Reimbursement Plan Administration Guide

A comprehensive guide for plan sponsors

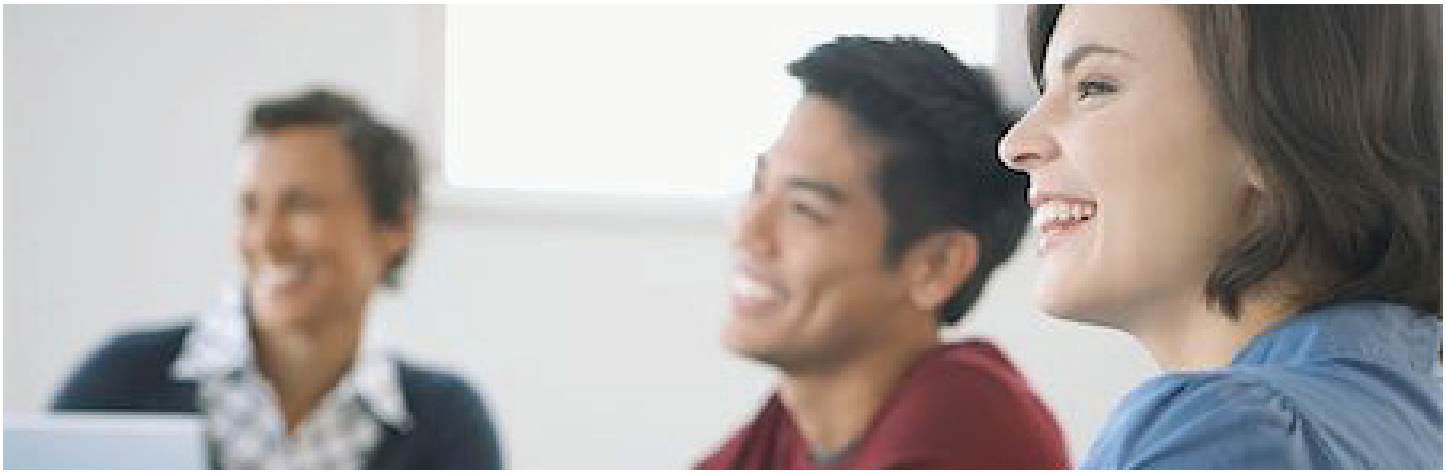
Sentinel Benefits & FINANCIAL GROUP

Table of Contents

Your Cafeteria Plan is governed by IRC Section 125. The services that Sentinel will provide to you and your employees have been designed to ensure that you meet the regulations of §125.

For more information or if you have questions about your plan, contact our Service Center by calling (855) 269-7878 or email clientcare@sentinelgroup.com.

Open Enrollment & Re-Enrollment



Much like a group health plan, a cafeteria plan requires employees to enroll or re-enroll in the program on an annual basis. Typically, the Open Enrollment "window" should be opened for participants between 30-60 days prior to the first day of the new plan year. A well-communicated open enrollment is the key to driving plan participation and employee awareness. Sentinel Benefits & Financial Group is dedicated to partnering with you to make your open enrollment process as successful as possible.

How do I get started?

Sentinel will contact you via email 60-90 days prior to the beginning of the plan year to outline the steps required to setup open enrollment. Sentinel has developed communication materials that will assist you in educating your employee base about the program and its benefits. During this time, we will confirm the enrollment period and ensure that the plan system is setup to accept the annual elections for the year.

How do employees enroll (re-enroll) in the plan?

Sentinel has three options for annual enrollment for plan participants. During the initial discussion regarding Open Enrollment, your Account Manager will review the three options with you. Regardless of the option you choose for your plan, it is important that Sentinel receive all enrollment information at least 15 business days prior to the beginning of the plan year to ensure that all required information is loaded timely and accurately.

1 Online enrollment

Allowing your employees to enroll online is the easiest, most secure annual enrollment option. Your employees will enter their annual elections and update any personal information by following Sentinel's step-by-step process. After the employee confirms their data an email confirmation is sent to that employee. Also, you as the plan sponsor will be able to create an annual election report to setup and verify payroll deductions.

