2020 Flexible Spending Enrollment Packet

Welcome to the flexible spending plan with SISCO! We look forward to assisting you in navigating the reimbursement plan you elected.

SisCo
Experience the Benefits

800 Main Street | P.O. Box 389 | Dubuque, IA 52001 | 1.800.457.4726 | www.SiscoBenefits.com

Table of Contents

Definitions

Flexible Spending Plan

IRS Section 125 (Flexible Spending Reimbursement) is available to you as an employee benefit. Flexible spending allows you to pay for certain expenses through a pre-tax payroll deduction which can result in *significant* tax savings. Please be aware if the scheduled processing day falls on a holiday or weekend your claims will be processed one business day prior. Plan your flex submissions accordingly.

Medical Reimbursement

Your medical/dental reimbursement plan will allow you to pay for out-of-pocket expenses with pre-tax dollars. For any tax-deductible health care expenses not covered by a health plan or other insurance, you simply complete a Flexible Spending Claim Form, attach the appropriate bills/receipts or explanation of benefits from your other insurance carrier, and send it to SISCO.

Dependent Care Reimbursement

Your dependent care expense plan allows you to pay for expenses that are incurred for the care (daycare, babysitting) of a qualifying dependent, or for related household services and are incurred for you to be gainfully employed. Submit a claim form for dependent care expenses actually incurred and you will be reimbursed from your Flexible Spending Account with pre-tax dollars that were deducted from your payroll.

The IRS requires that Form 2441 be filed with your Federal Income Tax Return, if you participate in a dependent care plan, listing the providers name, address, and social security or tax I.D. number.

Advantages of a Flexible Spending Account

A Flexible Spending Account (FSA) allows you to save up to 30% on your eligible healthcare and/or dependent care expenses every year by using pre-tax dollars. Consider how much you spend on healthcare and/or dependent care expenses for you and your qualified dependents in one year:

- Prescription drugs/medications
- Medical/dental office visit co-pays
- Eye exams and prescription glasses/lenses
- Vaccinations
- Daycare tuition

By using pre-tax dollars, you are taxed on a lower gross salary, thereby saving money that would otherwise be spent on federal, state and FICA taxes, and thereby you increase your take home pay.

Estimated Tax Savings		
	Not Enrolled in FSA	**Enrolled in FSA**
Gross Pay	$38,000	$38,000
FSA Contribution	$0.00	$2700.00
Taxable Income	$38,000	$35,300.00
15% Federal Taxes	($5,700.00)	($5,252.50)
4% State Taxes	($1,520.00)	($1,364.00)
7.65% FICA Tax	($2,907.00)	($2,654.28)
Medical Expenses	$2700	$0.00
Take-Home Income	$25,223.00	$25,879.23
Take Home increases by $656.23		

Use the below to estimate your election		
	Not Enrolled in FSA	**Enrolled in FSA**
Gross Pay		
FSA Contribution		
Taxable Income		
15% Federal Taxes		
4% State Taxes		
7.65% FICA Tax		
Medical Expenses		
Take-Home Income		

Based on the above graph, adding a flexible spending account can increase your net take-home pay by $706. (This is for illustration only. Actual dollar amounts may vary.)

Frequently Asked Questions

What is the benefit of participating in a flexible spending plan?

By signing a participating agreement, you agree to have your salary reduced by the agreed upon amount. Therefore, you are not responsible for federal income tax withholding or FICA on the amount of the reduction, thereby saving you 7.65% on FICA, plus whatever income tax you would be obligated to pay on this amount. While it's true that you forfeit unused money from your flexible spending account, you can still come out ahead even if you don't use all the money in your account.

When do I make my election?

You need to make your election during open enrollment at your employer. This usually occurs once per year prior to the start of the new plan year. The start of the plan year may vary.

Can I change my benefit election mid-year?

Changes can be made due to the qualifying events listed below and must be made within 31 days of the event. You may change your reimbursement election if you were enrolled in the plan prior to the qualifying event and you wish to change your election.

Medical reimbursement accounts can be changed with a qualifying event (i.e. marriage, divorce, death or a spouse or child, birth or adoption of a child, termination of employment of your spouse, or a change in work schedule).

Dependent care reimbursement accounts can be changed with a qualifying event (i.e. birth or death of a child, adoption of a child, dependent is no longer eligible for daycare, change in employment status thus changing the need for daycare, changing daycare providers, or a cost increase or decrease in daycare).

What happens if my reimbursement request exceeds the balance in my account?

