BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

VEHI - FLEXIBLE SPENDING ACCOUNT (FSA) PLAN DESIGN GUIDE

Please complete this form and return to BCBSVT 45 days before your effective date so we can properly administer your plan.
If you have any questions, please call our Sales line at 855-363-2583. When complete, email this form to mymoneybcbsvt.sales@HelloFurther.com or fax it to 1-866-231-0214; or mail it to BCBSVT MyMoney (PO Box 982814 El Paso, TX 79998-2814).

All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Legal Name _____

Employer's Street Address _____

City _____ State _____ ZIP Code _____

Employer's Tax I.D. Number (required) _____

Type of Corporation ☐ S Corporation* ☐ C Corporation ☐ Partnership* ☐ Sole Proprietor*
☐ Political Subdivision/Church ☐ LLC* ☐ Non-Profit ☐ Other_____

**2% or more shareholders of an S Corporation, along with partners in a partnership, sole proprietors and members of an LLC or PLLP do not have access to an FSA.*

Number of Employees Eligible for Plan: _____

Primary Contact Person:
(This person has access to all plan information and can add, edit, or remove portal access for additional contacts)

Primary Contact Person _____ Title _____

Phone Number ( ) _____

Email Address_____

Additional Contact Person:
(This person has access to the plan information and can edit access for group portal)

Additional Contact Person _____ Title _____

Phone Number ( ) _____

Email Address_____

Additional Contact Email Notifications

☐ Fee billing information ☐ Claim billing information

II. HEALTH PLAN GROUP STRUCTURE

Group Structure can also be submitted on an Excel spreadsheet.

Parent Code _____

Group Number(s) _____ _____ _____ _____ _____ _____ _____

Division Codes(s) _____ _____ _____ _____ _____ _____ _____

III. ACCOUNT ADMINISTRATIVE INFORMATION

Plan Year

Start date _____ End date _____

Plan Options *(select **all** that apply)*

☐ Medical Flexible Spending Account
☐ Dependent Care Flexible Spending Account

Eligibility Required for Plan documents *(generally matches that of the health plan.)*

Employees must work at least _____ hours per week to be eligible

Benefits will begin on: (select **only** one):

☐ First of the month following date of hire

☐ Date of hire

☐ First *day* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other

☐ First of the *month* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other

Maximum Employee Contribution Limits

	Maximum
Medical FSA $	$2,750 (IRS maximum is $2,750)
Dependent Care FSA $	$5,000 (IRS maximum is $5,000)

Does the Employer contribute to any account(s)? ☐ Yes ☐ No (default)

Note: The employer can contribute up to $500 to all eligible workers without the employee contributing. When employer is contributing an amount over $500, the employer's contribution cannot exceed the employee's election.

Grace Period

The grace period only applies to Medical and/or Dependent Care FSAs. It is the additional time period in which members can incur out- of-pocket expenses in the new plan year if money is left over from the previous plan year. Claims incurred during the grace period may be submitted until the end of the runout period. A grace period is not recommended for dependent care FSA. You may choose grace period or rollover, but not both.

The grace period can be up to two months and 15 days from the end of the plan year. The grace period cannot exceed the runout period end date for a Medical FSA. A grace period is not recommended if you currently offer an HSA or if you are considering adding one in the future.

If you would like to offer a grace period, indicate the grace period end date below:

Medical FSA _____/_____/_____

Dependent Care FSA _____/_____/_____

Rollover (for medical FSA only)

You have the option to allow employees to carry over up to $550 from the current plan year to their FSA for the following plan year. The rollover amount does not count towards the $2,750 FSA contribution limit. Without the rollover or grace period, balances at the end of the plan year are forfeited. **You may choose rollover or grace period, but not both.**

☐ Rollover (did not elect a grace period)

