



Sec. 125 Cafeteria Plan (Flex) Q & As

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

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

The following are questions frequently asked by Participants regarding their Sec. 125 Cafeteria Plan. We have summarized these for your review and general information. Your employer's plan document always governs.

Q. What does a Cafeteria/ Flexible Benefit Plan do?

- A.** It allows employees to pay for certain benefits with before-tax dollars. Basically, the Plan can consist of three separate, independent parts:
- 1) Insurance Premiums - Employees may pay for their portion of their employer sponsored health insurance coverage on a before-tax basis.
 - 2) Flexible Spending Accounts - Employees may pay for **out-of-pocket Medical Expense** with pre-tax dollars. Participants elect an annual dollar amount to be placed into a flexible spending account pre-tax. As eligible medical expenses are incurred by the employee and dependents, reimbursements are made to the participant for any eligible expenses not covered by any insurance coverage (up to the annual amount).
 - 3) Dependent/Child Care Expenses - Employees may pay for Dependent/Child care expenses on a before-tax basis. This includes daycare as well as after school care, etc.

Q. What expenses qualify for reimbursement under the Flexible Spending Account?

- A.** A Flexible Spending Account enables you to pay for expenses incurred during the plan year which are not covered by your insured medical plan or privately held insurance policies and save taxes at the same time. The account allows you to be reimbursed for out-of-pocket **medical, over-the-counter medicine** (with a doctor's prescription), **dental and vision expenses** incurred by **you and your dependents**. The expenses which qualify are those permitted by Section 213 of the Internal Revenue Code. A partial list of covered expenses is attached at the back of this handout. **(See pages 8 - 10 of this handout for partial lists of eligible expenses).**

Q. Can I Participate In the Plan even If I Am Not Covered By My Employer's Health Plan?

- A.** Yes. You can participate whether you are covered by the employer's health plan or not. You can even participate if you are not covered by any insurance plan. Your spouse and dependents do NOT have to be covered under your employer's health plan. The Cafeteria plan reimburses medical expenses not covered by insurance or by any third party.

Q. How much can I contribute to my Flexible Spending Account?

A. The most that you can contribute to your Health Care Flexible Spending Account each Plan Year is specified by your SPD. The maximum amount this year is specified on the enrollment form.

Q. Can I participate in this plan even though my spouse participates where they work?

A. Yes, as long as you do not submit claims for reimbursement for the **SAME** expense. The IRS does not allow double-dipping, i.e. you can only get reimbursed for the expense from one source, not two. Your spouse may submit claims to his/her Flex plan, and you may submit **other** claims to your Flex plan.

EXAMPLES OF EXPENSES ELIGIBLE FOR REIMBURSEMENT (not a complete list):

- Deductibles and co-pays under insurance policies
- Charges over Reasonable and Customary Fees
- Pre-existing conditions not covered by insurance
- Dental and orthodontic expenses
- Vision exams, glasses, or contacts, contact solution
- LASIK eye surgery
- Hearing aids, hearing aid batteries
- Routine physicals not covered by insurance
- Diabetic supplies
- Prescription drugs and medicine
- Birth Control
- Transportation to doctor or hospital
- Physical and mental therapy

You may NOT, however, be reimbursed for the cost of long-term care expenses or any cosmetic surgery or procedures. Many over the counter medicines are included if used for a medical reason. See back of the handout for a list.

Q. What expenses qualify for the Dependent Care Assistance Account (DCAP)?

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

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. All Qualifying Individuals must have the same principal place of abode as the employee for more than half the tax year. Dependent Care arrangements which qualify include:

- Day Care Centers,
- Pre-school and before or after school care.
- An "Individual" who provides care inside or outside your home. The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

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

Q. How do Sec. 125 Plan deferrals affect my payroll taxes?

A. Medical Expenses, Day Care Expenses and Group Insurance Premiums are all exempt from Federal, state and FICA taxes. You save all the taxes on dollars set aside into this program.

Q. Will my Social Security benefits be affected by participation in a Sec. 125 Plan?

A. Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf. However, for most people the current tax savings **are much greater** than any potential reduction in Social Security benefits.

