

State of Wisconsin Department of Employee Trust Funds Section 125 Cafeteria Plan Summary Plan Description



As Adopted Effective: January 1, 1990
Amended & Restated: January 1, 2023

Note: This document should be reviewed and approved by the Employer's legal counsel prior to being amended.

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Introduction	4
Article 1: Administrative Information	5
Article 2: Eligibility, Enrollment, and Contributions	6
1. What advantages and disadvantages are there to participating in the Cafeteria Plan? ..	6
2. Who is eligible to participate in the Cafeteria Plan?	6
3. How do I become a Participant?	6
4. What are the election periods for entering the Cafeteria Plan?.....	7
5. Under what circumstances can I change my election during the plan year?.....	8
6. When does my participation in the Cafeteria Plan end?.....	8
7. When does participation of my dependents in the Cafeteria Plan end?.....	9
8. What happens to my participation in the Cafeteria Plan if I take a leave of absence?	9
9. How are my elected benefit options paid for under the Cafeteria Plan?.....	9
10. How long will the Cafeteria Plan remain in effect?.....	10
11. What happens if my request for a benefit under the Cafeteria Plan is denied?	10
12. Under what circumstances can I continue my coverage under the Plan or portions of the Plan, even when I terminate my employment or otherwise lose eligibility?	11
13. Will my health information be kept confidential?.....	12
Article 3: Benefits under the Cafeteria Plan	13
14. What benefit options are offered under the Cafeteria plan?	13
15. What benefit options under the Cafeteria Plan involve only the pretax payment of my share of the premiums?	13
16. What benefit plan options under the Cafeteria Plan involve a spending account?	13
Article 4: Health Care FSA and LPFSA	14
17. What is the Health Care FSA?	14
18. What is the LPFSA?	14
19. How do I receive reimbursement under the Health Care FSA or LPFSA?	15
20. What happens if I don't use all of the money in my Health Care FSA or LPFSA by the end of the plan year?	16
21. Is there a minimum election amount and carryover requirement for FSA?.....	17
Article 5: Health Savings Account	18
22. What is the HSA?	18
23. How do I receive reimbursement under the HSA?	18
24. What happens if I don't use all of the money in my HSA by the end of the plan year? .	18
25. What happens to my HSA if I terminate employment or otherwise cease to be eligible	

for the Plan?	19
26. What happens to my HSA when I turn age 65?.....	19
Article 6: Dependent Day Care Account Program (DCAP)	20
27. What is the DCAP?	20
28. How will I be reimbursed under the DCAP?	20
29. What happens if I don't use all the money in my DCAP by the end of the plan year? ...	21
30. What additional tax effects regarding the DCAP should I know about?.....	21
Article 7: Life Event and Annual Election Modifications.....	22
31. When may I change my election during a plan year?.....	22
32. How long do I have to make an election change from the Qualifying Life Event?	22
33. Can I increase the election amount to pay for expenses incurred prior to a Qualifying Life Event?.....	22
Appendix I – Tax Impact Examples	23

Introduction

This is the summary plan description (SPD) for the State of Wisconsin Section 125 Cafeteria Plan (Plan). This SPD is a description, in summary form, of the provisions of the Plan. This document and other descriptive materials provided to you by the State of Wisconsin Department of Employee Trust Funds (ETF), Optum Financial, or your employer are intended to be written in a manner that is easy to understand and to summarize the benefits available to you under the Plan. The Plan Document and the written component plans of the individual plans offered through the Plan contain more detailed information about plan benefits and requirements. This SPD is intended to contain a consistent description of the Plan benefits, however, should there be any conflict between this SPD and the Plan, the terms of the Plan prevail. ETF, the Plan Administrator, shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD.

The State of Wisconsin Group Insurance Board reserves the right to change, amend, or terminate the Plan and any of the component plans at any time and for any reason, compliant with state law. The Plan, any changes to it, and any payments to you under the Plan's terms do not constitute a contract of employment and do not give you a right to remain employed with the State of Wisconsin. You and your beneficiaries may obtain copies of the Plan, the component plans, and related documents or examine these documents by contacting ETF. Many of these documents are also available on ETF's website.

The Plan offers the following benefit options:

- Health Premium Payment Plan
- Dental Premium Payment Plan
- Vision Premium Payment Plan
- Employee Life Insurance Coverage Premium Payment Plan
- Health Care Flexible Spending Account (FSA) under Code sections 105, 106, and 125
- Limited Purpose Flexible Spending Account (LPFSA) (in correlation with a HDHP and HSA) under Code section 223
- Health Savings Account (HSA) (in correlation with a HDHP) under Code section 223
- Dependent Day Care Account Program (DCAP) under Code section 129

Each benefit plan option has its own separate, written component plan. This SPD contains summaries of each benefit plan option, along with a description of the basic features of the Plan. In the event of a contradiction between this document and a component plan, the component plan will control.

Article 1: Administrative Information

Purpose:	The purpose of this Plan is to allow Participants to pay for certain qualified benefits offered by the Employer on a pretax basis.
Name, address, and phone number of Plan Sponsor:	State of Wisconsin Department of Employee Trust Funds (ETF) 4822 Madison Yards Way Madison, WI 53705-9100 608-266-3285
Name, address, and phone number of Plan Administrator:	Same as above.
Federal Tax Identification, Wisconsin Retirement System:	39-1103756
Controlling Law:	Wisconsin
Plan Number:	Not applicable.
Initial Effective Date: (the date the Plan was first established)	January 1, 1990
Amended and Restated Date:	January 1, 2023
Plan Year:	January 1 through December 31
Affiliated Employers Participating in the Plan:	All State of Wisconsin agencies, as defined in Wisconsin Statute 40.02 (54) , and all campuses of the University of Wisconsin System.
Third Party Administrator (TPA):	Optum Financial, Inc. 307 International Circle, Suite 200 Hunt Valley, MD 21030 833-881-8158 of-service@of.optum.com FEIN #26-1274092 This TPA is contracted under Section 8.02 of the Plan Document for the following programs: Health Care FSA, LPFSA, HSA, and DCAP.

Article 2: Eligibility, Enrollment, and Contributions

1. What advantages and disadvantages are there to participating in the Cafeteria Plan?

By participating, you save both federal income tax and FICA (Social Security) taxes. Participation will reduce the amount of your taxable compensation. Accordingly, this could reduce your Social Security benefits and other benefits based on taxable compensation. [Appendix I – Tax Impact Examples](#) illustrates the potential impacts of participation in a Cafeteria Plan.

Contributions to an HSA, Health Care FSA, LPFSA, or DCAP will not reduce your gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, deferred compensation, unemployment, or Worker's Compensation.

Questions regarding the tax effects of this Plan should be addressed to your financial advisor.

2. Who is eligible to participate in the Cafeteria Plan?

All employees are eligible to participate on the first of the month that begins on or after the date the employee receives an enrollment form from their employer. An "employee," for purposes of the cafeteria plan, does not include independent contractors, temporary employees, and leased employees. Employees who participate in the Plan are called "Participants."

Component plans may have different terms of eligibility that are not overridden by the terms of eligibility for the Cafeteria Plan. In other words, if you are eligible to participate in the Cafeteria Plan, it does not necessarily mean you are eligible to participate in all benefit options offered under the Cafeteria Plan. Refer to the eligibility information in this document or component plan for each of the benefit plan options to ensure you are eligible. You may contact ETF or search ETF's website for this information.

You may only pay for the coverage of yourself, your spouse, and your tax dependents. For purposes of health plan coverage, Health Care FSA, LPFSA, and HSA, a dependent includes any child of yours who, as of the end of the taxable year, has not attained age 27, even if they are married or not a tax dependent.

3. How do I become a Participant?

If you have otherwise satisfied the Cafeteria Plan Eligibility Requirements, you become a Participant by signing an individual Salary Reduction Agreement (SRA), sometimes referred to as an "Enrollment Form," on which you agree to pay for the benefit options that you choose with pretax contributions. The SRA is required only for the Health Care FSA, LPFSA, HSA, and DCAP. You will be provided with a Salary Reduction Agreement or Enrollment Form on or before your Cafeteria Plan Eligibility Date. You must complete the form and submit it to ETF or Optum Financial (as indicated on or with the SRA or Enrollment Form), during the applicable election period described in **question 4** below. You may also enroll during the year if you experience a life event that qualifies as a change in status, covered in **question 5** below. You cannot become a Participant in the Plan prior to the date you complete and properly submit the SRA.

In some cases, the Employer may require you to pay your share of the Benefit Plan Option coverage that you elect with pretax contributions. If that is the case, your election to participate in the benefit plan option(s) will constitute an election under the Cafeteria Plan.

Enrollment may also be accomplished via telephone, electronic communication, web or online enrollment systems, or any other method prescribed by ETF.

Coverage as a participant will generally start on the first of the month following completion and submission of the SRA.

4. What are the election periods for entering the Cafeteria Plan?

Examples:

A. I was just hired or am newly eligible (initial election period).

If you want to participate in the Cafeteria Plan when you are first hired, you must enroll during the initial election period described in the enrollment materials you will receive. If you make an election during the initial election period, coverage as a participant will generally start on the first of the month following completion and submission of the Salary Reduction Agreement (SRA). The SRA is required only for the Health Care FSA, LPFSA, HSA, and DCAP. The effective date of coverage under the benefit plan option(s) will be effective on the date established in their component plans. The election that you make is effective for the remainder of the plan year and generally cannot be changed during the plan year unless you experience a life event that qualifies as a change in status, covered in **question 5** below.

If you fail to complete, sign, and file a SRA or otherwise make an election during the initial election period, you will be deemed to have elected not to participate in the Cafeteria Plan for the remainder of the plan year. Failure to make an election under the Plan generally results in no coverage under the benefit options, however, the employer may provide coverage under certain benefit options automatically, as stated in the enrollment materials provided by your employer. The enrollment materials will also indicate if this automatic coverage will be withdrawn from your pay on a pretax basis.

B. I did not enroll when I was first hired or became eligible but would like to enroll for the next plan year, or I am enrolled, but would like to change my elections for the next plan year (annual election period).

The Cafeteria Plan also has an annual election period, a part of It's Your Choice. You may enroll or change your elections for the Plan for the next plan year. The annual election period will be identified in enrollment materials distributed to you prior to the annual election period. The election you make during this period will be effective the first day of the next plan year and cannot be changed unless you experience a life event that qualified as a change in status, covered in **question 5** below. On a similar note, you may be able to enroll outside of the annual election period if you experience a life event that qualifies as a change in status allowing for enrollment, covered in **question 5** below.

If you fail to complete, sign, and file a Salary Reduction Agreement (SRA) or otherwise make an election during the annual election period, you may be deemed to have elected

not to participate in the Cafeteria Plan. The SRA is required only for the Health Care FSA, LPFSA, HSA, and DCAP. Failure to make an election under the Plan generally results in no coverage under the benefit options, however, the employer may provide coverage under certain benefit options automatically, as stated in the enrollment materials provided by your employer. The enrollment materials will also indicate if this automatic coverage will be withdrawn from your pay on a pretax basis.

5. Under what circumstances can I change my election during the plan year?

Generally, you cannot change your election under the Cafeteria Plan during the plan year. However, there are a few exceptions.

First, your election will automatically terminate if you terminated employment or lose eligibility under the Cafeteria Plan or under all of the benefit options you have chosen.

Second, you may voluntarily change your election during the plan year if you experience a life event that qualifies as a change in status. To change your election, you must submit a written change of election form within the election change period, which is generally within 30 days of the event. More information on this is located within the Life Change Event Matrix of the Section 125 Cafeteria Plan Document.

Third, your election under this Cafeteria Plan may be modified downward during the plan year if you are a key employee or highly compensated individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory under federal tax law. You will be notified if this occurs.

If coverage under a benefit plan option ends, the corresponding pretax contributions for that coverage will automatically end.

6. When does my participation in the Cafeteria Plan end?

Your coverage under the Cafeteria Plan ends on the earliest of the following to occur:

- A. The date you make an election not to participate in the Plan;
- B. The date you no longer meet the eligibility requirements of the Plan;
- C. The date you stop employment with an Employer covered under the Cafeteria Plan;
- D. The date the Cafeteria Plan is either terminated or amended to exclude you or the class of employees you belong to.

If your coverage under the Plan ends during the plan year, your active participation in the Plan will automatically cease, and you will not be able to make any more pretax contributions except as otherwise provided pursuant to your employer's policy or an individual arrangement (e.g., severance arrangement where the former employee is permitted to continue paying for a benefit plan option under the Plan out of severance pay on a pretax basis). Generally, coverage will end at the end of the month in which the last payroll deduction was taken or the

month in which you terminate participation; more information on the end date of coverage can be found in the plan documents of the underlying benefit options. You may continue to submit claims incurred during your period of coverage to your FSA until the end of the run-out period for that plan year, even if your coverage ends during the plan year. The run-out period for the FSAs is 90 days after the end of the plan year.

If you are rehired or regain eligibility within the same plan year and more than 30 days after being terminated or losing eligibility, you may make new elections. If you are rehired or regain eligibility within the same plan year and within 30 days or less after being terminated or losing eligibility, the Plan elections that were in effect prior to the end of your participation in the Plan will be reinstated and remain in effect for the rest of the plan year.

You may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail in **question 12** below.

7. When does participation of my dependents in the Cafeteria Plan end?

Coverage for your eligible dependents ends on the earliest of the following to occur:

- A. The date your coverage ends;
- B. The date your dependents cease to be eligible dependents (e.g., you and your spouse divorce, your child ages out, etc.); or
- C. The date the Plan is terminated or amended to exclude the individual or the class of dependents of which the individual is a member from coverage under one or all of the benefit options.

Your covered dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail in **question 12** below.

8. What happens to my participation in the Cafeteria Plan if I take a leave of absence?

You may be eligible to continue your participation in the Plan, depending on the circumstances of your leave of absence. Talk to your employer about your ability to continue participation during leave.

9. How are my elected benefit options paid for under the Cafeteria Plan?

You may be given a choice to pay for any benefit plan option coverage that you elect with pretax or after-tax contributions. The enrollment materials provided by your employer will indicate whether you have an option to choose to pay with pretax or after-tax contributions.

When you elect to participate in a benefit plan option and the Cafeteria Plan, an amount equal to your share of the annual cost of the benefit plan option(s) you chose, divided by the applicable number of pay periods you have during a plan year is deducted from each paycheck after your election date. If you chose pretax contributions, the deduction is made before any applicable federal or state taxes are withheld.

Additionally, amounts determined by the Division of Personnel Management in the Wisconsin Department of Administration (under Wis. Stats. [§ 40.05 \(4\)](#) and [§ 40.515 \(1\)](#) and [\(3\)](#)) or another appropriate authority will be put towards the cost of your benefit plan options as a non-elective employer contribution. The amount of non-elective employer contributions applied towards the cost of the benefit options for each participant and level of coverage is subject to the sole discretion of the Division of Personnel Management or other appropriate authority and may be adjusted upward or downward at its discretion. The yearly non-elective employer contributions will be calculated in a uniform and nondiscriminatory manner and may be based on your dependent status, commencement or termination date of your employment during the plan year, and factors determined by the Division of Personnel Management or other appropriate authority. In no event will these employer contributions be disbursed to you in the form of additional taxable compensation except as otherwise provided in the enrollment material or the Cafeteria Plan Document.

In the event of an overpayment of benefits to you, the Plan Administrator has the right to recover the overpaid amount from you.

10. How long will the Cafeteria Plan remain in effect?

Operation of the Plan is subject to the control of the State of Wisconsin Group Insurance Board (Board). The Board has the right to modify or terminate the Plan or any of the benefit options and component plans at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of Cafeteria Plan Document.