Runout Period

The runout period is the deadline for participants to submit claims for the previous plan year. All eligible claims must be received by the end of the runout period. *The suggested runout period selected for a Medical FSA is 3 months from the end of the plan year or 3 months from employee termination. If a grace period is selected, the runout period must be equal to or greater than the grace period elected.*

If you selected **Medical FSA**:

Please indicate the length of the runout period for active Medical FSA employees: 3 months (months)

Please indicate how you would like runout to apply to terminated employees *(select **only** one)*

☐ The runout period noted above begins at termination date *(recommended)*

If you selected **Dependent Care FSA** please indicate the length of the runout period: 3 months (months)

IV. CLAIM REIMBURSEMENT PROCESSING

You will receive an automated email notification with the claim reimbursement totals. Sign into the Online Group Service Center to view and print your complete invoice detail under Claim Reimbursement Invoices.

Automated Clearinghouse Information ***(completion of this section is mandatory)***

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **claim reimbursements** made to our employees. The following bank account information is provided to Further for initiation of this procedure.

Bank Name _____

Type of Account: ☐ Checking ☐ Savings

Bank ABA Number _____

(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip)

Bank Account Number _____

V. ADMINISTRATIVE FEES

You will receive an automated email notification when your detailed billing information is available and another email notification two business days in advance of the scheduled ACH transaction confirming the amount of funds to be transferred. Sign into the Online Group Service Center to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **Administrative Fees.** The following bank account information is provided to Further for initiation of this procedure.

Please select **one:**
☐ **Use same bank account as indicated for claim reimbursements; OR**
☐ **Use bank account information indicated below:**

Bank Name _____

Type of Account: ☐ Checking ☐ Savings

Bank ABA Number _____

(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip)

Bank Account Number _____

(Funds will be drawn from your bank account on or after the 20th of each month.)

VI. REIMBURSEMENT

Reimbursement Options

You may select any of the features listed below that best meet your needs and those of your participants *(see section XI for more information and definitions):*

☐ **Option #1 (debit card)**- participants will automatically be issued a debit card. Participants have the option to discard their debit card and enroll in autopay, if they choose.

☐ **Option #2 (medical autopay)**- participants will be automatically enrolled in medical autopay. They may opt out of the autopay feature and elect a debit card, if they choose.

VI. REIMBURSEMENT (continued)

Pay-the-Provider

Include the Pay-the-Provider (must select one)

- ☐ Yes - The pay-the-provider election must match the autopay election. (If members are **automatically enrolled** in autopay, then members will also be auto enrolled in the pay-the-provider. Participants may opt out of pay-the-provider by requesting online or completing the pay-the-provider election form X22528.
  If members choose to **elect** autopay, then members will also be allowed to elect pay-the-provider.)
- ☐ No (Do not offer pay-the-provider)

VII. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

- ☐ Online Group Service Center. Employer will enroll participants online using the Online Group Service Center at **mymoneybcbsvt-group.hellofurther.com**
- ☐ Secure File Transfer
  Employer will enroll participants using a secure file transfer process.

VIII. DEDUCTION/CONTRIBUTION INFORMATION

BCBSVT is required to post payroll deduction information throughout the year for all employees choosing to participate in the plan. Funds should **not** be sent with any deduction information.

You have the option to send your enrollment deduction data to BCBSVT in the following three ways (select one):

- ☐ **Online Group Service Center (recommended)**: You may upload your deduction information here.
- ☐ **Secure File Transfer**: This option allows employers or their vendors to create a file using BCBSVT format requirements via automated secure upload. Choosing to use Secure File Transfer requires additional steps for setup.

IX. TRANSFER OF ADMINISTRATION

(This would include if your plan had rollover from the prior year.)

Is BCBSVT taking over administrative services from another administrator? ☐ Yes ☐ No

If yes, fill out the fields below.

If no, skip to the signatures section.

PRIOR ADMINISTRATOR INFORMATION:

Prior Administrator's Name: _____

PLAN YEAR INFORMATION:

*Please select one of the following and fill out the corresponding section.

