Flexible Benefit Plan Administration Section 125 Employer Reference Guide

01/2020

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A. THE FLEXIBLE BENEFIT PLAN

The Flexible Benefit Plan is a welfare benefit plan specifically authorized by Internal Revenue Code (IRC) Section 125 which was enacted by Congress in 1978. The purpose is to provide a valuable benefit where both the employer and employee experience significant tax savings. Generally, employees are given a choice to "redirect" part of their salary on a tax-free basis. Each employee then uses the "redirected" part of their salary to pay for expenses offered by the Plan.

In addition to an employee's own salary redirection, the employer may make contributions to the Plan (called a "Benefit Credit") which employees may also use to purchase allowable benefits.

What Benefits can be included in a Flexible Benefit Plan?

Allowable benefits that can be paid with tax-free dollars under a Flexible Benefit Plan include:

- Group Insurance Premiums (note that privately-paid premiums should not be paid through an employee's Flexible Benefit Plan):
  - Medical/Dental/Vision Insurance
  - Accidental Death and Dismemberment Insurance (AD&D)
  - Employee Group Term Life Insurance (up to $50K of coverage)
  - Disability Insurance (however, if premiums for disability insurance are paid tax-free, any benefits paid are taxable income)
- Flexible Spending Account (FSA) contributions:
  - Medical FSA
  - Dependent Care FSA
  - Adoption Assistance FSA
- Health Savings Account (HSA) contributions
- Paid Vacation Days

What Benefits cannot be included in a Flexible Benefit Plan?

The following benefits *cannot* be paid with tax-free dollars under a Flexible Benefit Plan:

- Educational Assistance Programs
- Scholarships
- Spouse Life Insurance
- Dependent Life Insurance
- Fringe Benefits, such as:
  - Medical Savings Accounts (MSAs)
  - Health Reimbursement Accounts (HRAs)
  - Long-Term Care Insurances or Services
  - Qualified Transportation Plans
  - Employer-provided meals and lodging
  - Contributions to a Code Section 403(b) Plan

How does it Work?

The employer determines which benefits to offer to employees. Then, each employee selects benefits from the Flexible Benefit Plan menu. The employee elects to redirect his or her salary in an amount sufficient to pay for each selected benefit. Most importantly, these amounts are redirected from the employee's salary **before** it is subject to federal income taxes, FICA (Social Security and Medicare taxes), RRTA (Railroad Retirement Tax Act) and most state and local income taxes. Of course, increased employee participation and higher salary redirections will result in increased savings for the employer and the employees.

For insurance premiums, the redirected amounts are set aside by the employer for payment to insurance carriers. For FSAs, the redirected amounts are placed into a separate account for each type of benefit elected

by the employee. As eligible services are provided, the employee can access funds from the appropriate Flexible Spending Account to cover the cost of the expense (via claim submission or use of a Beniversal® Prepaid Mastercard®).

B. WHAT ARE THE TAX SAVINGS?

The employee saves on federal income tax, FICA (Social Security and Medicare taxes), RRTA (Railroad Retirement Tax Act) and most state and local income taxes. The employer will save money because FICA will not need to be paid on the tax-free salary reductions for participating employees. In some cases, state unemployment and workmen's compensation taxes can also be avoided on these amounts.

Employer Tax Savings Example

This example illustrates employer tax savings with Flexible Benefits.

	Without Flex Benefits	With Flex Benefits
Gross Annual Payroll	$ 1,100,000	$ 1,100,000
Less: Employee Flex Benefits	$ -	$ (89,000)
Taxable Wages	$ 1,100,000	$ 1,011,000
Annual Employer FICA Contribution	$ 84,150	$ 77,342
Annual Employer Savings		**$ 6,808**

These figures are for illustration purposes only.

Participant Tax Savings Example

This example illustrates participant tax savings associated with Flexible Benefits.

	Without Flex Benefits	With Flex Benefits
Monthly Income	$ 2,000	$ 2,000
Less: Tax-Free Expenses:		
▪ Health Insurance		$ (200)
▪ Medical FSA		$ (25)
Taxable Wages	$ 2,000	$ 1,775
Less Taxes and After-Tax Expenses:		
Federal Income Tax	$ (300)	$ (266)
State Income Tax	$ (100)	$ (89)
FICA	$ (153)	$ (136)
Health Insurance	$ (200)	
Out-of-Pocket Medical Expenses	$ (25)	
Disposable Income	$ 1,222	$ 1,284
Monthly Participant Savings		**$ 62**
Annual Participant Savings		**$ 744**

These figures above are for illustration purposes only. Actual savings and tax rates may vary.

C. PLAN DOCUMENTATION

Plan Document

The Plan Document is an essential element in the successful implementation of a Flexible Benefit Plan. An

employer is required by law to have a written Plan Document before implementing a Flexible Benefit Plan. The Plan Document must include the following and must be made available, upon request, to all eligible employees.

Description of Qualified Benefits:
An IRC Section 125 Plan allows employers to provide their employees with the option to pay for various qualified benefits with tax-free dollars. The benefits offered are described in the Plan Document and are specified in the Plan Highlights, which is an attachment to the Plan Document.

Description of Eligibility Requirements:
Only those employees who meet the legal eligibility requirements may participate in an IRC Section 125 Plan (see Section D). The employer may further restrict eligibility requirements as long as the Plan is non-discriminatory (see Section R). The eligibility requirements are specified in the Plan Highlights, which is an attachment to the Plan Document.

Procedures Governing Participant Elections:
To participate in the company's Flexible Benefit Plan, employees must follow specific enrollment procedures as outlined in the Plan Document.

Types of Contributions:
The Plan Document indicates two types of contributions that may be used to fund IRC Section 125 Plans:

- Non-elective contributions are amounts that employers make available to eligible participants (typically called a "Benefit Credit") to purchase benefits in an IRC Section 125 Plan. Employers specify how the Benefit Credit can be used. For example, the employer can require that participants use the money exclusively for the purchase of benefits, or can allow participants to choose to take all or part of the funds as taxable salary.
- Elective contributions are amounts participants elect to have deducted to pay for qualified benefits in an IRC Section 125 Plan. These deductions are taken before taxes and are calculated on gross salary, thus reducing the participant's taxable income.