Your medical reimbursement account claims will be paid in full, up to the annual amount you have elected to have withheld for that plan year.

Dependent care reimbursement account claims will be processed and paid up to the balance in your account. If your claim exceeds that balance, SISCO will automatically reprocess your claims as your balance allows.

Please note: *the medical reimbursement account is separate from the dependent care account. Balances cannot be transferred from one account to the other.*

What happens to the money in my account if I should terminate employment?

You would be entitled to reimbursement for expenses which were incurred within the same plan year and before your termination date. Your plan allows you to submit claims up to 90 days after termination in the plan. If you do not have any claims to submit that were incurred prior to your last day of employment the funds may be forfeited.

When can I incur claims?

Your plan year allows you to incur claims from June 1, 2020 through May 31, 2021.

What happens to any money left over at the close of the plan year?

The Plan allows reimbursement in the year of the election. There are no extensions if there is money left in the account. This is why it's so important to enroll in what amount you know will be used. This is called a "Use it or Lose it" provision. Take precautionary steps, such as tracking your account balance online, contacting customer service at 1-800-457-4726 or emailing our flexible spending department at siscoflex@siscobenefits.com.

What is the filing deadline for claims submission?

You have 90 days to submit claims at the end of the plan year. The last day to submit claims is August 31, 2021

General Reimbursement Guidelines

- Reimbursement is not a guarantee without the correct documentation.
- Reimbursement of dependent care expenses will reduce and may eliminate your ability to claim dependent care credit on your Federal Tax Return.
- Health care expenses reimbursed through this account cannot be deducted on your Federal Income Tax Return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible dependents under the plan.
- Only the expenses for services or supplies furnished on or after the effective date of the plan can be submitted for reimbursement.
- Reimbursement of expenses should only be requested and made after you have collected all benefit payments available for all other insurance plans under which you and your eligible dependents are covered.
- Reimbursement will be made in accordance with the provisions of the plan. You accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

Eligible and Non-Eligible Expenses

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your federal income tax return (without regard to the 1% and 5% of adjusted gross income limitations).

This is a list of common reimbursable and non-reimbursable items under Section 502 of the Internal Revenue Code. This does not constitute legal or tax advice. For specific questions please see your plan administrator.

Eligible Expenses

Acupuncture	Infertility Treatments
Artificial Limbs	Insulin
Bandages	Lactation Expenses (Breast Pump, etc.)
Birth Control/ Contraceptive Devices	Laser Eye Surgery
Birthing Classes/ Lamaze	Legal Sterilization
Blood Pressure Monitor	Mileage to and from doctor appointments ($0.«Mileage_reimbursement_rate_» per mile)
Chiropractic	Nasal Strips
Contact Lenses	Orthopedic Inserts
Contact Solution	Physical Therapy
Co-Payments	Pregnancy Test
Crutches	Prescription Medication
Deductible/ Co-Insurance	Reading Glasses
Diabetic Supplies	Services Connected with Donating an Organ
Eye Exams	Sleep Apnea Services/ Products
Flu Shots	Smoking Cessation Programs
Glasses/ Safety Glasses (Prescription Only)	Treatment for Alcoholism or Drug Addiction
Hearing Aids and Aid Batteries	Vaccinations
Heating Pad	Wrist Supports
Incontinence Supplies	

Over the Counter Medication and Drugs

(Require a prescription or letter of medical necessity from your physician)

Pain Relieving Creams or Gels	Indigestion or Anti-Acid Relievers
Calamine Lotion	Laxatives
Canker/ Cold Sore Relievers	Nicotine Patch or Gum
Cold Medications	Pain Relievers
Diaper Rash Cream	Sinus Medications
Gas-X/ Baby Gas Drops	Suppositories
Hemorrhoid Creams and Treatments	Teething Gel
Hydrogen Peroxide or Rubbing Alcohol	Wart Removal Medications

Dental Expenses

Braces/ Orthodontic Services	Dental Implants
Cleanings	Dentures/ Adhesives
Crowns	Fillings
Deductible/ Co-Insurance	

Potentially Eligible Expenses

(These expenses are eligible only when incurred to a treat a medical condition. These expenses will require a Letter of Medical Necessity from your provider that will need to be submitted with your reimbursement request)

Ear Plugs	Support Hose
Massage Treatments	Varicose Vein Treatment
Nursing Services	Veneers
Orthopedic Shoes	Wigs (When hair loss is due to a disease)
Oxygen and Equipment	