☐ **TAKEOVER AT NEW PLAN YEAR:**

Please select the administrator that will be processing the runout claims for the previous plan year.
Note: If you have a grace period on your current FSA account, it is recommended that BCBSVT take over at the renewal date to reduce duplicate claim submissions.

☐ The prior administrator

☐ BCBSVT (recommended if grace period is applicable)

Medical FSA –

☐ Grace Period Grace Period End Date: _____

☐ Runout Period Runout Period: _____months

☐ Rollover Rollover Amount: _____

Dependent Care –

☐ Grace Period Grace Period End Date: _____

☐ Runout Period Runout Period: _____months

☐ **TAKEOVER AT MIDYEAR:**

What is the last date the prior administrator will process claims? _____

What is the date that the enrollment data and balances will be submitted to BCBSVT? _____

Please note: There will be a blackout period between when the data is received and when BCBSVT will begin to process claims. The plan will be set up according to the plan design guide submitted to BCBSVT.

X. ADMINISTRATIVE TIPS AND DEFINITIONS

ONLINE ACCESS: mymoneybcbsvt-group.hellofurther.com

With BCBSVT, your employees have access to a powerful tool for managing their FSA. By registering, your employees can:

- Enroll in direct deposit
- View recent claims or reimbursement requests
- Create and view a customized statement
- Manage their personal profile

You can also access forms and enrollment materials at **learn-mymoneybcbsvt.hellofurther.com.**

COORDINATING WITH AN HSA: For participants that have an FSA and an HSA, the FSA provides reimbursement for permitted benefits such as vision and dental care benefits until the health plan deductible is met. Once the health plan deductible is met, all Section 213(d) expenses, excluding deductible expenses, are eligible for reimbursement.

This affects only those participants who are eligible to contribute to their HSA. Participants who are not eligible to contribute to an HSA will have a general purpose FSA.

Please note: If the HSA is not administered by Further or the health plan is not with Blue Cross and Blue Shield of Vermont, the group is required to manually notify Further which employees are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (X22527) to Further to indicate that the deductible has been satisfied prior to receiving reimbursement for 213(d) eligible expenses.

COORDINATING WITH AN HRA:

* If the HRA allows reimbursement for health plan eligible expenses only, the HRA is primary and the FSA is secondary.

* If the HRA allows all 213(d) expenses to be reimbursed, the FSA is primary and the HRA is secondary because unused FSA funds are forfeited if not used for the applicable plan year.

PLAN DOCUMENTS: BCBSVT will be preparing your Plan Document and Summary Plan Descriptions (SPD). The documents will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.

REIMBURSEMENT OPTIONS:

DEBIT CARD: This feature allows a participant to use a debit card to access their medical FSA at point of service. Members with an FSA and an HSA will be automatically issued a debit card.

MEDICAL AUTOPAY: Eligible health expenses (i.e. deductible and/or coinsurance) as indicated on the health plan Explanation of Benefits will be electronically transferred to Further. Claims will be processed and reimbursed according to the participant's available balance.

Please note: Autopay is not appropriate for participants who have secondary health coverage.

DENTAL AUTOPAY: Eligible dental plan expenses (i.e. deductible and/or coinsurance) as indicated on the dental Explanation of Benefits, plus other patient responsibility amounts will be electronically transferred. Claims will be processed and reimbursed according to the participant's available balance. Please note that dental autopay is not appropriate for any participants that have secondary dental insurance coverage.

PAY-THE-PROVIDER: This feature allows a participant to have their medical claim reimbursements sent directly to their provider rather than to their home address or directly deposited into their bank account. This is only available for participants who have elected autopay.

XI. SIGNATURES

It is agreed that necessary information concerning current and future employees or employees and/or their dependents who participate in this Plan and employees whose participation is to be changed or discontinued, shall be provided to Further on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE,TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signature _____ Date_____

Printed Name _____ Title _____