Q. How do my Sec. 125 Plan deferrals affect my W-2?

A. The line item "Total wages, tips, other compensation" will be your gross salary less your contribution to the Sec. 125 Plan (i.e., gross salary of \$20,000 - \$2,000 Sec. 125 Plan contribution = \$18,000 reported to the IRS). Dependent care benefits are listed on the W-2 form as a separate information item.

Q. What is the Plan Year for the Flex Plan?

A. The plan year is specified on the enrollment form.

Q. How often do I receive a statement of my account?

A. You can view your account summary and remaining balance 24 hours a day via the Internet. In addition, the Administrator (Benefit Planning Consultants, Inc.) will provide you with periodic statements of your account during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year. Funds are forfeited if not used by the end of the Plan year.

Q. When Must I Decide Which Accounts I Want to Use?

A. You are required by Federal law to decide before the Plan Year begins. During the "election period," which will be the month or two preceding the beginning of each plan year, you must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance. However, you must still elect or waive participation in Flex or Dependent Care each year.

Q. When Will I Receive Payments From My Accounts?

A. During the course of the Plan Year, you may submit requests for reimbursement for expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Your informational package included a claim form for submitting requests for reimbursement for eligible expenses that are not paid by insurance. After you incur an eligible expense, you must fax the receipt or the EOB along with the claim form to BPC. If your claim is received at BPC by 3 PM Central Time Friday, you will be reimbursed on the next Friday.

You will also receive an Explanation of Benefits form verifying the amount deposited in your account. You will only be reimbursed from the Dependent Care Assistance Account to the extent that there are sufficient funds in the Account to cover your request. We do not make payments until the claims have accumulated to a minimum amount, typically \$25.00.

- Q. If a participant elects \$600 a year for their medical expense account, pays the first \$50 premium and incurs a \$400 expense, must the Cafeteria Plan reimburse the participant for the entire \$400 even though they have only paid in \$50?**
- A.** Yes. The maximum amount of reimbursement under a medical expense account is available at all times during the period of coverage.
- Q. Must medical expense account claims and dependent care claims be substantiated?**
- A.** Yes. Both medical expense accounts and dependent care plans may reimburse an expense only if the participant provides a receipt from an independent third party stating that the date the expense was incurred a description of the expense, and the amount of such expense. In the case of medical expenses the participant must also sign the claim form stating that the medical expense has not been reimbursed, or is not reimbursable under any other health plan coverage. For dependent care expenses the participant must provide a statement that includes date(s) of service, the name and employer identification number of the service provider, and the signature of the service provider.
- Q. When are medical and dependent care expenses "incurred" for purposes of a Cafeteria Plan?**
- A.** Expenses are treated as having been incurred when the participant is provided with the medical care or the dependent care that gives rise to the expense, and not when the participant is formally billed, charged for, or pays for the expense.
- Q. What Happens If I Don't Spend All Plan Contributions?**
- A.** Due to IRS regulations, any funds left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

For some plans with "Grace Periods", if you have not spent all of your contributions by the end of the Plan Year, you may continue to incur claims for expenses during the "Grace Period." The "Grace Period" can extend up to 2 1/2 months after the end of the Plan Year, during which time you can continue to incur claims and use up all amounts remaining in your Health Flexible Spending Account or Dependent Care Flexible Spending Account.

Any monies left at the end of the Plan Year and the Grace Period will be forfeited you must submit claims no later than 45 days after the end of the Grace Period

Q. May I Change My Elections in Future Plan Years?

A. Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for upcoming Plan Years. If you waive and do not make new elections during the "election period" before a new Plan Year begins, you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

Q. May I change my election during the year?

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

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

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

There are detailed rules on when a change in election is deemed to be consistent with a "change in status."

If you change day care providers or the cost of your day care changes significantly you may change your dependent care election amount during the year. You may not change your election under the Dependent Care Assistance Program if the cost change is imposed by a dependent care provider who is your relative.

