Checklist for
Medical Flexible Spending Account

Person to Contact with Questions: _____

Telephone Number: (____) _____

Email Address: _____

Internal Group Number or Billing Number (if any): _____

GENERAL PLAN INFORMATION

Group's Full Name: _____

Group's Address: _____

_____

If above address is a post office box, street address: _____

_____

Group's Telephone Number: (____) _____

Employer Identification Number (EIN): _____

Plan Year (month to month): _____

ERISA Plan Number: _____

Original Effective Date of Plan (month & year): _____

Date of this Restatement (month & year): _____

Type of Plan: Medical Flexible Spending Account under *Code* §§ 106 and 125

Is this a Limited Purpose Medical FSA? (If yes, refer to the Library Section for required provisions.) _____

Participating Employers: _____

_____

Third Party Administrator: _____
Name, Address, Phone:

_____

DEFINITIONS

"***Annual enrollment period***" means the period from [_____] through [_____] each year when eligible *employees* may enroll for participation and make elections under the *Plan*.

"***Benefit plan***" means the…

	…Medical…		…Dental…
	…Vision…		…Hearing…
	…Prescription drugs…		
	Other:		

…benefits provided under a group health plan established and maintained by the *Plan Sponsor*, or any successor thereto.

Regarding the above section, are they any benefits that are NOT covered*?* _____

Does the plan have a debit card feature? _____

"***Dependent***" means any of the following individuals who resides in the *participant's* household and over half of whose support the *participant* provides:

	…grandchildren of the *participant;*		…parents of the *participant;*
	…siblings of the *participant;*		…grandparents of the *participant;*

[Children of the *participant* who are under age 26, or who are disabled, will qualify as *dependents* regardless of whether the *participant* has provided one-half or more of the child's support for the taxable year, so long as the child has not provided one-half or more of his or her own support for the taxable year.]
OPTIONAL – KEEP or REMOVE

[Additionally, children of a *participant* who is divorced, legally separated, separated under a written separation agreement, or who has lived apart from his or her spouse at all times during the last 6 months of the calendar year, will be a *dependent* so long as they receive over one half of their support from their parents and are in the custody of one or both parents for more than one half of the calendar year.]
OPTIONAL – KEEP or REMOVE

"Domestic partner" means a person who has been in a domestic partnership with an *employee* for at least [_____] months and who…

["***Grace period***" means the period ending with the 15th day of the third month following the end of a *plan year* in which claims *incurred* for *qualified medical flexible spending expenses* may be considered eligible for reimbursement, subject to any unpaid balance in the *qualified medical flexible spending account*.]
OPTIONAL – KEEP or REMOVE

*["**Health savings account**"* **or "*HSA*"** means the tax-exempt trust or custodial account established in accordance with Section 223 of the Code to permit eligible *participants* to receive tax-favored contributions exclusively for the purpose of paying or reimbursing qualified medical expenses.]
OPTIONAL – KEEP or REMOVE

"***Spouse***" means…

	…an individual who is legally married to a *participant*, but shall not include an individual legally separated from a *participant* under a decree of legal separation.
	…an e*mployee*'s lawfully married spouse possessing a marriage license who is not divorced from the *participant.*

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?

	If you are an active, full-time *employee* regularly scheduled to work at least [_____] hours per week …	
		…and you have completed a *waiting period* of at least [_____] days

			(no more than 3 years)
			…of continuous *active employment* from your date of hire.
	If you are an active, part-time *employee* regularly scheduled to work at least [_____] hours per week …		
			…and you have completed a *waiting period* of at least [_____] days **(no more than 3 years)**
			…of continuous *active employment* from your date of hire.

When will my participation begin?
If you are a new *employee* who is eligible to participate, your entry date is the…

	…first day following your eligibility date…
	…first day of the month following your eligibility date …
	…date of hire…
	Other (please specify):

…provided that you have completed a *salary reduction agreement*.

If you are enrolling during an *annual enrollment period*, your entry date will be [_____] following the *annual enrollment period*, provided that you have completed a *salary reduction agreement.*

If you do not submit the *salary reduction agreement* to the *Plan Administrator* within [_____] days of becoming eligible, or during the *annual enrollment period*, then it will be assumed that you have decided not to participate in the *Plan*, and you will not have the opportunity to enroll until the next *annual enrollment period*.

