

FlexPro

Flexible Benefits Plan

Employee Enrollment Information Packet



Section 125 Flexible Benefits YOUR KEY TO SAVING\$

City of Peru

910

Participant Portal Employer ID: KBA009100

Get the most out of an FSA qualified account - visit

fsastore.com/FlexPro

PO Box 1179
Fort Mill, SC 29716

Email:
flexpro@keybenefit.com

Phone:
800.558.5553

Fax:
866.241.1488

Introduction

City of Peru has provided you with the opportunity to enroll in a Flexible Spending Benefit Plan. The information in this packet will help you decide if the City of Peru Flexible Spending Benefit Plan is right for you.

There are several advantages you can gain from enrolling in a Flexible Spending Plan. Below are just a few:

- Increased take home pay
- Easy access to funds to help pay for out-of-pocket healthcare and dependent care expenses.
- Reduced federal and/or state taxes

Information you will find in this packet

- What Is a Flexible Benefit Plan?
- Is a Flexible Spending Account Right for You?
- How Flexible Spending Accounts Work and How Much You Can Save
- Type of Eligible and Non-Eligible Expenses
- Over-the-Counter Medicine Reimbursements
- Frequently Asked Questions
- Your Plan Specifics
- Claims Procedures
- Flexible Benefit Carrover Option
- Online Account Access
- Claim Form
- Election Form/Salary Reduction Agreement
- Dependent/Spouse Information
- Direct Deposit Information
- Automatic Daycare Reimbursement Agreement

What is a Flexible Benefit Plan?

FlexPro by KBA is the administrator for your employer-sponsored Flexible Benefit Plan. A Flexible Benefit Plan is approved under Section 125 of the Internal Revenue Code and enables you to pay for certain expenses with pre-tax dollars.

Optional Benefits:

Employee Paid Insurance Premiums - This account automatically allows you to pay for your portion of some insurance premiums with tax-free dollars. This may include premiums for medical, dental, vision, group term life, cancer coverage, etc.

Health Care Flexible Spending Account (FSA) - Certain health care costs, including medical, dental, vision and hearing expenses that are not paid by insurance and other "out-of-pocket" expenses may be reimbursed by participating in a Health Care FSA. These expenses must be incurred within the plan year (or within the grace period if applicable) and may include but are not limited to: expenses for medical plan co-payments, deductibles, prescription drug co-payments and charges, physician office visits, chiropractic care, vision and dental and orthodontia care.

***Please note:** The cost of over-the-counter medicines may not be reimbursed through a Health Care FSA unless the medicine is prescribed by a physician.

Dependent Care Flexible Spending Account (DCAP) — Certain dependent care costs may be reimbursed by participating in the Dependent Care Flexible Spending Account. Qualified expenses may include fees for adult and child care centers, preschool and before/after school care. To be eligible, you and your spouse (if married) must be employed or a full-time student. Your dependent must be under age 13 or physically and/or mentally incapable of caring for themselves. As of each regular payroll deduction date established by your employer, your employer will credit an amount to your account. Eligible claims incurred during the plan year and submitted within the appropriate timeframe may be reimbursed up to the amount available in the account at the time of reimbursement. The maximum annual amount for the Dependent Care FSA is \$5,000 per family.

Certain leave of absence rules applies to reimbursement of dependent care expenses. Dependent Care expenses may not be reimbursed while on Leave of Absence (LOA). However, there is an exception for short term, temporary absences. An absence of no more than 2 consecutive calendar weeks is considered a short term, temporary absence. A taxpayer who is gainfully employed is not required to allocate expenses during a short, term, temporary absence from work, such as a vacation or minor illness, provided that the care giving arrangement requires the taxpayer to pay for care during the absence.

Is a Flexible Spending Account Right for You?

Medical plan copayments

Medical plan deductible

Medical plan coinsurance

Other medical care expenses not covered by insurance

Dental expenses (copays, cleanings, orthodontia, etc.)

Vision expenses (exams, glasses, contact lenses, LASIK, etc.)

Dependent Care Expenses that allow you and your spouse (if married) to be gainfully employed or a full-time student

If you answered YES to any of the above questions, you can reduce the taxes you pay by participating in your employer-sponsored Flexible Benefits Plan and **increase your take home pay!**

How Flexible Spending Accounts Work and How Much You Can Save

This illustration demonstrates how a participating employee might save \$650 in taxes during the Plan Year by paying for eligible expenses with pre-tax dollars through the Flexible Benefits Plan.

Please note: This example is for illustrative purposes only. Savings may vary depending on each person's eligible expenses and benefit election.


	Without Flex	With Flex
Annual Income	\$30,000	\$30,000
Eligible Out-of-Pocket Pre-Tax Expenses	\$ 0	\$ 2,750
Remaining income to be taxed	\$30,000	\$27,250
Estimated Taxes (estimate 30% including FICA, Federal and State)	\$ 9,000	\$ 8,175
Out-of-Pocket After-Tax Expenses	\$ 2,750	\$ 0
Take Home Pay	\$18,250	\$19,075
Total Annual Savings	\$ 0	\$ 825

IN 2020, YOU DECIDE HOW MUCH YOU SAVE!!

Use the below worksheet to figure **how much you can save** by participating in a Flexible Benefit Plan.

1. Health Care Expenses:	Enter your estimated family annual medical/dental/vision expenses that are not covered by insurance:	
	Medical Insurance Copayments, Deductibles and Coinsurance	\$
	Over-the-counter medical products	\$
	Over-the-counter medicines (prescribed by a physician)	\$
	Doctor Office Visits	\$
	Physical Examinations	\$
	Well-baby care	\$
	Chiropractic Care	\$
	Dental Exam Copayments and Dental Insurance Deductibles	\$
	Orthodontia Care and Other Out-of-pocket Dental Care	\$
	Vision Exams	\$
	Eyeglasses AND Contact Lenses	\$
	Other out-of-pocket eye care (LASIK or contact solutions, etc.)	\$
	Hearing Care	\$
	Other out-of-pocket medical care (not covered by insurance)	\$
	Total Annual Medical, Dental and Vision Expenses	\$
2. Dependent Care Expenses:	Enter your estimated weekly dependent care expenses:	
	Weekly expenses x 52 weeks = Total Annual Dependent Care Expenses	
3. Total Flex Savings:		
	Total annual expenses from above Health Care and Dependent Care	\$
	Multiply by an estimated tax savings of 30%	x 30%
	Your Estimated Annual Tax Savings	\$

More take-home money to help pay for those eligible expenses!



Types of Eligible and Non-Eligible Expenses

The following list, while not intended to be complete, illustrates expenses that may be reimbursed under the Flexible Spending Account. Some restrictions may apply. See provided annual plan documents for details.

HEALTH CARE FSA EXPENSES

Eligible Dental Expenses

Routine & Preventive Services & X-Rays
Orthodontia - <i>A treatment plan may be required</i> ---See Plan Specifics page for your plan's orthodontia guideline
Restorative services, fillings, extractions and dentures

Eligible Vision Expenses

Eye Exams
Prescription eyeglasses & sunglasses
Contact lenses & supplies
Corrective surgery (RK & LASIK)

ELIGIBLE MEDICAL CARE EXPENSES

Medically Necessary Medical Equipment

Wheelchair, crutches & lifts
Oxygen equipment & supplies
Blood pressure monitor

Diabetic Supplies

Insulin
Test strips, lancets, etc.
Glucose monitor

Physical Examinations

Annual physical exam, Prostrate Screening, Pap Smear & Mammogram
School & work physicals

Hearing Expenses

Testing
Hearing aids & hearing aid batteries & repairs

Counseling & Psychiatric Treatment

Must be prescribed by doctor to treat a medical condition. Doctor's statement may be required.

Psychologists
Psychotherapists
Psychiatrists

Miscellaneous Fees & Services

Physicians, surgeons, anesthesiologists or OB/GYN
Ambulance
Nursing (including room & board)
Chiropractic services

Other Eligible Expenses

Orthotics & orthopedic shoes (<i>medically necessary</i>)	Medical Supplies
Tuition at special schools for the handicapped	Laboratory fees
Therapy treatments (<i>when prescribed by doctor</i>)	Acupuncture
Travel necessary to seek medical treatment, including mileage (<i>limitations apply</i>)	Alcohol & drug rehabilitation expenses
Special equipment for those who are deaf and/or blind including books in Braille printed material, hearing devices and trained guide dogs	Prosthesis & artificial limbs
Weight loss programs & drugs: Eligible ONLY with doctor's prescription as part obesity and/or specific condition treatment (<i>Doctors statement of diagnosis and treatment plan's medical necessity required</i>)	Organ tissue donation expenses

ELIGIBLE DEPENDENT CARE FSA EXPENSES

Dependent Care FSA Eligible expenses include expenses necessary for you and your spouse (if married) to be gainfully¹ employed or a full-time student.
Eligible expenses include:

Expenses paid for the care of a dependent under age 13	Expenses paid to an eligible dependent care provider
Expenses paid for the care of a dependent who is physically or mentally incapable of caring for themselves (<i>if older than age 13</i>)	If you are divorced, your child must be in your custody for at least six (6) months out of the year

INELIGIBLE EXPENSES

The following list illustrates some Medical Care Expenses that are NOT ELIGIBLE under the plan.

Long Term Care Insurance	Marriage & family counseling
Treatments and or drugs used to improve your general health or well-being not as part of treatment for a medical condition.	Nutritional supplements/vitamins to treat a specific medical treatment. (may be approved with letter of medical necessity from physician.)
Hair replacement treatments & drugs	Vitamins to improve or to preserve general health are not eligible.
Health club dues	Teeth whitening, toothbrushes
Cosmetic treatments or surgeries even when performed by certified doctors or at medical facilities. (<i>certain exceptions apply</i>)	Vacations

The following list illustrates some of the Dependent Care expenses that are NOT ELIGIBLE under the plan.

Care for dependent that lives outside the employee's home	Kindergarten or Overnight Camps
Field trips, lunches, supplies and transportation fees	Registration fees (if not required to hold child's spot)

Note: An individual who is gainfully employed is not required to allocate expenses during short, temporary absences from work, such as for vacation or minor illness, when the care giving arrangement requires the employee to pay for care during the absence. An absence of up to two consecutive calendar weeks is treated as a short, temporary absence.

Get the most out of an FSA qualified account – visit: fsastore.com/FlexPro



Over-the-Counter Medicine Reimbursement

Under the provision of the bill HR 3590*, the cost of Over-the-Counter medicines may not be reimbursed through a Health FSA, HRA, HSA, unless the medicine is prescribed by a physician. The bill does not apply to items that are not medicines, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits. Such items may qualify as medical care if they otherwise meet the definition in Code §213(d).

*Code §213(d) defines "medical care" to include amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for affecting any structure or function of the body." Items merely beneficial to your general health such as dietary, nutritional supplements, vitamins, toothpaste, etc. are not eligible.

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Examples of Eligible Expenses

The following list, while not intended to be complete, illustrates some Over-the-Counter expenses that may be reimbursed under the Health Care FSA; some restrictions may apply and may require a Letter of Medical Necessity (LMN) from a physician. Information is subject to additional guidance from the IRS.

Eligible Expenses

Band-Aids/Bandages	Carpal Tunnel Wrist Supports
First Aid Kits	Cold/Hot Packs for Injuries
Insulin	Contact Lens Cleaning Solution
Condoms	Thermometers – ear or mouth
Pregnancy Test Kits	Rubbing Alcohol
Incontinence Supplies	Reading Glasses

Expenses requiring a prescription from a doctor

Antacids	Cold medicines
Allergy medicines	First aid cream
Cough drops	Throat lozenges
Pain Reliever	Laxatives
Calamine lotion	Bug bite medicine- Oral
Anti-diarrhea medicine	Diaper Rash Cream
Hemorrhoid medication	Sunburn ointments/ cream
Sinus medications	Nasal sinus sprays or strips
Spermicidal foam	Pedialyte-child dehydration

