eBenefits
ADMINISTRATORS, INC

A VARIETY OF MONEY SAVING CHOICES

Section 125 Cafeteria Plans
Proposal

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We **thank you** for the opportunity to present our comprehensive employee benefit solutions.

Welcome

As an independent business offering third party administration, eBenefits Administrators, Inc. understands the best way to help your business is to do it all. Our firm understanding of both brokerage and TPA services ensures a benefit strategy that maximizes the value of your insurance and saves you and your employees money.

Once we have your business, we plan on keeping it. We've invested heavily in the latest online technologies, providing you and your employees with a wealth of tools that simplify the claims process, eliminate paperwork, educate everyone on how plans work and provide unsurpassed access to account information.

Over the next few pages, we hope to give you a better understanding of Section 125 Cafeteria Plans and why eBenefits Administrators should be the only choice for your Cafeteria Plan administration needs.

You'll be pleased with our work, or we won't be. **That's our promise.**

Section 125 Cafeteria Plans

Cafeteria Plans provide participants a variety of **money saving options**.

What are Cafeteria Plans?

Governed under Section 125 of the Internal Revenue Code, Cafeteria Plans help you and your employees save money by using tax-free dollars to pay for group health insurance premiums, out-of-pocket medical expenses, the cost of dependent care and more. Much like a cafeteria offers choices ranging from blue plate specials to a la carte items, Cafeteria Plans offer employees the option to participate in any or all of several available plans.

eBenefits Administrators provides complete, comprehensive administration of Cafeteria Plan services. See page 7 for detailed information.

How Cafeteria Plans Work

An employee selects a contribution amount for the year, and the contribution is set aside to pay for eligible out-of-pocket expenses. Those expenses are paid for by using tax-fee dollars, which in turn lower year-end taxes and save the employee money. The employee then submits substantiation of their eligible expenses to eBenefits Administrators for reimbursement. See page 4 for detailed information on the claim submission process.

Benefits

Tax Savings

Employers save on payroll taxes (FICA, FUTA and SUI) and workers' compensation premiums. Generally, employers save 8% on FICA taxes and 10% on each pre-tax dollar employers contribute toward premiums.

Employees save on Federal, State and FICA taxes. The average employee saves 25-30% on dollars they are already paying. When you consider the average family pays $800 - $2,500 per year on medical expenses, that's a fairly significant savings!

Flexibility

Employees can choose how much money they want to contribute as well as what options they want to participate in.

Plan Types

There are three primary types of Cafeteria Plans:

Premium Only Plans (POPs)

If your employees are paying for any portion of their health insurance premiums, a POP deducts their portion from payroll on a pre-tax basis, resulting in lower employee and employer taxes. POPs are the most common component of all Cafeteria Plans and are most often used in conjunction with Flexible Spending Accounts and Dependent Care Assistance Plans. Eligible plans are limited to the employer's group plan(s) such as medical, dental and vision, as well as a number of voluntary products. (Disability plans should not be pre-taxed, otherwise the benefits are taxable.)

Flexible Spending Accounts (FSAs)

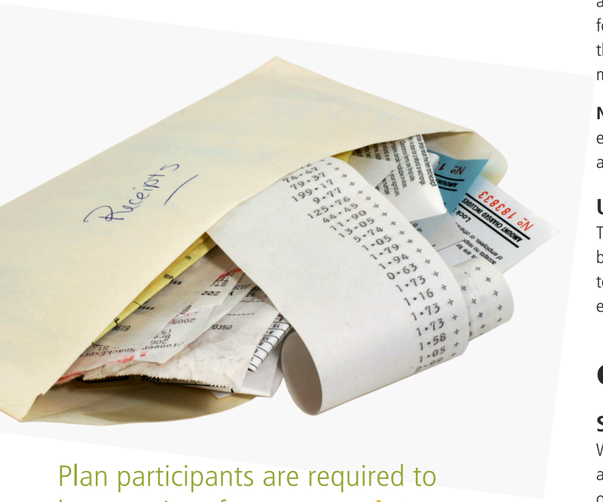
An FSA helps fill in the coverage gap between the health plan and out-of-pocket expenses like deductibles, office co-payments, prescriptions, over-the-counter drugs, dental and vision care. The expenses may be payroll deducted on a pre-tax basis, resulting in significant tax savings for employees and employers.

Many employers falsely assume an FSA is more complex to implement than a POP. However, the only difference between installing a POP and a plan that also includes an FSA is adding employee education.

Dependent Care Assistance Plans (DCAPs)

A DCAP allows employees to pay for qualified dependent care expenses like day care, nursery school, preschool, before/after-school care, adult day care facilities and adult in-home day care. Married couples filing jointly and singles can set aside up to $5,000 to pay for these expenses tax-free.

DCAPs help working parents pay for **child care expenses** tax-free.



Plan participants are required to keep copies of **every receipt**.

IRS Regulations

Uniform Coverage Rule

This rule applies to FSAs and states an employee's annual election amount must be made available from the beginning of the plan year. For example, if an employee elects $1,200 for the FSA plan year and has a $300 dental work claim in the first month, it is required that the employee is paid or reimbursed in full for the expense. The employer may set a maximum annual election amount to reduce costs associated with this rule.

Note: Once a plan election is made for the year, the election is irrevocable unless the employee incurs an IRS-defined qualifying event like marriage, divorce, birth or child adoption, employment status change, etc.

Use-it-or-Lose-it-Rule

This rule applies to both FSAs and DCAPs and states the funds an employee elects must be utilized by the end of the plan year. Any unused money is forfeited to the employer to offset the costs of plan administration. However, an employer can choose to give employees a grace period of up to 2 1/2 months after the plan year ends to file claims.

Claims

Submission

When an employee incurs an eligible health care or dependent care expense, they submit a claim to eBenefits Administrators for reimbursement. Each claim must be substantiated or validated with a detailed receipt.

A receipt for any type of medical, prescription, dental or vision service must include:

- Date
- Patient name
- Place of service
- Description of service
- Cost or copayment

A receipt for any type of over-the-counter item must include:

- Date
- Description of service
- Cost

When submitting a dependent care claim, a bill or receipt from the care provider is required. Services must be rendered during the plan year and must be incurred prior to reimbursement. Employees may submit one claim form at the beginning of the plan year, and they will be reimbursed according to their care provider's pay schedule.

Claim filing instructions, as well as claim forms, can be accessed online 24/7 in our forms library at http://www.ebeneadmin.com/employee/forms.shtml. All claim forms must be completed, signed and dated with the appropriate documentation attached.

Employees may also submit their claims online. With online claim submission, an employee can easily enter all their claim details and upload a PDF copy of their receipt via our secure web site. There are no paper forms, no faxing and no cover pages.

If an employee uses The Benny™ Prepaid Benefits Card, they may not need to submit any claims for reimbursement. However, employees are still required to keep back-up copies of all their receipts and documentation on-hand in case we needs to validate any account withdrawals due to IRS requirements. For additional information on The Benny Card, please see page 9.

Processing

Claims are processed on a weekly basis. All claim submissions must be received by eBenefits Administrators by 5 PM three business days prior to the scheduled processing day to be included in that week's reimbursement run. All claims received after the claim submission deadline will be held over until the next processing day. To simplify the process, we provide employees with calendars highlighting their employer's claim processing schedule.

We offer easy **online claim filing**.

Our debit card is proven to **reduce paperwork**.

Reimbursement

Employers may choose from five available reimbursement methods:

Add Net to Payroll

The employer receives via email a payment register and direct reimbursement voucher(s) documenting the processed claims. The employer forwards the information to their payroll department or payroll company. The payroll department then adds the reimbursement amounts to the employees' payrolls pre-tax or writes and distributes reimbursement checks to the employees. No reimbursements are generated by eBenefits Administrators.

Direct Deposit

The next day after processing occurs, the employer receives via email a payment register and direct reimbursement voucher(s) documenting the processed claims. eBenefits Administrators pulls the total amount listed in the payment register from the employer's bank account, and reimbursements are then transferred directly into the employees' bank accounts. Deposits may take 2-5 business days to process. The employer must provide us with their bank account information for this method, and employees must complete and submit a direct deposit form along with a voided check.

Check Mailed to Employee's Home

The next day after processing occurs, the employer receives via email a payment register, copies of the employees' reimbursement checks and an explanation of benefits documenting the processed claims. eBenefits Administrators pulls the total amount listed in the payment register from the employer's bank account. Once we have the funds necessary to cover claim reimbursements, reimbursement checks are mailed to the employees at the addresses we have on file. The employer must provide us with their bank account information for this method.

Signature-Ready Check

On the same day claim processing occurs, the employer is mailed a payment register, signature-ready reimbursement checks and an explanation of benefits documenting the processed claims. The employer's bank account information will be printed on the checks, and the employer is responsible for signing and distributing the checks to employees. With this method, the employer must provide us with their bank account information, and there is an increased cost due to check stock, envelopes and postage.

Debit Card

Our optional debit card, The Benny™ Prepaid Benefits Card, enables plan participants to pay for qualified expenses directly from their accounts, eliminating the wait for reimbursement and significantly reducing paperwork. See page 9 for additional information.

The eBenefits Administrators Difference

Comprehensive Administration

eBenefits Administrators provides complete, comprehensive administration of Cafeteria Plan services. Our experienced team effortlessly navigates the complex world of Cafeteria Plans, taking care of enrollment, account set-up, implementation, education, staff training and account administration.

Before a Cafeteria Plan is implemented, we make certain the plan passes discrimination testing as required by the IRS. We perform this testing throughout the year to account for the addition and deletion of employees for consistent plan maintenance.

We also provide an employer with all the necessary legal documentation they need to ensure the plan is IRS compliant. These documents include:

- Corporate resolution
- Adoption agreement which defines:
  - Benefit description
  - Eligibility rules
  - Participant elections and changes
  - Maximum employee election amount
  - Plan year definition
- Plan document
- Summary plan description

Our legal documentation is obtained through Sunguard Relius, one of the premiere document systems available. As regulations are created or revised, we promptly deliver updated documents to the employer.

Most importantly, we give employees the personalized support they need to understand and utilize all of the advantages a Cafeteria Plan offers. An employee can simply pick up the phone or email us anytime they have a question or concern.

We are dedicated to providing all-inclusive, **on-call customer care** before, during and after enrollment.

Online Tools & Resources

Our web site, www.ebeneadmin.com, provides 24/7 access to these helpful features:

Online Claim Submission

Employees may file claims, check claim statuses and review their accounts at any time. Employers can review aggregate status reports or drill down to the employee level to view payment history, outstanding debit card swipes, etc. See page 4 for additional information on the claim submission process.

Eligible Expense Matrix

Our detailed matrix lists common medical expenses that may be eligible and ineligible for reimbursement.

Forms Library

Employees can conveniently download claim filing forms, instructions and more in PDF format.

Tax Savings Calculator

Employers and employees can compare the savings between their current health plan and switching to a Cafeteria Plan using our interactive calculator.

Health Resources

We provide a comprehensive list of medical web sites so employees and employers can easily gather health-related information online.

IRS Regulation Updates

Employers can download the latest IRS rules and regulations in PDF format.

Participants have **24/7 access** to their benefit information.

The Benny™ Prepaid Benefits Card

eBenefit Administrators, through a partnership with Evolution Benefits, Inc. is pleased to present The Benny Card. The Benny Card is a MasterCard® debit card which enables plan participants to pay for qualified expenses directly from their accounts. The Benny Card is unequaled in its ability to provide convenience to the employee and simplify the administration of Flexible Spending Accounts, Health Reimbursement Arrangements and Health Savings Accounts.

Benefits

Ease of Use

Employees can use The Benny Card to pay for eligible expenses anywhere that accepts MasterCard. Transactions post online instantly, eliminating the hassle of claim forms, reimbursement checks and, in most cases, the need to submit receipts. The Benny Card greatly reduces the administrative work and cost typically associated with tax-advantaged accounts.

Increased Plan Enrollment & Tax Savings

Addition of The Benny Card to FSA administration has been shown to increase employee participation rates from 20-40% with an average annual contribution increase estimated from 10-50%. This leads to additional FICA tax savings for employers.

Multiple Accounts on One Card

The Benny Card coordinates fully with other health care product lines such as Health Savings Accounts and Health Reimbursement Arrangements, enabling multiple accounts to be accessed in a specific order on the same card. This creates a bridge between first dollar coverage, deductibles, coinsurance and 100% coverage.

Online Account Access

Employees can track expenditures and remaining account balances at www.MyBenny.com.

Usage of The Benny Card increases participation rates, leading to **additional FICA tax savings** for employers.

Substantiation & Compliance

Evolution Benefits provides the best in auto-substantiation technology to ensure IRS compliance and reduce the number of receipt requests. Cardholder follow-up is needed in only 10-20% of transactions. The technology's differentiating features include:

Compliance with Merchants Using the Inventory Information Approval System (IIAS)
IRS regulations specify that FSA and HRA debit cards may not be used at stores with the drug store and pharmacy merchant category code unless the merchant has the Inventory Information Approval System (IIAS). When an employee makes a purchase at an IIAS participating merchant, the merchant's system automatically recognizes and separates FSA-eligible from ineligible purchases. Alternative payment methods are requested for the ineligible items.

Compliance with Merchants Using the 90% Rule
IRS regulations state drug stores and pharmacies which have 90% or more gross sales in prescription drugs and eligible over-the-counter health care products can be viewed as health care merchants by plan administrators of debit card programs. When an employee makes a purchase at a merchant which meets the 90% rule, the merchant's system automatically recognizes and separates FSA-eligible from ineligible purchases. Alternative payment methods are requested for the ineligible items.

To view a list of participating IIAS and 90% rule merchants, please visit www.seg-is.org.

Patented Real-Time Data Matching at Point-of-Sale
Real-time substantiation occurs when The Benny Card is swiped at the pharmacy. Evolution Benefits has in place direct data links with the premiere pharmacy benefit managers (PBMs) including Argus, Caremark Rx, Catalyst Rx, Express Scripts, Innoviant, Medco Health, MedImpact, and PharmaCare. If a transaction matches PBM data, the transaction is approved and considered 100% substantiated, requiring no further action. A transaction is declined if the data does not match. This patented process requires no special handling at the point-of-sale and works completely in the background.

Retrospective Data Matching
Paid card transactions are compared to adjudicated claims from pharmacy, health plan, vision and dental carriers. If they match, the card swipe transaction is considered 100% substantiated, requiring no further action. Evolution Benefits currently receives feeds from over 100 carriers.

Employee-Level Copayment Matching
eBenefits Administrators collects copayment information from the employer and provides it to Evolution Benefits. Evolution Benefits then matches the copayment information retrospectively against card transactions. The system automatically calculates up to five multiple and combination copayments.

Recurring Expense Logic
Once a transaction has been substantiated the first time, transactions for the same amount in the same setting do not require another review. Evolution Benefits substantiates these transactions electronically.

In the event Evolution Benefits is unable to substantiate a transaction automatically after applying all the IRS-approved methods above, the employee will receive a letter or email requesting a receipt to ensure IRS compliance. When a receipt is requested, it must be submitted within 30 days, or the card will be deactivated.

Optional Wellness Programs & Tools

Poor diet, lack of exercise, smoking, obesity and stress are prime factors in 80% of costly chronic disease. Rising health care costs can be significantly controlled when individuals change unhealthy behaviors and take charge of their health. We offer best-in-class services so employees can better manage wellness, chronic care needs, disease prevention and embark on a proactive strategy to improve their overall well-being.

Health Advocate™

Navigate through the world of health care with confidence! This one-on-one program saves employees time and money while easing the burden placed on HR staff.

