Flexible Benefits Plan Questions & Answers

General Plan:

1. Who makes the rules regarding the Flexible Spending Accounts (FSAs)?
Some rules, such as eligibility requirements, can be established by the Employer; however, most rules are dictated by the IRS.

2. What is the maximum that I can elect?
The Health Care Spending Account maximum under the City's plan is $3,200. You and your spouse can elect up to the maximum under each of your respective employer's plans. The Dependent Care Spending Account maximum is $5,000 per household or $2,500 if you are married but filing your taxes separately.

3. What is the process for getting reimbursements from a Health Care or Dependent Care Spending Account?
Claims are processed by our third-party plan administrator ThrivePass. Participating employees are encouraged to create an online account with ThrivePass after enrolling in the plan. Claims can be submitted to ThrivePass by mail or fax with an accompanying claim form or entered directly into ThrivePass's online claims system. Claims entered by noon each Wednesday are processed by ThrivePass and reimbursements are issued to employees via check or direct deposit early the following week.

3. What is the enrollment deadline?
Elections must be made online through the City's Employee Self Service (ESS) system by November 30, 2024. The system will not allow elections after this date.

4. Can I change my election during the plan year?
In general, once an election (health, dental or vision premiums, health care reimbursement, dependent care reimbursement) becomes effective, it cannot be changed until the next plan year; however, there are a few exceptions to this rule. The most common exception is called a "status change." When you have a status change, you may revoke your election and submit a new election for the remainder of the plan year *if the election change is "consistent" with the status change event.* You have **30 days** following a status change to submit a new election, and the new election will be effective *after* it is received by Human Resources.

Status Change Events

- legal marital status (e.g., marriage, divorce, legal separation or annulment)
- number of dependents (e.g., birth, adoption, death of a spouse or other dependent)
- change in residence of you, your spouse or dependent *that affects eligibility for coverage* (e.g., you move out of an HMO's service area so are no longer eligible for a particular medical plan)
- employment status of you, your spouse or a dependent (e.g., termination or commencement of employment, strike, leave of absence and other employment change) that affects benefit eligibility
- dependent satisfies or ceases to satisfy the eligibility requirements of a plan (e.g., the dependent reaches limiting age for coverage, or student status changes)

5. How do I know if my election change is <u>consistent</u> with the event?
In general, an election change must be "on account of" and directly related to a status change *that affects your eligibility for the benefit.* For example, if you have a baby or get married, the consistency test is met if you increase your Health Care FSA. It would not be consistent to decrease the election. Contact Human Resources if you are considering possible changes due to a qualifying event.

6. What happens to my FSA accounts if my employment terminates?
In general, your Health Care FSA will terminate on the date of your final paycheck. You can still submit claims for your Health Care FSA, but the dates of service must be prior to the date of your final check from which an FSA contribution was deducted. For the Dependent Care FSA, you can continue to incur expenses beyond your termination date in order to spend down any balance.

7. Does my plan have a grace period?
No. The grace period has not been adopted.

8. Does my plan have a carryover for the Health FSA?
No. The carryover has not been adopted.

9. Can I appeal the denial of an FSA claim?
FSA claims must be reviewed within 30 days. If your claim requires additional information or is denied, you will receive notice in writing stating the specific reasons for the decision. If additional information is required, you have 45 days to provide the required information. If your claim is denied, you can request that the decision be reviewed by filing a written request with the Plan Administrator within 180 days after receiving notice that the claim was denied. The Plan Administrator will review your appeal and give you written notice of a final decision within 60 days after receiving a request for review.

10. If I participate in the Flexible Spending Accounts, what do I have to remember when I file my personal income taxes?
You cannot take expenses that are reimbursed under the Health Care FSA as itemized deductions on your federal tax return.

For the Dependent Care Account, you cannot use the same expenses for the FSA and the Dependent Care Tax Credit. Because the limit on eligible expenses for the tax credit is $6,000, many individuals who use the Dependent Care FSA for the full $5,000 will be able to use the tax credit on qualifying expenses in excess of $5,000 (up to the $6,000 limit). *Consult your tax advisor for additional help in determining what works best for you.*

11. Who can I contact for more information or a copy of the Summary Plan Document (SPD)?
Please contact Human Resources for further information or a hard copy of the SPD. An electronic version of the SPD is located on the Human Resources benefits webpage at www.icgov.org/benefits and can be accessed from any device with internet access.

<u>Premium Conversion:</u>

12. What is premium conversion and how do I elect it?
Premium conversion is the health, dental and vision insurance option which allows premiums to be deducted on pre-tax basis. Premium conversion is elected by electing the pre-tax health, dental or vision

insurance option.

13. If I don't make a new health, dental and/or vision election, will I be enrolled in premium conversion for 2025?

It depends! The City's Flexible Benefits Plan states that employees who fail to make a new health, dental and/or vision election during open enrollment will ***automatically carry forward their election from the previous plan year***. This means that health, dental and vision premiums will default to the pre/post tax status in place the prior year and will be **irrevocable** unless the employee experiences a qualifying status change event. For example, if an employee elected health, dental and vision premium deductions on a post-tax basis in 2024 and fails to make an election, those post-tax deductions will be carried forward for the 2025 plan year.

Health Care Spending Account:

14. What expenses can I submit for reimbursement under the Health Care Spending Account?

There is no list of eligible expenses published by the IRS. In general, medical expenses are those incurred for the diagnosis, cure, mitigation or prevention of disease, but do not include expenses that are merely beneficial to your general health. The expenses must be incurred while you are an active participant in the plan (e.g., prior to your coverage termination date if you terminate mid-way through the year). Expenses are considered "incurred" at the time the services are provided – not when you are formally billed or pay for the services. Note that a prescription expense is considered incurred when the prescription is filled and *ready* for pick-up – not when you actually pick it up and pay for it.

15. Are over-the-counter (OTC) drugs reimbursable under the Health Care Spending Account?

No. While the IRS has issued a ruling stating that certain over-the-counter items may be eligible, **the City's plan specifically excludes OTCs.**

NOTE: Items purchased from the Thrivepass online FSA store are NOT eligible for reimbursement.

16. Is orthodontia reimbursed any differently since treatment is ongoing?

Most often, orthodontia is reimbursed based on the terms of the contract or service agreement that you have with the orthodontist's office. If you're scheduled for a monthly payment, you can be reimbursed monthly. If you pay for your complete treatment up-front, though, your payment may be reimbursed on a pro-rated annual amount based on the duration of the contract. For example, your braces cost $3,000, are placed on January 2nd, you have no insurance coverage, you're expected to wear the braces for 24 months and you pay the full $3,000 on January 2nd. You can be reimbursed a lump-sum of $1,500 in 2025 and submit another claim for $1,500 in 2026.

Dependent Care Spending Account:

17. Who are eligible Dependent Care providers?

Eligible providers include: (1) a licensed provider, (2) an unlicensed provider unless the provider is caring for six or more nonresident individuals and (3) relatives of the employee other than a tax dependent of the employee or employee's spouse or the employee's child who is under age 19. If care is provided outside the employee's home (for example, at a day care center) the dependent must spend at least 8 hours per day at the employee's home.

18. Which is better---the Dependent Care Spending Account or the Dependent Care Tax Credit?

It is difficult to generalize about which option (FSA versus tax credit) will be most advantageous due to the number of factors that affect the analysis. Consult your tax advisor for additional help in determining which is more beneficial to you.