May I make mid-year changes in my *Plan* elections?
Change in status events include:

- Marriage.
- Divorce, legal separation, or annulment.
- Birth, adoption, or placement for adoption of a child.
- Death of a *spouse* or *dependent*.
- Termination or commencement of employment by you, your *spouse*, or your *dependent*.
- [Reduction or increase in hours of employment by you, your *spouse*, or your *dependent* which results in a change in eligibility under the *Plan* (including a switch from part-time to full-time employment status or vice versa, a strike, or a lockout).]
- Place of residence change by you, your *spouse*, or your *dependent*, which results in a change in eligibility.
- Commencement or return from an unpaid leave of absence by you, your *spouse*, or your *dependent*.
- A change in worksite of you, your *spouse*, or your *dependent*.
- Your *dependent* satisfies or ceases to satisfy the requirements for coverage due to attainment of age, or any circumstance that would make the *dependent* ineligible.
- The entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid by you, your *spouse*, or your *dependent*.
- If you, your *spouse*, or your *dependent* becomes eligible for *COBRA* continuation coverage under the *benefit plan*, you may elect to increase your contributions under this *Plan*.
- Any other change in status that the *Plan Administrator*, in its sole discretion, determines will permit a change or revocation of an election during a *plan year* according to regulations and rulings under the Internal Revenue Service.

If you experience such a change in status and wish to change your level of coverage, you must submit written notification to the *Plan Administrator* within [_____] days of your change in status.

The change in coverage becomes effective…

	…with the first pay period…
	…on the first day of the month…

	…on the date of the change…
	Other (please specify):

…following the date the written notification is received by the *Plan Administrator*, except that coverage for birth, adoption, or placement for adoption becomes effective the date of the event.

Must the election change be consistent with the change in status?

[You will be permitted to change an election during the *plan year* and make a new election for the remainder of the *plan year* only if the change you make is consistent with the event. For example, you can only change your election to contribute to the *premium only plan* or the *qualified medical flexible spending account* if:

- The change in status results in you or your spouse or dependent child, gaining or losing eligibility for health coverage under the *benefit plan* or another health plan of your spouse's or dependent child's employer; and
- The election change corresponds with that gain or loss of coverage.]

OPTIONAL – KEEP or REMOVE

When does my participation end? ***Please choose ONE***

	If your employment terminates, and you return to eligible employment with your *participating employer* within the same *plan year*, you will not be permitted to rejoin the *Plan*.
	If your employment terminates, and you return to eligible employment with your *participating employer:* • Within 30 days, you may rejoin the *Plan* provided that you keep your original election for that *plan year*; or • More than 30 days following termination of your participation, you may rejoin the *Plan* and make a new election for the remainder of the *plan year*, as long as the termination was not for the purpose of altering the original election.

Coverage for a rehired employee is effective on the:

	…date of rehire
	…first day of the month following the date of rehire
	Other:

What is the cost of *COBRA* coverage?

If you are eligible for and choose to continue coverage, you will be required to pay [_____]% of your normal contribution…

	…and [_____]% of the *employer contribution*.

BENEFITS

Grace period

To the extent that you have an unpaid balance remaining in your *qualified medical flexible spending account* at the end of the *plan year*, the *Plan* will also reimburse you for *qualified medical flexible spending expenses* which are *incurred* by you, your *spouse*, or your *dependent* before the 15th day of the third calendar month (i.e., 2 ½ month period) immediately following the end of the *plan year*.

OPTIONAL – KEEP or REMOVE

What are examples of qualified and non-*qualified medical expenses*?

Examples of non-*qualified medical expenses* include:

	Hormone therapy relative to gender identity disorders
	Sexual reassignment surgery, including all related expenses

Qualified medical flexible spending expenses

	If you also participate in a health reimbursement arrangement account under *Code* §§ 105 and 106 offered by the *Plan Sponsor*, the reimbursement of *qualified medical flexible spending expenses* under this *Plan* is not available for *qualified medical flexible spending expenses* that are covered by the health reimbursement account until the amount available from the health reimbursement account covering those

	same *qualified medical flexible spending expenses* has been exhausted. **OR**
	If you also participate in a health reimbursement arrangement under *Code* §§ 105 and 106 offered by the *Plan Sponsor*, you must first exhaust the amount available for the reimbursement of *qualified medical flexible spending expenses* under this *Plan* before seeking reimbursement for such *qualified medical flexible spending expenses* under the health reimbursement account.