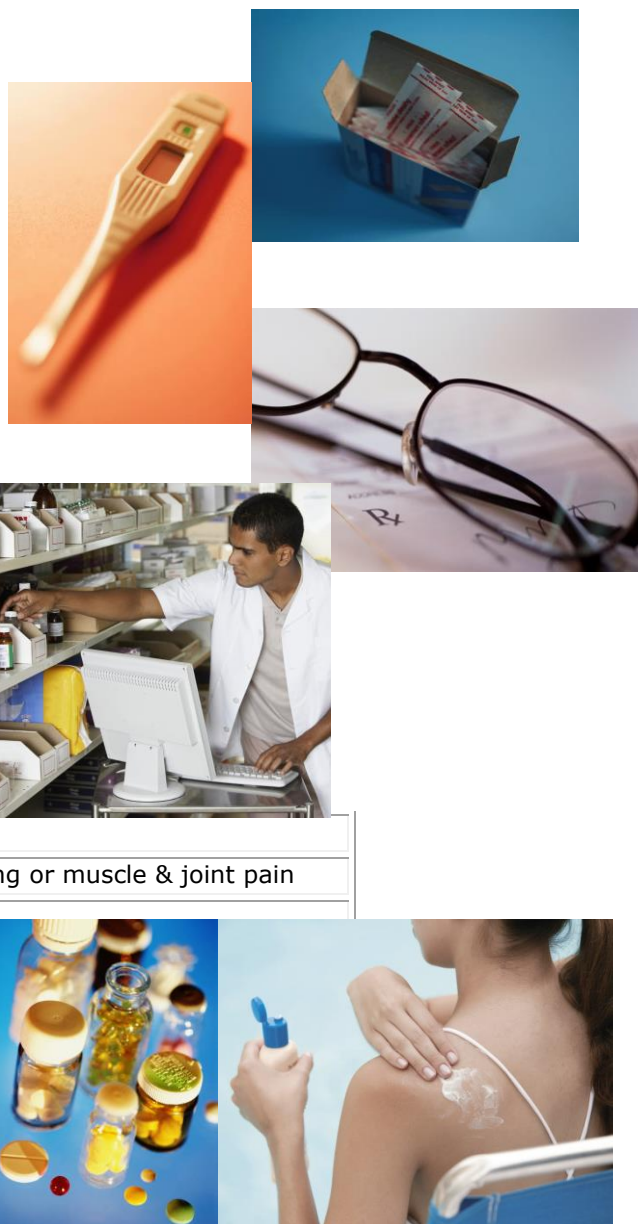
Menstrual cycle products for pain and cramp relief

Special Ointments/Creams and Rubs: for sunburn pain and healing or muscle & joint pain

Liquid adhesive for small cuts

Nicotine gum or patches for smoking cessation

Sleeping aids used to treat occasional insomnia



Frequently Asked Questions

This packet is only a brief overview of benefits that may be eligible under your plan. You should consult your Summary Plan Description for specific information about your plan.

Who can participate in the Plan?

All employees meeting eligibility requirements established by their employer may participate in the Plan.

Please note: IRS requires Employees to be **eligible** for enrollment under Employer's Group Health Plan to be eligible to enroll in Health FSA Account. This rule does not apply to Dependent Care.

How do I sign up?

Assuming eligibility has been met, Employers will provide access to enrollment prior to each Plan Year.

How do I determine how much money to allocate?

Be conservative! Consider your known expenses and not for what *might* happen. For dependent care, allow for ineligible times such as vacations or when you will not be paying the dependent care provider. A list of eligible expenses and a worksheet in this packet may help you calculate expenses.

Are there limits to what you may contribute to your FSA?

Yes, the maximum annual amount for the Health Care FSA and Dependent Care FSA is printed in your Summary Plan Description provided by your Employer and Plan Specific Page included in this packet.

I went to the doctor before the plan year began, but I did not pay the expense until after the plan year started.

May I include that expense?

No. Date of Services determines eligibility not date of payment. Charges must be incurred within the plan year

Can I change my annual allocation anytime during the Plan Year?

You may change your annual allocation under criteria for eligible status changes as defined in your Employer's Plan. Examples of qualifying changes in status are marriage or divorce, death of a spouse or dependent, birth or adoption of a child, and change in your employment or in your spouse's employment. Status changes must be consistent with the status change event. Please consult your Summary Plan Description for complete details.

What happens if I do not use all my annual allocation?

The IRS has established a "use it or lose it rule." If you do not use all your annual allocation, you will forfeit any remaining amount. For example, if you allocate \$500 and only submit \$450 in expenses, you will lose the \$50. We recommend being conservative when you determine your annual allocation, especially at first. **Please note, your Employer offers a carryover option. This option allows up to \$500.00. Please see Carryover page for more details.**

What expenses are eligible under the Flex Plan?

A summary of eligible and ineligible expenses is included in this packet. New rules for Over-the-Counter Medicines are also explained. See Next topic for details. Please pay special attention to the orthodontia claims submission requirements for your Plan which are listed on the Plan Specifics page.

Are Over-the-Counter Medicines or Drugs eligible?

Over-the-counter medicines may not be reimbursed through a FSA, HRA, or HSA, unless the medicine is prescribed by a physician. The new bill does not apply to items that are not medicines, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits. Such items may qualify as medical care if they otherwise meet the definition in Code §213(d). (Code §213(d) defines "medical care" to include amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.")

Can I sign up for the Dependent Care plan and still take the Dependent Care tax credit on my annual tax return?

The amount you pledge towards the Dependent Care account reduces the amount you can claim as a tax credit, dollar for dollar. Most employees (depending on your family income) will experience a higher tax savings on the Dependent Care Plan. You should consult with your accountant to see which option works best for your situation.

What happens if I terminate my employment?

You may still submit eligible receipts for expenses incurred within the time frames established by your Employer. Also, you may be eligible to continue coverage under the Health Care FSA option through federal COBRA regulations.

How do I submit a claim for reimbursement?

For Health Care FSA expenses, the quickest way for payment is to log into your online account (or mobile app), registration may be required.

<https://keybenefit.wealthcareportal.com/Page/Home>

After you log in, Select Claim, My Claim Activity then select "Submit Claim". Our Claims Administrators will then review your submitted reimbursement request(s). Copies of receipts for Health Care FSA expenses must be uploaded with your request for reimbursement. In this reimbursement method, you will be asked to agree to the conditions for reimbursement therefore, eliminating the need for you to complete a claim form.

If you choose to manually submit a claim, copies of receipts for Health Care FSA expenses must be submitted along with a signed claim form. Manual claims may be faxed, mailed or emailed to the address listed on the claim form.

