BMO

Health Care and Limited Purpose Flexible Spending Accounts

Plan Details

alight

Smart-Choice Accounts®

Quick Facts

Vendor	Alight Smart-Choice Accounts PO Box 64009 The Woodlands, TX 77387-4009
Support	Human Resources Center (HRC) at 1-888-927-7700
Governance	The Health Care Flexible Spending Account and Limited Purpose Spending Account plans are governed by Internal Revenue Code (IRC) Section 125 which allows employees to pay for qualified medical, dental and vision expenses with pre-tax dollars. The official IRS publications that provide information on these plans are: Publication 502: Medical and Dental Expenses and Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans

Overview

BMO offers two types of Flexible Spending Accounts (FSAs) to help you save on eligible health care expenses by using pre-tax dollars.

- **Health Care Flexible Spending Account (HCFSA) -** The HCFSA helps pay for out-of-pocket medical, prescription, dental, and vision expenses for you and your eligible dependents.
- **Limited Purpose Flexible Spending Account (LPFSA) -** The LPFSA is designed for individuals enrolled in a High Deductible Health Plan (HDHP) and participating in a Health Savings Account (HSA).

  Initially, the LPFSA can only be used for dental and vision expenses, such as:

  - Fillings, X-rays, braces, and caps
  - Eyeglasses, contact lenses, solutions, and LASIK eye surgery

  Once you satisfy your HDHP deductible, you may contact Smart-Choice to convert your LPFSA into a Full Purpose Health Care FSA, allowing you to use your contributions for medical expenses as well.

Important note about HSA participation

If you are contributing to an HSA (whether through BMO or elsewhere) and wish to also contribute to an FSA, you must enroll in the LPFSA.

Until your HDHP deductible is met, only dental and vision expenses are eligible for reimbursement. After meeting the deductible, you can expand your LPFSA coverage to include medical expenses by contacting Smart-Choice.

What's Covered

You can use your Health Care Flexible Spending Account (HCFSA) to pay for eligible health care expenses for yourself and your eligible dependents that may not be fully covered by your medical, dental, or vision plans. This includes costs like deductibles, copayments, coinsurance, and other out-of-pocket expenses.

Important: Expenses reimbursed through your HCFSA cannot also be claimed as deductions on your federal income taxes or be reimbursed by another plan, HSA or FSA.

Examples of Eligible Expenses

Provided they are not reimbursed by any other plan, eligible expenses include:

- Acupuncture
- Allergy shots
- Chiropractor services
- Contact lenses, exams, and related materials (e.g., saline solution)
- Copayments, deductibles, and coinsurance
- Dental expenses not covered by your dental plan
- Medically necessary dietary supplements (with a physician's prescription)
- Eyeglasses and vision exams
- Equipment for individuals with disabilities (e.g., car controls, special phones)
- Hearing exams, hearing aids, and batteries
- Immunizations and vaccinations
- Insulin
- LASIK eye surgery
- Medical/dental expenses exceeding reasonable and customary limits
- Nursing home confinement for illness treatment
- Over-the-counter (OTC) medicines (no prescription required) and menstrual care products
- Physical therapy
- Prescription drugs for illness or injury
- Routine medical exams, including school physicals
- Smoking cessation and weight loss programs (if prescribed)
- Syringes, needles, and injections
- Transportation for necessary medical care (e.g., taxis, buses, airfare, parking)
- Well-baby care
- Wheelchairs
- X-rays

For a complete list of eligible expenses, see IRS Publication 502: Medical and Dental Expenses. For specific questions, contact the claims administrator.

Ineligible FSA expenses

Expenses that do not qualify as tax-deductible under federal income tax laws are not eligible for reimbursement through the HCFSA.

Below are examples of ineligible expenses:

- Cosmetic products
- Cosmetic surgery (unless required due to an accident or injury)
- Custodial care in institutions (e.g., nursing homes)
- Expenses incurred before your HCFSA participation begins
- Expenses paid by another group health or dental plan
- Teeth whitening or external bleaching
- Health club or gym membership dues
- Health care expenses reimbursed by another plan or insurance
- Health insurance premiums
- Household or domestic help
- Maternity clothing
- Uniforms
- Vitamins taken for general health (not prescribed)
- Weight loss or smoking cessation programs not prescribed by a physician

Contributions

The IRS sets annual pre-tax contribution limits for FSAs. BMO uses the maximum determined by the IRS each year.

The amount you elect to contribute to your FSA will be automatically deducted from your pay during the first two pay periods of each month. If there is a third pay period in the month, no deductions will be taken - unless an exception applies (e.g., to recover missed deductions).