2 Enrollment file upload

Sentinel has created a pre-formatted file that can be provided to you for generating an upload into Sentinel's record-keeping system. Choosing the file upload option will allow you the flexibility to offer paper enrollment forms to your participants or utilize other HR systems that you may use to collect and provide employee benefit information.

3 Direct feed from a third party

If your employees complete their benefit enrollment using a third-party HRIS, we can receive an electronic enrollment file from your HRIS provider.

What if I want on-site enrollment support?

Included in Sentinel's annual services is access to all of our open enrollment communications that can be provided to your employees. If you would like for Sentinel Benefits & Financial Group to provide on-site support to your employees, Sentinel can provide this professional service at the rate quoted in your service agreement.

New Enrollment & Status Changes

As employees join or leave your organization, you may need to enroll new participants or update the status of existing ones. Adding employees or changing their status can easily be done from the employer portal, either on an individual basis or by importing a file.

How can I add, enroll and update employees?

Under the **Employees** tab, select Add Employee. Enter the Personal and Employment Information and click Add Employee. In the Confirmation section click Add Enrollment. Select the plan and click Enroll. Enter the Effective Date and Election/Employer Contribution and click Add Enrollment(s).

How can I update an employee's status?

Under the **Status** tab, within the Actions section, click Add New Status. Select the Status from the drop down menu. Enter the Status Effective as of date and click Add Status.

How can I import data directly from a file?

Under the **Imports** tab, you can import demographic, enrollment and contribution files directly into the portal using standard CSV formatted import files. Once on the **Imports** home page, you would select the type of data to be imported, then:

1. Open the template in excel
2. Enter or paste your data into the template
3. Check for field matches by viewing setup data
4. Save as CSV to a location you can remember
5. Upload file

Once imported, any errors will be displayed and can be easily updated from the **View Errors** button. Clicking on the record number allows you to correct the error. Then, click **Queue Record** and correction is made. You can then resubmit the file to import the corrected records.

Special rules for terminated employees

Health Reimbursement FSAs

A terminated employee is not eligible for reimbursement of claims for services that occurred after the separation from service. However, if the employee incurred expenses prior to the separation from service, those claims are eligible for reimbursement if they are deemed to be eligible expenses and the claims are submitted prior to the end of the Plan's run-out period, as defined in the Plan Document.

Dependent FSAs

If allowed by the provisions of the Plan Document, a terminated employee is entitled to be reimbursed for Dependent Care claims incurred at any time during the plan year in which they separate service, up to the amounts credited to their account. Simply stated, an employee can be reimbursed for qualified dependent care expenses during the plan year, even after termination, if they have a remaining balance in their account upon termination of employment. The

remaining balance is defined as actual contributions made to the account minus any previously paid claims.

COBRA coverage

An employee can elect to continue a Health FSA under COBRA unless one of the following exceptions apply:

- The employer falls under the small employer exemption of COBRA
- Upon termination, the cost of the premiums outweighs the benefit
- The employee's termination date is the same as the Plan-Year End date

Health FSA is only covered under COBRA until the earlier of when the participant is reimbursed all their remaining benefits or the end of the plan year in which their employment was terminated.

Special rules for participants on a leave of absence

If a participant goes on a qualified unpaid leave while they are still considered an active employee (e.g. Family and Medical Leave Act of 1993 - FMLA), the participant has two options for managing their Flexible Spending Account for the remainder of the plan year. Once an option has been chosen, the participant has 30 days from the first day of leave to submit their request to an authorized plan representative.

Revoke the election entirely (change it to zero)

The participant can decide to revoke their FSA participation upon a qualified leave of absence; however, once the employee returns to work they cannot participate again in the plan for that plan year unless they experience a qualified status change while on leave. If a qualified status change has been experienced, the participant can either keep the amount the same as it was when they made the decision to revoke their election, or they may reduce their annual election by the amount that would have been contributed while on leave.

Any Health FSA or Dependent Care expenses incurred while on leave are not eligible for reimbursement under this option.