All receipts must be independent third-party receipts showing the name of the provider, the date of service, the type of service, the amount of the service and the patient's name. If your insurance company covers the expense, please submit the receipt to the insurance company first. You may then forward a copy of the Explanation of Benefits from the insurance company along with the signed claim form to FlexPro. Cancelled checks and credit card receipts (unless itemized) are not eligible as receipts for Health Care FSA expenses. The total amount of reimbursement you selected for the Plan Year will be available at all times during the Plan Year.

For Dependent Day Care FSA expenses, there are three ways to request reimbursement.

1. You may complete the Automatic Dependent Daycare Reimbursement Agreement included in the Employee Information packet. This will automatically reimburse the amount listed on the form to cover the amount of the day care expense not to exceed your payroll deduction.

2. You may log into your account <https://keybenefit.wealthcareportal.com/Page/Home> and request reimbursement. Reimbursement of expenses incurred during the Plan Year shall not exceed the balance of your Plan Year Account at the time of the reimbursement.

3. If you choose to manually submit a claim, statements or receipts, which shows the day care provider's name & tax id number, the date of service, the amount of the service and the dependent's name along with a signed claim form. If you prefer, you may also complete the dependent care section of the claim form and have the provider sign, including the provider's tax id number. Reimbursement of expenses incurred during the Plan Year shall not exceed the balance of your Plan Year Account at the time of the reimbursement. Manual claims may be faxed, mailed or emailed to the address listed on the claim form.

Will I receive information throughout the year telling me where I stand on my account?

Yes, you will receive periodic reports via email showing what has been credited to your account. You may also access your personal account online at any time, by setting up your account at

<https://keybenefit.wealthcareportal.com/Page/Home>.

Will my participation in the Flex Plan affect my Social Security?

You will not pay Social Security taxes on the money you contribute to the Flex Plan. Therefore, your future Social Security benefits may be slightly reduced. However, the tax savings you receive from this plan should be more than any reduction in your Social Security benefits.

Section 125 Plan Specifics

City of Peru - 910

PLAN YEAR: 01/01/2020 - 12/31/2020

PLAN OPTIONS			
Premium Plan Option	Plan Maximums		Plan Minimums
Health FSA Plan Option:	\$ 2,750.00	FSA Option Minimum:	
Dependent Care (DCA)FSA Plan Option:	\$ 5,000.00	DCA Option Minimum:	
Plan Maximum Totals	\$ 7,750.00 Total Premiums		
Eligibility Requirements:			
Employees must work 30 hours per week and may begin participation immediately.			
Participation in the Premium Plan Option by New Hires:			
Annual Open Enrollment			
Participation in the Health FSA Plan Option by New Hires:			
Upon Eligibility			
Participation in the Dependent Care FSA Plan Option by New Hires:			
Annual Open Enrollment			
Participation by Terminated Employees in the Health FSA:			
Terminated Employees will be allowed 0 days past termination to continue incurring expenses and 90 days to submit.			
Participation by Terminated Employees in the Dependent Care FSA:			
Terminated Employees will be allowed 0 days past termination to continue incurring expenses and 30 days to submit.			
Premium Deductions:	Premiums will automatically be deducted as pre-tax without a signed Waiver of Participation form on file.		
Claims Submission:			
Claims must be received by noon EST Friday for checks issued Wednesday. Checks issued weekly. Checks issued Weekly.			
Orthodontia Services:			
Your Employer offers Up Front Orthodontia payments. The total reimbursement for orthodontia services may be made as services begin provided the participant actually paid for those service in full at the beginning of treatment.			
or			
At the time services begin, the initial down payment may be reimbursed. The remaining balance is reimbursed according to the monthly payment structure outline in the Orthodontia contract. A copy of the Orthodontic contract must be provided to KBA-Flexpro at time of reimbursement.			
Carryover Option FSA:			
If a balance remains in the account, an amount up to \$500 will be transferred to the next plan year.			
Grace Period: DCA only for carryover enable Employers			
Runout Period: Flexible Spending (FSA), Dependent Care (DCA):			
Claims must be submitted no later than 90 days after the end of the Plan Year.			
Note: Paper claims should be submitted during this runout time.			
Notification Timeframe for Status Changes:			
Status changes must be submitted within 30 days of the qualifying event.			

HEART ACT	
HEART Act - Qualified Reservist Distribution (QRD) Amount:	The amount contributed to the Health Care FSA as of the date of the QRD request minus any reimbursements (recommended).
HEART Act - Medical Expenses Incurred After the Qualified reservist distribution (QRD):	Permit employees to continue to submit Health Care FSA claims incurred before the end of the Health Care FSA plan year (and grace period, if applicable).

Claims may be submitted to:	
	Mail: Key Benefit Administrators - PO Box 1179 – Ft. Mill, SC 29716-1179
	Fax: 866-241-1488 or 844-560-6757
	Email: Flexpro@keybenefit.com or keybenefit_receipts@alegeus.com
	Online: https://keybenefit.wealthcareportal.com/Page/Home
	Download our Mobile APP to access many of our website features from your smart phone or tablet - Android or Apple
	<u>Get the most out of an FSA qualified account – visit: fsastore.com/FlexPro</u>

Substantiation Requirements

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Substantiation Request

The following substantiation criteria may be required.

- Name of Patient
- Date of Service or Date of Purchase
- Name of Provider or Merchant
- Type of Service or Supply
- Amount of Service or Supply
- Copy of prescription as required (over-the-counter medicines, etc.)

Please note: Cash register receipts or credit card receipts are NOT ELIGIBLE unless the receipt includes the information outlined above.

Substantiation and/or Claim Form Submission

You can submit responses to substantiation requests and/or claims for reimbursement several different ways. Please be sure to include a signed claim form, including detailed receipts/invoices when you are submitting substantiation or requesting a reimbursement.

On-Line Submission – If applicable, substantiation information and/or requests for reimbursement may be uploaded directly to your personal account at <https://keybenefit.wealthcareportal.com/Page/Home>.

Please see the “[Online Account Access](#)” section of this document for more information on setting up and using your online account.

Fax Submission - Please fax your substantiation/claims to (866) 241-1488 or questions to (844) 560-6757

Email Submission - You may also submit your substantiation or claim requests via email at keybenefit_receipts@alegeus.com or questions to flexpro@keybenefit.com.

Note: PDF and JPG format of the receipts preferred. Links and Encrypted documents may not pass through security software.

Mail Submission - Mailed substantiation information and/or claims should be sent to:

KBA FlexPro
P.O. Box 1179
Ft. Mill, SC 29716-1179

You will find a Claim Form within this Employee Information Packet.

Flexible Benefits Carryover Option

City of Peru - 910 has elected the Carryover Option.

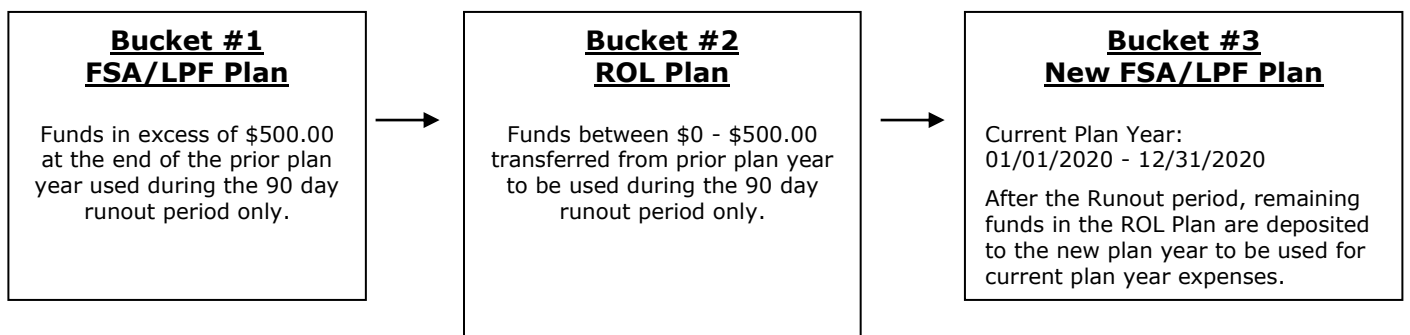
Q: What is the Carryover Option?

A: The Carryover Option is an IRS regulation change affecting how FSA funds may be handled at the end of the Employer's plan year. Employers may elect to allow employees to carryover up to \$500.00 for the duration of the Employer's Run out Period. Electing to adopt the Carryover option automatically disallows any Grace Period in effect for any Flexible Spending (FSA) or Limited Purpose Flex (LPF) type plans. For Employers with the Grace Period Option, it would continue to be in effect for any Individual Premium or Dependent Care (DCA) type plans unless specifically amended to remove the Grace Option for the entire Employer Benefit Plan.

Q: How does the Carryover affect eligible transactions and reimbursement requests?

A: Funds up to \$500.00 from the Employee's FSA/LPF accounts will be rolled over to a Rollover (ROL) Plan on the first day of the next plan year.

- **Bucket #1** - As of the first day of the new plan year, balances exceeding \$500.00 will remain in the prior year account. In order to use these funds, you will need to submit a manual claim form (or upload to www.mywealthcareonline.com/flexpro). These funds can **only** be used during the 90 day runout period and for prior year expenses **only**. Note: At the end of the runout period, any unused funds not rolled over will be forfeited.
- **Bucket #2** - As of the first day of the new plan year, balances between \$0 - \$500.00 will be moved to Bucket #2, Rollover (ROL) Plan. These funds can be used for **both current** year and **prior** year expenses during the 90 day runout period. In order to use this money, you will need to submit a manual claim form (or upload to www.mywealthcareonline.com/flexpro). Note: at the end of the runout period, any unused funds will be rolled over to the current plan year.
- **Bucket #3** - Once the 90 day runout period is over, funds remaining in Bucket #2 Rollover (ROL) Plan will be transferred to the FSA/LPF account for the current plan year to be used for current year expenses in addition to any funds elected for the new plan year.



Employee Experience

FlexPro Website:

Employee web access is available 24 hours a day, 7 days a week. Employees can review their accounts online for pending or ineligible transactions. Unresolved, pending, or ineligible transactions may result in the temporary deactivation of Flex Benefit cards, where applicable, until the transactions are resolved.

- Employee website: <https://keybenefit.wealthcareportal.com>

Create your account:

When you first log in for the 1st time you will need to complete some setup steps: You will need to Create a User Name. If you receive a message that the one you want is already in use, add numbers or letters to make your user name unique in the FlexPro system. You will also choose your own secure password to let you log in the first time. Complete the fields for your demographics: **your name, email address, preferred email, mobile phone number and Employee ID** FlexPro will be using your SSN with no extra spaces or characters – **Example: 666456789**

You will need your Employer ID for your registration ID or if, your Employer offers a debit card and you have that in hand, your debit card number. Complete the final fields and follow the instructions to complete the set up.

- **Your Employer ID is "KBA009100"**

FlexPro Upload Feature:

Upload Claims for Reimbursement and Receipts for pending Debit Card transactions directly from a PC, tablet or your smartphone. Some tablets and phones do require the mobile app to present all available features. FlexPro is mobile optimized but carrier and phone version may interfere. You can check your claim history, find any unresolved transactions and upload directly to that transaction any required documentation. You can also download forms for your account, including a claim form.

E-Mail alerts:

FlexPro will send you notices about your account when we have an email address in your account. You can log in and opt in and out so only the ones you wish will be sent by email for regular communications. Many notices are also sent directly to participant portal. Options for notices are for situations occurring with your account: confirmation when you change your email or address and when we have received claims you have submitted. You will also be sent regular plan year notices important for the plan and your account balance throughout the plan year.

Mobile Phone Alerts:

Use your online account to set up SMS text alerts for common communications. Find out when the claim you submitted has been entered or set your annual plan reminders to avoid missing the plan deadlines for turning in claims. You will need to have an online account to set this up. Some charges may apply depending on your phone provider. With a mobile phone number receiving alerts via text message

Text "Bal" to 97487 to receive your current balance

Web Chat:

No time for a phone call? Have Flex questions while at work? No problem! Just open the website

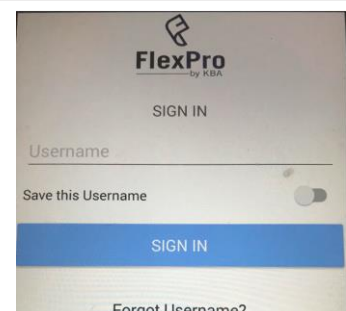
<https://keybenefit.wealthcareportal.com> and look for the **FlexPro Chat** link on the left side. Click, then begin chatting with FlexPro staff any time during normal business hours (8am-5pm Monday through Friday).