If the plan has a *Debit Card Feature*, please answer the following:
Thus, the *debit card's* use is limited to

	Physicians		Vision care offices
	Pharmacies		Hospitals
	Dentists		Other medical care providers

Within [_____] days of using your *debit card*, you must submit an invoice or receipt from the merchant or provider of service.

How do I file a claim for benefits?
You must submit a properly completed and documented claim to:

	Third Party Administrator **OR**
	Plan Administrator

Is there a time limit for filing claims?
Claims for reimbursement under a *qualified medical flexible spending account* should be submitted within [_____] days following the date the expense was *incurred*.

All claims for reimbursement must be submitted within [_____] days following the end of the…

	…plan year or if earlier, …
	…grace period or if earlier…

… [_____] days following the date you cease to participate in the *Plan*, or the claims will be denied.

Is there a minimum claim amount?
The minimum amount a *participant* may submit for reimbursement for *qualified medical flexible expenses* is $[_____], except at the end of the **(plan year OR grace period)** in which the expense was *incurred*.

What if I do not use all of the money in my *qualified medical flexible spending account* by the end of the *plan year*?
You have [_____] days after the end of the **(plan year OR grace period)** to file any *qualified medical flexible spending expenses incurred* for that year.

If you DID NOT use the "grace period" language, and want to allow the carryover option, please complete the following?
If you fail to file for reimbursement within this time limit, or if you did not *incur* enough *qualified medical flexible spending expenses* to meet your annual salary reduction amount, you may carryover unused amounts up to [_____] **($500 max)**.

FUNDING

How is the *Plan* funded?

	Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary reduction agreement*. **OR**
	Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary reduction agreement* together along with any *employer contributions.*

	Qualified medical flexible spending expenses will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary reduction agreement*. **OR**
	Qualified medical flexible spending expenses will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary reduction agreement* along with the amount that the *participating employer* has agreed to contribute to your account.

Please choose one of the next two statements:
Your annual salary or wage may be reduced in an amount not to exceed the amount established by the *Plan Sponsor* for each *plan year*.
OPTIONAL – KEEP or REMOVE

OR

Your annual salary or wage may be reduced in an amount not to exceed $[_____] ***($2,650 maximum)*** for full-time *employees* and $[_____] for part-time *employees*.
OPTIONAL – KEEP or REMOVE

If you contribute at least $[_____] to your *qualified medical flexible spending account*, the *participating employer* will contribute $[_____] to your account.
OPTIONAL – KEEP or REMOVE

Employer contributions will be funded to your account pro rata over the number of consecutive pay periods in the *plan year*.
OPTIONAL – KEEP or REMOVE

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the *Plan*?
The *Plan Administrator* has retained the services of the *third party administrator* to provide certain claims processing and other ministerial services.
OPTIONAL – KEEP or REMOVE

Do the *Plan Administrator's* duties include appointing and supervising a TPA to pay claims? _____

MISCELLANEOUS INFORMATION

Will the *Plan* provide a statement of benefits?

	On or before January 31st of each year, the *Plan Administrator* will furnish each *participant* who received benefits under the *Plan* a written statement showing…
	Throughout the *plan year*, the *Plan Administrator* will provide access to a web-based online system to each *participant* who received benefits under the *Plan* which will show…

…the amounts paid or the expenses *incurred* by the *Plan Sponsor* in providing reimbursement under the *Plan* for *qualified dependent care flexible spending expenses* and *qualified medical flexible spending expenses* for the prior *plan year*.

CLAIMS REVIEW PROCEDURE

Requirements for appeal
Appeals should be directed to the TPA or Plan Administrator: _____

Please provide the fax number for the above: _____

Decision on review to be final
Any legal action for the recovery of any benefits must be commenced within [_____] after the *Plan's* claim review procedures have been exhausted.

The following questions ONLY apply if there are 2 levels of appeal. If your Plan has only 1 level of appeal, please skip these questions.

Full and fair review of all claims
Participants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and [_____] days to appeal a second adverse benefit determination;

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the *Plan's* adverse decision regarding the first appeal, you have [_____] days to file a second appeal of the denial of benefits.

HIPAA PRIVACY PRACTICES

Disclosure of Protected Health Information *("PHI")* to the *Plan Sponsor* for *Plan Administration* Purposes

- The following employees, or classes of employees, or other persons under control of the *Plan Sponsor*, shall be given access to the *PHI* to be disclosed:
