BenefitHelp SOLUTIONS

Know your options. Enjoy the advantages .

2025 Open Enrollment Packet

This packet includes general information and forms related to the plans that are available to you through your employer. Not all of the information, maximums or benefits and examples may be applicable to you. Please refer to your summary plan documents for benefit that are specific to plans offered through your employer.

Sign up for a flexible spending account – and start saving

Today, everyone is faced with rising healthcare costs and complex employee benefits. At BenefitHelp Solutions, helping you means more to us than just paying claims and answering phones quickly. It's about helping you understand your benefits and saving you money.

Did you know that there's a simple way to get your hands on additional spendable income, month after month? If you, like most people, spend a few hundred dollars or more each year in out-of-pocket healthcare costs, you can get 25 to 40 percent of that money back in your pocket when you sign up for a Flexible Spending Account (FSA).

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How an FSA works

With an FSA, you determine how much out-of-pocket childcare and healthcare expenses you have each year, and then you have that amount (divided by the number of payroll periods) automatically set aside from your paycheck. The money is pulled out before taxes are deducted and held in a special account for you. When you start paying healthcare or dependent care expenses, you get reimbursed from your FSA account — and that money never gets taxed. The bottom line: you get more spendable income for paying off credit-card debt, planning a much-needed vacation or finally getting yourself an iPhone. What will you do with the money you'll save?

Manage your flexible spending account online

Log on to benefithelpsolutions.com 24/7 to view your account activity, submit claims, and update your profile information.

Example of Peter's annual savings	With an FSA	Without an FSA
Peter's taxable income	$30,000	$30,000
Pre-tax amount deposited into an FSA	$1,200	$0
Peter's taxable income	$28,800	$30,000
Subtract estimated Federal, State & FICA taxes	$8,060	$8,400
Take home pay spent on FSA eligible expenses	$0	$1,200
Peter's actual spendable income	$20,740	$20,400
Annual savings	$340	$0

In this example, Peter is saving $340 by simply enrolling in an FSA. Enroll in a dependent care account as well and save even more. Your savings results may vary based on your income, tax bracket and amount contributed to the FSA account.

Two account types

Healthcare Spending Account

A Healthcare Spending Account allows you to pay for eligible expenses not covered by your healthcare plan. Some eligible expenses include:

- ✓ Deductibles, copayments and coinsurance for medical and dental plans
- ✓ Prescription medications and approved over-the-counter healthcare products
- ✓ Eye exams, glasses, prescription sunglasses, contact lenses and solutions, and LASIK eye surgery

Dependent Care Spending Account

A Dependent Care Spending Account reimburses you for care provided by eligible caregivers for dependents age 12 and younger, or for a disabled spouse or other dependents whom you claim for tax purposes. A few examples of eligible dependent care expenses:

- ✓ Care provided in your home by an eligible caregiver
- ✓ Care provided outside your home at a qualified day care provider
- ✓ Care provided at a licensed day care facility
- ✓ Summer day camps
- ✓ Before- and after-school programs

For more detailed dependent care information, click on FSA Accounts in the member section at benefithelpsolutions.com.

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Limited Purpose Accounts

A limited purpose health flexible spending account (limited health FSA) or limited purpose health reimbursement arrangement (limited HRA) is just like your regular health FSA or HRA, except that it only reimburses expenses for vision and dental care.

Eligible expenses

- Dental expenses, such as cleanings, fillings, crowns and orthodontia
- Vision expenses, such as contact lenses, eyeglasses, refractions and vision correction procedures

The definition of dependents under federal guidance has been expanded to include adult children up to the age of 26. This means your health FSA may pay for eligible medical care expenses of your dependent through the age of 26.

When to enroll

- When you are first hired, you will be invited to join the limited health FSA or limited HRA once any probationary periods have ended. Please see your summary plan document regarding the procedure for enrolling once you are eligible to participate.
- After an applicable change in status, you may be allowed to make changes to an election you made when you were first hired or during open enrollment. Please see your Summary Plan Description for a list of applicable change in statuses and any timelines imposed.
- During open enrollment, you must make new elections. You may change your election or decide not to participate. Open enrollment usually occurs a month or two prior to the start of the plan year. Your human resources department will provide additional information regarding your open enrollment.

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Determining your FSA contribution

To help you determine how much money you should set aside for your FSA, use this worksheet to calculate your out-of-pocket expenses for the year. For a full list of eligible FSA account expenses and eligibility requirements, visit us online at benefithelpsolutions.com/members/resources/eligible-healthcare-expenses.

Healthcare Expenses	
Medical expenses not covered by insurance	Annual estimate
Deductibles, copays, coinsurance	
Prescription drugs	
Over-the-counter items	
Dental expenses not covered by insurance	Annual estimate
Checkups and cleanings	
Fillings, X-rays, crowns, bridges	
Dentures, inlays	
Orthodontia	
Vision and hearing expenses not covered by insurance	Annual estimate
Exams	
Prescription eyeglasses	
Contact lenses and cleaning solution	
Corrective eye surgery	
(LASIK, cataract, etc.)	
Hearing aids and batteries	
Total healthcare expenses	$
Dependent care expenses	**Annual estimate**
Licensed day care, nursery	
or pre-school	
Before and after school programs	
Summer day camps	
Total dependent expenses	$

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Hassle-free Reimbursement

Payment

Benefits Card

Not all employers offer the Benefits VISA (Benefits Card) option. To find out if you are eligible for a Benefits Card, please contact your group administrator.

The Benefits Card provides direct access to your Flexible Spending Account, allowing you to pay for eligible healthcare expenses at qualified locations wherever VISA is accepted. When you use your Benefits Card, you no longer have to wait for reimbursement because the money is deducted directly from your FSA account at the time of purchase. However, in most instances, you will still have to submit supporting documentation for your purchases. Your Benefits Card can be used at participating grocery stores, pharmacies and wholesale clubs with vision and pharmacy services (most of these stores have elected to participate in the IRS Benefits Card program); or at hospitals, and medical, dental and vision provider offices.

When you're at the grocery store or pharmacy and it's time to pay, swipe your Benefits Card and select "Credit," if asked. The Benefits Card automatically approves your eligible items and debits the money from your FSA account. If you are also buying non-eligible items, the terminal or clerk will ask you for another form of payment. Then just pay the remainder with another card, cash, or check as you'd normally do.

When paying for services provided by a medical, dental or vision care provider, the Benefits Card can automatically approve services that match a set copay or a multiple of that copay (not coinsurance) from your group health plan(s). Supporting documentation for these services is not needed; however, if the provider's charge is an amount other than the copay, you can still use the Benefits Card to have the expense directly deducted from your account. You will just need to submit supporting documentation to BenefitHelp Solutions when you receive the letter requesting it. **The Benefits Card should only be used to pay for expenses incurred in the current plan year. If it is used for prior plan year expenses, you will be required to refund your account.**

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Reimbursement

AutoPay

Not all employers offer the AutoPay option. To find out if you are eligible for AutoPay, please contact your group administrator.

AutoPay is an option that allows you to be reimbursed automatically for your eligible out-of-pocket medical, dental and prescription expenses processed by your medical administrator without having to submit claim forms or supporting documentation (currently, Moda and Delta Dental is the only administrator eligible). When your medical administrator receives a claim from your provider, they will process and pay the claim according to your plan benefits. The administrator will send you an Explanation of Benefits (EOB) and, at the same time, send the information to BenefitHelp Solutions for automatic reimbursement of eligible out-of-pocket expenses. The amount shown on the EOB in the Patient Responsibility column is the amount you will automatically receive — up to your annual FSA election amount.

Orthodontia and IRS-ineligible expenses, such as cosmetic procedures, are excluded from AutoPay.

Direct deposit

By having your Flexible Spending Account reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a Direct Deposit Remittance Advice. The Remittance Advice will provide a full explanation of what was paid. All direct deposits will be initiated on the same day as the normal check reimbursement date.

Contact us

benefithelpsolutions.com

phone: 855-378-0197

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Flexible Spending Account Carryover

A carryover allows you to transfer up to the IRS carryover maximum of $660 (or your plan's carryover maximum amount if different) of your remaining balance at the end of the plan year into the following year. Think of it like a safety net for your FSA. If you end up spending less than you anticipate when making your elections during open enrollment, you can tap into those funds next year.

- ✓ Carryover funds become available to you on the last day of the plan year. They can be used for both prior plan year and current plan year expenses through the run-out (claim filing) period. After the runout period the carryover funds can only be used for current plan year expenses.
- ✓ You are able to carry over up to $660 while still electing the full maximum annual election in the new plan year.
- ✓ If you have the payment card, it will continue to work as normal, using your carryover funds first.

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Eligible medical care expenses

Commonly asked questions about over the counter medications and items, adult children and the coordination of multiple accounts.

Medical care expenses for you, your spouse and your dependents are all available for reimbursement or purchase with your healthcare flexible spending accounts (health FSAs), 213(d) healthcare reimbursement arrangements (HRAs) and health savings accounts (HSAs). Eligible medical care expenses include many over the counter items that you purchase without the involvement of your physician or insurance.

Over the counter items

Over the counter items that have an established medical function, do or do not, contain an active ingredient are available for purchase using your account without involvement from your healthcare provider. This includes things like:

- Band aids
- Braces and supports
- Catheters
- Contact lens supplies and solutions
- Denture adhesive
- Diagnostic tests and monitors
- Elastic bandages and wraps
- Insulin and diabetic supplies
- Ostomy products
- Reading glasses
- Wheelchairs, walkers and canes

Stockpiling is not permitted. Only reasonable quantities to be used in the plan year of the same over the counter item can be reimbursed. BenefitHelp Solutions interprets reasonable to be no more than three of the same over the counter product purchased in a single month. If there is a medical condition requiring more than what BenefitHelp Solutions considers reasonable, you may submit a letter of medical necessity.

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Adult dependents

The definition of dependents under federal guidance has been expanded to include adult children up to the age of 26. This means your health FSA may pay for eligible medical care expenses of your dependent through the age of 26.

Does my adult dependent have to be a tax dependent?

No. Your adult dependent does not have to be your tax dependent, living with you or attending school. However, any dependents of your dependent will not be eligible unless they are your tax dependent.

If my dependent will be 27 in June and my plan year ends in December, can I claim his or her expenses through May?

No. The IRS allows you to use your account for dependent claims only if that dependent will not be 27 during the tax year, January to December.

If my 24-year-old child has insurance through his employer, does the employer plan have to pay or deny eligible medical care expenses before I can use my account to pay the medical expenses?

Yes.

Questions?

Contact a BenefitHelp Solutions customer service representative at 855-378-0197 for more information.

Understanding the limit for your health FSA

An employee of a specific (or related) employer can have just one health FSA and the election for that health FSA cannot exceed the IRS limit.

What if I have a second job and my second job offers a health FSA?

You may elect to participate in the second health FSA and make the full IRS allowed election amount election.

My spouse also has access to a health FSA. Are there any restrictions on their election?

Your spouse, regardless of whether he or she has the same employer, can make an independent election of up to the IRS maximum.

How do I submit claims for reimbursement from my health FSA when I have more than one insurance plan covering me?

When you have more than one insurance plan, the expense must be processed by all of your insurance carriers before you submit your claim for reimbursement or use your benefits card to pay for the final cost.

My spouse and I both have a health FSA; how do we submit claims using both accounts?

You may use both accounts as you normally would, just be careful to not submit the same expense to each account.

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Why pay tax on the items you need?

With a flexible spending account (FSA) you can use tax-free funds to take your health to the next level from out-of-pocket medical costs to eligible health products that help you feel your best.

- **The largest selection** of guaranteed FSA eligible products
- **Shop with your FSA card** or any major credit card
- Check what's eligible in our **expansive eligibility list**
- **Get money-saving tips** from our Learning Center
- Questions? **Access 24/7 support** (call or chat)

$5
Off your purchase
One use per customer
Expires 12/31/2025

Visit **fsastore.com/BenefitHelpOE** for the largest selection of exclusively FSA eligible products with zero guesswork.

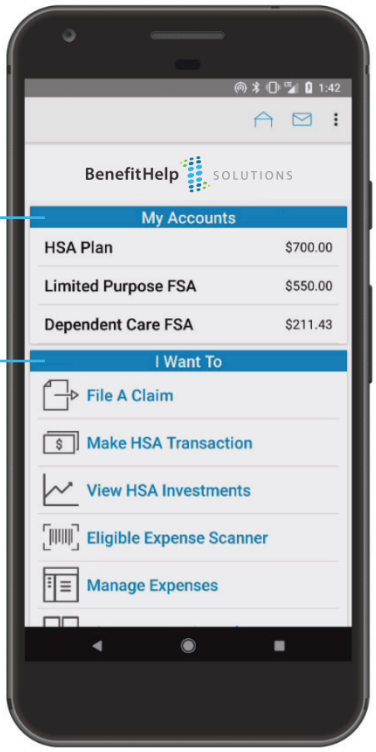
Use code **SHOP24D** at checkout.



BenefitHelp SOLUTIONS

Manage your benefits *on the go.*

Want an easy way to check your account balances and submit receipts from anywhere? The BenefitHelp Solutions Mobile App lets you access your accounts with a touch of a finger. Designed to help you quickly find what you need, our Mobile App provides secure, on-the-go access to all your accounts.



View balance information for your account(s) right away

Use the "I Want To" section to make payments, view HSA investments and scan items for eligibility

Stay up to speed

Wondering whether you have enough money to pay a bill or make a purchase? The BenefitHelp Solutions Mobile App puts the answers at your fingertips*:

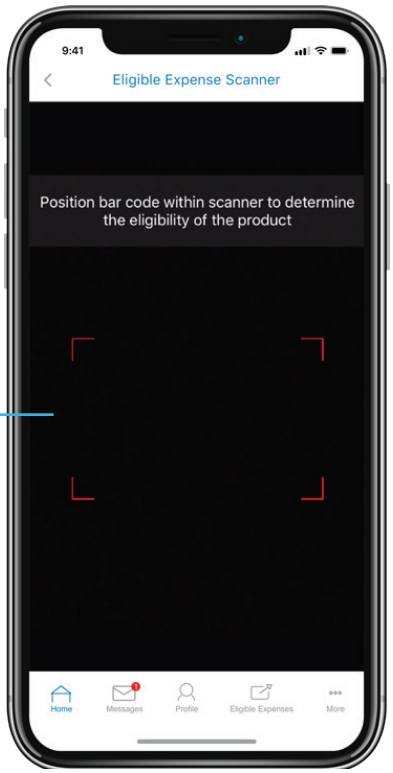
- Enjoy real-time access including an intuitive app design and navigation
- Log in to your account(s) using your fingerprint
- Quickly check account details for medical and dependent care
- View account summary
- View in-app messages and text alerts that provide instant notifications about your account(s)
- Access a list of eligible expenses
- Retrieve a lost username or password
- Use app with Apple® or Android™ smartphone

Tap to take action

Whether you're on the couch, waiting in line, or at your desk, you can use the BenefitHelp Solutions Mobile App to take action quickly.*

- Submit claims for medical and dependent care FSA, HRA, VEBA, transportation, tuition and premium reimbursement plans
- Snap a photo of a receipt to submit now or store for later
- Make an HSA distribution or contribution and view HSA investment details
- Use the Eligible Expense Scanner to determine if a product qualifies as a medical expense
- Pay yourself or your care provider
- Add and store information on new payees
- Enter and view expense information and receipts
- Report a debit card as lost or stolen

Imagine what you can do with The BenefitHelp Solutions Mobile App



With a quick barcode scan, you'll know in an instant whether an item qualifies as an eligible expense

Check balances

Wondering if you can pay for an elective procedure? No need to wait for an answer — your account balance is right at your fingertips.

Scan expenses

Scan a product bar code to find out if it qualifies as a medical expense.

Make payments quickly

Capture receipts and record eligible expenses when they happen. Add payees and pay bills from any account.

Get started with the BenefitHelp Solutions Mobile App in minutes.

Download on the App Store

ANDROID APP ON Google Play

Download the BenefitHelp Solutions app for your chosen device from the Apple App Store or Google Play and log in using the password you use to access the BenefitHelp Solutions consumer portal.

** Some functionality listed may require additional products and services*

Get help anytime!

BenefitHelper is available 24/7/365 to help you with your account, debit card, claims, receipts and much more.

Need to know your account balance? Want to view a claims status? No problem. Simply access our new automated chat tool, BenefitHelper, 24 hours a day, seven days a week, 365 days of the year, to get the answers you need, when you need them.

With BenefitHelper, you can get quick answers to your most frequently asked questions about your account, debit card, claims, receipts and much more.

Account

- Account balances
- Eligible expenses

Debit card

- Debit card status
- Debit card replacement
- Report lost/stolen card

Claims

- Claims status
- Denied claims

Receipts

- Upload and view receipts
- Receipt validation/documentation help

Continued on back **>**

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How to access BenefitHelper

Just follow these easy steps to access BenefitHelper.

1. Log in to your Benefithelp Solutions member portal at bhsconsumer.lh1ondemand.com.
2. Select the “Need Help” icon to get started.

Don’t have a member portal account?

To create a new account, visit **bhsconsumer.lh1ondemand.com**. Select “Get Started” and complete the information to verify your identity.

Questions?

We’re here to help. Please call BenefitHelp Solutions at 855-378-0197.

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Flexible Spending Account (FSA) and Dependent Care Account (DCA) Enrollment or change form

Benefits Card

BenefitHelp SOLUTIONS

29139899 (12/18)

____/____/_____

* **Effective date**

PLEASE PRINT CLEARLY

* **This information is mandatory.** Enrollment may be delayed if fields with an asterisk are not filled out.

Section 1 Application reason

Please refer to your plan's summary plan documents for a complete list of qualifying status changes. Election changes cannot be retroactive and must be consistent with the event.

☐ New enrollee -OR- ☐ Update election due to a qualifying life event. Please describe qualifying life event below:

_____

_____

Section 2 Account holder information

* First name	M.I.	* Last name	* Date of birth ____/____/_____	* Social Security number

* Mailing address	* City	* State	* ZIP
* Physical address	* City	* State	* ZIP

* Email address	* Contact phone number

* Employer City of Salem	Division	* Hire date ____/____/_____	* Group identification number (if known)

Section 3 Payroll (check one)

☐ Weekly (52 pay periods/yr) ☐ Bi-weekly (24 pay periods/yr) ☐ Bi-weekly (26 pay periods/yr) ☐ Semi-monthly ☐ Monthly

☐ Other _____

Section 4 Benefit election (check all that apply)

☐ Waive participation	You will not be eligible to participate in the healthcare or dependent care account until the next open enrollment period unless an applicable change of status occurs. Please notify your employer of any change in status within 30 days of the applicable change.
☐ Enroll me in the healthcare flexible spending account (FSA)	* Annual election (up to $3,200)
☐ Enroll me in the dependent care assistance program (DCAP) If married and filing seperately, DCAP election should not exceed $2,500	* Annual election (up to $5,000)

Section 5 Reimbursement (for additional information, please review page 2)

Benefits card	☐ I would like a Benefits Card[1]	☐ I already have a Benefits Card	
Direct deposit[2]	☐ Enroll me in direct deposit[3]	☐ Checking ☐ Savings	Bank name
	Routing number		Account number

[1] BHS will issue two benefit cards in your name.

[2] If you do not opt in for Direct Deposit manual claim submissions will be reimbursed by check. If you do request direct deposit, your bank account will be credited and debited (called a micro-deposit) in a random amount ranging between $0.01 and $0.99. You will receive an email notification with further instructions for activating direct deposit.

[3] Please include a voided check with your enrollment form.

Section 6 Authorization

I have read and agree to the terms and conditions on pages 1 and 2 and authorize my employer to reduce my salary on a per-pay-period basis.

* Employee signature	* Signature date

Please return to your human resources or benefits department upon completion.

Benefits Card

The Benefits Card provides direct access to your flexible spending account (FSA), allowing you to pay for eligible health care expenses at qualified locations where VisaTM is accepted. When you use your Benefits Card, you no longer have to pay for eligible expenses out of your pocket and wait for reimbursement. The money is deducted directly from your FSA account at the time of purchase. You may need to submit supporting documentation for certain purchases.

When using your Benefits Card at pharmacies, simply swipe your card first and choose “Credit” if asked. The card is a smart card that will only pay for IRS-eligible FSA purchases. The store clerk will ask you for another form of payment to pay for your other purchases. You then pay for the non-FSA-eligible items with another card, cash or check. Your IRS-eligible purchases are automatically approved and paid directly from your FSA account. That’s it — no claim forms to submit!

When paying for services provided by a medical, dental or vision provider, the Benefits Card can automatically approve services that match a set copay or a multiple of that copay (not a percentage coinsurance) from your group health plan(s). Supporting documentation for these services is not needed. If the provider’s charge is not a copay, you can still use the Benefits Card and benefit from having the expense directly deducted from your account. For expenses that do not match the copay, you will need to submit supporting documentation. In some situations, your card will automatically be approved even if it is an ineligible expense. This most often happens when paying for services incurred in a prior plan year or for services where you coincidentally owe a multiple of the copayment. It is your responsibility to use your Benefits Card only for eligible expenses.

Direct deposit

By having your flexible spending account reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a direct deposit remittance advice. The remittance advice will indicate the date your claim was paid and the amount that will be deposited to your bank account. All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to 2-3 business days to appear in the designated account. Should you make any changes to your bank account, such as account closure or change in account number, please notify BenefitHelp Solutions immediately. If there is an interruption in the direct deposit service, you will receive checks for reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.

Terms and Conditions

By signing this application:

1. **Acceptable plan terms.** You agree to abide by the terms, conditions and provisions of the plan contained in your employer’s plan documents. These documents are available to you through your human resources or benefits department.
2. **Responsibility.** You acknowledge that the Internal Revenue Code (IRC) permits claim reimbursement only for eligible expenses incurred after the effective date and prior to the termination date of your healthcare flexible spending account, dependent care assistance program and/or commuter expense reimbursement program. You assume full responsibility for all taxes, penalties, interest or other consequences that may be assessed to you by any state, federal or other governmental taxing authority as a result of receiving reimbursement for a disallowed expense. You will only use your account to pay for eligible expenses incurred by yourself and/or your tax dependents. You understand that BenefitHelp Solutions, its agents or employees, will not be held liable if you submit ineligible expenses for reimbursement. Expenses cannot be reimbursed by any other plan. If requested, you agree to provide appropriate supporting documentation within the requested time frame. You understand that you cannot change or revoke an election until open enrollment or during an applicable change in status.
3. **Dependent care.** You understand that the IRC prohibits you from claiming the Federal Child Care Tax Credit for dependent care assistance program expenses that have been reimbursement through your dependent care assistance program account.
4. **Plan modification.** You have been informed that the plan offered by your employer may be modified from time to time, and you agree that your employer may cancel or amend your plan according to the employer’s independent judgment and discretion without your consent or prior notice.
5. **Social security.** You choose to participate in the plan knowing that your salary reduction elections may reduce your FICA withholdings (Society Security) and that this may reduce your Social Security benefits upon retirement.
6. **Forfeiture.** You understand that you must claim reimbursement for eligible expenses incurred during the plan year for which you were an active participant within the run-out period of the plan year (and grace period if applicable), as stated in your Summary Plan Document. If any unused amounts remain in your account(s) after any carryover (if applicable), these amounts will be forfeited.
7. **Benefits Card.** If it is determined that the Benefits Card paid for an ineligible expense, you will either refund your account the amount of the ineligible expense or offset the ineligible expense with an eligible expense. If you fail to do so, the ineligible amounts may be included as taxable income at the end of the year. You understand that if you do not provide supporting documentation as required, your Benefits Card may be deactivated until your account is settled.
8. **HSA contributions.** You understand that if you, your spouse or your children participate in an HSA plan, HSA contributions may be disallowed if any HSA participants also participate in the healthcare flexible spending account.
9. **Status change.** Unless otherwise noted in your Plan Documents, Qualified Status Changes (QSCs) must be submitted within 30 days of the event. Please discuss with your human resources department to determine if your event is a QSC. If there's an election change, you understand that additional funds due to an increase in your election can only be used for claims incurred on or after the date of change.

Limited Flexible Spending Account (FSA)
Benefits Card

BenefitHelp SOLUTIONS

59589840 (9/19)

_____ /_____ / _____

*** Effective date**

PLEASE PRINT CLEARLY

*** This information is mandatory.** Enrollment may be delayed if fields with an asterisk are not filled out.

Section 1 Application reason

Please refer to your plan's summary plan documents for a complete list of qualifying status changes. Election changes cannot be retroactive and must be consistent with the event.

☐ New enrollee -OR- ☐ Update election due to a qualifying life event. Please describe qualifying life event below:

_____

_____

Section 2 Account holder information

* First name	M.I.	* Last name	* Date of birth _____ /_____ / _____	* Social Security number

* Mailing address	* City	* State	* ZIP
* Physical address	* City	* State	* ZIP

* Email address	* Contact phone number

* Employer City of Salem	Division	* Hire date _____ /_____ / _____	* Group identification number (if known)

Section 3 Payroll (check one)

☐ Weekly (52 pay periods/yr) ☐ Bi-weekly (24 pay periods/yr) ☐ Bi-weekly (26 pay periods/yr) ☐ Semi-monthly ☐ Monthly

☐ Other _____

Section 4 Benefit election (check all that apply)

☐ Waive participation	You will not be eligible to participate in the healthcare until the next open enrollment period unless an applicable change of status occurs. Please notify your employer of any change in status within 30 days of the applicable change.
☐ Enroll me in the healthcare flexible spending account (FSA)	* Annual election (up to $3,200)

Section 5 Reimbursement (for additional information, please review page 2)

Benefits card	☐ I would like a Benefits Card[1] ☐ I already have a Benefits Card		
Direct deposit[2]	☐ Enroll me in direct deposit[3]	☐ Checking ☐ Savings	Bank name
	Routing number	Account number	

[1] BHS will issue two benefit cards in your name.

[2] If you do not opt in for Direct Deposit manual claim submissions will be reimbursed by check. If you do request direct deposit, your bank account will be credited and debited (called a micro-deposit) in a random amount ranging between $0.01 and $0.99. You will receive an email notification with further instructions for activating direct deposit.

[3] Please include a voided check with your enrollment form.

Section 6 Authorization

I have read and agree to the terms and conditions on pages 1 and 2 and authorize my employer to reduce my salary on a per-pay-period basis.	
* Employee signature	* Signature date

Please return to your human resources or benefits department upon completion.

Benefits Card

The Benefits Card provides direct access to your flexible spending account (FSA), allowing you to pay for eligible health care expenses at qualified locations where VisaTM is accepted. When you use your Benefits Card, you no longer have to pay for eligible expenses out of your pocket and wait for reimbursement. The money is deducted directly from your FSA account at the time of purchase. You may need to submit supporting documentation for certain purchases.

When using your Benefits Card at pharmacies, simply swipe your card first and choose “Credit” if asked. The card is a smart card that will only pay for IRS-eligible FSA purchases. The store clerk will ask you for another form of payment to pay for your other purchases. You then pay for the non-FSA-eligible items with another card, cash or check. Your IRS-eligible purchases are automatically approved and paid directly from your FSA account. That’s it — no claim forms to submit!

When paying for services provided by a medical, dental or vision provider, the Benefits Card can automatically approve services that match a set copay or a multiple of that copay (not a percentage coinsurance) from your group health plan(s). Supporting documentation for these services is not needed. If the provider’s charge is not a copay, you can still use the Benefits Card and benefit from having the expense directly deducted from your account. For expenses that do not match the copay, you will need to submit supporting documentation. In some situations, your card will automatically be approved even if it is an ineligible expense. This most often happens when paying for services incurred in a prior plan year or for services where you coincidentally owe a multiple of the copayment. It is your responsibility to use your Benefits Card only for eligible expenses.

Direct deposit

By having your flexible spending account reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a direct deposit remittance advice. The remittance advice will indicate the date your claim was paid and the amount that will be deposited to your bank account. All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to 2-3 business days to appear in the designated account. Should you make any changes to your bank account, such as account closure or change in account number, please notify BenefitHelp Solutions immediately. If there is an interruption in the direct deposit service, you will receive checks for reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.

Terms and Conditions

By signing this application:

1. **Acceptable plan terms.** You agree to abide by the terms, conditions and provisions of the plan contained in your employer’s plan documents. These documents are available to you through your human resources or benefits department.
2. **Responsibility.** You acknowledge that the Internal Revenue Code (IRC) permits claim reimbursement only for eligible expenses incurred after the effective date and prior to the termination date of your healthcare flexible spending account, dependent care assistance program and/or commuter expense reimbursement program. You assume full responsibility for all taxes, penalties, interest or other consequences that may be assessed to you by any state, federal or other governmental taxing authority as a result of receiving reimbursement for a disallowed expense. You will only use your account to pay for eligible expenses incurred by yourself and/or your tax dependents. You understand that BenefitHelp Solutions, its agents or employees, will not be held liable if you submit ineligible expenses for reimbursement. Expenses cannot be reimbursed by any other plan. If requested, you agree to provide appropriate supporting documentation within the requested time frame. You understand that you cannot change or revoke an election until open enrollment or during an applicable change in status.
3. **Plan modification.** You have been informed that the plan offered by your employer may be modified from time to time, and you agree that your employer may cancel or amend your plan according to the employer’s independent judgment and discretion without your consent or prior notice.
4. **Social security.** You choose to participate in the plan knowing that your salary reduction elections may reduce your FICA withholdings (Society Security) and that this may reduce your Social Security benefits upon retirement.
5. **Forfeiture.** You understand that you must claim reimbursement for eligible expenses incurred during the plan year for which you were an active participant within the run-out period of the plan year (and grace period if applicable), as stated in your Summary Plan Document. If any unused amounts remain in your account(s) after any carryover (if applicable), these amounts will be forfeited.
6. **HSA contributions.** You understand that if you, your spouse or your children participate in an HSA plan, HSA contributions may be disallowed if any HSA participants also participate in the healthcare flexible spending account.
7. **Status change.** Unless otherwise noted in your Plan Documents, Qualified Status Changes (QSCs) must be submitted within 30 days of the event. Please discuss with your human resources department to determine if your event is a QSC. If there's an election change, you understand that additional funds due to an increase in your election can only be used for claims incurred on or after the date of change.
8. **Benefits Card.** If it is determined that the Benefits Card paid for an ineligible expense, you will either refund your account the amount of the ineligible expense or offset the ineligible expense with an eligible expense. If you fail to do so, the ineligible amounts may be included as taxable income at the end of the year. You understand that if you do not provide supporting documentation as required, your Benefits Card may be deactivated until your account is settled.

Reimbursement Request Form

1893 (10/21)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

Completion guide

This form is for the reimbursement of any out-of-pocket expenses. Documentation to substantiate purchases made with your debit card must be submitted with a copy of a Receipt Reminder. Please be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software.

Step 1: Accountholder information

- Complete required fields with account holder information and follow the steps below.

Step 2a: Reimbursement information

- **Plan type:** Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Did you file online:** If a claim was filed online at bhsconsumer.lh1ondemand.com, mark "Y" for yes; if not, mark "N" for no.
- **Date(s) expense(s) incurred:** Provide the date or range of dates the expenses were incurred.
- **Merchant/provider name:** Provide the name of the merchant or facility where the expense was incurred.
- **Name of person receiving product/service:** Provide your name or the name of the tax dependent for which the service was provided or the product was purchased.
- **Claim amount:** Provide the total amount requested for the specified expense.
- **Total reimbursement requested:** Total the amounts in the "Claim Amount" boxes.

Step 2b: Dependent care provider signature and certification

- Should the daycare provider be unable to provide a receipt, a signature is required in order for your Dependent Care Account (DCA) claim(s) to be paid.

Step 3: Participant certification

- Sign and date the form after reading the Participant Certification.

Documentation requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (Please be advised: if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider
- For Adult Care Services, a letter from the doctor or a Medical Necessity form is required to identify that the dependent is physically or mentally disabled and unable to self-care.

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the copayment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "copayment" is not clearly identified, have the provider write "copayment" on the receipt and sign it.

Instructions:

1. Complete all sections of this form.

2. Securely email, mail or fax completed form and supporting documentation (see below) to:

Secure Email: BenefitHelpSolutionsCDHSupport@healthaccountservices.com

Address: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108

Fax: 855-778-9837

3. If you have any questions about completing this form, please contact BenefitHelp Solutions Consumer Services at (855) 378-0197. We have representatives available Monday-Friday, 7:00am to 7:00pm CST.

Reimbursement Request Form

1893 (09/21)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth _____ / _____ / _____	* Social Security number

* Mailing address	* City	* State	* ZIP
* Physical address	* City	* State	* ZIP

* Email address	* Contact phone number

* Employer
City of Salem

Section 2 Reimbursement information

2a) Claim information

**Please select only one to start, change, or stop reimbursement.*

* Plan type[1]	* Did you file online (Y or N)	* Date(s) expense(s) incurred	* Merchant/provider name	* Name of person receiving product/service	* Claim amount
					$
					$
					$
					$
				* Total reimbursement requested	= 0.00

[1] Plan types: FSA-Flexible Spending Account; DCA-Dependent Care Account; LFSA-Limited Flexible Spending Account; HRA-Health Reimbursement Arrangement

2b) Dependent care provider signature and certification (dependent care claims only)

If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your daycare provider must complete this step. If you would prefer to file only one claim for the plan year, please access the Recurring Dependent Care Request Form at www.BenefitHelpSolutions.com.

* Dependent's name	* Dependent's Social Security number	* Dependent's date of birth (mm/dd/yyyy)	* Service type (choose one)
		_____ / _____ / _____	☐ Child care ☐ Adult care**

* If choosing adult care as an expense, please submit a medical necessity form if you haven't already.

I certify the information provided above is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

* Dependent care provider signature	* Date

Section 3 Participant certification

I certify that the reimbursement request I am submitting are eligible expenses as defined by the IRS and I have not been previously reimbursed for these expense, nor am I seeking reimbursement for these expenses from any other source. I understand BenefitHelp Solutions, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. I certify that the reimbursement is for the purpose of a qualified expenditure for an eligible individual as defined by the Internal Revenue Service (IRS) code. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify BenefitHelp Solutions. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

* Participant signature	* Date

Automatic Orthodontia Request Form

0454 (9/20)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

This form is to be completed for any consumer that wants to receive automatic reimbursement for orthodontia expenses. Payments are issued at the beginning of each month for which services are still being provided. If participating in automatic reimbursement for these expenses, the benefits debit card cannot be used to pay the provider.

Instructions:

1. Complete all sections of this form.

2. Securely email, mail or fax completed form and supporting documentation (see below) to:

Secure Email: BenefitHelpSolutionsCDHSupport@healthaccountservices.com

Address: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108

Fax: 855-778-9837

3. If you have any questions about completing this form, please contact BenefitHelp Solutions Consumer Services at (855) 378-0197. We have representatives available Monday-Friday, 7:00am to 7:00pm CST.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth _____ / _____ / _____	* Social Security number
* Mailing address		* City	* State	* ZIP
* Physical address		* City	* State	* ZIP
* Email address			* Contact phone number	
* Employer City of Salem				

Section 2a Orthodontia information

Please complete this section for the individual receiving orthodontic services/treatment. If you have multiple individuals receiving treatment, please submit each one on a separate form.

* Start date of treatment (mm/dd/yyyy): **A.** _____ / _____ / _____	* End date of treatment (mm/dd/yyyy): **B.** _____ / _____ / _____
* Person receiving orthodontic services/treatment	*Monthly cost of treatment $

*Please select only one	
☐	**Contract attached:** I have attached a copy of the contract or payment plan for each qualifying dependent for which orthodontic services are being provided. **Please skip step 2b.**
☐	**Orthodontist signature:** My orthodontist has completed and signed **step 2b.**
☐	**Stop automatic orthodontia:** I have previously enrolled in automatic reimbursement and request that it be stopped, effective (mm/dd/yyyy) _____ / _____ / _____

Section 2b Orthodontist certification

I, _____, certify the information provided on this form is accurate and that services are being provided to the specified individual(s) through the dates indicated in Box A and Box B. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

* Orthodontist signature	* Date

Section 3 Participant certification

To the best of my knowledge, the information provided is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that BenefitHelp Solutions including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If submitting expenses for my Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), I certify that I, or the individual for whom I am requesting reimbursement, continue to have Minimum Essential Coverage (MEC). I understand that if I fail to maintain MEC, any reimbursements made from my QSEHRA during the month in which I did not have MEC will become taxable. If submitting expenses for my Individual Coverage Health Reimbursement Arrangement (ICHRA), I certify that I, or the individual for whom I am requesting reimbursement, have (or had) individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage) during the month the expense was incurred. If there are any changes in the provided information, I understand it is my responsibility to notify BenefitHelp Solutions I understand that I should retain a copy of all submitted documentation in the event of an IRS audit and that, pending approval, reimbursement will begin the first month following the date of my submission.

* Participant signature	* Date

Recurring Dependent Care Request Form

1892 (09/21)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

This form is to be completed each plan year and as changes occur when the participant wants to receive recurring reimbursement of dependent care expenses. Reimbursements will not be made prior to when the dependent care services are provided. Documentation must be retained for your records and provided to BenefitHelp Solutions upon request. Receipts can be uploaded through the participant portal or faxed to 855-778-9837. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

Instructions:

1. Complete all sections of this form.
2. Securely email, mail or fax completed form and supporting documentation (see below) to:

   Secure Email: BenefitHelpSolutionsCDHSupport@healthaccountservices.com

   Address: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108

   Fax: 855-778-9837

3. If you have any questions about completing this form, please contact BenefitHelp Solutions Consumer Services at (855) 378-0197. We have representatives available Monday-Friday, 7:00am to 7:00pm CST.

Section 1 Consumer Information

* Consumer first name	M.I.	* Last name	* Date of birth _____ / _____ / _____	* SSN or BHS identification number
* Mailing address		* City	* State	* ZIP
* Physical address		* City	* State	* ZIP
* Email address			* Contact phone number	
* Employer City of Salem				

Section 2 Auto-Dependent Care (DCA) information

2a) Recurrence status

Please select only **one to start, change, or stop reimbursement.*

☐	**Start recurring DCA:** Please begin recurring reimbursement of my dependent care expenses. I understand BenefitHelp Solutions will request receipts as proof that expenses have been incurred.	**Effective date (mm/dd/yyyy)**
☐	**Change recurring DCA information:** Please update my recurring reimbursement information with the provided information effective by the date specified in box A.	**A.** _____ / _____ / _____
☐	**Stop recurring DCA:** Please stop recurring reimbursement of my dependent care expenses effective by the date specified in box B.	**B.** _____ / _____ / _____

2b) Dependent's information

*Dependent(s) name(s)	* Dependent's Social Security Number	* Dependent's date of birth (mm/dd/yyyy)	* Start date of service (must be within current plan year)	* End date of service (must be within current plan year)	* Service type (choose One)
		_____ / _____ / _____			☐ Child care ☐ Adult care**
		_____ / _____ / _____			☐ Child care ☐ Adult care**

**If choosing Adult Care as the Service Type, you must provide a letter from a doctor or a Medical Necessity Form that identifies that the dependent is physically or mentally disabled and unable to self-care.

Recurring Dependent Care Request Form

1892 (09/21)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

Section 3 Dependent care provider information and signature (to be completed by the provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

* Provider's name	Cost per month/week (circle one) $_____ per month/week	* Provider's signature
* Provider's name	Cost per month/week (circle one) $_____ per month/week	* Provider's signature

Section 4 Participant Certification

To the best of my knowledge, the information provided is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that BenefitHelp Solutions including its agents and employees, will be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN), and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify BenefitHelp Solutions. I understand that it's my responsibility to retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form, I certify the above.

* Participant signature	* Date