Q. Can a participant request reimbursement for expenses incurred before they sign an election?

A. No. Expenses that are incurred before the later of the date the plan is in existence and the date the participant is enrolled in the plan will not be treated as having been incurred during the period for which the participant is covered by the plan.

Q. Must my child reside with me for day care expenses to be eligible for reimbursement from a Sec. 125 dependent care flex account?

A. Your child must reside with you for more than half of the year in order for day care expenses to be eligible for reimbursement from your dependent care flex account.

Q. Are child support payments eligible as Sec. 125 deferrals?

A. No, but the health expenses you incur for your child are eligible, no matter who has custody.

Q. If an employee has dependent care expenses, is it better to take the credit, or elect to pay the expenses through the Cafeteria Plan?

A. It depends on the adjusted gross income of the participant. For 2006, the dependent care credit goes from 35% to 20% as the adjusted gross income increases from \$15,000 to \$43,000. An employee must also take into account the increase or decrease in Earned Income Credit and Child Tax Credit tax benefits that result from choosing DCAP participation versus claiming the Dependent Care Tax Credit. Employees are advised to consult with their tax advisor with regard to this issue.

Q. What is the effect of reimbursement of dependent care expenses on the dependent care credit?

A. Under the Family Support Act of 1988, any reimbursed dependent care expenses must be used to offset the childcare credit. For example, if a participant has one child they are entitled to a credit on the expenses up to \$3,000. Assuming they are reimbursed \$1,000 under a dependent care plan, they would only be able to claim a credit on the difference between \$3,000 and \$1,000 or \$2,000.

Q. How long is the run-out period following the end of the plan year for claims to be submitted to the medical expense and dependent care accounts?

A. 90 days following the end of the plan year for un-reimbursed qualified medical expenses and dependent care expense claims. For Plans that have the 2 1/2 month "Grace Period" a participant has 45 days after the "Grace Period" ends to file un-reimbursed qualified medical and dependent care expenses.

Q. Who pays the Cafeteria Plan administration expense?

A. Usually the company (employer) pays the administration expense.

Q. What happens if I terminate employment?

A. If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

-- Health Insurance: You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

-- Day Care: You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate.

-- Flex out-of-pocket medical: Your participation in Flex will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses incurred **prior** to your date of termination.

Under Federal law, if you, your spouse, and/or your covered dependents lose coverage under this Plan, then you, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage. You are required to inform the Administrator of the following Qualifying Events: divorce, legal separation or a covered dependent ceasing to be a dependent in order for the Administrator to determine your spouse or dependents continuation rights in these situations.

Illustration Of Possible Employee Tax Savings With A Cafeteria Plan

Tax Savings	Employee in 10% Federal Tax Bracket	Employee in 25% Federal Tax Bracket	Employee in 35% Federal Tax Bracket
Federal Tax	10%	25%	35%
State Tax (IL)	3%	3%	3%
FICA / Medicare	7.65%	7.65%	1.45%
Total Tax Saved	20.65%	35.65%	39.45%

Employee's federal income tax rate	15%	27%	30%
Annual salary reduction contribution to qualified non-taxable cafeteria plan benefits	1,300	2,600	3,000
Potential Annual tax savings			
Federal income tax	195	702	900
State income tax @ 3%	39	78	90
FICA tax @ 7.65%	99	199	230
Total Potential Annual Tax Savings	\$ 333	\$ 979	\$ 1,220

Notes:

Laws and codes that govern Cafeteria Plans are subject to change. Always check for updates.

BPC's Home Page is at: <http://www.bpcinc.com>



Eligible Flex Expenses

The following is a **partial list** of the many eligible flex expenses you may incur. If you are uncertain whether an expense is eligible under flex, please call your BPC administrator.

Expenses must be for medical care. Expenses incurred or obtained primarily for personal, cosmetic or general health are **NOT** eligible.