Benefit Account Contributions:
The Plan Highlights, which is an attachment to the Plan Document, specifies the types of accounts for which a participant can make elections, as well as the maximum election allowed for Flexible Spending Accounts. For each participant, a separate account will be maintained for each benefit selected, and the salary reduction amount elected by the participant will be credited (through equal payroll deductions) to the benefit accounts maintained for that participant. The amount credited to an account for each pay period will be the portion of the salary reduction amount allocated for that benefit plus the benefit credit, if any.

Plan Year Dates:
The beginning and ending date of the Plan Year will be determined by the employer and are specified in the Plan Highlights which is an attachment to the Plan Document. A Plan Year should be for a 12-month period. A short Plan Year may be implemented as needed, for example, to align the IRC Section 125 Plan Year with other existing plans. However, there should never be two consecutive short Plan Years.

Summary Plan Description (SPD)

A separate document which summarizes the Plan's eligibility requirements, benefits and election requirements in easy-to-understand terms is called a Summary Plan Description and must be made available to all Flexible Benefit Plan participants.

Plan Highlights

The customized features of the Plan, including eligibility requirements, Plan effective date, loss of eligibility time frames and Plan Year dates are specified in the Plan Highlights, which is an attachment to the Plan Document. The Plan Highlights must be made available to all Flexible Benefit Plan participants.

Adopting the Plan

The Flexible Benefit Plan *must* be formally adopted before the effective date. The following documents must be retained by the employer along with the Plan Document:

- Record of Adoption (on the last page of the Plan Document).
- Amendment Resolution (for an amendment to an existing Plan, if applicable).

D. ELIGIBILITY REQUIREMENTS

Legal Requirements

By law, the following employees are *not* eligible to participate in an IRC Section 125 Plan:

- Self-employed.
- Partners in a partnership.
- A more-than-2%-shareholder in an S-Corporation.
- An employee who is the spouse, child, parent or grandparent of a more than 2% shareholder.

Employer Requirements

The employer may establish additional eligibility requirements for each type of benefit account and may even establish different eligibility requirements for different covered benefits. Only those employees who meet the eligibility requirements may participate in an IRC Section 125 Plan. Eligibility requirements are specified in the Plan Highlights. (Note that eligibility cannot be restricted in such a way that the Plan discriminates in favor of Key or Highly Compensated Employees.)

E. ELECTIONS

When can an Election be Made?

Three events allow eligible employees to make an IRC Section 125 Plan election. The election must be made prior to the effective date for each of these events:

- When an employee first becomes eligible.
- During annual open enrollment (before the beginning of each new Plan Year).
- If an event occurs that the IRS has identified as permitting a mid-year change.

Prospective Elections

Elections generally must be *prospective* (e.g. made before the effective date of coverage):

- New hires must make elections before the first pay date following the date of eligibility.
- Exception: If the waiting period for eligibility for a new hire is less than 30 days after the date of hire, the employer may allow the employee to make elections within 30 days after the date of hire with elections retroactive to the date of hire.
- Elections during annual open enrollment must be completed before the first day of the new Plan Year.

Irrevocable Elections vs. Permissible Change Events

- Elections made under an IRC Section 125 Plan are irrevocable, which means that once an election is made it generally cannot be changed until the next Plan Year. However, the IRS has issued regulations identifying “permitted change events” that allow changes in elections in the middle of a Plan Year. These permissible events are outlined in the SPD and Plan Document. Election changes are prospective with one exception: HIPAA regulations require that a *retroactive* 30-day special enrollment period be provided for mid-year election changes due to birth, adoption or placement for adoption.

Period of Coverage

Elections must be made for the entire coverage period:

- The normal coverage period is the entire Plan Year.
- The coverage period for a particular participant will be limited to the time the participant is eligible during the Plan Year. For example, if the participant becomes eligible March 1 for a calendar year Plan Year, the employee would be covered from March 1 through December 31.

F. FSA ADMINISTRATION

Election Amounts

Medical FSA:

- The IRS limits the amount an employee can contribute to a Medical FSA per Plan Year:
  - For Plan Years beginning on or after January 1, 2020, the maximum limit is $2,750.
  - Employers who establish an amount below the IRS maximum reduces the risk caused by the Uniform Coverage Rule (see Medical FSAs below).

Dependent Care FSA:

- Maximum amount a participant can set aside per calendar year for reimbursement of eligible dependent care services, as defined by IRC Section 21(b), is limited to the smallest of the following amounts:
  - $5,000 if single or if married and filing jointly; $2,500 if married and filing separately.
  - The earned income of the participant.
  - The earned income of the participant's spouse.

Adoption Assistance FSA:

- The IRS sets the maximum annual contribution for an Adoption Assistance FSA. The maximum allowed is specified in the Plan Highlights, if applicable.

Estimating Expenses

For each account, an employee must estimate eligible expenses for the coverage period and make FSA election(s) accordingly.

- Medical, Dependent Care and Adoption Assistance FSAs must be elected and maintained separately (participants cannot use money from one account to pay for expenses that are eligible under a different type of account).
- In consideration of the Use-or-Lose Rule, participants should be conservative when making elections.

Use-or-Lose Rule

Prior to 2013, the Use-or-Lose Rule required that FSA funds not used within a specific time frame be forfeited by the participant. Beginning January 2013, the Use-or-Lose Rule was modified to allow a limited rollover of Medical FSA funds. The employer has the option to allow participants to rollover up to $550 of unused Medical FSA funds at the end of the Plan Year to the next Plan Year.

- The Plan Highlights indicates what happens to unused funds at the end of the specified time frame.
- Unused funds are not refundable to the participants.
- Funds not used during the specified time frame and not claimed by the end of the run-out (as specified in the Plan Highlights) may be forfeited and returned to the employer. (This does not include eligible Medical FSA rollover funds.)
- Employers may use forfeited FSA funds to subsidize administrative costs of the Plan or to offset losses arising when a participant's reimbursements exceed contributions. Regulations explicitly state that forfeited funds cannot be returned to a participant based on that participant's individual claims experience. However, the employer has the option of distributing forfeited funds to all participants on a reasonable and uniform basis.

If the Plan has adopted an Extended Grace Period (EGP), the following information also applies:

- The Medical FSA rollover option is not permitted with EGP.
- Participants are allowed to access any unused amounts remaining in an FSA at the end of the Plan Year to reimburse expenses for eligible services provided during a 2-1/2 month grace period after the close of the Plan Year.
- The EGP must apply to all participants in the Plan.
- The Plan Highlights specifies the time frames that must be followed by participants:
  - EGP end date (last eligible date of service).
  - Run-out end date (last date claims must be received by BRI).
  - Last re-submission date allowed for claims denied during run-out, if applicable.
- An employee must be a participant in the Plan on the last day of the Plan Year to take advantage of the EGP following the end of that Plan Year. The exception to this rule is when COBRA (if offered by the employer) is elected for a Medical FSA.
- If the Plan includes the Beniversal Card, your Plan Highlights will indicate how funds are handled.

