# Checklist for
# Combination Medical FSA and Dependent Care FSA

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

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 plan***" means the…

| | | | |
|---|---|---|---|
| | …medical… | | …dental… |
| | …vision… | | …hearing… |
| | …prescription drug… | | |

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

Does the Plan have a Debit Card feature? ____________________________________________

If yes, the Debit Card applies to:

| | |
|---|---|
| | Medical flexible spending account expenses |
| | Dependent care flexible spending account expenses |

"***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 under this Plan? ____________________________________________
If YES…***"Domestic partner"*** means a person who has been in a domestic partnership with an *employee* for at least [__________] months …

"***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**

"***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**

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

"***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*?**
You are eligible to participate in the *Plan* if you are eligible to participate in the *benefit plan.*
**OPTIONAL – KEEP or REMOVE**

**For more detail than listed above, please choose from the following:**

| | |
|---|---|
| | 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**

**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.*

| | |
|---|---|
| | [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*. |

**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* 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.
- Your *dependent* satisfies or ceases to satisfy the requirements for coverage due to attainment of age, or any similar circumstance that would make the *dependent* ineligible.
- 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*.
- 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.*

**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 *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:*<br>• Within 30 days, you may rejoin the *Plan* provided that you keep your original election for that *plan year*; or<br>• 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. |
|---|---|
| | 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***

Is there a grace period for medical 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. |
|---|---|
| | 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. |

**OPTIONAL – KEEP or REMOVE**

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

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? ________________________________________

**If the plan does not have a debit card feature, please skip to "How do I file a claim for benefits?" below.**

***Debit card feature***

Thus, the *debit card's* use is limited to…

| | | | |
|---|---|---|---|
| | …physicians | | …pharmacies |
| | …dentists | | …vision care offices |
| | …hospitals | | |

…and other medical care providers of service or providers of dependent care service.

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. |

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.

**How do I file a claim for benefits?**

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 *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 you 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*. |
| | …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]. |

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 be contributed to the Medical FSA? ***($2,650 maximum)***__________________________________

**How much can I elect to contribute to my *qualified dependent care flexible spending account*?**
How much can be contributed to the Dependent Care FSA? ______________________________

**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

For *health savings accounts* under a *premium only plan*, on your enrollment form, you must indicate the amount that you would like to contribute to your *health savings account* for each month in which you are eligible. Unless you indicate otherwise, your entire contribution for the *calendar year* will be apportioned pro rata for each pay period, and taken out of your salary on a pre-tax basis.
**OPTIONAL – KEEP or REMOVE**

**Forfeiture of salary contribution amounts**
Your *health savings account* will be owned by you, not by your *participating employer*. It is your decision how the funds are invested. Because you own the *health savings account,* you will have control over the assets.
**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* or 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: ______________________________

**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:

| | |
|---|---|
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