Ineligible Expenses

Adoption Fees	Hand Sanitizer
Athletic Mouth Guards	Health/ Athletic club fees
Auto Insurance providing Medical coverage	Illegal Treatment or Medication
Child or newborn care instruction	Insurance Premiums
Cosmetic Procedure/ Surgery	Late payment fees
Cosmetic Supplies	Long term care services
Counseling (marriage)	Lotion or skin moisturizers
CPR Classes	Mattress
Deodorant	Medicare Premiums
Dental Floss	Missed appointment fees
Denture Cleaner	Non-prescription safety glasses
Diapers/ Diaper Services	Non-prescription sunglasses
Diet Foods	Nursing Home care
Dietary and Fiber supplements	Oral Care (over the counter), Chapstick
Distilled Water	OTC Drugs/ medications without a prescription
Education Classes	Personal use items (Pillows, shampoo, etc.)
Disaster Survival Kit (Non-Emergency)	Private Hospital Rooms
Exercise Equipment	Toiletries
Eye drops for comfort	Toothbrush/Toothpaste/Teeth Whitening
Eyeglasses case	Vitamins/ Supplements / Herbal Supplements
Hair Re-growth products/ Hair Removal	Weight Loss drugs/ programs for general well being

Instructions for filing a Flexible Spending Claim

To submit a claim for processing, fill out a reimbursement form. This form is available online at www.SISCOBenefits.com or by contacting our customer service department. The form must be signed and dated. Mail the completed form and attachment(s) to the address indicated on the reimbursement form.

Supporting Documentation for medical reimbursement

Documentation of the expense is required with the claim form. According to the IRS guidelines, the expense must process through all available health plans before reimbursement under a flexible spending plan is allowed. Here are two examples of approved documentation. A canceled check is not considered acceptable evidence.

Explanation of Benefits (EOB): This is the form you receive from your insurance company each time a claim is submitted to your health, dental, or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by health, dental, or vision plans, you must attach an EOB.

Receipts: Claims for medical/dental expense not covered by your group health plan cannot be processed without acceptable evidence of the expenses. Acceptable evidence includes receipts, which contain the following information:

- Description of service or supply
- Date expense was incurred
- Person or organization providing service
- Amount of expense
- Name of person (family member) for whom the service(s) were provided for

Supporting Documentation for dependent care reimbursement

Documentation of the expense is required with the claim form. There are multiple ways to submit for reimbursement. If you would not like to submit a manual claim, you are able to fill out the attached dependent care contract. The will allow you to be paid automatically throughout the year.

Receipts: Acceptable evidence includes receipts, which contain the following information:

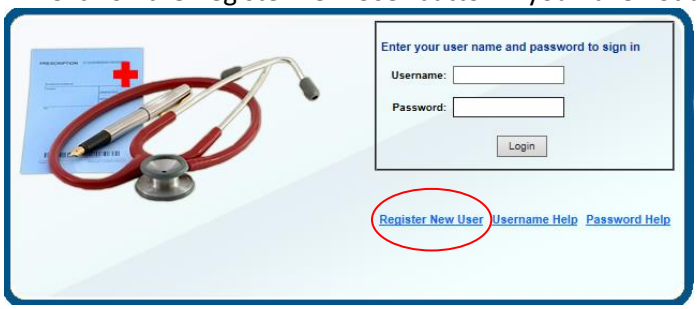
- Date expense was incurred
- Amount of expense
- Person or organization providing service (need tax ID or provider signature)
- Name of person (family member) for whom the service(s) were provided for

Accessing the Benefit Information Network

How To Register As A New User

1. Access the Benefit Information Network at www.siscobenefits.com and click on BIN Login.

2. Click on the Register new User button if you have not already signed up.

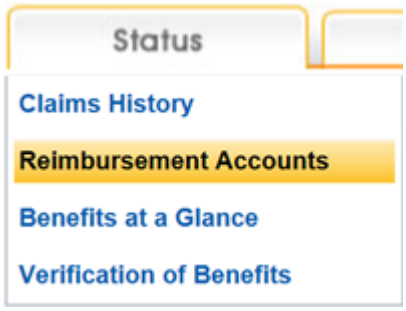


3. Enter your desired User ID and Password, and then enter your password again in the "Verify Password" section. If you are the person with the insurance coverage, you are the **SUBSCRIBER**. Click on the "I am the subscriber" button to continue.

   NOTE: If you have someone else who has insurance coverage under your plan that person can also create a User ID and Password, but they would click on the button that states, "I am a dependent of the subscriber".