11. What happens if my request for a benefit under the Cafeteria Plan is denied?

- A. Upon receipt of a notice of denial from Optum Financial, you may file a written appeal within 90 days of the date of receipt of the notice. The written appeal should be sent directly to Optum Financial in accordance with its procedures, found at myoptumfinancial.com/etf.
- B. If the claim is again denied, a participant may appeal the decision to ETF for either an informal review or a departmental determination within 60 days of the receipt of the notice of the second denial. For an informal review, ETF will respond within 60 days. For a departmental determination, ETF will respond within 90 days.
- C. Departmental determinations may be appealed to the State of Wisconsin Group Insurance Board (Board) within 90 days of ETF's decision. Board appeals are conducted in accordance with [Wisconsin Administrative Code Chapter ETF 11](#).
- D. As provided in Wisconsin law ([Wis. Stat. 40.08 \(12\)](#)), decisions of the State of Wisconsin Group Insurance Board (Board) may be reviewed by an action filed in the circuit court for Dane County, within 30 days after the notice of the Board's decision is mailed. In some circumstances (described in the notes to [Wis. Stat. 40.08 \(12\)](#)), an appeal may be filed directly to the circuit court without following all of the above procedures.

12. Under what circumstances can I continue my coverage under the Plan or portions of the Plan, even when I terminate my employment or otherwise lose eligibility?

Federal law (such as COBRA) requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (known as continuation coverage) at group rates in certain instances where coverage under the plans would otherwise end. Continuation coverage applies to the underlying health insurance, the Health Care FSA, and the LPFSA. The table below is intended to summarize the continuation rights set forth in federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

	Covered Employee	Covered Spouse	Covered Dependent
Covered employee's termination of employment or reduction in hours of employment	X	X	X
Divorce or legal separation		X	
Child ceasing to be an eligible Dependent			X
Death of the covered employee		X	X

There are special rules pertaining to FSAs that determine when continuation coverage is extended. Continuation coverage is only extended when year-to-date deposits exceed year-to-date claims paid.

If you do not choose continuation coverage, your coverage will end on the date you would otherwise lose coverage.

If you choose continuation coverage, you may continue the level of coverage you had in effect prior to the qualifying event terminating coverage. However, if plan benefits are modified for similarly situated active employees, they will be modified for you and qualified beneficiaries as well. You will be eligible to make a change in your benefit election with respect to your FSA upon the occurrence of a life event that would allow an active employee to change their benefit elections.

In order to continue coverage, you or your covered dependent must inform ETF in writing of the event within 60 days of the later of the date of the qualifying event or the date on which coverage is lost because of the qualifying event. The written notice must identify the qualifying event, the date of the qualifying event, and the beneficiaries impacted by the qualifying event. Upon notification of the qualifying event, ETF will inform you of your right to choose continuation coverage by sending you the appropriate election forms. You may be required to provide additional supporting documentation. An employee or covered dependent is responsible for notifying the administrator of the continuation coverage if he or she becomes covered under another group health plan.

You will be required to pay the entire cost of your continuation coverage. The cost will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution will be due 45 days after you make your election. Subsequent contributions will be due the first day of

each month, but you have a 30-day grace period following the due date in which you make your contribution. Failure to make contributions within the required time period will result in automatic termination of your continuation coverage.

The maximum period for which coverage may be continued is the end of the plan year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of the qualifying event and the level of non-elective contributions provided by the employer). You will be notified of the applicable maximum duration when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- A. If the contribution for your continuation coverage is not paid on time or is significantly insufficient;
- B. If you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- C. If you become entitled to Medicare; or
- D. If the employer no longer provides group health coverage to any of its employees.

13. Will my health information be kept confidential?

Yes. HIPAA (the Health Insurance Portability and Accountability Act of 1996) requires the administrators of group health plans, including the Health Care FSA and LPFSA, to take steps to ensure that your protected health information is kept confidential.

Article 3: Benefits under the Cafeteria Plan

14. What benefit options are offered under the Cafeteria plan?

Under the Cafeteria Plan, the following benefit options may be elected:

- Health Premium Payment Plan
- Dental Premium Payment Plan
- Vision Premium Payment Plan
- Employee Life Insurance Coverage Premium Payment Plan
- Health Care FSA
- LPFSA (with HDHP and HSA)
- HSA (with HDHP)
- DCAP

The LPFSA and HSA are limited to employees with high deductible health plans. The Health Care FSA is limited to employees without high deductible health plans. However, aside from these limitations, you may choose whatever combination of benefit options works best for your needs.

Each benefit plan option has its own separate, written component plan. This SPD contains summaries of each benefit plan option, along with a description of the basic features of the Plan. In the event of a contradiction between this document and a component plan, the component plan will control.

15. What benefit options under the Cafeteria Plan involve only the pretax payment of my share of the premiums?

If you have elected to participate in coverage, under the Cafeteria Plan, you may choose to have your premiums for health coverage, dental coverage, vision coverage, and employee group life insurance coverage taken pretax out of your pay. If you stop participation in the Plan due to termination or loss of eligibility, deductions from your pay will stop. Further information regarding the premium payment plans can be found in Article V and Article VII of the Section 125 Cafeteria Plan Document.

16. What benefit plan options under the Cafeteria Plan involve a spending account?

If you are not enrolled in a high deductible health plan, under the Cafeteria Plan you can elect to participate in a Health Care FSA and a DCAP.

If you are enrolled in a high deductible health plan, under the Cafeteria Plan you can elect to participate in a LPFSA, HSA, and a DCAP.

Money deposited into an account can only be used for the purposes allowed by that type of account. For example, money deposited to a Health Care FSA cannot be used to pay for dependent care expenses and is limited to eligible medical expenses.

Article 4: Health Care FSA and LPFSA

17. What is the Health Care FSA?

The Health Care FSA is a flexible spending account that you can elect to use, depositing to a specified amount of pretax contributions to be used for reimbursement of eligible medical expenses. Eligible medical expenses include expenses not covered by your health insurance or another source that are allowed under the [Internal Revenue Code section 213 \(d\)](#), but do not include expenses for long term care services, health insurance premiums, and non-prescription drugs. Eligible medical expenses allowed under this plan include payments for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; for transportation primarily for and essential to such services; and prescription drugs and insulin. An expense is incurred when you are furnished with the medical care or services giving rise to the claimed expense, regardless of when the expense is paid. You may use the Health Care FSA to cover eligible medical expenses for yourself, your spouse, and your dependents. You may only use money placed in your Health Care FSA for purposes allowed by the Health Care FSA.

The Health Care FSA can only be elected if you are not enrolled in a high deductible health plan.

By electing the Health Care FSA, you choose to have amounts withheld from your pay on a pretax basis and allocated to your Health Care FSA. Your account will be debited for reimbursements disbursed to you as you file claims. The entire annual amount you elect to put towards the Health Care FSA, minus any amounts you have already claimed, will be available to you at any time during the plan year regardless of the actual year-to-date contributions to your Health Care FSA. You cannot submit reimbursements in excess of the annual amount you elected to put towards your Health Care FSA. In 2023 you may not elect to put more than \$2,850 in your Health Care FSA. No actual account is created; the Health Care FSA is merely a bookkeeping account, and benefits are paid as needed from the employer's general assets.

The Health Care FSA follows the general procedures described in [Article 2: Eligibility, Enrollment, and Contributions](#).

18. What is the LPFSA?

The LPFSA is a flexible spending account that you can elect to use in combination with a high deductible health plan and HSA, placing a specified amount of pretax contributions to be used for reimbursement of limited eligible health care expenses prior to meeting your deductible. Limited eligible health care expenses include expenses not covered by your health insurance or another source that is allowed under the proposed Treasury Regulation, [Internal Revenue Code Regulations section 1.125-5 \(m\)](#). These include expenses for dental and vision. An expense is incurred when you are furnished with the eligible medical care or services giving rise to the claimed expense, regardless of when the expense is paid. You must enroll in the high deductible health plan and HSA to be eligible to participate in the LPFSA. You may use the LPFSA to cover eligible expenses for yourself, your spouse, and your dependents. You may only use money deposited to the LPFSA for purposes allowed by the LPFSA.

After you meet the deductible for your high deductible health plan, the LPFSA can be used to cover costs that are eligible medical expenses, as defined in **question 17** for Health Care FSA.

You must notify Optum Financial that you have met your deductible for the high deductible health plan by submitting an attestation and supporting documentation (see [Deductible Met Form](#)) via the employee portal provided by Optum Financial.

By electing the LPFSA, you choose to have amounts withheld from your pay on a pretax basis and allocated to your LPFSA. Your account will be debited for reimbursements disbursed to you as you file claims. The entire annual amount you elect to put towards the LPFSA, minus any amounts you have already claimed, will be available to you at any time during the plan year regardless of the actual year-to-date contributions to your LPFSA. You cannot submit reimbursements in excess of the annual amount you elected to put towards your LPFSA. You cannot be reimbursed for an expense already reimbursed through your HSA. In 2023, you may not elect to put more than \$2,850 in your LPFSA. No actual account is created; the LPFSA is merely a bookkeeping account, and benefits are paid as needed from the employer's general assets.

The LPFSA follows the general procedures described in [Article 2: Eligibility, Enrollment, and Contributions](#).

19. How do I receive reimbursement under the Health Care FSA or LPFSA?

Under the Health Care FSA or LPFSA, you have several reimbursement options. You can complete and submit a written request for reimbursement; you can use an electronic payment card (Health Care Card) to pay the expense; you can file a claim directly from your online account at myoptumfinancial.com/etf; or, you can file a claim from your mobile phone via the Optum Financial mobile application.

In order to be eligible for the Health Care Card, you must be an active employee and agree to abide by the terms and conditions of the Health Care Card Program as set forth in the Health Care Cardholder Agreement, including any fees applicable to participate in the program, limitations as to card usage, and the Plan's right to withhold and offset for ineligible claims. The card will be turned off when you terminate employment or coverage under the plan and may not be used during any applicable continuation coverage periods. The card must only be used for eligible expenses; failure to do so will result in termination of card use privileges and you will be required to pay back any improperly paid claims. Card use is limited to health care providers, pharmacies, supermarkets, grocery stores, or discount stores that are Inventory Information Approval System (IIAS) approved. You must obtain and retain a receipt each time you use the card.

Generally, regardless of which FSA you choose, the options will work as follows. When you incur an eligible expense, you may file a claim with Optum Financial through one of the methods above. You must include with your claim a written statement from an independent third party (e.g., receipt) associated with each expense that indicates the following:

- A. The nature of the expense (i.e., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the receipt must indicate the Rx number, or the name of the drug and a copy of the prescription recognized under applicable state law;
- B. The name of the provider (address to be included if appropriate);
- C. Who the expense was for (i.e., name of the person who incurred the service or expense);

D. The date the expense was incurred; and

E. The amount of the expense.

Optum Financial will process the claim once it receives the above information (see [Substantiation Requirements](#)). Reimbursement will be made as soon as possible after receiving the claim, processing it, and determining that the claim is eligible for reimbursement. If the expense is determined to not be eligible, you will be notified. All claims must be submitted for reimbursement during the plan year or the run-out period, which runs for 90 days after the end of the plan year. Services that are not incurred during the plan year cannot be reimbursed under that plan year's account.

For example, claims for a surgery conducted in December of 2022 would need to be submitted for reimbursement to your 2022 FSA, not your 2023 FSA, even if you do not receive a bill until 2023. Under the run-out period, you would have until March 31, 2023, to submit claims incurred during the 2022 plan year.

20. What happens if I don't use all of the money in my Health Care FSA or LPFSA by the end of the plan year?

As described above, eligible expenses must be incurred **during** the plan year and while you are a Participant in the Plan. An expense is incurred when you are furnished with the medical care or services giving rise to the claimed expense, regardless of when the expense is billed or is paid. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. Except as provided below, you may not be reimbursed for any expenses arising before the FSA becomes effective, before your salary reduction agreement becomes effective, or for any expenses incurred after the close of the plan year, or, after a separation from service or loss of eligibility (except for expenses incurred during an applicable continuation period).

The Plan does have a carryover provision for the Health Care FSA and LPFSA. Under the carryover provision, any funds up to \$570 remaining in your account after the run-out period has ended will be transferred to the subsequent plan year automatically. As stated above, the run-out period lasts for 90 days after the end of the plan year. Any funds in excess of \$570 at that time will be forfeited to the Plan and retained by ETF.

If you are an active employee and have a balance to carry over to the next plan year but have not made an election for an FSA for the next plan year, the carryover will automatically create an account for you in the next plan year. Additionally, if you switch FSA types from the Health Care FSA to LPFSA or LPFSA to Health Care FSA, the carryover will automatically transfer to the new account type. However, the balance cannot be deposited to other types of spending accounts (e.g., DCAP).

If you do not have an active FSA on December 31 (i.e., coverage has been cancelled, waived, or terminated in the middle of the plan year while you maintain active employment status), you will not be eligible for the FSA carryover provision.

Amounts carried over do not impact your annual election for the next year. For example, assume that at the end of the 2022 plan year and run-out period you have \$750 remaining in your FSA account.

\$570 would automatically be carried over into the 2023 account, and the remaining \$180 will be forfeited to the Plan and retained by ETF. You will still be able to contribute the maximum amount of \$2,850 to your 2023 account, and with the carryover you would have \$3,420 in your account if you choose to contribute the maximum allowed.

21. Is there a minimum election amount and carryover requirement for FSA?

Effective January 1, 2023, there is a minimum election of \$50 required to enroll in the Health Care FSA and LPFSA. Participating members who are in active employment status on December 31, 2022, will have their carryovers made available by April 15, 2023.

By the end of December 31, 2023, any FSA balance of \$50 or greater will automatically be carried over into the next plan year (2024). Balances that are less than \$50 will require the minimum election for remaining balances to be carried over.

Examples of Account Minimums:

- A. If the employee enrolls in the 2023 Health Care FSA and elects to contribute \$1,000:
 - This meets the \$50 minimum annual election
- B. If the employee has \$22 in their FSA at the end of the year (2023) and re-enrolls for the next plan year (2024):
 - Employee must elect to contribute at least \$50
 - The \$22 carries over
- C. If the employee has \$22 in their FSA at the end of the year (2023) and does not re-enroll for the next plan year (2024):
 - The \$22 is forfeited because the \$50 minimum account balance required for carryover is not met

Article 5: Health Savings Account

22. What is the HSA?

The HSA is an individual, user-owned account that you can elect to use in combination with a high deductible health plan or LPFSA, placing a specified amount of pretax contributions to be used for reimbursement of eligible medical expenses in the account on a pretax basis. Eligible medical expenses include expenses not covered by your health insurance or another source that are allowed under the [Internal Revenue Code section 213 \(d\)](#). Eligible medical expenses allowed under this plan include payments for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; for transportation primarily for and essential to such services; and prescription drugs and insulin. Additionally, the HSA may be used to pay for premiums for federally-required continuation coverage, premiums for long term care insurance as limited by the IRS, premiums for health coverage for a spouse or dependent while that spouse or dependent is receiving unemployment compensation, and health insurance premiums (other than Medigap) if you have attained age 65, as allowed by [Internal Revenue Code section 223](#). An expense is incurred when you are furnished with the medical care or services giving rise to the claimed expense, regardless of when the expense is paid. You may use the funds in your HSA to pay for eligible medical expenses for yourself, your spouse, and your dependents. If you used the funds in the HSA for other purposes, you will pay income tax and, if you are under age 65, a 20% penalty.

By electing the HSA, you choose to have amounts withheld from your pay on a pretax basis and allocated to your HSA. Your account will be debited for reimbursements disbursed to you as you file claims. Only the current balance of your HSA will be available to you. You may only be reimbursed up to the amount currently in your HSA. You cannot be reimbursed for an expense already reimbursed through your LPFSA. In 2023 you may not elect to put more than \$7,750 in your HSA if you have a family plan and \$3,850 if you have a single plan.

The HSA follows the general procedures described in [Article 2: Eligibility, Enrollment, and Contributions](#), however, you may prospectively change your HSA elections on a monthly basis. You do not need to experience a life event to change your HSA election.

23. How do I receive reimbursement under the HSA?

Reimbursement under the HSA follows the general procedures of **question 19**. However, documentation is not required to request a reimbursement from your HSA. You should maintain receipts and other documentation sufficient to prove any expense is a qualified medical expense to the IRS in the event of audit or other request from the IRS, ETF, or Optum Financial.

24. What happens if I don't use all of the money in my HSA by the end of the plan year?

Any leftover amounts will automatically roll over to the next year and may remain in your account indefinitely until used.

25. What happens to my HSA if I terminate employment or otherwise cease to be eligible for the Plan?

The amounts placed in your HSA belong to you and are nonforfeitable to the Plan. Upon termination, you retain ownership of your HSA.

26. What happens to my HSA when I turn age 65?

You can open and contribute to an HSA at age 65 or later as long as you meet HSA eligibility requirements, which are:

- You're covered on an HSA-qualified medical plan (HDHP)
- You're not someone's tax dependent
- You don't have any conflicting coverage (including enrollment in Medicare)

Turning age 65 does not, in and of itself, preclude you from remaining HSA-eligible absent any disqualifying coverage.

If you choose to delay your Medicare or Social Security benefits when you turn age 65, you can continue contributing towards your HSA as long as the above requirements are met.

In the event that you sign-up for Social Security benefits at a later date, your Medicare Part A coverage will be backdated six (6) months for coverage (not earlier than when you turn age 65). This means that you will also not be eligible to contribute towards your HSA for those six (6) months. Under IRS rules, that leaves you liable to pay the six months' of tax penalties on your HSA.

Article 6: Dependent Day Care Account Program (DCAP)

27. What is the DCAP?

The DCAP is a flexible spending account that you can elect to use, placing a specified amount of pretax contributions to be used for reimbursement of eligible employment-related expenses. Eligible employment-related expenses include expenses for household and dependent care services necessary for gainful employment under Internal Revenue Code section 21 (b) (2), but do not include expenses paid to dependents or spouses. These expenses must be for the care of a child under age 13 or a spouse or other tax dependent who is physically or mentally incapable of caring for themselves, and the individual being cared for must have the same principal place of residence as you for more than half the year. An expense is incurred when you receive the dependent care giving rise to the claimed expense, regardless of when the expense is paid. You may only use money deposited to the DCAP for purposes allowed by the DCAP.

By electing the DCAP, you choose to have amounts withheld from your pay on a pretax basis and allocated to your DCAP. Your account will be debited for reimbursements disbursed to you as you file claims. The account will be debited for dependent care reimbursements disbursed to the Participant in accordance with this Article 6. In the event that the amount in the account is less than that amount of reimbursable claims at any time during the plan year, the excess part of the claim will be carried over into following months within the same plan year, to be paid out as the DCAP balance becomes adequate. In no event will the amount of dependent care reimbursements exceed the amount deposited to the DCAP. In 2023, you may not elect to put more than \$5,000 in your DCAP, or \$2,500 if you and your spouse file separate tax returns. No actual account is created; the DCAP is merely a bookkeeping account, and benefits are paid as needed from the employer's general assets.

The DCAP follows the general procedures described in [Article 2: Eligibility, Enrollment, and Contributions](#).

28. How will I be reimbursed under the DCAP?

Under the DCAP, you have several reimbursement options. You can complete and submit a written request for reimbursement; you can file a claim directly from your online account at myoptumfinancial.com/etf, or you can file a claim from your mobile phone via the Optum Financial mobile application.

When you incur an eligible expense, you may file a claim with Optum Financial through one of the methods above. You must include with your claim a written statement from an independent third party (e.g., receipt) associated with each expense that indicates the following:

- A. The nature of the expense (i.e., what type of service was provided);
- B. The name of the provider (address to be included if appropriate);
- C. Who the expense was for (i.e., name of the person who incurred the service or expense);

D. The date the expense was incurred; and

E. The amount of the expense.

Optum Financial will process the claim once it receives the above information (see [Substantiation Requirements](#)). Reimbursement will be made as soon as possible after receiving the claim, processing it, and determining that the claim is eligible for reimbursement. If the expense is determined to not be eligible, you will be notified. All claims must be submitted for reimbursement during the plan year or the run-out period, which runs for 90 days after the end of the plan year. Services that are not incurred during the plan year cannot be reimbursed under that plan year's account.

You must have incurred the expense in order to receive payment. "Incurred" means the service has been provided without regard to whether you have paid for the service. Payments for advance services are not reimbursable because they have not yet been incurred. For example, employee A pays the monthly day care fee on January 1 and then submits a copy of the receipt on January 3. The expense for the entire month is not reimbursable until the services for that month have been performed. In addition, you must certify with each claim that you have not been reimbursed for the expense(s) from any other source and you will not seek reimbursement from any other source.