For the FSAs, the entire annual elected amount is available to you on the first day of the Plan year, or on the effective date of coverage if you enroll mid-year. This allows you to access your full contribution amount early in the year, even though payroll deductions continue throughout the year.

IRS Non-Discrimination Rules for FSAs

To maintain their tax-advantaged status, FSAs must comply with IRS non-discrimination testing rules. These rules are designed to ensure that FSAs do not disproportionately benefit highly compensated employees (HCEs) or key employees over other participants.

The Plan Administrator may take corrective action at its discretion to ensure compliance with these rules. Corrective actions may include:

- Capping annual contribution limits for highly compensated employees
- Reducing FSA elections for highly compensated employees
- Imputing income on any excess benefit amount received by highly compensated employees

These measures help preserve the integrity and tax-favored status of the plan for all participants.

Other Special IRS rules

The special tax advantages of the FSAs are offered based on current Code rules. The same federal tax laws that allow pre-tax savings on your reimbursements also place certain restrictions on your accounts as follows:

- Your deductions for one kind of FSA cannot be transferred to the other. For example, you cannot transfer remaining Health FSA funds into your DCFSA to pay for eligible dependent care expenses.
- The money you set aside each calendar year must be used for that calendar year's expenses while you were actively participating. Any money that is not used will be forfeited except for the allowed Health FSA carry-over amount (see Carryover amounts for more information).
- Once you make your Health FSA election, your contributions will continue the first two pay periods for the rest of the calendar year. You may, however, change your elections if you experience a qualifying life event or status change that necessitates a mid-year election change.

Claims for reimbursement

As you incur eligible expenses during the Plan year, you can submit claims to your Smart-Choice flexible spending account for reimbursement. Each expense you submit will be reviewed by Smart-Choice to determine whether it qualifies for reimbursement under IRS rules. The service must be incurred during the Plan year and while you were actively participating to qualify for reimbursement. Pre-paid services that were charged or billed but not provided during the Plan year are not eligible for reimbursement.

Smart-Choice debit card

If you contribute $150 or more to your HCFSA, you can use the prepaid card to pay for eligible health care expenses. As you use your Smart-Choice card, eligible health care expenses will be deducted automatically from your account. You will receive a letter with

one Smart-Choice card issued in your name, activation instructions, and benefit cardholder agreement.

You may request additional cards for your spouse and/or eligible dependent(s) through the Smart-Choice website.

The Smart-Choice card remains active as long as your account is in good standing, you continue to participate in a Health FSA, and you remain actively employed. Your card will be canceled upon termination of employment—inactive participants may not use the Smart-Choice card. By signing and using the card, you certify that:

- You'll only use the card for your own eligible health care expenses and those of your eligible Dependents under the Plan.
- The expenses incurred were for health care services or supplies purchased on or after the date your Health FSAs took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your Dependents are eligible.
- Any expenses paid for with the card have not been, or will not be, reimbursed by another source.

The Smart-Choice card has been designed for use at merchants and providers that primarily sell health care products and services (for example, pharmacies, physician's offices, hospitals, and dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be prompted to use it as either "credit" or "debit." If you choose the credit option, you must provide your signature.

The Smart-Choice card has a pre-assigned PIN that cannot be changed. Once coverage is active, you will be able to obtain your PIN on the Smart-Choice portal. To view this log into the Smart-Choice portal, navigate to the debit cards page, and select the Smart-Choice card for which you need to locate the PIN. Once selected, the card information will expand, and employees will see the four-digit PIN listed on the right side of the information card. Note, the PIN will be displayed once the card is in an active status. You can activate the card directly on the Smart-Choice portal, through the mobile app, or upon the first use with an eligible expense.

Deadline to file claims

You have until April 30 of the following year to submit any health care claims incurred in the previous calendar year while you were actively participating. However, certain carryover provisions apply which are outlined below.

Important: save your itemized receipts. All Smart-Choice card transactions must be verified as eligible health care expenses, and you may be required to provide Smart-Choice with supporting documentation to validate your expenses. The card provides the

convenience of immediate access to your funds. In some situations, your expenses will be automatically validated when you use your Smart-Choice card to purchase eligible items with select merchants that accept health care debit cards. The Smart-Choice card does not eliminate the requirement to keep documentation for your expenses. In many cases, you may need to provide documentation to Smart-Choice for expenses you paid for with your Smart-Choice card. Even if you are not required to submit the itemized receipts, documentation should be retained in the event you are subject to an IRS audit.