Continue participating while on leave

If the participant wishes to continue participation in the Plan during their leave, he or she will be responsible for making up any missed contributions which would have occurred had they not been on leave. There is flexibility regarding how to make up FSA contributions, but the method must be established in advance and the contributions must be made in the same plan year as the leave of absence. If they are not made up in the same plan year, the participant will need to repay on an after-tax basis, causing them to lose a portion of their tax benefit of participating in the plan.

If a participant chooses this option, all Health FSA expenses incurred during the leave period will be considered eligible; however, claims for dependent care expenses incurred during the leave period are **not eligible** for reimbursement.

If a participant chooses to continue participating while on leave, what are the "make-up" options?

Make a lump sum salary reduction prior to leave

How? The participant will have a reduction taken from the last paycheck prior to going on leave. The amount of the reduction will be equal to the sum of all of the reductions that will be missed while on leave.

Why? This option is preferred if the leave period is well determined and the participant can afford to take a lump sum deduction on their final paycheck prior to going on leave. The benefit to this option is that the participant knows that their plan contributions are allocated and they are preserving the tax advantage of these contributions prior to going on a leave of absence.

Make a lump sum salary reduction after returning from leave

How? Once the participant returns from leave he or she would elect to have the full amount missed while on leave deducted from their first paycheck upon returning.

Why? This option allows the participant to quickly make up any missed contributions during the absence period. This would be a good option if the participant is confident that they will be returning by the end of the plan year, but they are not certain when they will be returning. Again, consideration must be given to determine if the participant can afford a balloon reduction of pay on a specific pay period.

Increase pay period contributions after returning from leave through the end of the plan year

How? The participant's year-to-date contributions would be subtracted from their annual election for the year. This amount would be divided by the number of remaining pay dates in the plan year after the participant returns from the leave of absence.

Why? This option is popular because it allows the participant to spread out the missed contributions across multiple pay periods, which will lessen the financial burden to repay those missed contributions.

Employee Qualified Election Changes

Upon electing coverage under a cafeteria plan, an employee's election is irrevocable until the end of the Plan Year unless:

- The employee experiences a change in status or a significant cost of coverage change
- There is a termination of employment
- There is an approved leave of absence

What is considered a change in status event?

There are certain life changes that will allow a participant to change or cancel their coverage under a cafeteria plan. For a change to an existing election to qualify, the change in status must be due to one of the following reasons.

- Change in legal marital status
- Change in the number of tax dependents
- Commencement of employment *(including spouse or dependent employment)*
- Termination of employment *(including spouse or dependent terminations)*
- Change in work schedule which affects benefit eligibility
- Change in place of residence or work which affects the coverage in a benefit plan

How do I properly document an election change?

The employee will complete a Change Form and provide a copy to Human Resources (or designated personnel) at your company. This must be done within 30 days of the Status Event. It is important to note that unless for birth, adoption or placement of adoption of a child, *retroactive* changes are not allowed. The change should become effective with the next pay period beginning after the form is submitted and approved by the Employer. A copy of the form should be filed in the employee's personnel file.

How do I update an election?

Under the **Employees** tab, select the employee. From the Enrollments option, click **Update** in the **Actions** column next to the benefit election to be updated. Choose the applicable update reason (either a correction to an existing election or new election due to a status change), enter the effective date and new election amount, and save your change.

Allocating Plan Contributions

Sentinel will process contributions in relation to the employee's pay schedule with the employer. To properly administer the allocation of contributions, it is critical that there is clear and timely communication between the Plan Sponsor and Sentinel. Sentinel's preferred method is to allocate contributions based on each participant's annual election. It will be the explicit responsibility of the Plan Sponsor to notify Sentinel timely of any adds/drops to coverage or if there are Qualified Status Changes that will impact the annual benefit election of a participant.

Here are the contribution processing options that we provide:

Auto-post

Sentinel's preferred method of allocating contributions is designed to reduce the administrative burden for the Plan Sponsor. By utilizing our auto-posting capabilities, we will automatically post contributions on each pay date without requiring a payroll period contribution file. By posting contributions to participant accounts based on annual election instructions (or any approved qualified status changes made during the year), any discrepancies between contribution amounts are eliminated.