If the Plan has adopted a Rolling Medical FSA, the following information also applies:

- Participants are allowed to roll over up to $550 of unused funds Medical FSA from one Plan Year into the next Plan Year.
- The employer can set a lower maximum rollover amount, but they cannot set the rollover amount to anything greater than $550.
- Benefit Resource requires a minimum rollover amount of $10. The employer can set a minimum rollover amount above $10.
- The Medical FSA rollover option is not permitted with EGP. EGP can continue to be offered on a Dependent Care FSA.
- The amount that a participant rolls over does not affect the amount that can be elected for the current Plan Year Medical FSA.
- Once the current Plan Year run-out period and the denial grace period has passed, as indicated in the Plan Highlights, participants will have access to rollover funds.
- Participants who are eligible to participate in a Medical FSA in the next Plan Year and decide not to make an election in the next Plan Year can still use rollover funds for reimbursement of eligible medical expenses once the funds are available.
- Claims that were not reimbursed during the current Plan Year due to insufficient funds will be processed after the rollover funds become available.
- If the employer is offering a Medical FSA rollover and an HSA, the Plan documents must reflect what happens to the rollover funds for an otherwise HSA eligible individual. In order to ensure individuals are HSA eligible, the plan may:
  - Allow HSA eligible employees to automatically forfeit their Medical FSA rollover dollars. OR
  - Allow HSA eligible employees to automatically convert their FSA rollover funds to a Limited Medical FSA.

Eligible FSA Expenses

In general, eligible FSA expenses:

- Must be for services provided during the time frame specified in the Plan Highlights.
- Must be for services specified as eligible in the Plan Highlights and other Plan materials.
- Have not been and will not be reimbursed from any other source.
- Must not be claimed as a deduction or credit on income tax.

Ineligible FSA Expenses

If an employer has reason to believe that an FSA participant knowingly submitted an expense that is not eligible, is an expense for someone other than the enrolled participant or the participant's spouse or eligible dependents, the employer may immediately discontinue the participant's participation in the FSA and prohibit the participant from again participating in the Plan. The employer may request from the participant any information reasonably necessary to assist in such determination. Failure of the participant to provide such information shall be cause for the employer to find that the participant knowingly submitted an ineligible expense.

Medical FSAs

Eligible Medical FSA Expenses

- The service that meets the definition of medical care as found in Code Section 213(d):
  - Must be primarily to prevent, treat, diagnose or mitigate a physical or mental defect or illness.
  - Must be a service/item that would not be used except for a particular medical condition.
  - Cannot be solely for cosmetic reasons.
  - Cannot be merely beneficial to one's general health.
- Expenses must be for an eligible medical service provided to the participant, the participant's spouse or the participant's eligible dependents.
- The Medical Care Expense Worksheet (available on the BRI website, www.BenefitResource.com, under the Forms section) identifies some expenses that are eligible for reimbursement from a Medical FSA and can help employees estimate expenses.

The Uniform Coverage Rule for Medical FSAs

- On the first day of the coverage period, the participant must have access to the full Medical FSA election for eligible medical expenses.
- If a participant loses eligibility (including termination of employment) and the amount reimbursed from the account exceeds the amount contributed to the account, the employer cannot recoup those funds.
- The employer is solely responsible for providing funds for payment of all reimbursements, even if total reimbursements exceed the Plan's cash balance. (This risk can be reduced by setting the amount that Plan participants are allowed to elect for a Medical FSA below the maximum allowed by the IRS.)

Income Tax Reporting for Medical FSAs

- Employee Medical FSA contributions under an IRC Section 125 Plan should not be included in taxable wages on the participant's Form W-2.
- Beginning with Form W-2 issued in January 2013, employer contributions to a Medical FSA are reported on the participant's W-2. This reporting is for informational purposes only.
- Medical FSA contributions are not reported on the participant's income tax return.

Dependent Care FSAs

Eligible Dependent Care FSA Expenses

- Expenses must be for the care of a qualified person, which is someone who:
  - Spends at least 8 hours per day in the participant's home and
  - Meets one of the following definitions:
    - A dependent who was under age 13 when the care was provided and for whom an exemption can be claimed (see IRS Pub 503 for special regulations re: divorce/separation).
    - A spouse or dependent who is physically or mentally incapable of self-care, has the same principal place of abode as the participant for more than half of the year and for whom an exemption can be claimed on the participant's tax return.
- The dependent care must enable the participant to be gainfully employed or to look for work. If married, the dependent care must also enable the participant's spouse to work, look for work or attend school full-time.

- The service must be for physical care, not for education, meals, etc.
- The amount claimed must not exceed the lesser of the employee's earned income for the year; or if the employee is married at the end of the taxable year, the spouse's earned income.
- The service may be provided in the participant's home or another location, but not by someone who is the participant's minor child or dependent for income tax purposes (e.g. an older child).
- If the service is provided by a day care facility that cares for six or more individuals at the same time, the facility must comply with state day care regulations.
- Overnight camps and lessons in lieu of day care are not eligible for payment from a Dependent Care FSA.
- Examples of qualified services:
  - Child Care
  - Nursery School
  - Before/After School Care
  - Adult Care
  - In-Home Dependent Care

The Uniform Coverage Rule does not apply to Dependent Care FSAs

- The participant has access only to the actual cash balance in the Dependent Care Account at any given time.

Income Tax Reporting for Dependent Care FSAs

- In general, tax-free contributions to a Dependent Care FSA should not be included in taxable wages. However, if the participant's total Dependent Care FSA contributions exceed the $5,000 IRS annual maximum, the excess amount should be included as taxable wages.
- On the participant's Form W-2, Box 10 should reflect that participant's tax-free Dependent Care FSA contributions for the calendar year, up to $5,000.
- The participant must report information about the dependent care provider and the Dependent Care FSA dollar amount with their annual income tax return:
  - On Form 2441 with a Form 1040 return.
  - On Schedule 2 with a Form 1040A return.
- Employees should contact tax advisors to determine whether using a Dependent Care FSA or claiming the Dependent Care Tax Credit on the income tax returns is more advantageous. The advantage of each option depends on such variables as taxable wages, tax bracket and the number of dependents for whom the employee has eligible dependent care expenses.