Carryover amounts

The Health FSAs and LPFSA allow for up to 20% of the IRS annual limit of unused funds to be carried over into the next Plan year. The carryover funds can then be used for eligible expenses incurred in the current Plan year.

You will not be eligible for any carryover amount if you incur a break in eligibility greater than 31 days at any point within the Plan year, if you are not eligible for the Plan as of December 31, or if you are continuing your coverage through COBRA and have not paid your premiums to extend your coverage through December 31.

How carryover works:

- Carryover only applies to health FSAs. Unused DCFSA funds will not carry over and will be forfeited if not used by the deadline.
- Carryover amounts are available as of the first day of the following Plan year.
- Money will carry over from one year to the next only if you are an eligible HCFSA participant on December 31 of any year. You are also eligible for the carryover balance if your employment with the company has ended, and you have elected COBRA coverage and pay for your premium through December 31. If you have a balance, your carryover will be available through your full COBRA eligibility period.
- If money from your Health FSA is carried over from one year to the next, you may still contribute up to the maximum Health FSA contribution for the new Plan year.
- Up to 20% of the IRS annual limit may be carried over to the new Plan year, even if you do not elect to contribute to the health FSA for the new Plan year.
- If you have more than the IRS carryover limit of unused money in your Health FSA as of December 31, of any year, the unused amount exceeding the limit may not be carried over and this unused excess amount will be forfeited.
- If you have unused HCFSA amounts at the end of a Plan year and elect to contribute to an HSA in the following Plan year, any amount (up to the applicable limit) that you carry over into the subsequent Plan year will be carried over to the LPFSA.
- The carryover rule will continue to apply until you are no longer employed by the Company, or you become ineligible for benefits with the Company.

Keep in mind that you still may file claims for reimbursement of eligible expenses incurred in the current calendar year until April 30 of the following Plan year, whether or not unused money is carried over from one year to the next.

Debit cards

The carryover balance will be available on the first day of the new Plan year (January 1). In accordance, the full balance (including any carryover funds) will also be available on the Smart-Choice card – even if you do not re-enroll. The carryover amount does not affect the ability to elect the maximum annual contribution amount available under the Plan.

Reimbursement for health care expenses

You can file Health FSA claims as often as you like. You will receive reimbursement from your account up to the total amount you elected for the Plan year and any carryover amount if applicable, even if you have not yet contributed the full amount at the time of your request. Refer to the carryover amounts section for additional information on how claims are paid from carryover funds.

Submit your FSA claim form to Smart-Choice along with your receipts for expenses. If you have other group coverage, you will also need to include the Explanation of Benefits (EOB) form provided by the insurance company, if it is an expense that was partially paid by the other group coverage.

All receipts submitted for reimbursement from a Health FSAs must clearly state that the expense is for a qualifying expense as determined by the benefits plan. If a receipt does not clearly identify the expense, you will receive a request for additional information needed to process the claim.

How to file a claim for reimbursement

To submit claims for reimbursement online, go to **Workday**, click on the **My Benefits & Retirement** app, select your network status (on or off the BMO network); click on Reimbursement Accounts. You also have the option to submit your claims through the paper form available on the website, or by submitting your claims through the Smart-Choice app.

You or your authorized representative may file claims for Plan benefits. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

Overpayment process

An overpayment on your account may occur if you have used your Smart-Choice debit card to pay for non-qualified products or services, you have not provided the required documentation to substantiate a qualified expense paid for with your Smart-Choice debit card, or you have been reimbursed for a claim that was subsequently determined to be invalid. Once an overpayment has been identified, you will need to resolve an overpayment on your account to avoid suspension on your Smart-Choice card. If you have received notification of an overpayment, it can be satisfied in the following ways:

1. Resubmit the claim that resulted in an overpayment with additional receipts or other documentation. If the entire claim is approved, the overpayment will be satisfied.
2. Submit new claims for eligible expenses. If your future claims are approved, the overpayment will automatically be paid back by these claims until the full overpayment amount is paid back.
3. Repay the overpayment amount back to be credited to your account by accessing the Smart-Choice website and repaying online, or by mailing a check payable to Smart-Choice Accounts, PO Box 64009, The Woodlands, TX 77387-4009.