Online portal file upload

Sentinel has created a pre-formatted file that can be provided to you for generating an upload into Sentinel's record-keeping system. This file will be loaded on a pay period basis in order to confirm the deductions taken from each employees' paycheck.

Direct feed from a payroll system

We can receive the ongoing contribution files directly from an outside payroll provider or payroll system.

Utilization & Reimbursements

Participants can take advantage of using their FSA dollars anytime during the plan year, as well as during any grace period or run-out period allowed by the Plan's document. Depending on your Plan's document, Health FSA participants may also have the ability to carry over up to $500 from one plan year to the next.

What options do participants have to utilize the plan benefits?

Sentinel's Benny Debit Card

Participants that take advantage of the debit card will enjoy an 80% auto-adjudication rate which means that your participants will not typically need to submit documentation of their activity to Sentinel. Instead, the transaction will automatically reduce their account balance. Even better, participants will not need to pay out-of-pocket and wait to be reimbursed.

Go green! Submit claims electronically

In the event that participants did not use the Sentinel Benny Card at the point of purchase, a plan participant has the ability to submit an electronic claim request to Sentinel for reimbursement by completing a few simple steps:

1. Log in at sentinelgroup.com
2. Select File a Claim from the "I Want To…" section of the home page
3. Follow the claim filing wizard to enter the claim details and upload receipt(s)

In addition, included in the functionality of our mobile application is the ability for participants to file new claims and submit associated receipt images all from their phone or other mobile device. Participants can submit a claim, take a photo of their supporting documentation, and attach the image to the claim.

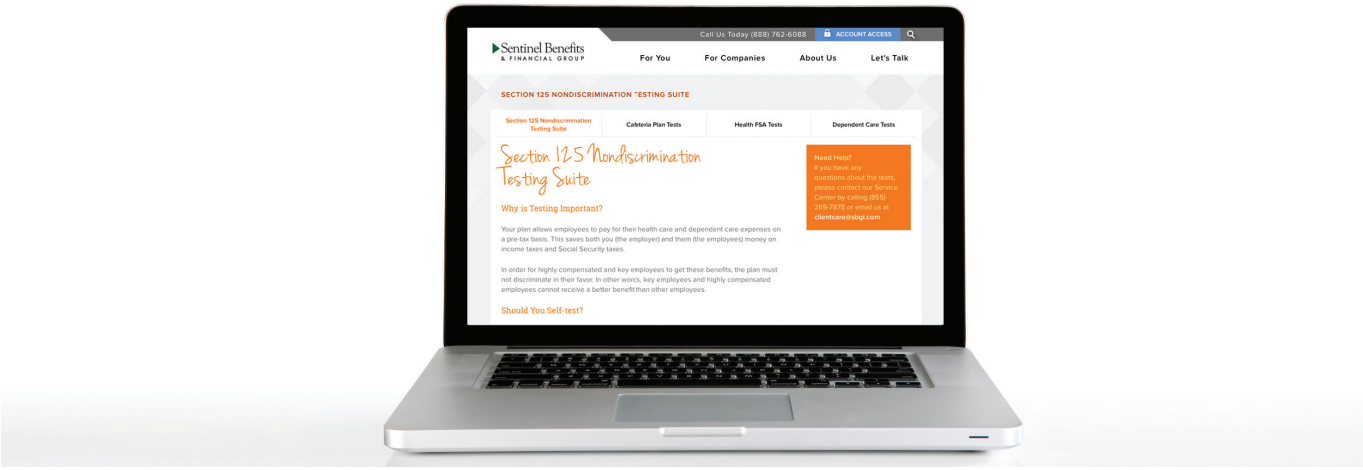
Important! Participants should keep all of their receipts or other substantiation of reimbursement claims in case of an audit of their personal tax return.

Paper claim form. Download a claim form and submit a claim to Sentinel

Participants can download the FlexChoice Claim Form by visiting sentinelgroup.com. The form will explain how to remit the claim and substantiation to Sentinel for adjudication.

