of age, student status or any similar circumstance as provided in your health plan.
- Change in residence, including a change in the residence of you, your spouse or dependent, or Judgment, Decree or Order. A Judgment, Decree or Order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for your dependent child or foster child, or

Medicare/Medicaid. A gain or loss of Medicare or Medicaid **eligibility.**

Special Enrollment Right. A special enrollment right under HIPAA arising when health coverage is terminated, described below, or

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Summary
OF CHANGE EVENTS

When am I entitled to special enrollment rights? You may be entitled to special enrollment rights if:

(i) you decide before the beginning of the Plan Year not to elect a particular benefit because you or your dependents are covered under another plan (such as your spouse's health insurance policy), and

(ii) coverage under that other plan is later terminated because either:

(a) The coverage was continuing coverage under COBRA (the law which lets employee continue benefits after employment is terminated) and the COBRA coverage is exhausted, or

(b) The coverage was not under COBRA and was terminated because of (1) loss of eligibilityfor coverage, or (2) the cessation of employer contributions for the coverage.

How do I exercise special enrollment rights? Within 30 days after coverage under the other plan ends, you submit a "Change in Status Form" electing coverage under the Plan to replace the coverage you lost under the plan. As usual, the changed election must be consistent with the loss of coverage under the other plan, thus meeting the Consistency Rule.

ARE RETROACTIVE CHANGES PERMITTED?

Retroactive changes are not permitted except for a 30-day grace period allowing an increase in health insurance and Health FSA after the birth of a child, adoption, or placement for adoption. For new employees, if election form is submitted within 30 days of the qualifying event, expenses from first date of employment are eligible.

HOW DO I CHANGE MY ELECTIONS?

You can change your election by filing the "Change in Status Form" with the Plan Administrator. If you are separating from service, you may change your elections by completing the "COBRA Qualifying Event–Separation Form" with the Plan Administrator.

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Administrative PROCESS

DEDUCTION AND REIMBURSEMENT PROCESS

Over the Course of the Plan Year, there will be pre-tax salary reductions equal to your total election. Tax-free reimbursements will be made for eligible expenses you submit. The schedule for pre-tax salary reductions and tax-free reimbursements depends on what Service Option your employer is utilizing and your employer's plan documents.

REIMBURSEMENT PROCESS

You may submit for reimbursement any time after the service has been provided. Complete the "Reimbursement Claim Form" and submit it along with your receipts through our mobile app, consumer portal, or via mail to:

Aviben
1995 E. Rum River Dr. S, Cambridge, MN 55008
- or - fax the form and receipts to Aviben at 763-552-6055.

*Note that Dependent/Daycare FSA and Outside Health Insurance / Excepted Benefit Premiums claims submitted will be reimbursed based on the salary reductions made to date.

*Full-Use and Limited-Use FSA claims submitted to Aviben for eligible health care out-of-pocket expense will be reimbursed up to the total election amount regardless of the year-to-date salary reduction.

Once the claim has been adjudicated you will receive an ACH to your account of choice. Please complete the "Direct Deposit Form" provided to you in this packet, or enter your account information on the secure consumer portal, or through our mobile app.

INVOICES ACCOMPANYING CLAIM FORMS MUST HAVE THE DATE OF SERVICE, TYPE OF SERVICE, AND COST OF SERVICE TO BE ELIGIBLE FOR REIMBURSEMENT.

CONTACT US!

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