29. What happens if I don't use all the money in my DCAP by the end of the plan year?

As described above, eligible expenses must be incurred *during* the plan year and must be submitted for reimbursement prior to the end of the run-out period, which runs for 90 days after the end of the plan year. Participants may submit claims for reimbursement of eligible employment-related expenses incurred during the plan year and after Participants cease participation so long as such claims are submitted prior to the end of the run-out period. Any amounts left over after the end of the run-out period will be forfeited to the Plan. You are not entitled to receive any direct or indirect payment of any amount that represents the difference between the eligible expenses you have incurred and the amount you elected to contribute to your DCAP.

30. What additional tax effects regarding the DCAP should I know about?

You will not normally be taxed on your DCAP reimbursements so long as your family aggregate DCAP reimbursement (under this DCAP and another employer's DCAP) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. You may not claim any other tax benefit for the tax-free amounts received by you under this DCAP, although any remaining unreimbursed balance of your eligible employment-related expenses may be eligible for the dependent care credit. Questions regarding the tax effects of the DCAP or any other portion of this Plan should be addressed to your financial advisor.

Article 7: Life Event and Annual Election Modifications

31. When may I change my election during a plan year?

Excluding HSAs, you can change your election only if you have a “Qualifying Life Event.” A Qualifying Life Event is an event that, under the law and the terms of the Plan, permits election changes. Please keep in mind that any and all of these changes need to impact eligibility in order to be a Qualifying Life Event.

Upon the occurrence of a Qualifying Life Event, you can change your election, but only in a way that is consistent with the Qualifying Life Event. This is sometimes referred to as the “Consistency Rule.”

Examples of the Consistency Rule:

- A. A dependent loses or gains eligibility for coverage under your spouse’s health insurance. While you may change your election to adjust for that dependent’s situation, you may not modify your election to add or remove coverage under the Plan for another dependent.
- B. You got married during the plan year. You may change your election to: (1) add coverage for your spouse; (2) elect Health Care FSA coverage for your spouse; or (3) drop coverage for yourself under the Plan in order to be covered under your spouse’s insurance.
- C. Your child is going to turn age 13 within the tax year and loses dependent coverage under your Dependent Day Care Account. You may change or reduce your election amount for the Plan.

HSAs are subject to different change of elections rules and do not require a Qualifying Life Event to make an annual election modification.

32. How long do I have to make an election change from the Qualifying Life Event?

Excluding HSAs, you have an election period of 30 days after the Qualifying Life Event occurs. You must complete and submit a written change of election form within 30 days after the event occurs.

33. Can I increase the election amount to pay for expenses incurred prior to a Qualifying Life Event?

No, you cannot use the increased contribution amount to pay for expenses prior to the Qualifying Life Event. You can use the additional contributions prospectively from the time of the effective date.

For example, you had a Qualifying Life Event due to the birth of dependent on October 15. You decide to increase your Health Care FSA annual election from \$1,000 to \$1,500 effective November 1.

The additional \$500 annual election increase cannot be used to pay for expenses incurred prior to November 1. The amount of the increase can only be used to pay for eligible expenses starting from the effective date of November 1.

Appendix I – Tax Impact Examples

As indicated in the SPD, participating in the Plan can actually increase your take home pay. Consider the following example*:

You are married and have one child. The employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay \$2,400 in premiums (\$400 for your share of the employee-only premium, plus \$2,000 for family coverage under the employer's major medical insurance plan). You earn \$50,000 and your spouse (a student) earns no income. You file a joint tax return.

* Example for illustrative purposes only. Personal results will vary based on tax bracket and income.

	If you participate in the Cafeteria Plan	If you do not participate in the Cafeteria Plan
1. Gross Income	\$50,000	\$50,000
2. Salary Reductions for Premiums	\$2,400 (pretax)	\$0
3. Adjusted Gross Income	\$47,600	\$50,000
4. Standard Deduction	(\$9,700)	(\$9,700)
5. Exemptions	(\$9,300)	(\$9,300)
6. Taxable Income	\$28,600	\$31,000
7. Federal Income Tax (Line 6 x applicable tax schedule)	(\$3,590)	(\$3,904)
8. FICA Tax (7.65% x Line 3 Amount)	(\$3,641)	(\$3,825)
9. After-tax Contributions	(\$0)	(\$2400)
10. Pay after Taxes and Contributions	\$40,365	\$39,821
11. Take Home Pay Difference	\$544	

Participation in these benefit options will reduce salary used for calculating your Social Security benefit. However, the benefit reduction is small compared with the tax savings earned. The following table compares the possible lifetime Social Security reduction with tax savings realized through these cafeteria programs.

Number of years using tax-free premiums	Estimated reduction in Total Lifetime Social Security benefits		Total tax savings**
	MALE	FEMALE	
10	\$1,536	\$1,865	\$2,718
20	\$3,071	\$3,729	\$5,436
30	\$4,608	\$5,596	\$8,154
35 or more	\$5,376	\$6,528	\$9,513

** Tax savings based on a 15% federal income tax and 7.65% Social Security tax, with \$100 in tax-free contributions per month. Your savings will be even greater when you include your state income tax. Higher tax brackets will also increase tax savings; Social Security reduction remains the same. Assumes retirement at age 65. The difference in male and female estimates is based on life expectancy at retirement.