Nondiscrimination Testing & Reporting

For your plan to remain qualified under Section 125, it must not discriminate in favor of Key or Highly Compensated individuals with regard to plan eligibility, benefits or coverage. Sentinel Benefits & Financial Group has developed an online tool designed to guide you through each of the required tests. Please visit sentinelgroup.com/125plantesting.htm at any time during the year to test the status of your plan.



About the tests

If you sponsor a Cafeteria/Section 125 Plan, there are three tests to complete. If you also offer Health Flexible Spending Account (FSA) or Dependent Care FSA benefits, there are additional tests to complete. All of the possible tests are listed below.

What tests are required?

Cafeteria plan tests

1. **Cafeteria Plan Eligibility Test:** To automatically pass the test, your plan must be offered to all of your employees except union employees and non-resident aliens. In addition, the requirements to join the plan must be the same for all employees, the premiums paid through the plan must be the same for all employees and the waiting period must be less than 3 years. Please consult your plan document for the eligibility requirements of your plan.

2. **Cafeteria Contributions & Benefits Test:** A plan cannot discriminate in favor of highly compensated participants as to contributions and benefits. If the plan consists solely of health insurance benefits and the employer pays for 100% of the cost of health benefits; or, pays 75% of the cost of the most expensive plan offered, the plan is deemed to be not discriminatory. If additional benefits are included (i.e. FSA benefits), the rule is that the percentage of benefit dollars compared to compensation for the Highly Compensated Employee group should be equal to or less than the same percentage for non-Highly Compensated Employees.

3. **Cafeteria Plan Key Employee Concentration Test:** This test measures the amount of pre-tax benefits provided to key employees versus all other employees. This is the test that small employers most often fail. Key employees cannot receive more than 25% of the pre-tax benefits from the plan.

Health FSA tests

1. **Health FSA Eligibility Test:** Under the Health FSA Eligibility Test, a plan may not discriminate in favor of HCIs as to eligibility to participate. A plan may satisfy any of these three sub-tests in order to pass:

   - Subtest #1: The plan benefits 70% of all non-excludable employees.

- Subtest #2: The plan benefits 80% or more of all non-excludable employees who are eligible to benefit, if 70% or more of all non-excludable employees are eligible to benefit under the plan.

- Subtest #3: Nondiscriminatory Classification Test. Safe Harbor and Unsafe Harbor Percentage Tests.

2. **Health FSA Benefits Test:** Under the Health FSA Benefits Test, a plan may not discriminate in favor of HCIs and all participants should be benefiting from the plan in the same way as HCIs.

The Benefits Test consists of two requirements that must be met in order for the Health FSA to pass.

- First Requirement: No Discrimination on the Face of the Plan.

- Second Requirement: No Discrimination in Operation

In order for a Health FSA to be nondiscriminatory on its face, it must satisfy the following conditions as a matter of plan design and in operation. Examples of this include:

- The required employee contributions must be identical for each benefit level;

- The maximum benefit level that can be elected cannot vary based on percentage of compensation, age, or years of service;

- The same type of benefits (e.g., medical expenses) provided to HCIs must be provided to all other participants; and

- Disparate waiting periods cannot be imposed.

Dependent Care tests

1. **Dependent Care Eligibility Test:** The Eligibility Test is designed to ensure that a minimum percentage of non-HCE's are eligible to participate in the plan and that benefits are available to them on a nondiscriminatory basis.

2. **Dependent Care Contributions & Benefits Test:** This test is used to determine if non-HCEs are benefiting from the plan in the same way as HCEs. This is a subjective test. As long as the benefit maximum is the same for all employees the plan will pass this test.

3. **Dependent Care More-Than-5% Owners Test:** This test is used to determine if owners are receiving too much benefit from the Dependent Care benefit. As long as more-than-5% owners are receiving less than 25% of the total DCAP benefits then the plan will pass this test.

4. **Dependent Care 55% Average Benefits Test:** This test is used to determine if HCEs are receiving too much benefit from the Dependent Care (DCAP) benefit. If the average DCAP benefit for the non-HCE group is at least 55% of the average DCAP benefit for the HCE group then the plan will pass this test. The 55% average is the average for all employees, not just the employees who are participating in the dependent care benefit.

What if I need help?

