Checklist for
Combination Medical 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 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

"***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

"***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 contribution agreement***" means…

	… a written agreement by a *participant* to reduce his salary or wage in order to fund a *qualified medical 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* 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*.

Are domestic partners covered under this Plan? ____

"***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* 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* 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* 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 *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***

	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.
	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

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*?

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

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

Debit card feature

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 the Section "How do I file a claim for *qualified medical flexible spending expenses.*"

Are claims for Medical Expenses to be directed to the TPA 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 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.*

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

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 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 the amount established by the *Plan Sponsor* for each *plan year*.
	Your annual salary or wage may be reduced in an amount not to exceed $[__________] ***($2,650 max)*** for full-time *employees* and $[__________] for part-time *employees*.

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

Minimum Election Amounts
The minimum amount you may elect to contribute to your *qualified medical 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: