Checklist for
Combination Medical FSA, Dependent Care FSA, and Premium Only Plan

Person to Contact with Questions: _____

Telephone Number: (____) _____

Email Address: _____

GENERAL PLAN INFORMATION

Group's Full Name: _____

Group's Address: _____

_____

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

_____

Group's Telephone Number: (____) _____

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

Employer Identification Number (EIN): _____

Plan Year (month to month): _____

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

Date of this Restatement (month & year): _____

Is this an ERISA Plan? _____
If so, ERISA Plan Number: _____

Type of Benefits Offered (please circle): Medical FSA Dependent Care FSA Premium Only Plan

Will the Premium Only Plan include contributions to a Health Savings Account? _____

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:

_____

Is this a Union Plan: _____
If so, what is the Name of the Union: _____
What is the Local Number: _____

Is this a Government Plan: _____

If so, is HIPAA applicable: _____

Does the Plan comply with any state mandated benefits: _____

List all states in which the Plan has Participants: _____

Is this a Church Plan: _____

If so, is HIPAA applicable: _____

Does the Plan comply with any state mandated benefits: _____

List all states in which the Plan has Participants: _____

DEFINITIONS

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

"***Benefit cost***" means the cost of premiums for…

	…medical…		…dental…
	…vision…		…hearing…
	…prescription drug…		

…coverage for a *participant*, his spouse, and dependent children under the *benefit plan* which *participant is* required, as a condition of coverage, to pay.

Does the Plan have a Debit Card feature? _____

"***Dependent***" means…

	…grandchildren of the participant…		…siblings of the participant…
	…parents 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

Are Domestic Partners covered: _____

If YES, please complete the following:

"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* and *qualified dependent care flexible spending expenses* may be considered eligible for reimbursement, subject to any unpaid balance in the applicable *qualified medical flexible spending account* or *qualified dependent care flexible spending account*.
OPTIONAL – KEEP or REMOVE

"***Plan year***" means the period from [_____] through [_____] each year.

"***Premium only plan***" means…

	…the vehicle through which a *participant* may elect to pay his share of *benefit costs* by reducing his

	salary and using pre-tax dollars.
	…the vehicle through which a *participant* may elect to pay his share of *benefit costs* by reducing his salary and using pre-tax dollars, [or, if the *participant* elects not to have his salary reduced to pay *benefit costs* under "May I Elect Not to Participate," for the *participating employer* to make an after-tax contribution to the *participant's* salary or wage.]

"***Salary reduction agreement***" means…

	… a written agreement by a *participant* to reduce his salary or wage in order to fund a *qualified medical flexible spending account*, a *qualified dependent care flexible spending account*, or to pay *benefit costs.*
	… a written agreement by a *participant* to reduce his salary or wage in order to fund a *qualified medical flexible spending account*, a *qualified dependent care flexible spending account*, or to pay *benefit costs,* [or, if the *participant* elects not to have his salary reduced to pay *benefit costs* under "May I Elect Not to Participate," a written agreement for the *participating employer* to make an after-tax contribution to the *participant's* salary or wage.]

"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.
	… a *participant*'s lawfully married spouse possessing a marriage license who is not divorced from the *participant*.
	…an *employee's domestic partner.*

"***Waiting period***" means an interval of time during which the eligible *employee* is in the continuous, *active employment* of his *participating employer* before he becomes eligible to participate in the *Plan*.
OPTIONAL – KEEP or REMOVE

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
	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 three years)] of continuous *active employment* from your date of hire]; or]

OPTIONAL – KEEP or REMOVE

	If you are an active, part-time *employee* regularly scheduled to work at least [_____] hours per week
	[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 three years)]*** of continuous *active employment* from your date of hire.]]

OPTIONAL – KEEP or REMOVE

If you are not a *participant* in the *benefit plan*, and have decided to decline coverage under that plan because you have comparable health care coverage, you may elect to receive cash compensation as described in this section. You must complete a salary contribution agreement declining coverage in the *premium only plan* in order to receive cash compensation
OPTIONAL – KEEP or REMOVE

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

	...first day…
	…first day of the month…

	Other:

…following your eligibility date, provided that you have completed a *salary contribution agreement*.

You must complete a proper *salary contribution agreement w*ithin [_____] days from your original eligibility date in order to participate in this *Plan* for the *plan year*.

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 contribution agreement.*

	Eligible *employees* who do not participate in this *Plan* may not pay any required contributions to the *benefit plan* with pre-tax dollars, nor may they pay *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* using pre-tax dollars.
	Eligible *employees* who do not participate in this *Plan* may not pay any required contributions to the *benefit plan* with pre-tax dollars[and are not eligible to choose the cash compensation alternative], nor may they pay *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* using pre-tax dollars.

	[Unless you experience a change in circumstances, as described below,] your *salary contribution agreement* will continue in force for that *plan year,* and you will be required to complete a new *salary contribution agreement* for each subsequent *plan year* for which you decide to participate in this *Plan*.
	Your *salary contribution agreement* will continue in force for that *plan year,* and you will be required to complete a new *salary contribution agreement* for each subsequent *plan year* for which you decide to participate in this *Plan*.

However, once you elect to contribute to a *premium only plan,* that election will continue to remain in effect from *plan year* to *plan year*, unless you affirmatively elect to cease your participation by so indicating on a new *salary contribution agreement.* If you decide to discontinue your participation in the *premium only plan* during the annual election period, you must affirmatively indicate your intention to do so by completing a new *salary contribution agreement.*

OPTIONAL – KEEP or REMOVE

If you do not submit the *salary contribution agreement* to the *Plan Administrator* within [_____] days of becoming eligible, or during the *annual enrollment period*, 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* or following a change in status event described below.

May I elect not to participate in the *benefit plan*?

You may elect not to participate in the *benefit plan* by completing and filing an appropriate election/declination form with the *Plan Sponsor* within [_____] days of your original eligibility period or an *annual enrollment period*.

	If you elect not to participate in the *benefit plan*, you will be entitled to receive $[_____] in cash compensation from the *Plan Sponsor*.
	If you elect not to participate in the *benefit plan* [due to the fact that you are currently enrolled in a different health *benefit plan* which is comparable to the *benefit plan*], you will be entitled to receive $[_____] in cash compensation from the *Plan Sponsor*.

	You will be required to provide evidence of the comparable coverage to the *Plan Sponsor* in order to receive the cash compensation.

	Any such cash compensation paid to you will be on an after-tax basis within [_____] days from your election not to participate
	Any such cash compensation paid to you will be paid on an after-tax basis on a pro rata basis on the [_____] day of each month.

May I make mid-year changes in my *Plan* elections?
However, you may make a mid-year election change if you experience a change in status event listed below, if that change in status event affects the eligibility for benefits of you, your *spouse*, or your *dependent*, and the election change you make is consistent with the change in status event. 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* child (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 significant change in the cost of dependent care.
- A change in dependent care providers.
- A dependent care provider's cessation of business.
- 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.
- A change in worksite of you, your *spouse*, or your *dependent*.
- 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 to the *premium only plan* or the *qualified medical flexible spending account.*
- 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.

OPTIONAL – KEEP or REMOVE

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., as well as a new *salary contribution agreement* reflecting your new contribution elections.

The change in coverage becomes effective…

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

…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

What if there is a change in the cost of coverage during the *plan year*?
If the *benefit costs* significantly increase or decrease (as determined by the *Plan Sponsor*), you may make a corresponding change in your election to participate in the *premium only plan.*
OPTIONAL – KEEP or REMOVE

When does my participation end? *Please choose ONE*

	ALL ON SAME DATE: If you terminate employment with the *participating employer*, your participation in this *Plan* will terminate on the last day you are *actively at work* unless you elect to continue your participation in accordance with the guidelines provided in the "*COBRA* continuation coverage" section.
	POP AT END OF MONTH: If you terminate employment with the *participating employer*, your participation in the Medical Flexible Spending Account and the Dependent Care Flexible Spending Account will terminate on the last day you are *actively at work* unless you elect to continue your participation in accordance with the guidelines provided in the "*COBRA* continuation coverage" section. If you termination employment with the *participating employer,* your participation in the Premium Only Plan will terminate on the last day of the month following your termination of employment.

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*, plus a [_____]% administration fee.

BENEFITS

Qualified medical flexible spending expenses
Is there a grace period for medical expenses? _____

If the Plan also has an HRA, please choose one of the following:

	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.
	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.

What are examples of qualified and non-*qualified medical flexible spending expenses*? *Do you want to specifically exclude these items…*

Examples of non-*qualified medical flexible spending expenses* include:

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

***Qualified dependent care flexible spending expense*s**

Is there a grace period for dependent care expenses? _____

Debit card feature

The debit card is available for:

	qualified medical flexible spending expenses		qualified dependent care flexible spending expenses

If you contribute to both a *qualified medical flexible spending account* and a *qualified dependent care flexible spending account*, you will receive…

	…one card for both accounts.
	…a separate card for each account.

