



SelectAccountSM

FLEXIBLE SPENDING ACCOUNT (FSA) PLAN DESIGN GUIDE

For Office Use Only

SelectAccount Group Number _____

Enrollment Specialist _____

Please fill out this form in its entirety and return to SelectAccount 45 days prior to your effective date in order for us to properly administer your plan. If you have any questions on how to complete the form, please call our Group Leader Line at 1-888-460-4013 or our Agent Service Line at 1-888-460-4015. When complete, either fax form to (651) 662-1180 or toll-free at 1-866-231-0214, or mail to SelectAccount, PO Box 64193, Saint Paul, MN 55164. **Incomplete forms will be returned to you resulting in delays.**

I. EMPLOYER INFORMATION

Employer's Name _____

Employer's Street Address _____

City _____ State _____ Zip Code _____

Employer's Tax I.D. Number _____ Nature of Business _____

Type of Corporation S Corporation* C Corporation Partnership* Sole Proprietor*

Political Subdivision/Church LLC* 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: _____

Person Responsible For Authorization of Plan Design:

Name _____ Title _____

Phone Number () _____ Fax Number () _____

Email Address _____

Main Contact Person _____ Title _____

Phone Number () _____ Fax Number () _____

Email Address _____

II. TAKEOVER INFORMATION

Is SelectAccount taking over administrative services from another FSA administrator?

Yes No (If yes, continue below. If no, continue to section III.)

Please indicate the current plan year start date _____ end date _____

Please select one :

Takeover at renewal date:

Will the prior administrator handle the runout period for the prior plan year? Yes (recommended) No

Takeover mid plan year:

Will the prior administrator continue processing claims? Yes No (recommended)

If SelectAccount is taking over administrative services, please provide us with enrollment data. This information should include the effective date, current available balance and any pending claim amount for each participant.

If the prior administrator is continuing to process claims, please provide us with the prior administrator's name, address and phone number below so we can forward any appropriate information to them.

Name _____

Address _____

Phone Number () _____

III. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health plan carrier: Blue Cross and Blue Shield of Kansas

IV. FLEXIBLE SPENDING ACCOUNT ADMINISTRATIVE INFORMATION

Plan Year

FSA start date _____ FSA end date _____

Plan Options (select *all* that apply)

- Pre-Tax Group Insurance Premium
- Medical Flexible Spending Account
- Dependent Care Flexible Spending Account

If you selected the Medical Flexible Spending Account plan option above, are you **also** offering an HSA or HRA?

- No Please continue to the Minimum and Maximum Contribution Limits section on page 3.
- Yes If **yes**, please indicate below which accounts (HSA or HRA) are being offered:

Health Savings Account (HSA)

If you are also offering an HSA, is it administered by SelectAccount? Yes No

Please select one FSA option below: (select **only one**)

- Post-Deductible FSA (recommended)

A post-deductible 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.

(Choosing a Post-Deductible FSA affects only those participants contributing to their HSA. Participants not contributing to their HSA have a general purpose (Full) FSA.

Please note: If the HSA is not administered by SelectAccount and the health plan is not with Blue Cross and Blue Shield of Kansas, the group is required to manually notify SelectAccount which participants are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (F8978) to SelectAccount to indicate that the deductible has been satisfied prior to receiving reimbursement for 213(d) eligible expenses.

- Limited-Purpose FSA

A Limited-Purpose FSA is limited to expenses for permitted benefits such as vision and dental care benefits both before and after the health plan deductible is met.

(Choosing a Limited-Purpose FSA will affect everyone in the FSA, including those FSA participants who are not contributing to the HSA.)

Please note: Limited-Purpose FSA is recommended when the HSA is not administered by SelectAccount and the health plan is not with Blue Cross and Blue Shield of Kansas.

Health Reimbursement Account (HRA)

If you are also offering an HRA, is it administered by SelectAccount? Yes No

If **yes**, please select a primacy option below: (select **only one**)

- HRA pays first, FSA pays second

If the HRA allows reimbursement for health plan eligible expenses only, it is suggested to have the HRA as primary and the FSA as secondary.

- FSA pays first, HRA pays second

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

HRA and FSA pay only after all other insurance has paid. Plan Design Guides will need to be completed for any SelectAccount plans that interact with the FSA, if not previously completed. HRA Plan Design Guide (F9067) HSA Plan Design Guide (F9052)

IV. FLEXIBLE SPENDING ACCOUNT ADMINISTRATIVE INFORMATION (continued)

Eligibility

Participants must be _____ years of age to be eligible

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

Waiting period (select **only one**): None 30 days 60 days 90 days

Benefits will begin on:

- Date of hire (only available with "none")
- First day after completion of the waiting period (not available with "none")
- First of the month after completion of the waiting period (if this falls on the first of the month, benefits begin that month)
- Other

How long do participants have to make their election after they become eligible to participate? _____
(Select Account will assume 30 days if not indicated)

Terminations (applies to Medical FSA only)

Allowing continuation on an after-tax basis is mandatory.

Do you also wish to allow continuation on a pre-tax basis, taken from the employee's last paycheck, with the employee's written permission? Yes No

Minimum and Maximum Contribution Limits

	Minimum	Maximum
Medical FSA \$ _____		\$ _____
Dependent Care FSA \$ _____		\$ Defined by IRS
Qualified Parking \$ _____		\$ Defined by IRS
Vanpooling \$ _____		\$ Defined by IRS

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

If yes, indicate which accounts and amount of contribution: (select **all that apply**)

- Medical \$ _____ per participant at the start of the plan year.
- Dependent Care \$ _____ per participant at the start of the plan year.
- Other Insurance Premium \$ _____ per participant at the start of the plan year.
- Vanpooling \$ _____ per participant at the start of the plan year.
- Parking \$ _____ per participant at the start of the plan year.

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.

Would you like to add a grace period to the end of the plan year for **Medical FSA**? Yes No

If yes, please indicate the end date of the grace period _____

Would you like to add a grace period to the end of the plan year for **Dependent Care FSA**? Yes No

If yes, please indicate the end date of the grace period _____

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.

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. A runout period always begins at the end of the plan year, and if a grace period is selected, it runs concurrently with the grace period.

If you selected **Medical FSA**:

Please indicate the length of the runout period for active Medical FSA participants _____
(Length of runout period must be indicated in whole and/or half month increments. Half months equate to 15 days.)

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

- Same as active participants
- The runout period noted above begins at termination date

IV. FLEXIBLE SPENDING ACCOUNT ADMINISTRATIVE INFORMATION (continued)

Runout Period (continued)

If you selected **Dependent Care FSA** please indicate the length of the runout period _____
(Length of runout period must be indicated in whole and/or half month increments. Half months equate to 15 days.
Runout for terminated and active participants is the same for dependent care.)

V. FLEXIBLE SPENDING ACCOUNT OPTIONAL FEATURES

You may select any of the features listed below that best meet your needs and those of your participants. *Additional fees apply. Please refer to the fee schedule.*

Crossover

Offering crossover eliminates the need for participants to complete and file a claim form to be reimbursed for eligible health plan expenses. The crossover election applies across all spending accounts (i.e. medical FSA, HRA, or HSA).

Medical Crossover

Eligible health plan expenses (i.e. deductible and/or coinsurance) as indicated on the Explanation of Benefits plus out of pocket expenses for prescription drug copays, will be electronically transferred to SelectAccount. Claims will be processed and reimbursed according to the participant's available balance. Please note crossover is not appropriate for participants who have secondary health coverage with Blue Cross or another carrier. *(This feature is only available if health plan is with Blue Cross and Blue Shield of Kansas)*

- Select one: Automatically enroll all participants in medical crossover. *(Participants may opt out by completing the medical crossover form F7856.)*
 Offer medical crossover to participants. *(Participants may elect crossover by completing the medical crossover form F7856. Highest participant fee applies. Please refer to the fee schedule)*
 Do not offer medical crossover to participants. **Highest participant fee applies.** Please refer to the fee schedule.

Debit Card

This optional feature allows a participant to use a debit card to access their FSA at point of service. If a participant elects the debit card option, crossover is no longer available. Substantiation requirements apply. Additional fees apply and an employer deposit is required. **Please refer to fee schedule.**

- Offer debit card to participants. participants may elect the debit card by completing form F8936
 Do not offer debit card to participants

VI. FLEXIBLE SPENDING ACCOUNT FEES

For participants who have an FSA stacked with a SelectAccount HSA or HRA, only the SelectAccount FSA fee will apply. The HSA or HRA participant fee will be waived. Debit card fees still apply.

Participant Fees

- Employer Paid
Indicate billing frequency: annually monthly
(If employer paid, billing frequency must match employer paid debit card billing frequency.)
 Participant Paid *(Billed annually and taken from participant's account balance.)*

Debit Card Fees

If you are offering debit cards to your participants, please complete this section:

- Employer Paid
Indicate billing frequency: annually monthly
(If employer paid, billing frequency must match participant fee billing frequency.)
 Participant Paid *(Billed annually and taken from participant's account balance.)*

VII. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

- Electronic file
- Paper form(s)

Ongoing Enrollment Data will be sent via:

- Full Electronic File - submit a full file that replaces all existing data (*preferred*)
- Partial Electronic File - submit a file including new hires/changes/terminations only
- Paper form(s)

(Contact SelectAccount service numbers found on page 1 of this form, or consult with your sales representative for electronic format requirements)

VIII. PAYROLL INFORMATION

Please select one:

- The payroll contribution frequency is the same for all participants and is:
 - weekly bi-weekly monthly bi-monthly other _____

Please indicate the first payroll date: _____

- The payroll contribution frequency differs by employee classification or location.
If payroll contribution frequency differs by employee classification or location, please attach a payroll schedule for the plan year for each classification or location, including contribution frequency and the first payroll date.

SelectAccount recommends submitting payroll data 2 business days prior to the payroll date.

FSA PAYROLL REPORTING INFORMATION

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

We offer three options for sending us your payroll deduction data:

Electronic File (recommended): This option requires employers to create a file using SelectAccount format requirements. This option is required for employers with 50 or more participants and is recommended for all employers. (Contact the group leader line for file format requirements)

Paper Report: This option is a report that the employer creates each payroll date and sends to SelectAccount via fax or mail. This option may only be used for employers with fewer than 50 participants.

On File: This option requires the employer to complete a standard form that SelectAccount provides. SelectAccount will automatically post these amounts each payroll date throughout the plan year. If you use this option, you must provide updated information throughout the year for new participants, terminations, and election changes. This option may only be used for employers with fewer than 15 participants.

Your FSA payroll contribution data will be sent via:

- Electronic File
- Paper Report
- On File

Please indicate the contact person for payroll information, if different from main contact person:

Name _____ Title _____

Phone Number () _____ Fax Number () _____

E-mail Address _____

IX. REIMBURSEMENT PROCESSING

Please indicate the contact person for reimbursement payments, if different from main contact person:

Name _____ Title _____

Phone Number () _____ Fax Number () _____

E-mail Address _____

Please indicate how you wish to be notified regarding claim reimbursement amounts: *(select only one)*

Fax Fax Number () _____

Email E-mail Address _____

Please indicate your preferred claim reimbursement report format: *(select only one)*

Standard Report (lists each employee, by location)

Total Only Report (lists totals only, by location)

Automated Clearinghouse Information (completion of this section is mandatory)

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

Bank Name _____ Type of Account: Checking Savings

Bank Location/Branch _____

Bank ABA Number _____ Bank Account Number _____

Please include a void check.

X. ADDITIONAL LOCATIONS

Multiple SelectAccount locations are available for 51+ groups only. If you want multiple SelectAccount locations, please complete and attach the Locations Addendum (F8928). Locations must be the same across all products administered by SelectAccount. If you wish to have different ACH accounts by location, please complete the ACH Authorization form (X9055).

XI. PLAN DOCUMENTS

Will SelectAccount be preparing your Plan Document and Summary Plan Description (SPD)?

Yes (Plan Documents and SPD's will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.)

No (If no, please forward copy of your plan documents to us.)

XII. ADDITIONAL REQUIRED INFORMATION

Agent Name (if applicable) _____

Agent Code _____ Agent Phone _____

Agency Name (if applicable) _____

Agency Code _____ Agency Phone _____

Internal:

Sales Representative _____ Email Address _____

Sales Representative Number _____ Phone _____

Health Account Coordinator _____ (internal use only)

SelectAccount Account Coordinator _____ (internal use only)

Special Instructions: _____

XIII. SIGNATURES

It is agreed that necessary information concerning participants or participants and their dependents participating in or subsequent to the effective date of the Plan and participants whose participation is to be changed or discontinued shall be furnished to SelectAccount 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 _____