4. Create your account by filling in the required data, which includes:
   - Your participant ID (this is the SSN of the employee)
   - Your last name (not case-sensitive)
   - Your zip code
   - Your date of birth
   - Email address and password hint are not required fields, but are extremely useful in the situation where you forget your user name and/or password.

5. Once you have registered successfully, you will see different tabs at the top of the page. Flexible Spending account information is under Status →Reimbursement Accounts.



6. You will see different areas that include a summary of your account, claim activity and contribution history. The summary will show any claim amount processed, rollover amounts and remaining annual pledge.

Summary

Participant ID:
Name:
Group Name:
Effective:

Contribution Summary	
Annual Employee Contribution	1300.00
Annual Employer Contribution	.00
Annual Other Contribution	.00
Total Annual Contribution	**1300.00**

Fund Balance Summary	
Rollover From Prior Year	.00
Interest Posted	.00
Contributions Posted	1100.00
Payments	531.32
Fund Balance	**568.68**

Claims Summary	
Claims Received to Date	3186.71
Ineligible Claims	.00
Applied To Deductible	.00
Claims Paid	1269.00
Claims Unpaid to Date	1044.94

Deductible Summary	
Annual Deductible	.00
Deductible Satisfied	.00

Pledge Summary	
Total Pledge	1300.00
Remaining Pledge	768.68

7. The Activity Detail will show any contributions and/or claims submitted.

Activity Detail

Transaction Date	Processing Date	Description	Amount
01/15/2016	01/14/2016	Employee Contribution	50.00
01/29/2016	01/29/2016	Employee Contribution	50.00
02/12/2016	02/11/2016	Employee Contribution	50.00
02/26/2016	02/26/2016	Employee Contribution	50.00
02/22/2016	02/26/2016	Payment	-531.32

8. The Contribution History will show all contributions into the account.

Contribution History

From Date	To Date	Qualifying Event	Contributor	Contribution Amount	Contribution Frequency	Annual Contribution
01/01/2016	12/31/2016	BEGINNING OF YEAR	Employer	0.00		0.00
01/01/2016	12/31/2016	BEGINNING OF YEAR	Employee	50.00	Biweekly	1,300.00

Contact SISCO with any questions at 1-800-457-4726 Monday – Thursday 7:00 a.m. to 7:00 p.m. and Friday 7:00 a.m. to 5:00 p.m. You can also email us at SISCOFlex@SISCOBenefits.com.

SISCO
Experience the Benefits

Flexible Spending Election Form

Hodge Company

June 1 2020 through May 31 2021
Plan Year 2020

Section I - Employee Information

Employee-Last Name First Name Initial	Date of Birth	Social Security Number

Street Address	City	State	Zip Code

Type of Election: ☐ Annual Election ☐ New Hire ☐ Family Status change * see below

Explanation for change in Family Status _____

Effective date of this election (date of first paycheck with flexible spending reduction) _____

Pay Period: Bi-Weekly

Section II - Flexible Spending Agreement

I hereby elect to have my salary reduced and a corresponding amount credited to my account in the elected plan(s) below. Any changes made through a qualifying event will be effective on the qualifying event date. I have read and understand the Summary Plan Description.

I agree to notify the Company if I have reason to believe that any medical care expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand for any liability it may incur for failure to withhold federal and state income tax or Social Security tax from any reimbursement I receive on any non-qualifying expenses.

Section 125 agreement:

☐ I authorize to have my premium contribution(s) for Medical and Dental Health (if any) withheld prior to taxes as provided in Section 125.

Medical/Dental Election:

☐ I authorize that my earnings be reduced in the amount of $_____ 26 deductions) for other medical/dental expenses, for a yearly contribution of $ _____ ($2750 maximum).

Dependent Care Election:

☐ I authorize that my earnings be reduced in the amount of $_____ (26 deductions) for dependent care expenses, for a yearly contribution of $ _____ ($5000 maximum).

Employee's Signature Date	Accepted by Date

Section III - Declining Flexible Spending Coverage

I hereby waive participation in the Hodge Company Flexible Spending Account Plan for 2020. I understand I will not be able to elect participation until the new plan year begins.