Virtual Client Representative:

Use the FlexPro customer service number to call anytime, day or night. Listen to the prompts and follow the steps. You will be provided a list of current options available. If you call during regular business hours, you can opt out to speak with FlexPro staff by calling

- **800-558-5553 (8am-5pm EST)**

FlexPro Mobile: Employees can download the app from the App Store or Play Store by searching "FlexPro Mobile". Employee accounts must be registered with <https://keybenefit.wealthcareportal.com> in order to use this application on mobile devices. Once installed, Employees can log in with the ID information used in their registered account. Check your balance, add dependents, request new cards, update your address and more from your phone or tablet. See the Upload feature for a quick way to submit documentation for unresolved transactions and to submit new claims.



Fax or Email FlexPro:

While uploading your claim to the website is quickest, FlexPro offers another way to fax and email your requests for reimbursement and resolutions for pended transactions. Using either the fax number or email address below will direct your claim information and substantiation documents directly to the online portal for processing. *For emails, please send anything other than text as an attachment rather than pasting to the body of the message to prevent system errors reading the data.*

- **Fax: 844-560-6757 or 978-364-5086 | Email: KeyBenefit_Receipts@alegeus.com**

Direct Deposit Reimbursement Information

Your employer has also chosen the Direct Deposit Reimbursement option. This feature allows employees who elect it to receive their Flexible Spending Account reimbursements as a direct deposit (or ACH) directly into their bank account.

How Direct Deposit Works

Employees can either submit the Direct Deposit Authorization form (attached) to KBA FlexPro or set up their direct deposit through www.mywealthcareonline.com/flexpro.

Once your direct deposit is set up, any future claims submitted for payment would be processed using this feature (it will not apply to claims prior to the date the account was set up).

You will receive an email confirmation when the reimbursement is generated and the money will be deposited directly into your bank account within 2-3 business days from the time of the email. You do not have to wait for your check to be delivered in the mail and do not have to go to the bank to deposit or cash your reimbursement.

Employee website: <https://keybenefit.wealthcareportal.com>

KBA-FlexPro Flexible Spending Account - Enrollment Form

Employer City of Peru - 910	Employee Effective Date / /	(Required) SSN	(Required) DOB
Printed Employee Last Name	Employee First Name	EE Middle Initial	Gender (CIRCLE) M F
Printed Home Address	Printed City	State	(Required) ZIP CODE
Email Address:	Day Time Phone	Mobile Phone	
Number of Per Pays per Plan Year	Pay Roll Schedule	Department	

No, I do not wish to participate in any Employer sponsored Flexible Spending Accounts.

Yes, I am eligible for enrollment in my employer's Group Health Plan (GHP). I understand IRS regulations require me to be eligible to enroll, however I am not required to participate in my employer GHP to participate in the Health Care FSA.

Yes, I wish to participate in any Employer sponsored Flexible Spending Accounts, see details below for my election. Pursuant to my Employer's Flexible Benefits Plan ("Plan"), I elect to have my salary reduced by the total pre-tax amount specified below. I authorize my Employer to apply that amount toward those plan benefits listed on this form with the total to be distributed among each benefit as shown.

Health Care Flexible Spending Accounts Expenses	Your Maximum Health Care FSA is \$ 2,750.00.
# of deductions from effective date:	_____
Per Pay Period Health Care Expenses (not paid by insurance)	\$ _____
Annual Health Care FSA Total	\$ _____

(I understand if my spouse participates in an HSA at their employer, I may not be able to participate in this general Health Care FSA.)

Dependent Day Care (DCA) Flexible Spending Account Expenses	Your maximum DCA is \$ 5,000.00
# of deductions from effective date:	_____
Per Pay Period Dependent Care Expenses	\$ _____
Annual Dependent Day Care Total	\$ _____

Employee Signature _____ Date _____

My Signature indicates I have read, understand and agree to the following:

Understand and agree to the following:

- I cannot change or revoke my election until the next Plan Year unless my Status changes (as defined in my Employer's Plan). I understand my benefit elections may not be reduced below the amount that has been taken pre-tax as of the date of the status change.
- Any funds remaining in my reimbursement accounts at the end of the plan year will be forfeited by IRS regulations to my employer.
- If my employment terminates for any reason, I understand expenses must be incurred and submitted within the time frames set out in the Plan.
- I understand that any receipt I submit must be for an eligible expense incurred by me, my spouse or my qualified dependent(s) during the applicable Plan Year.
- Before the first day of each Plan Year, I will be offered the opportunity to modify my elections for the following Plan Year.
- My Employer may reduce or cancel the election of any non-taxable benefit or otherwise modify my election in accordance with the Plan if my Employer in its discretion, deems that action advisable to satisfy the requirements of the Internal Revenue code or the regulations there-under.
- Dependent Care expenses for the care of a qualifying individual that are for purpose of enabling the employee and the spouse, where applicable to be gainfully employed or attend school full-time are eligible. Dependent Care may not be reimbursed while on Leave of Absence (LOA). Exception for short, temporary absences. An absence of no more than 2 consecutive calendar weeks is considered a short, temporary absence. A taxpayer who is gainfully employed is not required to allocate expenses during a short, temporary absences from work, such as for vacation or minor illness, provided that the care given arrangement requires the taxpayer to pay for care during the absence.*
- Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to be included in the enrollment. Individuals may request enrollment for such children for 30 days from the date of notice.

* Subject to state/local laws.