Adoption Assistance FSAs

Eligible Adoption Assistance FSA Expenses

- Expenses must be for the legal adoption of an eligible child. An eligible child is:
  - Under 18 years of age, or
  - Any individual who is physically or mentally incapable of self-care.
- Expenses must be for reasonable and necessary adoption fees, court costs and attorney fees or other expenses directly related to the legal adoption of an eligible child by the participant.

The Uniform Coverage Rule does not apply to Adoption Assistance FSAs

- The participant has access only to the actual cash balance in the Adoption Assistance Account at any given time.

Income Tax Reporting for Adoption Assistance FSAs

- Participant contributions are not subject to federal income tax withholding, but they must be reported on Form W-2, Box 12 using code "T".
- These contributions are subject to federal Social Security, Medicare tax (FICA) and unemployment tax (FUTA).

- The participant must claim the income exclusion by filing IRS Form 8839 with the Form 1040 tax return.

Online Account Information

The employer can access participant Account Summary information at any time on the BRI website, www.BenefitResource.com, after secure login under Reporting. Each participant can access account details on the website at any time. (For login information, see Section G.)

Initial/Annual Enrollment

- Eligible employees who wish to participate must enroll before the effective date of the Plan Year.
- The employer must ensure that deductions begin on the first pay date of each new Plan Year.
- If enrollment is done via the BRI website, www.BenefitResource.com or through the BRiEducation mobile site:
  - By the date indicated on the Implementation Schedule, the employer must provide an electronic file to BRI that lists all eligible employees. BRI will provide a file layout for this purpose. (For file upload information, see Section K.)
  - If the employer submits employee enrollment information online, paper enrollment forms should be retained for the employer's records.
  - If the employer allows employees to enroll online, no paper enrollment forms are required because the employee acknowledges and agrees that the login information serves as an electronic signature authorizing enrollment.
  - The BRI website and BRiEducation mobile site will remain open during the time frames indicated on the Implementation Schedule.
- If non-web enrollment is done:
  - The employer should make enrollment forms available to all eligible employees and upon completion, these forms should be retained by the employer. Enrollment forms can be obtained from the BRI website, www.BenefitResource.com, under the Forms section.
  - The employer must submit an electronic file with participant basic data and elections. BRI will provide a file layout for this purpose. (For file upload information, see Section K.)
- To assist in the plan announcement, BRI offers *Email Communication Services*:
  - The employer can down email templates to send communications.
  - Sign up to have BRI send the emails.

  To get started, visit www.BenefitResource.com

On-going Elections and Changes

- As employees become eligible or experience permissible change events during the Plan Year, they may enroll or change elections by completing the established enrollment/change process. Note: web enrollment is available for the employer during the Plan Year for ongoing elections and changes, if Plan design permits. Again, enrollment records should be retained by the employer.
- The employer must submit to BRI an electronic file indicating each new election or changed election. (For file upload information, see Section K.)
- The employer must ensure that appropriate deductions begin on the first pay date after the effective date of the coverage/change.

Loss of Eligibility, including Termination of Employment

In order to prevent ineligible use of FSA funds, it is critical that the employer notifies BRI immediately regarding an FSA participant losing eligibility for coverage, preferably prior to the event occurring. Please note the following:

- The information provided to BRI must include:
  - Participant Name
  - Member ID

- Account type
- Date of loss of eligibility

- The information should be provided via one of the following:
  - On the BRI website, www.BenefitResource.com, after secure login under Manage Participants (if permitted by Plan design).
  - Electronic File (For file upload information, see Section K.)
  - Fax
- Time frames for submission of claims after loss of eligibility are specified in the Plan Highlights. Note that if a participant is eligible to elect COBRA coverage for a Medical FSA, the employer must notify the participant of those rights. The employer should contact its COBRA administrator for guidelines.

G. WHERE TO GET ASSISTANCE

- Information for the employer is available:
  - Online with secure login at the BRI website, www.BenefitResource.com:
    - Initially, employers can obtain their secure login password as follows:
      - Select *First-Time Login* from the login page
      - Enter your Login ID which is your employer 9-digit Federal Tax ID (without the dash)
      - Select *Submit*
      - An email will be sent to the email address that BRI has on file
    - Employers can obtain forgotten passwords by following the prompts when selecting *Trouble Logging In?* from the login page.
    - Reports (e.g. Plan Reports, Financial Reports, Enrollment Reports), Plan documentation, forms, educational materials and more are available 24/7.
    - Announcements (monthly updates regarding Plan documentation, BRI processes, etc.)
  - On the BRI website, www.BenefitResource.com, on the Media Center page under the About tab.
  - Via telephone by contacting the Plan's assigned BRI Client Operations Specialist at (866) 996-5200 Monday - Friday, 8am – 5pm (Eastern Time).

- Information for participants is available:
  - Online with secure login at the BRI website, www.BenefitResource.com:
    - First time users will need to create a login by following the prompts under *Register an Account*.
    - Users who have previously logged in will be required to enter their existing Login ID and Password.
    - Account Summary and detail, Plan documentation, forms and much more are available 24/7.
    - Live Chat with BRI Participant Services Representatives is available via participant login.
  - On the BRI website, www.BenefitResource.com:
    - On the Media Center page under the About tab.
    - Under the Participants tab.
  - Via the BRiMobile app for iPhone, iPad and Android devices. This allows real-time access to view account information, submit claims and upload receipts.
  - Via BRiAlerts where participants can elect to receive real-time transaction alerts by email or text. Participants can elect to receive BRiAlerts through BRiWeb or BRiMobile.
  - Via BRiEducation mobile site where participants can access a variety of resources including videos, frequently asked questions and calculators.
  - Via QuickBalance at (888) 996-9225 or www.BRIWEB.mobi
    - Available to cardholders 24/7 for real time account balance information.
  - Via telephone at (800) 473-9595:
    - BRI's automated IVR system is available 24/7 for account information.
    - BRI Participant Services Representatives are available Monday - Friday, 8am – 8pm (Eastern Time).

- Please note that IVR and website account information is typically updated every 24 hours.