Impact of an Overpayment

If your account has an overpayment amount over $100, your Smart-Choice Card will be suspended until the overpayment is repaid. While you're unable to use your card, you may submit claims on the site, via fax, through postal mail, or using the mobile app. **IRS rules state that failure to resolve your overpayment before the end of the plan year can result in tax implications.**

Tips to Avoid an Overpayment

Here are some suggestions to keep in mind when using your Smart-Choice Card:

- Always save your itemized receipts! You may need them if Smart-Choice notifies you to provide documentation for your transaction.
- Send receipts or other documentation for your transaction by the due date.
- Review eligible health care expenses on this site to become familiar with items and services for which you can use your card.
- Don't use your Smart-Choice Card to pay for ineligible health care items.
- Consider shopping at IIAS-certified merchants, where items are automatically identified as eligible or ineligible at checkout.

Notice of a denied claim

If you are denied a full or partial claim for benefits, you will receive written or electronic notice (if valid email on file) of the denial and the notice will:

- explain the reason for the denial;
- refer to the pertinent provision of the Plan on which the denial is based;

- describe any additional material or information necessary for properly completing the claim
- explain why such material or information is necessary
- explain the claim review procedures and
- for HCFSA and LPFSA claims:
  - disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request); or
  - if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

Appealing denied claims

If you are not satisfied with the determination of a claim denial, please contact the Human Resources Centre at 1-888-927-7700 and speak with a Smart-Choice representative. If after investigation, you are still not satisfied with the determination, you may file an appeal within 180 days of receiving a claim denial. To make an official appeal of the denial of your reimbursement, you must complete and return the Claims Review Form by requesting from the Smart-Choice representative. If you do not submit a Claim Review Form during this period, no further action will be taken, and you will not be able to file an appeal for the claim later.

When completing the Claim Review Form, state the reason you think you are entitled to reimbursement, including any documentation or information you feel supports your appeal.

The review will be by a person who was not involved in the initial determination, and will consider all comments, documents, and other information submitted by you, without regard to whether that information was submitted or considered in the initial determination. You are entitled to receive, free of charge upon request, any document relevant to your claim for benefits. Your appeal will be reviewed within 30 days from the date of receipt for health care, or within 60 days from the date of receipt for dependent care and provide you with a written explanation of the benefit determination.

Statements

A statement reflecting the activity in your FSA is distributed at the beginning of the fourth quarter each year. Each statement will show your contributions to date, claims paid and available account balances. This information is also available by navigating to Workday, click on the My Benefits & Retirement app, depending on where you are connecting to Workday from, select your network status (on or off the BMO network), click on Reimbursement Accounts.

Please note any amounts that remain in an overpayment status after the Plan year-end deadline (April 30), will appear on your current year W2 as taxable income.

Forfeitures

Before you elect your annual FSA contribution, carefully review, and consider your health needs and previous expenses. IRS regulations require that any amount over the allowed carryover amount for your HCFSA that is not used for reimbursement of eligible expenses incurred by December 31 and submitted for reimbursement by April 30 be forfeited.

You must submit claims for eligible expenses by April 30 of the **following** calendar year. Your claims must be received by the claim's administrator on or before April 30 to be eligible for reimbursement. Any unclaimed balance remaining in your account above the allowed carryover amount after April 30 will be forfeited.

Any amounts remaining in your account, including carryover amounts, upon termination of employment will be forfeited unless you are eligible for and elect COBRA continuation coverage (Health FSA only).

When coverage ends

Your contributions to the FSAs end if any of the following events occur:

- your employment with the Company ends for any reason,
- you become ineligible to participate (see Eligibility), or
- you go on Long Term Disability leave.

If you have a balance in your HCFSA when your coverage ends, you may claim qualified expenses incurred while you were a participant in the Plan, up to the amount you elected less any prior reimbursements. Active coverage ends on the last day of the month in which your employment ends.

To be eligible for reimbursement, your claims must be received by the Claims Administrator no later than April 30th of the following calendar year.

You may be able to continue your HCFSA or LPFSA coverage through COBRA. See Continuing health care coverage under COBRA for more information.

It is your responsibility to notify the Company of any change in your status or the status of any of your Dependents that affects eligibility for coverage under the Plan within 31 days of the status change.

Continuing coverage through COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the health FSAs ends, you or your covered dependents may be

eligible to temporarily continue your coverage at your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your eligible dependent to lose coverage under the Plan.

To be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were eligible to have their eligible expenses reimbursed under the health FSAs on the day before a qualifying event:

- the Employee
- the Employee's dependent child
- the Employee's Spouse

Special rule for the Health FSAs

If your Health FSA coverage ends because of a COBRA-qualifying event, COBRA continuation coverage for your Health FSA will be available only if the maximum benefit available under the health FSA for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the Plan year. COBRA coverage ends at the end of the Plan year in which the qualifying event occurs.