Employee's Signature Date	Accepted by Date

SISCO
Experience the Benefits

Flexible Spending Reimbursement Request Form

Participant Name:_____ Date of birth:_____

Participant ID#:_____ Group #:_____

MEDICAL/DENTAL/VISION EXPENSES -- ATTACH EOBS OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				
5				
6				
7				
8				

DEPENDENT CARE -- ATTACH EOBS OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				

I hereby certify that:

- The information given on this reimbursement form is complete and accurate.
- I have not previously received reimbursement for these expenses from this Flex account or from any other source.
- All health/daycare expenses listed above comply with the requirements and guidelines listed in the Flexible Spending plan document.

Signature_____ (Date) ____/____/_____

KEEP A COPY FOR YOUR FILES

Mail: Flexible Spending Dept., SISCO, P.O. Box 389, Dubuque, IA 52004-0389

Fax: 563-587-5703 Email: siscoflex@siscobenefits.com

Claims must be received at SISCO, two (2) business days before your scheduled flexible spending run.

SISCO
Experience the Benefits

Dependent Care Contract

This form is being submitted to establish that a contract for services exists between me and the individual/entity who has signed below in which I have agreed to purchase dependent care services for the period indicated. A new contract is required each year.

Participant Information

Employee Name:_____ SSN#:_____

Address:_____

City:_____ State:_____ Zip:_____

Day Care Contract

My Contract Year will begin on_____, and will end on_____.

Provider's Name:_____

I/We agree to provide day care services for the above mentioned employee. This service will be provided on the following basis:

Time Period	Frequency	Rate of Pay
_____AM	Daily	$_____Hourly
To	Weekly	$_____Daily
_____PM	Monthly	$_____Weekly

Based on the above schedule, it is anticipated that the above mentioned employee will incur fees which will total, during the period stated above, a minimum of: $_____(per year)

Provider's Signature_____ Date _____

Title_____

Provider's SSN# OR EIN# _____

If the terms of this contract were to change at any time, you will need to contact us.

SISCO
Experience the Benefits

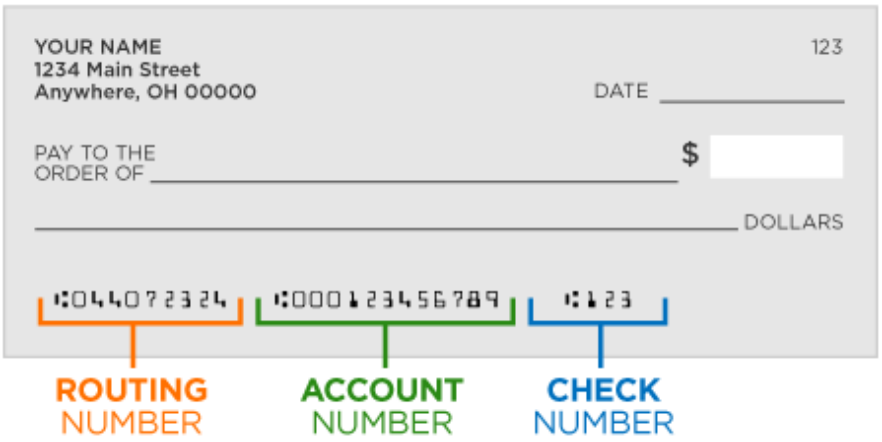
Direct Deposit Authorization Form

Automatic Direct Deposit of your FSA reimbursements is a convenient feature that many employees take advantage of that will save time for handling reimbursement checks. If you decide to take advantage of Automatic Direct Deposit, your FSA checks will be deposited automatically in any checking or savings account you select.

By completing the Authorization Form below, you are directing your employer and your financial institution to deposit your reimbursements to your checking or savings account.

Direct Deposit Form		
Group Name		Group Number
Participant Name		Participant ID
Participant Mobile Phone Number		Participant Email Address
Financial Institution		Financial Institution Phone Number
Financial Institution Address		
Checking/Savings Account Routing # -9 Digits		Checking/Savings Account # -6-13 Digits
Account is a checking or savings account	○ Savings	○ Checking

I hereby authorize my employer to deposit reimbursements from my Flexible Spending Account directly into my checking or savings account indicated above. I also authorize the financial institution names above to accept my deposits and to credit the amount to my account. This authority will remain in effect until my employer has received written cancellation notice from me in such time and such manner as to afford my employer a reasonable opportunity to act upon it.



Signature:_____

Date:_____

Please note: Direct deposit will continue year to year. If you signed up last year, you do not need to sign up again unless your account information has changed.

Please fax completed form to SISCO at 563-587-5703, mail completed form to PO Box 389 Dubuque Iowa 52004, or email completed form to siscoflex@siscobenefits.com.