H. BENIVERSAL CARD FOR THE MEDICAL FSA

The Beniversal Card

If the Plan includes the Beniversal Card, participants who elect a Medical FSA will automatically receive a Beniversal Card to access Medical FSA funds when paying for eligible medical expenses. The Beniversal Prepaid Mastercard is issued by The Bancorp Bank pursuant to a license by Mastercard International Incorporated. The Bancorp Bank; Member FDIC. Mastercard is a registered trademark of Mastercard International Incorporated. This is a limited access card and cannot be used at all Mastercard acceptance locations. No cash access.

The employer will provide an annual pre-fund amount equal to a percentage of the total Medical FSA elections in order to ensure that sufficient funds are available to cover daily Medical FSA Beniversal Card transactions. (Mastercard and the card issuing bank require that pre-funding be available for all Medical FSA accounts.) The total Beniversal Card Medical FSA transactions are debited from the pre-fund account each day based on the prior day's transactions. In order to maintain the pre-fund balance through the Plan Year, Medical FSA card transaction amounts must be replenished by BRI daily.

The pre-fund amount is based on a percentage of the total annual Medical FSA elections for Beniversal Medical FSA card participants and is provided by the employer. Beniversal Card participants' Medical FSA balances do not include pre-funding amounts.

The pre-fund amount required each Plan Year varies due to election amounts for Beniversal Medical FSA card participants. With each new Plan Year, BRI will calculate the pre-funding difference between the amount for the prior Plan Year and the current Plan Year. If the pre-funding amount for the new Plan Year is less than the prior year, the difference will be credited to the employer. If the pre-funding amount for the new Plan Year is greater than the prior year, the difference will be transferred from the employer.

How does the Beniversal Card Work?

- The Beniversal Card allows the cardholder to access Medical FSA funds at the point-of-sale (POS) (The cardholder has access to the full election, minus any previous transactions/reimbursements).
- The Beniversal Card will be issued before the beginning of the coverage period for new enrollees.
- The participant can continue using the card through the expiration date on it as long as they continue to participate in the employer sponsored Plan.
- Each participant receives two cards at their home address via U.S. mail. The participant should sign one card and the participant's spouse or an eligible dependent can sign and use the second card.
- The participant will need to activate the Beniversal Card before using it by either:
  - Going online at www.BenefitResource.com or
  - Calling the toll-free number on the card activation sticker.
- The Medical FSA funds on the Beniversal Card may only be used to pay for eligible medical services provided at qualified merchants, such as:

- Chiropractors	- Hospitals	- Medical Labs	- Podiatrists
- Dentists	- IIAS merchants*	- Medical supply stores	- Vision
- Doctors	- 90% merchants**	- Orthodontists	

* An IIAS merchant has an Inventory Information Approval System (IIAS) that can automatically identify eligible medical expenses. A list of IIAS merchants is available at the Benefit Resource website www.BenefitResource.com.

** A 90% merchant has registered with a national organization, certifying that 90% or more of its revenue is from the sale of eligible medical items. A list of 90% merchants' locations is available at the Benefit Resource website www.BenefitResource.com.

- The cardholder must *SAVE ALL RECEIPTS* in the event that followup is needed for a Medical FSA card expense.
- Payments using Medical FSA funds on the Beniversal Card must be completed:
  - After an eligible medical service has been provided. The IRS allows one exception: eligibility of orthodontia expenses can be based on the date of service, the date of payment or the payment due date on statements/coupons.
  - During the time frame indicated in your Plan Highlights.
- If employment terminates and/or eligibility is lost, the Medical FSA funds will not be available via the card even if COBRA coverage is elected. Claims may only be submitted for reimbursement of out-of-pocket expenses for eligible medical services using a claim form, within the time frame specified in the Plan Highlights. (For claim submission information, see Section I.)

Approved vs. Declined Transactions

- Beniversal Card transactions from the Medical FSA should be approved at the POS if all of the following are true:
  - The card was activated.
  - The account is currently active.
  - The expense is eligible under the Plan.
  - The merchant is qualified.
  - Sufficient funds are available.
- If the transaction is declined at the POS, the participant can pay for the eligible medical service by another means and then submit a claim requesting reimbursement.

Auto-adjudication of Medical FSA Transactions on the Beniversal Card

- The IRS requires verification of all Medical FSA expenses.
- Many Medical FSA transactions can be auto-adjudicated, which means that BRI can determine electronically whether the expense was for an eligible service. When this is possible, the participant does not need to submit followup.
- BRI will attempt to auto-adjudicate Medical FSA transactions using:
  - **IIAS technology:**
    Transactions at IIAS merchants who identify eligible medical FSA items will be auto-adjudicated.
  - **Co-pay matching:**
    Transactions will be auto-adjudicated if:
    - a participant is enrolled in an employer-sponsored group health insurance plan,
    - the Medical FSA transaction matches the co-pay under that plan for that type of expense, and
    - the employer has provided both the group health insurance co-pay information and the participant group health insurance election to BRI.
      - The employer will provide the health insurance information on the Group Insurance Form (GIF) and a copy of the co-pay summaries associated with the plans listed on the GIF. The participant group health insurance elections need to be provided with the FSA enrollment information.
  - **Recurring matching:**
    If a participant has already provided followup documentation for a previous Medical FSA transaction identifying it as an eligible expense, each "recurring" transaction for the same amount at the same type of vendor will be auto-adjudicated.
  - **Insurance Carrier matching (based on availability):**

If an approved insurance carrier file is available, BRI will attempt to match carrier records in the file against card transactions made by participants. To learn more or to set-up the carrier matching option, please contact the assigned Client Operations Specialist.

- **Receipt Eraser (opt-in service):**
  The employer can make Receipt Eraser available to participants. Receipt Eraser is a participant opt-in service that provides claims data to Benefit Resource in order to substantiate card transactions and reduce the need for participants to supply documentation. At least 37 carriers are immediately available including: Aetna, Cigna, BC of CA, BCBS-IL, Coventry, Empire BCBS, Premera, Regence, Unicare, United Healthcare, VSP, etc. Approximately 80 other carriers available for selection and can be added once at least 6 participants opt-in for the service.