If you would like Sentinel to complete these tests for you, please download and complete the census spreadsheet at sentinelgroup.com/125census.xls and email it back to clientcare@sentinelgroup.com. You will need to save the spreadsheet on your computer before you can email it back to Sentinel. There are additional fees for Sentinel to administer these tests. Please consult your Sentinel Services Agreement for further clarification, or call your Account Manager.

Annual reporting

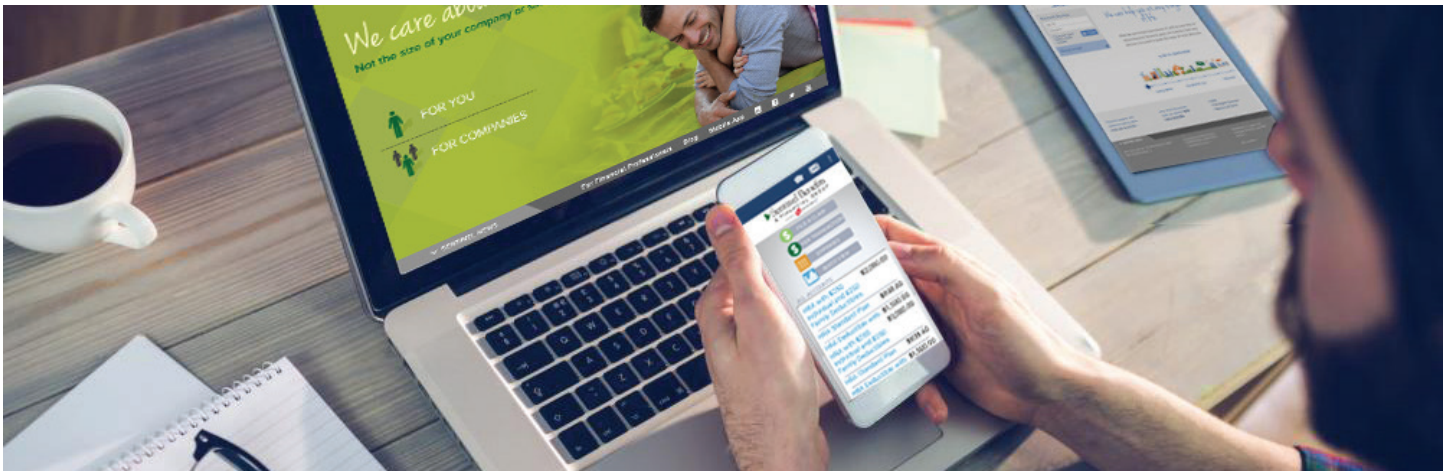
There is currently no annual filing requirement for Section 125 Plans. However, the underlying benefits may be required to file a Form 5500 if they are considered a Health & Welfare Plan. Group Health Insurance Coverage and Health FSAs are two examples of underlying benefits that may be required to file an Annual Form 5500.

There is an exemption for filing an Annual Form 5500. If your Plan has fewer than 100 participants at the beginning of the Plan Year and your Health Reimbursement is "unfunded," the Plan is exempt from filing a Form 5500. Your Health Reimbursement is "unfunded" if the benefits are paid from the general assets of the company and not from a trust account separated for the specific purpose of paying out benefits.

If your Health Reimbursement Plan has 100 or more participants at the beginning of the Plan Year, a Form 5500 must be filed by the end of the 7th month following the Plan Year End (unless an extension is filed). Sentinel will prepare the Form 5500 at the rate quoted in your Service Agreement.

Online Tools

Sentinel's website has been designed to offer you and your plan participants the easiest access to all of the answers you are looking for. There are many resources that can be found online at sentinelgroup.com.



To log into your account, go to sentinelgroup.com and select "I am an Employer." From the login box dropdown menu, select "FSA, HSA, HRA, and Commuter Accounts." Once you're on the login page, enter your Username and Password and click Login.If you cannot locate your Username and Password, please contact your Account Manager at 855-269-7878.

Once you're logged in, everything you need to efficiently and effectively manage your plan is found on the home page. You will see a history of the reports and notifications with quick links to the latest versions. From the home page, you can:

- View employee level data.
- Check on status of file imports
- Log requests
- Read plan documents
- Download forms

You can also access the tabs at the top of the page or links at the bottom of the page for easy navigation.

How do I view reports and notifications?

On the Home Page, under the Reports tab, there will be a list of all available reports that can be viewed. Simply select the relevant enrollment, financial, contribution or plan information report desired and it will automatically be displayed.

What kind of employee-level data can I access?

Under the tab titled Employees, you can get real-time data on all enrolled employees. You can search for employees using first name, last name or employee identifier (defined ID or SSN). Once in the employee view, you can access the following information:

- Account Summary
- Demographics
- Account Balances
- Enrollments
- Contributions
- Claims
- Payments
- Status

How can I access my plan information?

Under the Plans tab, you will find options to view the same info as the employees for all active and inactive plans. Information available is:

- Plan Summaries
- Plan Details and Rules
- Documents

Where would I access plan forms?

Under the Resources tab, you can download and print any forms needed. You will also have access to any other documents or custom materials related to your plans in this tab.

Glossary of Terms

Cafeteria Plan (IRS Code §125) – A group benefit plan established by an employer for employees. Cafeteria Plans are authorized under the U.S. Internal Revenue Code, Section 125. Also referred to as a Section 125 Plan or Flexible Spending Plan (FSA).

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – A federal act which requires each group health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage.
Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment.

Dependent Care Assistance Program (DCAP) – A written plan that meets the requirements of code §129, under which employees are provided with dependent care assistance. Most DCAPs are flexible spending arrangements (FSAs) offered under a cafeteria plan.

DOL – The United States Department of Labor

Explanation of Benefits (EOB) – An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment.

Employee Retirement Income Security Act of 1974 (ERISA) – Governs the administration, supervision, and management of pension and welfare plans.

Flexible Spending Arrangement (FSA) – A reimbursement plan (including Health FSA or DCAP) that gives employees coverage under which eligible expenses may be reimbursed, subject to certain conditions such as a maximum benefit limit. Under FSA, contributions are made before FICA taxes for both the employee and employer.

Health FSA – A Flexible Spending Arrangement (FSA) under which participants may be reimbursed for certain medical expenses that are not reimbursed through insurance or other arrangements (examples include: co-payments, deductibles, vision, dental)

Health Insurance Portability and Accountability Act (HIPAA) – legislation designed to improve the portability of health coverage, reduce health care costs by standardizing the process of health care transactions, and increase the security and privacy of health care information.

Health Reimbursement Plan (HRA) – A type of Medical Reimbursement Plan funded by employer contributions only as an account for reimbursement of deductible or out-of-pocket medical expenses; funds rollover at the discretion of the employer. An HRA is sometimes offered in conjunction with a High Deductible Health Plan.

Health Savings Account (HSA) – a trust or custodial account funded by employer contributions and/or employee salary reduction for reimbursement of deductible or out-of-pocket medical expenses. An HSA is ONLY available in conjunction with an HDHP. Regulated primarily by IRS Section 223, but can be funded through a Cafeteria Plan.

High Deductible Health Plan (HDHP) – A health insurance plan that has a high minimum deductible, which does not cover the initial costs or all of the costs of medical expenses. The deductible forces the insurance holder to pay the first portion of a medical expense before the insurance coverage kicks in. The minimum deductible for a plan to fall into the category of an HDHP varies each year.

Open Enrollment Period – The period during which members can elect to join a plan, usually without providing evidence of insurability.

Protected Health Information (PHI) – Under HIPAA, individually identifiable health information that is maintained or transmitted in any form or medium by a covered entity or business associate.

Qualified Transportation Plan – a reimbursement plan regulated by IRS Section 132. A QTP reimburses employees' eligible transit and parking expenses, up to the IRS statutory limit or a lower limit set by the employer.

Waiting Period – A specified number of days that the insured must wait before becoming eligible for coverage. It could also apply to the time an insured is required to wait before becoming eligible for a certain type of benefit. For example, a new insured may have to be continuously insured for 12 months before becoming eligible for benefits for major services under voluntary dental insurance.

First Use: 9/11/2018