- Abdominal/Back Supports
- Abortion (legal)
- Acupuncture
- Air Filter
- Alcoholism (inpatient treatment)
- Ambulance Services
- Arches/Orthopedic Shoes (to the extent they exceed the cost of regular shoes)
- Artificial Eyes
- Biofeedback Therapy (in medically necessary situations)
- Blood Tests
- Braille Books & Magazines
- Childbirth Classes
- Chiropractor
- Christian Science Fees
- Contact Lens Solution
- Contact Lenses
- Contraceptives
- Copay and Coinsurance Amounts
- Counseling (marriage counseling does not qualify)
- Crowns/Bridges
- Crutches
- Deductibles
- Dental X-rays
- Dentures
- Diagnostic
- Drug Addiction (in-patient treatment)
- Exams/Teeth Cleaning
- Eye Examinations
- Eyeglasses
- Fillings
- Guide Dog
- Gum Treatment
- Hearing Aids & Batteries
- Hearing Exams
- Hospital Bed
- Hospital Services
- Infertility
- Insulin
- In-vitro Fertilization
- Laboratory Fees Laser Eye Surgeries
- Lead Paint Removal
- Learning Disability (special school/teacher)
- Medic Alert Bracelet or Necklace
- Metabolism Tests
- Mid-Wife Expenses
- Norplant Insertion or Removal
- OB/GYN Exams
- Ophthalmologist, Optometrist
- Oral Surgery, Orthodontia/Braces
- Over-the-Counter Medications (with a doctor's prescription)
- Oxygen Equipment
- Patterning Exercises
- Physical Examination
- Physical Therapy
- Pre & Post Natal Treatment
- Pre-existing Condition Expenses
- Prescribed Birth Control
- Prescription Drugs
- Prescription Sunglasses
- Private Hospital Room Differential
- Prosthesis
- Psychiatrist
- Psychologist
- Speech Therapy
- Spinal Fluid Tests
- Splints/Casts
- Sterilization
- Support Hose
- Syringes
- Transplants (includes organ donor)
- Transportation Expenses
- Tuition Fee at special School for Disabled Child
- Urine/Stool Analyses
- Vaccinations/Immunizations
- Vasectomy and Reversal
- Well Baby Care
- Wheelchair
- Wigs (hair loss due to disease)
- X-Rays



Eligible Over-The-Counter Expenses

OTC Changes Beginning January 1, 2011

Over-the-counter (OTC) medicines or drugs (other than insulin) will not be eligible for reimbursement under a Health FSA, HRA, or HSA without a doctor's prescription. Other OTC items that are medical supplies (not medicines or drugs), such as bandages, crutches, and contact lens solutions are still covered without a prescription.

In summary, the law change is as follows:

- Participants will still be able to use their tax advantaged health care accounts for purchases of ALL OTC drugs and medicines, as long as they have a doctor's prescription.
- The rule applies to all tax-advantaged health care accounts, including Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs).
- The rule takes effect January 1, 2011 and applies to purchases on or after January 1, 2011, regardless of plan year. The only acceptable form of documentation for reimbursement for OTC drugs and medicines is a doctor's prescription, as regulated by state law.
- Insulin, medical devices (crutches, blood sugar monitors, etc.) and items such as bandages, contact lens solutions, denture adhesives, etc. remain eligible and will not require a prescription.

Examples of OTC supplies that remain reimbursable without a prescription:

Bandages	Braces & Supports	Catheters
Contact lens supplies & solutions	Denture Adhesives	Diagnostic tests & solutions
Elastics Bandages & wraps	First aid supplies	Insulin & Diabetic supplies
Ostomy products	Reading glasses	Wheelchairs, walkers, canes

Examples of OTC items that are considered drugs and medicine that will require a prescription for reimbursement:

Acid controllers	Allergy & sinus medications	Antibiotic products
Anti-diarrhea medicine	Anti-gas medicine	Anti-itch and insect bite remedies
Anti-parasitic treatments	Baby rash ointments & creams	Cold sore remedies
Cough, cold, and flu medicines	Digestive aids	Feminine anti-fungal products
Hemorrhoid preparations	Laxatives	Motion sickness medicine
Pain relievers	Respiratory treatments	Sleep aids & sedatives

To access claim forms and other information please visit us at www.bpcinc.com