Flexible Benefit Medical Plan Claim Form

Did You Know? You can submit your claim online <https://keybenefit.wealthcareportal.com/Page/Home>

Employer: City of Peru - 910

Employee Last Name*	Employee First Name* & Middle Initial	Employee Effective* / /
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Social Security Number*	Email Address	Date of Birth* / /
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Home Address*	City*
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State*	Zip Code*	Phone ()	Mobile Phone ()
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Yes, there are changes to my information. Please update my records to match

***I Understand and Agree that:** To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses with the date of service incurred by me, my spouse, or my qualified dependent(s) during the applicable plan year. I certify that these expenses have not been reimbursed by any other source, nor will any reimbursement be sought from any other source. By signing and submitting a Dependent Care Reimbursement Request, I am certifying that expenses for which I request reimbursement satisfy all dependent care guidelines. I and my spouse, where applicable, are gainfully employed or am/are a full-time student and not on leave. In accordance with the Flex Benefit Plan, I authorize my Flexible Spending Account(s) to be reduced by the amount requested.*

Employee Signature (Required for Reimbursement): _____ **Date:** _____

NOTE: THIS SIGNED FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

A Few Reminders:

- Medicare Expenses:** Expenses that may be covered by your (or your spouse's) medical, dental or vision plan must first be submitted to the appropriate insurance carrier. The Explanation of Benefits (EOB) you receive from your insurance carrier may then be submitted to Key Benefit Administrators - FlexPro as a qualifying receipt towards your FSA Plan. Medical care receipts must be from an independent third party and must include the Name of the Patient, Name of the Provider, Type and date of Service or Supply provided (Names of Prescriptions are required), and the Amount of the Service or Supply. Receipts for eligible Over-the-Counter (OTC) drugs or medicines must include the same information as listed above. If necessary, please add additional pages. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. Cancelled checks are not acceptable receipts. This form must be signed and submitted with applicable receipts.
- Request for reimbursement may be submitted online. This form is not required when you submit your claim from your personal online account. If you have not already set up your personal online account today at <https://keybenefit.wealthcareportal.com/Page/Home>
- To claim mileage, you must provide map quest, google maps, etc. showing the distance traveled for medical care. This can be for doctor visits, hospital visits and picking up a RX.
- The cost of **Over-the-Counter medicines may not be reimbursed** through a Health FSA, HRA, HSA, **unless the medicine is prescribed by a Physician.** Copy of prescription from Physician is required.

• Flex Card Substantiation Mark for YES

Name of Patient or Dependent	Date(s) of Service	Name of Provider or Merchant	Type of Service or Supply	Charge for Each Supply/ Service	
				\$	
				\$	
				\$	
				\$	
# of pages Submitted			Total	\$	

CLAIMS: FAX: 844-560-6757 EMAIL: keybenefit_receipts@alegeus.com MAIL: PO BOX 1179 FORT MILL, SC 29716

FlexPro Mobile is available on the APP and Play Stores

If necessary, please add additional page(s).



Flexible Benefit Dependent Care Plan Claim Form

Did You Know? You can submit your claim online <https://keybenefit.wealthcareportal.com/Page/Home>

Employer: City of Peru - 910

Employee Last Name*	Employee First Name* & Middle Initial	Employee Effective* / /
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Social Security Number*	Email Address	Date of Birth* / /
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Home Address*	City*
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State*	Zip Code*	Phone ()	Mobile Phone ()
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Yes, there are changes to my information. Please update my records to match

I Understand and Agree that: To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses with the date of service incurred by me, my spouse, or my qualified dependent(s) during the applicable plan year. I certify that these expenses have not been reimbursed by any other source, nor will any reimbursement be sought from any other source. By signing and submitting a Dependent Care Reimbursement Request, I am certifying that expenses for which I request reimbursement satisfy all dependent care guidelines. I and my spouse, where applicable, are gainfully employed or am/are a full-time student and not on leave. In accordance with the Flex Benefit Plan, I authorize my Flexible Spending Account(s) to be reduced by the amount requested.

Employee Signature (Required for Reimbursement): _____ Date: _____

NOTE: THIS SIGNED FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Dependent Care:

Dependent Day Care receipts must include the Name of the Provider, Dates of Service, Name of the Dependent(s), Fee for Service or you may have your Dependent Day Care Provider complete and sign below (Original Signature required).

Dependent(DEP)(s) Name:	DEP Date of Birth	Date(s) of Service From	Date(s) of Service To	Fees for Service
				\$
				\$

Dependent Care Provider Name	Dependent Care Provider Tax ID or SSN
Dependent Care Provider Signature	Date:

CLAIMS: FAX: 844-560-6757 EMAIL: keybenefit_receipts@alegeus.com MAIL: PO BOX 1179 FORT MILL, SC 29716

FlexPro Mobile is available on the APP and Play Stores If necessary, please add additional page(s).

A Few Reminders:

- Dependent Care expenses for the care of a qualifying individual are for the purpose of enabling the employee and the spouse, when applicable, to be gainfully employed or attend school full-time are eligible.
- Dependent Care may not be reimbursed while on Leave of Absence (LOA). Exception for short, temporary absences.
- A taxpayer who is gainfully employed is not required to allocate expenses during a short, temporary absence from work, such as for vacation or minor illness, provided that the caregiving arrangement requires the taxpayer to pay for care during the absence.

NOTE: An absence of no more than 2 consecutive calendar weeks is considered a short, temporary absence.



Dependent/Spouse Add, Change Card Request* Form

NOTE: Provided Employee fields marked * ALL are required for enrollment and IRS Medicare Reporting.

Employer: City of Peru - 910					
Employee Last Name*		Employee First Name* & Middle Initial			Employee Effective* ... / /
Social Security Number*		Email Address			Department
Date of Birth* / /	Gender* F M	Phone ()		Mobile Phone ()	
Home Address*				City*	
State*	Zip Code*		Yes, there are changes to my information. Please update my records to match		

NOTE: Provided Dependent fields ALL are required for enrollment and IRS Medicare Reporting.

Card Issue	Gender	First Name	Last Name	SSN	Date of Birth
Spouse Yes No	M F				
Child Yes No	M F				
Child Yes No	M F				
Child Yes No	M F				
Child Yes No	M F				
Child Yes No	M F				

***Employer Plans and Flex Benefit Cards:** Employer Plan designs may prohibit the use of Benefit Cards for all or restrict Dependent access. All Employees and dependents will be enrolled according to the Plan and enrollment form. Card requests will be processed according to the Employer's Plan regarding cards.