Expenses that are not Automatically Adjudicated

If a Medical FSA transaction cannot be auto-adjudicated:

- BRI will contact the participant to request followup documentation for the expense. Participants will not know at the POS whether an expense was auto-adjudicated, so they must **SAVE ALL RECEIPTS** in case BRI requests followup.
- If followup is requested, the participant can respond via secure login, BRiMobile app, fax or mail with one of these options:
  - Submit documentation (such as an itemized receipt and/or insurance company Explanation of Benefits (EOB)) for the expense.
  - Repay online using a personal checking or savings account or send in a check or money order. (Note: repayment cannot be done by the BRiMobile app.)
  - Submit other eligible claims to offset the expense.
- If BRI does not receive followup within the indicated time frame, access to the Medical FSA funds and reimbursement of claims will be suspended until the required followup is provided by the participant.
- Once followup is provided by the participant, the account will no longer be suspended. Reimbursement of eligible claims and use of the Beniversal Card to access to the Medical FSA funds may resume.
- If a participant fails to provide followup prior to the end of the Plan Year run-out, the amount of those transactions must be reported as taxable income on the participant's Form W-2 or a Form 1099. (For more information about imputed income, see Section N.)

I. CLAIM REIMBURSEMENT

For an eligible medical expense that was not paid with Medical FSA funds on the Beniversal Card, a participant can receive reimbursement from the Medical FSA by submitting a claim. Dependent Care and Adoption Assistance FSA funds are not available on the Beniversal Card and can only be reimbursed by submitting a claim. Claim forms and other supporting documentation can be accessed at the BRI website, www.BenefitResource.com, under the Forms section.

Submission of Claims

- A service being claimed:
  - Must be provided to the participant or the participant's spouse or eligible dependents.
  - Must be provided during the participant's coverage period within the Plan Year.
  - Must be submitted *after* a service is provided but prior to the end of the run-out specified in the Plan Highlights. (One exception: IRS regulations allow orthodontia expenses to be reimbursed based on either the date of service, the date of payment or the payment due date on statements/coupons.)
- Options for claim submission are as follows:
  - Using their smartphones, the BRiMobile app allows claims to be submitted on-the-go. Participants download the app from the Apple App Store or Google Play.
    - They log into BRiMobile, select *Submit a Claim,* enter the claim details, either take a picture or upload receipts and submit the claim.

- The BRI website allows a participant to complete a claim online (this option is **not** available for Adoption Assistance FSA claims). To use this easy feature, the participant will:
    - Securely log in at www.BenefitResource.com.
    - Select *Submit Claims/Receipts* and follow the on-screen prompts to submit the claim.

  Claim forms are also available to complete and fax or mail at the BRI website, www.BenefitResource.com, under the Forms section.

- To help ensure timely reimbursement, participants should carefully follow the instructions and guidelines regarding claim submission.
- For each item being claimed, a written statement from an independent third party (e.g. an invoice from the provider of service, such as a doctor's bill) must be included with the claim form. The statement from the provider must clearly indicate the following:
  - Name of the provider
  - Type of service provided or item purchased (prescriptions must include drug name)
  - Date the service was provided
  - Out-of-pocket expense
  - Name of person receiving the service
- Please note that ***items on a claim form or supporting documentation should never be highlighted because highlighted items are often illegible*** (e.g. on copies, on faxes and when documents are scanned).

Processing of Claims

- BRI reviews each claim to determine its eligibility for payment under the Plan.
- Claims are reimbursed according to the schedule specified in the Plan Highlights.
- Reimbursements are issued once eligible claims reach the minimum amount specified in the Plan Highlights. During the run-out after the end of each Plan Year, reimbursements will be issued without regard to the required minimum.
- Participants can elect to have reimbursements directly deposited into a bank account. Participants have two options to set up Direct Deposit for reimbursement:
  - Submit Direct Deposit information online:
    - Securely log in at www.BenefitResource.com.
    - Under View Profile, select *Direct Deposit* and follow the on-screen prompts.
  - An Authorization Agreement for Direct Deposit Reimbursement form (found on the BRI website, www.BenefitResource.com, under the Forms section) can also be completed and faxed or mailed to Benefit Resource.
- Participants with Direct Deposit will receive notice of a direct deposit each time a reimbursement is issued. Participants who do not elect Direct Deposit will receive paper checks.
- All participants will receive a Benefit Statement with each reimbursement. The Benefit Statement lists claims processed and amounts paid and/or denied. If the participant can resolve the reason for a denied amount, the claim can be resubmitted.
- If all items on a claim are denied, the participant will be notified of the reason for the denial via U.S. Mail.
- Claim and reimbursement detail is available to participants:
  - On the Benefit Statement accompanying each reimbursement.
  - Online with secure login at the BRI website, www.BenefitResource.com.
- Reimbursement summary information is available to employers 24/7 with secure login at the BRI website, www.BenefitResource.com,

J. PAYROLL DEDUCTIONS

The Employer must set up Deductions in Payroll

- Separate payroll deductions should be set up for each benefit elected under the Flexible Benefit Plan.

- Contributions under IRC Section 125 are not subject to federal income tax, FICA (Social Security and Medicare taxes), RRTA (Railroad Retirement Tax Act) and most state and local income taxes.
- Employers should check with state and local tax authorities to determine the status of IRC Section 125 contributions in their jurisdictions.
- On each pay date, a payroll deduction file must be uploaded to BRI no later than 1:00 pm (Eastern Time).
- Files should be uploaded to the BRI website, www.BenefitResource.com. (For file upload information, see Section K.)

K. ELECTRONIC FILES

In order to protect the employer and the participants' information, BRI provides a secure file exchange method at the BRI website, www.BenefitResource.com. (For login information, see Section G.)

To upload files:

- Under File Transfer, select *Secure File Upload*.
- Indicate the type of file and Plan type that will be uploaded.
- Enter email address.
- Browse the hard drive and select the file that will be uploaded.
- Add comments, if any.
- Click Upload; a confirmation email will be sent to the email address entered during this process.

To download files:

- Under File Transfer, select *Secure File Download*.
- Follow the instructions on the screen to download the file.

L. FUNDING

How to fund a participant account:

- Funds to cover the amount of payroll deductions must be available upon receipt of the payroll deduction file, or
- Funds to cover the amount of the reimbursements that were issued must be available the business day following the processing date. .

Any funds received later than the agreed schedule will be subject to a late charge equal to 2% of the funds that were not received in time.

M. FORFEITURES

As indicated in Section F under "Use-or-Lose Rule", employers may use forfeited funds remaining in FSAs to subsidize administrative costs of the Plan or to offset losses arising when participants' reimbursements exceed contributions. Regulations explicitly state that forfeited funds cannot be returned to participants based on individual claims experience; however, these funds may be distributed to participants overall on a reasonable and uniform basis if the employer so chooses. Once the Plan run-out has ended, the Plan will be reconciled and, if applicable, forfeited funds will be returned to the employer, in the form of a check, along with supporting documentation.