The *debit card's* use is limited to…

	…physicians		…pharmacies
	…dentists		…vision care offices
	…hospitals		…providers of dependent care services

Within [_____] days of using your *debit card*, you must submit an invoice or receipt from the merchant or provider of service, including the information required under either Sections "How do I file a claim for *qualified medical flexible spending expenses*" or "How do I file a claim for *qualified dependent care flexible spending expenses"* as applicable.

Are claims for Medical Expenses to be directed to the TPA or Plan Administrator? _____

Are claims for Dependent Care Expenses to be directed to the TPA or Plan Administrator? _____

Is there a time limit for filing claims?

All claims for reimbursement of *qualified medical flexible spending expenses* must be submitted within [_____] days following the end of the…

	…plan year
	…grace period

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

All claims for reimbursement of for *qualified dependent care flexible spending expenses* must be submitted within [_____] days following the end of the…

	…plan year
	…grace period

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

Is there a minimum claim amount?
The minimum amount may submit for reimbursement for *qualified medical flexible spending expenses* is you $[_____], except at the end of the…

	…plan year in which the expense was *incurred.*
	…grace period in which the expense was *incurred.*

The minimum amount you may submit for reimbursement for *qualified dependent care flexible expenses* is $[_____], except at the end of the…

	…plan year in which the expense was *incurred.*
	…grace period in which the expense was *incurred.*

What if my *qualified medical flexible spending account* balance or my *qualified dependent care flexible spending account* balance is less than my claim?
At no time during the…

	…plan year will the amount paid for claims exceed the amount of contributions made to the *qualified dependent care flexible spending account.*
	…plan year [or the grace period] will the amount paid for claims exceed the amount of contributions made to the *qualified dependent care flexible spending account*.

What if I do not use all of the money in my *qualified medical flexible spending account*?
You have [_____] days after the end of the…

	…plan year…
	…grace period…

…to file any *qualified medical flexible spending expenses incurred* for that year.

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 contribution amount…

	…you forfeit any unused funds in your account.
	OR
	…you may carryover unused amounts up to [_____] **($500 maximum)**.

What if I do not use all of the money in my *qualified dependent care flexible spending account*?
You have [_____] days after the end of the…

	…plan year…
	…grace period…

…to file any *qualified dependent care flexible spending expenses incurred* for that year.

If, on the date of termination, you have a balance remaining in your *qualified dependent care flexible spending account*, any *qualified dependent care flexible spending expenses incurred* after the date of termination but during the *plan year* will be reimbursed by the *Plan* in accordance with the guidelines in this section.
OPTIONAL – KEEP or REMOVE

FUNDING

How is a *qualified medical flexible spending account* 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 contribution agreement*
	Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary contribution agreement* [together 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 contribution agreement*.
	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 contribution agreement* [along with the amount that the *participating employer* has agreed to contribute to your account].

Your annual salary or wage may be reduced in an amount not to exceed $[_____] ***(up to $2,600)*** each *plan year*.

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

How much can I elect to contribute to my *qualified dependent care flexible spending account*?
If you are not married you may contribute up to $[_____] to a *qualified dependent care flexible spending account*; however, in the event that your *earned income* is less than $5,000, you may contribute an amount not to exceed your *earned income* for the taxable year.

Minimum Election Amounts
The minimum amount you may elect to contribute to your *qualified medical flexible spending account* is $[_____] each year.

The minimum amount you may elect to contribute to your *qualified dependent care flexible spending account* is $[_____] each year.

SALARY CONTRIBUTION AND DISCRIMINATION

Termination, revocation, or amendment of salary contribution elections
However, with regard to the *premium only plan* only, once you have elected to participate in a *premium only plan*, your participation will continue from *plan year* to *plan year* unless you affirmatively elect to cancel or change that participation by completing the appropriate salary contribution agreement.
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

The duties of the *Plan Administrator* include the following:

- To appoint and supervise a *third party administrator* to pay claims;

OPTIONAL – KEEP or REMOVE

MISCELLANEOUS INFORMATION

Will the *Plan* provide a statement of benefits?
Will the Plan provide a statement of benefits? _____
If "NO," please move on to "CLAIMS REVIEW PROCEDURE"; If "YES," please choose an option…

	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, qualified medical flexible spending expenses,* and *benefit costs* 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: _____

Appeal of Claims or Disputed Claims
However, should a participant have a claim for benefits under this *plan*, either because the wrong amount was taken from the participant's salary, or because the *benefit cost* was not properly paid, the participant must notify the *Plan Administrator* within [_____] days after the pay-period in which the incorrect amount was taken from the participant's salary, so that the *Plan Administrator* may make the necessary adjustments.

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:

