



My Company Plan

Appendix to the BESTflex Plan Summary Plan Description

This document outlines all of the options included in your company's BESTflex Plan. It may include options you have chosen not to participate in. For further information about your plan, refer to your BESTflex Plan Summary Plan Description.

My Plan

Organization Name	Waukesha County (W2755)
Cafeteria Plan Name	Waukesha County Flexible Compensation Plan
Plan Year	January 1 - December 31

My Plan Eligibility

Benefit Type	Eligibility
Dependent Care FSA	The employee is eligible the first of the month following 60 days of employment. Only employees who are regularly scheduled to work at least 20 hours weekly can participate.
Health Care FSA - Standard	The employee is eligible the first of the month following 60 days of employment. Only employees who are regularly scheduled to work at least 20 hours weekly can participate.
HSA Contributions	Employees must participate in a qualified High Deductible Health Plan. See your Summary Plan Description (SPD) for more information.
Insurance Premiums	Employees otherwise eligible for certain insurance coverages (listed in the My Other Pretax Benefits section) are eligible to pay for those premiums before taxes.

My FSA Options

You may choose to participate in and contribute to the following flexible spending account (FSA) options.

Dependent Care FSA (with Grace Period)	Used for daycare expenses incurred for the care of your child(ren) or other eligible dependents. You (and your spouse, if you are married) must be working, looking for work, or be a full-time student to use this account. <table><tr><td>Minimum Plan Year Contribution:</td><td>\$260</td></tr><tr><td>Maximum Plan Year Contribution:</td><td>\$5,000</td></tr></table> Grace Period Details: Your Dependent Care FSA option includes a grace period, which extends your plan year by 2 months and 15 days. This allows you to continue to incur eligible expenses for payment from your Dependent Care FSA until March 15 and submit them for reimbursement. Please refer to Dependent Care FSA Details in your BESTflex Plan Summary Plan Description (SPD) for more information.	Minimum Plan Year Contribution:	\$260	Maximum Plan Year Contribution:	\$5,000
Minimum Plan Year Contribution:	\$260				
Maximum Plan Year Contribution:	\$5,000				
Health Care FSA - Standard	Used for eligible medical, vision, and dental expenses incurred by you, your spouse, your eligible child(ren) or your eligible dependent(s). This plan is not compatible with making health savings account (HSA) contributions in the same plan year.				

Minimum Plan Year Contribution:	\$260
Maximum Plan Year Contribution:	\$2,750

Submitting FSA Claims

The Accessing Your Funds section in your BESTflex Plan Summary Description includes more information about the following.

Submitting FSA Claims for Reimbursement Online, through the Mobile App, or on a Claim Form

You may submit claims for reimbursement online at www.ebcflex.com, through the mobile app, or by filling out and submitting a claim form. Reimbursement is made in the order claims are received. The first claim received and processed is the first one paid from the FSA.

Paying for Eligible Health Care Expenses with the Benefits Card

Your employer's Health Care FSA includes a Benefits Card. The Benefits Card is a prepaid debit card you can use to pay for eligible expenses with funds directly from your Health Care FSA balance.

The Benefits Card debits your Health Care FSA when you use the card at approved service providers and retailers to pay for eligible expenses. Remember to save your receipts and purchase documentation when using the Benefits Card. If your transaction cannot be automatically substantiated at the point of sale, you will be sent a Documentation Request to verify the expense is eligible for payment from your Health Care FSA.

You can only use your Benefits Card for an expense incurred in the same plan year it is paid. To be reimbursed during your runout period for prior plan year expenses, submit a claim for reimbursement online, through the mobile app, or on a claim form.

If you use your Benefits Card while you have pending claims for reimbursement that you previously submitted, your Benefits Card transaction may be processed before the pending claims. As a reminder, the first claim processed is the first one paid from the Health Care FSA.

Runout Period

Your runout period is 3 months long and you may submit claims for eligible expenses incurred during the plan year until March 31, 2021. If you end your employment or lose eligibility mid-plan year, you will still have 3 months to submit Health Care FSA claims from the date your employment ended or you lost eligibility.

My Other Pretax Benefits

The BESTflex Plan allows your employer to withhold certain pretax benefit contributions from your payroll before taxes, which saves you money.

Group Insurance Premiums	Renewal Date
Dental Insurance	January 1
Medical Insurance	January 1
Vision Care	January 1

Health Savings Account (HSA) Contributions If you are an eligible HSA accountholder, your BESTflex Plan allows you to contribute to your HSA on a pre-tax basis by making a salary reduction election.

Additional Details

Employer Contributions For Employees who complete the full Health Risk Assessment Program, the Employer will provide \$1,125 for single coverage and \$2250 for family coverage annually. For Employees who complete the partial Health Risk Assessment Program, the Employer will provide \$844 for single coverage and \$1,688 for family coverage annually. For Employees who do not complete the Health Risk Assessment Program, the Employer will provide \$500 for single coverage and \$1,000 for family coverage annually. This contribution can be used towards the Health Savings Account.

Administration Fees Your employer is paying all fees for this plan.

My Health Care FSA ERISA Information

ERISA Status The Plan is not governed by ERISA

Your company, Waukesha County, has adopted the BESTflex Plan (the Plan) and has engaged Employee Benefits Corporation, P.O. Box 44347, Madison, WI, 53744 (telephone: 608 831 8445; toll free: 800 346 2126), to provide services related to the Plan. For purposes of federal law, the Employer is the Plan Sponsor and the Plan Administrator.

Employee Benefits Corporation Contact Information

Web Address	www.ebcflex.com
E-mail Address	participantservices@ebcflex.com
Fax Number	(608) 831-4790
Mailing Address	Employee Benefits Corporation PO Box 44347 Madison, WI 53744-4347
Phone Number	Monday-Friday 7:00 am-5:00 pm Central Time (800) 346-2126 (608) 831-8445