N. IMPUTED INCOME

When Beniversal transactions result in ineligible transactions or transactions that require followup and they are not resolved by the end of the Plan Year run-out, they must be reported as taxable income on the participant's Form W-2 or a Form 1099.

How Imputed Income Works

Imputed income results when a participant fails to provide followup for a card transaction that cannot be automatically adjudicated by BRI. After the Plan Year run-out has ended, BRI will provide a report for the employer that lists these amounts. It is then the employer's responsibility to report the taxable income amount for each participant. Medical FSA accounts that were suspended due to these transactions will be unsuspended once BRI reports the imputed income amounts to the employer.

O. INVOICING FOR ADMINISTRATION

Invoices

- BRI invoices clients for administration costs at the end of each month.
- Invoices should be paid in full (as invoiced). Any billing discrepancies should be discussed with the BRI Accounting Department. Any credits due will be issued when an agreed upon amount is determined.
- An invoice will be sent to the Accounts Payable Department unless BRI is directed otherwise.
- All charges are billed based upon the signed Service Agreement and appear on the invoice as follows:
  - *Plan Set-up Fee*: includes Plan Design, Plan documents, initial enrollment and associated materials.
  - *Monthly FSA Account Administration*: a fee associated with the day-to-day administration of the Plan based on the number of participants. The employer is billed for participants through the end of the run-out following the Plan Year.
  - *Beniversal Card Activation Fee (if applicable)*: a fee charged for cards ordered/created within that month.
  - *Federal Wire Fee*: a fee charged if the employer sends funds to BRI via Fed Wire. (There is no fee for sending funds via ACH transfer.)
  - *Additional Plan Support*: a fee charged on a per usage basis for materials, consulting, on-site sessions, etc.

Payments for Invoices

Payments for invoices are due net upon receipt. BRI offers a number of ways payment can be remitted for monthly administration invoices.

- *Direct Payment*: eliminates the need for check writing and mailing. Payment will be automatically deducted from the employer's bank account 15 days after the invoice date
- *ACH Credit Payment*: to control the timing and amount of an electronic payment, the employer can send BRI an ACH credit initiated from its cash management or accounts payable system. **Important**: to be properly credited, ensure that company name and all invoice numbers are included with payment in the additional fields (addenda records) of either the CCD+ or CTX standard ACH formats.
- *By Check*: make check or money order payable to BRI. Please do not mail cash.

Contact the BRI Accounting Department by phone at (866) 996-5200 Monday - Friday, 8am – 5pm (Eastern Time):

- To change invoice payment method at any time.
- With any questions regarding an invoice.

P. QUESTIONS AND ANSWERS

Frequently Asked Questions (FAQs) are available at the BRI website, www.BenefitResource.com, under the FAQs tab.

Q. RESOURCE CENTER FOR PARTICIPANTS

The Participant Resources page at www.BenefitResource.com, under the Resources tab, contains valuable information for participants:

- BRiMobile app allows on-the-go account access to view balances, access detailed transaction information, submit claims and upload receipts. The app is available for download from the Apple App Store or Google Play.
- Calculators for determining savings or to estimate election amounts.
- BRiAlerts allows participants to sign up to receive alerts, by email or text, when transactions occur, when deposits are made and a duplicate transaction is suspected. Participants can easily setup BRiAlerts when they log into their secure account at www.BenefitResource.com.
- BRiEducation is a mobile site designed to educate employees during the open enrollment process through videos, clear content, dynamic FAQs and calculators. When ready, employees can proceed to enroll, all through their smartphone or handheld device.

R. NON-DISCRIMINATION TESTING

Under the Internal Revenue Code, Flexible Benefit Plans are subject to a number of different tests designed to ensure that employers do not provide a disproportionate share of benefits to highly paid employees. Some tests apply to the Flexible Benefit Plan itself as a separate benefit program. The Plan will be tested shortly after the beginning of each Plan Year and again near the end of the Plan Year to ensure compliance with IRS regulations. The employer will be asked to provide certain information required for BRI to be able to perform the tests.

Concentration Test

Probably the most familiar requirement for Flexible Benefit Plans is the Concentration Test, which limits the amount of non-taxable benefits selected by Key employees. Under this test, the value of non-taxable benefits selected by Key employees cannot exceed 25% of the total non-taxable benefits selected by all participants under the Plan. If the Concentration Test fails and adjustments are not made, the Key employees must report the value of their benefits under the Plan as taxable income. The employer must pay social security and unemployment taxes on that gross income.

A Key employee is an employee who meets the definition on the IRS Compliance Data Form provided when a Plan is first implemented and each Plan Year thereafter. An example of the Concentration Test follows:

Employees	# of Participants	Total Contributions	Benefit %
Key	8	$ 30,000	21.4%
Non-Key	72	$ 110,000	78.6%
Total	80	$ 140,000	100.0%

In this example, the Plan passes the Concentration Test because the Benefit % for Key employees does not exceed 25%. If the Key employees' tax-free contributions were greater than 25%, then those employees' contributions would have to be decreased to equal 25% or less of the total. If the Plan continues to be in non-compliance, the value of benefits under the Plan for each Key employee must be reported as taxable income.

Fair Cross-Section Test

Flexible Benefit Plans must also pass an eligibility test called the Fair Cross-Section Test. The purpose of this test is to ensure that a fair percentage of lower-paid employees are covered by the Plan. The test requires employers to measure the percentage of Non-Highly Compensated Employees (NHCEs) eligible to participate in the Plan against the percentage of Highly Compensated Employees (HCEs) eligible to participate in the Plan.

A Highly Compensated Employee is an employee who meets the definition on the IRS Compliance Data form provided when a Plan is first implemented and each Plan Year thereafter. An example of the Fair Cross-Section Test follows:

Employees	Total Employees	# of Eligible Employees	% of NHCEs who are Eligible	IRS Minimum % of Eligible NHCEs
HCEs	4	4		
NHCEs	46	38	83%	50% (can vary)
Total	50	42		

This example shows that the Plan complies with the Fair Cross-Section Test rules. If the Plan failed the test, the company would have to increase the number of NHCEs eligible for the Plan or decrease the number of HCEs eligible to participate. If the Plan continues in non-compliance, the value of benefits under the Plan for each HCE must be reported as taxable income; the employer, would have to pay social security and unemployment taxes on that gross income.

55% Average Dependent Care Test

A Dependent Care FSA Plan must meet the requirements of the 55% Average Dependent Care Test. For this test, the average amount of benefits provided to Non-Highly Compensated Employees (NHCEs) must be at least 55% of the average benefits provided to Highly Compensated Employees (HCEs). Note that regulations allow certain employees to be excluded from this test (e.g. based on age, salary, length of service or union membership).

During the Plan Year, the test may be performed on annual elections in order to estimate whether or not there will be non-compliance issues at the end of the Plan Year. If the Plan is determined to be discriminatory, Dependent Care FSA elections for HCEs should be adjusted accordingly.

The test done at the end of the Plan Year is based on total deposits. If the Plan is not in compliance, the excess benefits received by each HCE must be reported as taxable income and the employer must pay social security and unemployment taxes on that gross income.

S. FORM 5500

BRI will prepare Form 5500s for clients who have contracted to receive this service.

Who must complete Form 5500?

Employers who are subject to ERISA and *have greater than 100 participants* in a Flexible Benefit Plan must prepare and file a Form 5500 for a Welfare Benefit Plan. The Form 5500 must be filed for the individual benefits available through its Flexible Benefit Plan, such as group health insurance, group term life insurance, etc. Employers with less than 100 participants, churches and government agencies are currently exempt from this filing.

When must Form 5500 Be Filed?

The employer must file the Form 5500 by the last day of the seventh month after the end of each Plan Year. As of 2010, all Form 5500 filings are required to be submitted electronically. Please refer to the U.S. Department of Labor website for more information relating to the new EFAST filing system.

GLOSSARY

Benefit Resource, Inc. (BRI). An outside entity (service provider) that handles certain Plan administrative responsibilities for the employer.

Benefit Statement. A statement that explains what portion of a claim amount is paid and/or denied.

Beniversal Card. A prepaid card that may be used to pay for eligible medical services at the point-of-sale with available Medical FSA funds.

Beniversal Card Transaction. A payment made with a Beniversal Card.

COBRA. The federal Consolidated Omnibus Budget Reconciliation Act of 1985 which may allow participants to continue coverage for certain qualified benefits under a Cafeteria Plan even after losing eligibility.

Elections. Salary reductions based on an employee's written or electronic agreement and used to pay for qualified benefits.

Eligible Expenses. Medical, Dependent Care and/or Adoption Assistance expenses that are eligible for reimbursement from an FSA under a Flexible Benefit Plan.

Eligibility Requirements. Conditions (such as length of service) specified by a Plan as required for participation in the Plan.

Enrollment Period. The time period specified in the Plan Document during which employees are given the opportunity to elect to participate in a Flexible Benefit Plan.

ERISA. The Employee Retirement Income Security Act of 1974. This act deals with specific employee rights under benefit plans.

Explanation of Benefits (EOB). A statement sent to the subscriber explaining action taken by the insurance plan regarding a claim filed on his or her behalf.

Extended Grace Period (EGP). Modification of the Use-or-Lose Rule per IRS Notice 2005-42 that allows a Plan to extend the eligible dates of service for an FSA for up to 2-1/2 months after the end of the Plan Year.

FICA. The Federal Insurance Contributions Act (includes Social Security and Medicare taxes).

Flexible Benefit Plan. A written Plan that meets the requirements of IRC Section 125 under which eligible employees may choose between cash or qualified benefits, thus allowing employees to pay for these benefits on a tax-free basis. May also be referred to as a Cafeteria Plan.

Flexible Spending Account (FSA). A reimbursement account(s) that is usually offered through a Flexible Benefit Plan and provides eligible employees with tax-free coverage for eligible Medical, Dependent Care and/or Adoption Assistance expenses.

Form W-2. Form issued by the employer to the employee to indicate earnings and withholdings at the end of the tax year. This form must be issued by January 31 for the previous calendar year.

Forfeitures. Unused contributions remaining in an FSA after the run-out following the end of a Plan Year. Forfeitures cannot be refunded to the participant.

FUTA. The Federal Unemployment Tax Act. FUTA taxes are paid by employers only.

HIPAA. The federal Health Insurance Portability and Accountability Act which, among other aspects, allows portability of health coverage and increases security and privacy of health care information.

IIAS. An Inventory Information Approval System that can identify eligible medical expenses at the point-of-sale when using a medical FSA card. Certain merchants (drugstores, grocery stores, discount stores) can only accept medical FSA cards if they have IIAS in place.

IRC Section 125. Internal Revenue Code Section 125 refers to the regulations governing Flexible Benefit Plans.

Irrevocable. Refers to the general requirement that tax-free election amounts made under a Flexible Benefit Plan cannot be changed during the Plan Year (subject to certain exceptions).

Non-elective Contributions. Employer funds that may be provided to employees for the purchase of benefits. These are sometimes referred to as "Benefit Credits."

Open Enrollment. A designated period before the beginning of each new Plan Year during which employees may elect benefits for that new Plan Year.

Plan Document. A formal written document that sets forth the Plan's terms and conditions.

Plan Highlights. Part of the Plan Document that contains specific information regarding eligibility requirements, Plan Year dates, eligible expenses, etc. The Plan Highlights must be made available to participants in the Plan.

Plan Year. The 12 month period of time specified in the Plan Document for the operation of the Plan.

Qualified Benefits. Benefits that may be offered under a Flexible Benefit Plan (e.g. Health Insurance, Dental Insurance, Group Term Life Insurance, Medical FSA, Dependent Care FSA, Adoption Assistance FSA).

RRTA. Railroad Retirement Tax Act.

Run-out. A period of time after the end of a Plan Year or after loss of eligibility during which a participant may submit claims requesting reimbursement for eligible expenses. The run-out time frame is specified in the Plan Highlights.

Summary Plan Description (SPD). A document that summarizes the Plan in an easy-to-understand style. The SPD must be made available to participants in the Plan.

Tax-free Contributions. Contributions that are made to pay for qualified benefits under a Flexible Benefit Plan. These contributions are not included in taxable wages.

Uniform Coverage Rule. A requirement under IRC Section 125 that the full Plan Year election for a Medical FSA be available to the participant for payment of eligible expenses, even if eligible expenses exceed contributions to the account at the time.

Use-or-Lose Rule. Prior to January 2013, IRC Section 125 required that any remaining funds in a Medical, Dependent Care or Adoption Assistance FSA after the run-out following the end of the Plan Year be forfeited by the participant. Effective January 2013, Notice 2013-71, issued by the Department of Treasury, modified the rule to allow a rollover of up to $550 unused Plan Year Medical FSA funds.