Capital

An Independent Licensee of the Blue Cross Blue Shield Association

FLEXIBLE SPENDING ACCOUNT (FSA) PLAN DESIGN GUIDE

Please complete this form and return to Capital Blue Cross 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 capitalbluecross.sales@HelloFurther.com or fax it to 866.231.0214.

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:

Health Spending Employer Portal Access Type: (check one) ☐ Edit Access ☐ View Only Access

Primary Contact Person _____ Title _____

Phone Number ( ) _____

Email Address_____

Additional Contact Person:

Health Spending Employer Portal Access Type: (check one) ☐ Edit Access ☐ View Only Access

Additional Contact Person _____ Title _____

Phone Number ( ) _____

Email Address_____

Please indicate if additional contact should receive email notifications for:

☐ Fee billing information ☐ Claim billing information

II. HEALTH PLAN GROUP STRUCTURE

Please list only the Subgroup IDs for employees who will be eligible for FSA. Group Structure can also be submitted on an Excel spreadsheet.

Group ID _____ Subgroup ID(s) _____ _____ _____ _____

III. AGENCY/BROKERAGE INFORMATION

Agency Name: _____ Agency Code: _____

Agent Name: _____ Agent Code: _____

Agency Contact Name *(if different than agent)*: _____

Email: _____ Phone: _____

Address: _____

IV. 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 ***(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

Minimum and Maximum Employee Contribution Limits

	Minimum	Maximum
Medical FSA	$_____	$_____ **(IRS maximum is $2,750)**
Dependent Care FSA	$_____	$_____ **(IRS maximum is $10,500 for 2021 only)**

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 additional contribution (if any) cannot exceed the employee's election.

Grace Period

The grace period is the additional time period in which members can incur out- of-pocket expenses in the new plan year with money left over from the previous plan year (if any). Claims incurred during the grace period may be submitted until the end of the runout period. 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 for Medical FSA 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: _____ (months)
(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 employees *(select **only** one)*

☐ The runout period noted above begins at date of termination (*recommended)*
☐ Same as active employees (*Runout period begins to run from the end of the plan year*)

If you selected **Dependent Care FSA** please indicate the length of the runout period: _____ (months)
(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 employees is the same for dependent care.)

V. CLAIM REIMBURSEMENT PROCESSING

You will receive an automated email notification weekly with the claim reimbursement totals. An email will only be generated in weeks where an amount is due. 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, on behalf of Capital Blue Cross, to charge our bank account through Automated Clearinghouse for **claim reimbursements** made to our employees. The following bank account information is provided 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 _____

VI. 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 your capitalbluecross.com account to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information

I hereby authorize Further, on behalf of Capital Blue Cross, to charge our bank account through Automated Clearinghouse for **Administrative Fees.** The following bank account information is provided 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.)

VII. REIMBURSEMENT

Medical FSA 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 Capital Blue Cross branded 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.

VII. REIMBURSEMENT (continued)

Pay-the-Provider

With Reimbursement Options 1 or 2 above, autopay will be included. If a member is automatically enrolled or chooses to enroll in autopay, do you want to include Pay-the-Provider? (must select one)

☐ Yes - (If members are **automatically enrolled** in autopay (Option 2), 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 (F11241))
If members choose to **elect** autopay (Option 1), then members will also be allowed to elect pay-the-provider)

☐ No (Do not offer pay-the-provider)

Copay amounts

The copay amounts provided below will allow these amounts to auto-substantiate when the debit card is used. Documentation will not be required for reimbursement.

Please indicate the health plan copay amounts below. If you have more copays than what is listed below, please complete the Group Copay Form F11264. Amounts must be indicated on the PDG or the Group Copay Form, otherwise the copay amounts will not be added.

Medical: _____ _____ _____ Vision: _____ _____ _____

Drug: _____ _____ _____ Dental: _____ _____ _____

VIII. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

☐ Capital Blue Cross Employer Portal
Employer will enroll participants online via the Capital Blue Cross employer portal. (Note: FSA enrollment is done separately from medical plan enrollment.)

☐ Secure File Transfer
Employer will enroll participants using a secure file transfer process.

IX. DEDUCTION/CONTRIBUTION INFORMATION

Capital Blue Cross 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 Capital Blue Cross in the following two ways (select one):

☐ **Online via Capital Blue Cross Employer Portal (recommended)**: You may upload your deduction information here.

☐ **Secure File Transfer**: This option allows employers or their vendors to create a file using Capital Blue Cross format requirements via automated secure upload. Choosing to use Secure File Transfer requires additional steps for setup.

X. TRANSFER OF ADMINISTRATION

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

Is Capital Blue Cross 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 Capital Blue Cross take over at the renewal date to reduce duplicate claim submissions.

- ☐ The prior administrator
- ☐ Capital Blue Cross (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 Capital Blue Cross? _____

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

XI. ADMINISTRATIVE TIPS AND DEFINITIONS

ONLINE ACCESS: Capital Blue Cross Employer Portal

Your employees have access to a powerful tool for managing their HSA. By registering at capbluecross.com/funds, your employees can:

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

You and your employees can also access forms and enrollment materials at **learn-capitalbluecross.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 those expenses applied to the In-Network deductible for the QHDHP, 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 Capital Blue Cross or the health plan is not with Capital Blue Cross, the group is required to manually notify Capital Blue Cross which employees are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (F11231) to Capital Blue Cross 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.

PLAN/ACCOUNT SUMMARIES: Capital Blue Cross will prepare and provide a Benefit Summary to the group contact.

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. 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.

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.

XII. 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 Capital Blue Cross 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 _____