Health Advocate's services are delivered by a team of independent registered nurses, medical directors and administrative experts who aid consumers with clinical and insurance issues. The program addresses the entire family's needs including the employee, employee's spouse or domestic partner, dependent children and parents and parents-in-law.

A participant can make a toll-free call to their assigned personal health advocate whenever they need to resolve a range of time-consuming tasks such as deciphering claims, locating the best medical facilities and specialists, assisting with eldercare and much more. Below is a more detailed list of Health Advocate's features.

- Finds the best doctors, dentists, hospitals and other health care providers anywhere in the country
- Expedites appointments including hard-to-reach specialists
- Arranges specialized treatments and tests
- Provides comparative health cost estimates
- Negotiates billing and payment arrangements
- Assists with eldercare such as finding adult daycare, assisted living and other related issues facing parents and parents-in-law
- Works with insurance companies to obtain appropriate approvals for needed services
- Obtains unbiased health information about complex medical conditions to help make informed decisions
- Helps resolve insurance claims
- Answers questions about test results, treatments and medication prescribed by physicians
- Assists in the transfer of medical records, x-rays and lab results
- Locates and researches the newest treatments for a medical condition
- Explains benefits and helps facilitate access to appropriate care

Consult A Doctor™

Reach a licensed physician anytime, anywhere.

Consult A Doctor provides participants with on-demand, 24/7 phone and email access to U.S. based and licensed physicians. Participants and their families can connect instantly with Consult A Doctor's network of physicians for information, advice and treatment including prescription medication when appropriate. There are no waiting rooms, no insurance forms, no limitations on usage and no one is denied. Best of all, there is no copayment from the employee and no cost against the health plan.

Recieve treatment and advice from **licensed physicians** at any time without the hassle of copayments and waiting rooms.

Fee Schedule

All online tools and resources are included at no extra charge to the employer.

Annual Administration Fee	
Annual administration fee	$300.00
Initial Set-Up Fee	
New clients may reduce the initial set-up fee by 50% and renewal clients may have the fee waived by submitting their employee census data using our Microsoft Excel spreadsheet. Please call 800.494.6804 for more information.	
1 - 200 employees	$250.00
201 - 500 employees	$500.00
501 - 1000 employees	$800.00
1000+ employees	Contact us for a custom quote.
Monthly Administration Fee per Participant	
The rates shown below will be higher if multiple reimbursement methods are selected.	
Add net to pay	$3.50
Direct deposit	$4.50
Check mailed to employee's home	$6.00
Signature-ready check	$5.50
Debit card (The Benny™ Prepaid Benefits Card) The fee becomes $9.00 if both a DCAP and FSA are used together.	$4.50
Optional Wellness Programs & Tools Fees per Participant	
Health Advocate™	$1.25
Consult A Doctor™	$2.00
Minimum Monthly Fee	
Minimum monthly fee	$50.00

If invoice payment reaches 60 days past due, services will be suspended.

Frequently Asked Questions

Can you have an FSA combined with a Health Savings Account (HSA)?
A general-purpose FSA would prevent an individual from being eligible for HSA contributions. However, limited-purpose FSAs do not prevent HSA eligibility. A limited-purpose FSA may only permit coverage for vision, dental and preventive care and must be specifically spelled out in the Section 125 Cafeteria Plan document. The limited-purpose FSA can be very beneficial to participants. Just as with a general-purpose FSA, 100% of the election will be available at the start of the plan year.

What FSA expenses are eligible for reimbursement?
Below is a quick reference list of eligible expenses according to the Internal Revenue Code and Federal court. This listing may not be inclusive of all eligible expenses. For more information, please view IRS Publication 502 at www.irs.gov/pub/irs-pdf/p502.pdf.

Eligible Medical Expenses

- Acupuncture
- Adoption medical expenses (incurred before adoption is finalized)
- Alcoholism treatment
- Allergy medications
- Allergy shots and testing
- Ambulance (ground or air)
- Artificial limbs
- Blind services and equipment
- Body scans (MRIs)
- Braces and supports
- Capital expenditures (primary purpose must be medical care and prescribed by physician)
- Car controls for handicapped (prescribed by physician)
- Childbirth preparation classes (mother)
- Chiropractor services
- Christian science practitioners (for medical care only)
- Co-insurance amounts and deductibles
- Contact lenses and solution
- Crutches
- Dental treatment (x-rays, fillings, extractions, dentures, etc.)
- Diagnostic tests
- Doctor's fees
- Drug addiction treatment and facilities
- Eye examinations and eyeglasses
- Fluoride device (prescribed by dentist)
- Halfway house (adjustment to mental hospital)
- Hard-of-hearing services and equipment
- Healing services fees
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- Lasik eye surgery
- Lodging (limits apply)
- Medical alert bracelets and necklaces
- Medical monitoring and testing devices (if prescribed by physician for medical condition)
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations (legal)
- Optometrists
- Orthodontia care
- Orthopedic care
- Osteopaths
- Oxygen and/or oxygen equipment
- Physical exams (except for employment-related physicals)
- Physical therapy
- Prescription drugs
- Psychiatric care and psychologists
- Psychotherapists
- Radial keratotomy
- Schools (special, relief or handicapped)
- Sexual dysfunction treatment
- Surgical fees
- Swimming pool (if prescribed by physician for treatment for medical condition)
- Therapy treatments (prescribed by physician)
- Transportation (essentially and primarily for medical care - limits apply)
- Vaccinations
- Vitamins (prescription by physician)
- Walkers
- Weight-loss programs (if prescribed by physician for treatment of medical condition)
- Wheelchairs
- X-rays

Eligible Over-the-Counter Items

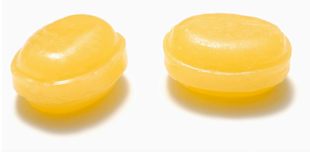
- Acne medication
- Allergy medications
- Anti-fungal creams and powders
- Anti-itch lotion
- Antacid tablets, liquids and pills
- Antibiotic ointments and sprays
- Anti-diarrhea medications
- Condoms
- Contraceptive creams
- Corn patches
- Cough syrups, cough drops and throat lozenges
- Diabetic supplies and equipment
- Diaper rash creams and ointments
- Eczema cream
- Eye drops and eye wash products
- First-aid products (bandages, dressings, kits, hydrogen peroxide and rubbing alcohol)
- Flu shots
- Medicated rubs
- Menstrual pain relievers
- Nasal sprays
- Nicotine medications and nasal sprays
- Ovulation kits
- Pain relievers (Aspirin, Tylenol, Motrin, etc.)
- Pregnancy tests
- Rehydration liquids for babies
- Sleep aids
- Teething gel for babies
- Wart remover products

What FSA expenses are ineligible for reimbursement?
Below is a quick reference list of ineligible expenses according to the Internal Revenue Code and Federal court. This listing may not be inclusive of all ineligible expenses. For more information, please view IRS Publication 502 at www.irs.gov/pub/irs-pdf/p502.pdf.

Ineligible Medical Expenses

- Advance payment for services to be rendered
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Body piercing
- Bottled water
- Chauffeur services
- Commuting expenses of a disabled person
- Controlled substances
- Cosmetic surgery and procedures
- Cosmetics
- Dancing lessons
- Diapers for infants
- Diaper service
- Ear piercing
- Electrolysis
- Fees written off by provider
- Food supplements
- Funeral, cremation or burial expenses
- Hair transplant
- Health Savings Accounts (HSAs)
- Household and domestic help
- Health programs offered by resort hotels, health clubs and gyms
- Hygiene products
- Illegal operations and treatments
- Illegally procured drugs
- Insurance premiums not reimburse able under FSAs
- Long-term care services
- Maternity clothes
- Medical Savings Accounts (MSAs)
- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Personal items
- Preferred provider discounts
- Social activities
- Special foods and beverages
- Swimming lessons
- Tattoos/tattoo removal
- Teeth whitening
- Transportation expenses to and from work
- Travel for general health improvement
- Uniforms
- Vitamins without prescription

Cough drops are an **eligible expense**.



Ineligible Over-the-Counter Items (Continued from previous page.)

- Aromatherapy
- Baby bottles and cups
- Breast enhancement systems
- Cosmetics
- Cotton swabs
- Dental floss
- Deodorants
- Dietary supplements
- Face creams and moisturizers
- Feminine care
- Fiber supplements
- Food and/or low calorie foods
- Fragrances
- Hair regrowth products
- Herbs
- Lip balm
- Medicated shampoos and soaps
- Oral care
- Petroleum jelly
- Shampoos and conditioners
- Spa salts
- Suntan lotion
- Toiletries
- Toothpaste
- Vitamins (daily)
- Weight-loss drugs for general well being

Note: As of January 1, 2011, over-the-counter (OTC) medications will no longer be eligible for reimbursement under FSAs with the exception of insulin medications. This would include items such as pain, allergy, headache medications, etc. Non-medication products such as band-aids, blood-pressure monitors, dental and vision expenses, etc. will still be eligible. **Exceptions to this rule:** If a participant has a physician's written prescription or note of medical necessity (NMN), OTC medications are still eligible for reimbursement. A copy of the prescription or written documentation must be submitted with the receipt(s).

Who is qualified for care under a DCAP?

Dependent care expenses must be for the care of one or more qualified dependents. Qualified dependents include:

- A dependent that is under the age of 13 when the care was provided and can be claimed as an exemption on a participant's income taxes.
- A dependent who is mentally or physically challenged and can be claimed as an exemption on a participant's income taxes.
- A spouse who is mentally or physically challenged.

What DCAP expenses are eligible for reimbursement?

Below is a quick reference list of eligible expenses according to the Internal Revenue Code and Federal court. Expenses claimed under a DCAP may not be applied toward the dependent care tax credit on an participant's income tax return. In most cases, the DCAP tax deduction is greater than the dependent care tax credit.

- After-school care
- Adult day care facilities
- Adult in-home day care
- Care provided at a day-care center or other location outside your home
- Housekeeping services provided at least in part for the dependent
- In-home dependent care
- Private preschool program
- Public or private before-school/after-school care
- Summer day camp (if cost is reasonable compared to other alternatives and the main purpose is to provide for the child's well-being)

Qualified DCAP expenses must also meet the criteria below. For more information, please view IRS Publication 503 at www.irs.gov/pub/irs-pdf/p503.pdf or consult your tax advisor.

- The service is necessary so that the participant and their spouse can work or look for work.
- The service may be provided in the participant's home or another location, however it cannot be provided by a minor child or dependent that can be claimed on the participant's income taxes.
- If the service is provided in a day care center, the center must charge a fee. If the center cares for six or more dependents who are not residents, it must comply with all applicable regulations and state and local licensing laws.
- Services must be for the physical care of the child and not education, meals, etc.
- The service may also be for a spouse or dependent who is incapable of self-care and regularly spends at least eight hours per day at the home.
- The same rules that apply for child care apply to the care of other dependents, except the dependent does not need to be under the age of 13.

What DCAP expenses are ineligible for reimbursement?

Below is a quick reference list of ineligible expenses according to the Internal Revenue Code and Federal court. This listing may not be inclusive of all ineligible expenses.

- Babysitting for social events
- Care provided by your spouse, your child under the age of 19 or someone you claim as a dependent for tax purposes
- Food or clothing provided for your dependent
- Overnight camp expenses
- School expenses for children in first grade or above
- Transportation expenses to and from the care location

Pay for preschool **tax-free** with a Dependent Care Assistance Plan.

Notes

eBenefits
ADMINISTRATORS, INC

For more information about Section 125 Cafeteria Plan administration or additional services offered by eBenefits Administrators, please call **814.866.9400** or toll-free **800.494.6804**.

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MEMBER-PROVIDED SOLUTION

UBA® United Benefit Advisors
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