Disclaimer: Cardholder must be age 18 or older and considered as eligible to be a dependent under Employer Plans. Dependent funding will be determined by current Plan set up.

I UNDERSTAND AND AGREE THAT:

- ✓ By completing and signing this form, I am requesting the listed dependents added to my employer sponsored Plan and when indicated to have a Card issued to them in their name. I accept responsibility for all Card transactions by any of the issued Cards for my Employer Sponsored Plan and confirm they are for expenditures incurred within the Plan Year.
- ✓ Each time the Flex Card is presented for payment, the signed receipt will evidence the expense has been incurred within the Plan year dates, is a qualified expenditure and has not been nor will be reimbursed in any other way.
- ✓ Upon request from FlexPro, I will immediately submit required documentation for the resolution of pending Card transactions.
- ✓ If Cards are used for unqualified expenditures as determined by FlexPro in administration of the Plan, I have violated this Agreement and my obligations under my Employer's Plan. When requested by FlexPro on behalf of the Plan, I must immediately re-pay unqualified expense amounts back to the Account. Access to Cards may be immediately suspended or revoked for failure to comply.

Employee Signature _____ Date _____

Direct Deposit Authorization Form

Employer: City of Peru - 910				
Employee Last Name*		Employee First Name* & Middle Initial		Employee Effective* / /
Social Security Number*		Email Address		Date of Birth* / /
Home Address*			City*	
State*	Zip Code*	Phone ()	Mobile Phone ()	
Yes there changes to my information. Please update my records to match				

TWO WAYS TO CHOOSE TO SIGN UP:

Choice #1:

1. Log on to: <https://keybenefit.wealthcareportal.com/Page/Home>
2. Select your username and then under profile select edit profile.
3. Enter your bank information – see Sample Screen Image Below

OR

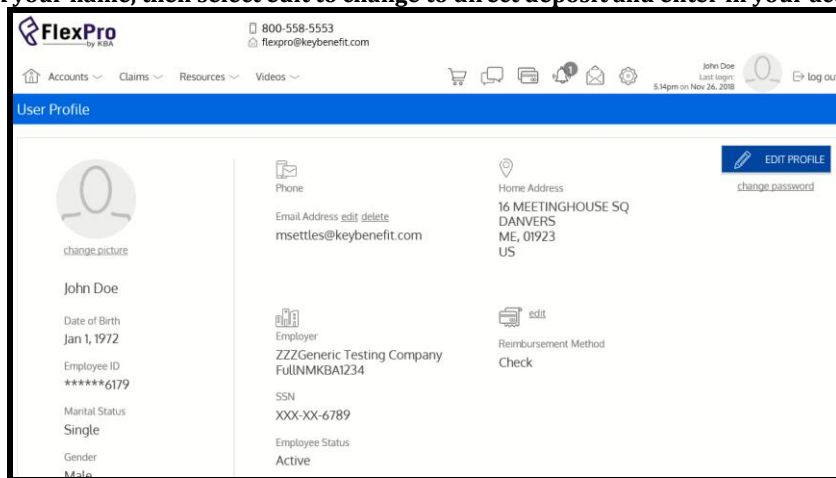
Choice #2: Complete, sign and return this form. Please allow 5 business days for processing.

Type of account:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings**
Financial Instruction Name	
Account Number:	
Transit Routing Number:	
**Use the TRN from your Checking Account, not the number on the Savings Deposit Slip	
Employee Signature	Date

Disclaimers

- You may update your direct deposit information online anytime.
- No need to submit this form if enrolling for the Direct Deposit feature online.
- Claims processed before the direct deposit is set up will be paid by check
- Bank Deposits failures may be assessed a \$30.00 fee for account corrections. This includes but is not limited to:
- Rejections due to bank changes not provided to FlexPro resulting in failed deposits
- Employee online entry errors resulting in failed deposits
- Submitted documentation with incorrect account and or routing data resulting in failed deposits

Sample Screen Image: Click your name, then select edit to change to direct deposit and enter in your account information.



Automatic Dependent Daycare Reimbursement Agreement

Plan Effective date-01/01/2020 - 12/31/2020			
Employer: City of Peru - 910			
Employee Last Name*		Employee First Name* & Middle Initial	
Social Security Number*		Email Address	
Date of Birth* / /		Employee Effective* / /	
Gender* F M		Phone ()	
Home Address*		Mobile Phone ()	
State*		City*	
Zip Code*		Yes, there are changes to my information. Please update my records to match	

Dependent Care Information

I request an automatic reimbursement of the amount listed below for Dependent Day Care to cover the amount of day care in an amount not to exceed my payroll deduction:

Day Care Provider:			
Day Care Provider Address:		City	State
			Zip Code
Tax Identification Number:		Day Care Phone Number () -	
Child Name:	Date of Birth:	Weekly Rate: \$	
Child Name:	Date of Birth:	Weekly Rate: \$	
Child Name:	Date of Birth:	Weekly Rate: \$	
Day Care Provider Signature:			Date:

Reminder:

- Dependent Care expenses for the care of a qualifying individual that are for enabling the employee and the spouse, when applicable, to be gainfully employed or attend school full-time are eligible.
- Dependent Care may not be reimbursed while on Leave of Absence (LOA). Exception for short, temporary absences. An absence of no more than 2 consecutive calendar weeks is considered a short, temporary absence.
- A taxpayer who is gainfully employed is not required to allocate expenses during a short, temporary absence from work, such as for vacation or minor illness, provided that the care giving arrangement requires the taxpayer to pay for care during the absence.

All changes in amounts of automatic reimbursement will require a new form be completed and forwarded to the Flex Department:

FlexPro @ Key Benefit Administrators	P.O. Box 1179	Ft. Mill, SC 29716-1179
Toll-Free Fax: 866-241-1488	Or 844-560-6757	
Email: flexpro@keybenefit.com	Or keybenefit_receipts@alegeus.com	

I certify that these charges are eligible Dependent Day Care expenses under the Internal Revenue Code and that I will not request reimbursement from any other source. I also certify that these services will not be claimed as a credit on my personal income tax return.

I understand that it is my responsibility to advise Key Benefit Administrators of any changes to my arranged day care fees in writing one week prior to the reimbursement date.

Employee Signature _____ Date _____