

## LIMITED PURPOSE FSA ADDENDUM



### Group Information

Group Name: \_\_\_\_\_ Health Plan Group Number: \_\_\_\_\_

### Plan Year

FSA start date \_\_\_\_\_ FSA end date \_\_\_\_\_

### Administrative Information

#### Terminations

Allowing continuation on an after-tax basis is mandatory.

Do you also wish to allow continuation on a pretax basis, taken from the employee's last paycheck, with the employee's written permission?

☐ Yes ☐ No (default)

#### Minimum and Maximum Employee Contribution Limits

Minimum \$ \_\_\_\_\_

Maximum \$ \_\_\_\_\_

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

If yes, indicate amount of contribution:

\$ \_\_\_\_\_ per participant at the start of the plan year.

**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 or Rollover

**Choose One:** You may choose rollover or grace period, but not both. Without the rollover or grace period, balances at the end of the plan year are forfeited.

##### ☐ **Grace Period**

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 run-out period.

Indicate your grace period end date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

##### ☐ **Rollover**

You have the option to allow employees to carry over up to \$500 from the current plan year to their FSA for the following plan year. The rollover amount does not count towards the annual FSA contribution limit. Indicate what happens to unused balances at the end of the plan year.

##### ☐ **None**

#### Run-out Period

The run-out 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 run-out period. *(Length of run-out period must be indicated in whole and/or half-month increments. Half months equate to 15 days.)*

Please indicate the length of the run-out period: \_\_\_\_\_ (months)

## Reimbursement

- Employees use the debit card to pay for expenses just as they would use a bank debit card. All participants will be issued one debit card. A debit card for dependent(s) may be requested online.
- Online Requests – Employees request reimbursement through our secure online member service center at HorizonBlue.com.

### **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 or attach a separate spreadsheet indicating the copay amounts:

Medical: \_\_\_\_\_

Vision: \_\_\_\_\_

Drug: \_\_\_\_\_

## Enrollment Data Information

Initial Enrollment Data will be sent via:

- ☐ Group Online Service Center. Employer will enroll participants online using the Group Online Service Center at horizonblue.com/employers
- ☐ Electronic file (*Electronic enrollment file format requirements will be provided via email following the approval of the plan setup.*)

## Claim Reimbursement Processing

You will receive an automated email notification with the claim reimbursement totals. Sign in to 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 Horizon to charge our bank account through Automated Clearinghouse for **claim reimbursements** made to our employees. The following bank account information is provided to Horizon 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 \_\_\_\_\_

## Signature

Effective Date of Change(s): \_\_\_\_\_

\_\_\_\_\_  
Group Contact Signature

\_\_\_\_\_  
Signature Date