BlueCross BlueShield of Kansas | FURTHER℠ Formerly SelectAccount®

FLEXIBLE SPENDING ACCOUNT (FSA) PLAN DESIGN GUIDE

Please complete this form and return to Further 45 days before your effective date so we can properly administer your plan.
If you have any questions, please call our Sales line at 855-363-2583. When complete either send via secure email only, to Further.Group.Administration@hellofurther.com, fax this form to 1-866-231-0214; or mail it to Further, PO Box 64193, St. Paul, MN 55164.

All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Employer's Name_____

Employer's Street Address _____

City _____ State _____ Zip Code _____

Employer's Tax I.D. Number (required) _____

Type of Corporation ☐ S Corporation* ☐ C Corporation ☐ Partnership* ☐ Sole Proprietor*
☐ Political Subdivision/Church ☐ LLC* ☐ Non-Profit ☐ Other_____

**2% or more shareholders of an S Corporation, along with partners in a partnership, sole proprietors and members of an LLC or PLLP do not have access to an FSA.*

Number of Employees Eligible for Plan: _____

Person Responsible For Authorization of Plan Design:
(Responsible for signing the Plan Design Guide and approving the plan design)

Name _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address _____

Main Contact Person:
(Has access to all plan information when calling Further and will automatically be granted full access to the Online Group Service Center)

Main Contact Person _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address_____

Additional Contact Person:
(Has access to the plan information indicated below when calling Further. Access to the Online Group Service Center may be granted by the Main Contact who will decide what online access is assigned by logging into the Online Group Service Center)

Additional Contact Person _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address_____

Additional Contact Person has access to when contacting Further:

☐ All plan information OR ☐ Fee billing information ☐ Claim billing information

* Log into the Online Group Service Center to grant access to additional users or to add more contacts.

II. AGENCY/BROKERAGE INFORMATION

Agent/Broker Name *(if applicable)* _____ Email Address _____

Agent/Broker Code _____ Agent/Broker Phone _____

Agency/Brokerage Name *(if applicable)* _____ Email Address _____

Agency/Brokerage Code _____ Agency/Brokerage Phone _____

Agency/Brokerage Tax ID _____-_____

Agency/Brokerage Address_____

III. TRANSFER OF ADMINISTRATION

Is Further taking over administrative services from another FSA administrator? ☐ Yes ☐ No

With your previous FSA plan, was rollover allowed to carry over from year to year? ☐ Yes ☐ No

(If yes on either question, Further will contact you)

IV. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health plan carrier _____

A health plan must be offered in order to offer an FSA.

Is your plan fully insured or self insured? ☐ Fully Insured ☐ Self Insured

V. FLEXIBLE SPENDING ACCOUNT ADMINISTRATIVE INFORMATION

Plan Year

FSA start date _____ FSA end date _____

Plan Options *(select **all** that apply)*

☐ Medical Flexible Spending Account
☐ Dependent Care Flexible Spending Account

☐ Premium Reimbursement Account* (Employer sponsored group health plan)
☐ TaxSaver Health Options PRA* (Employers that do not sponsor a group health plan)

* These plan options are not flexible spending accounts but are covered under the IRS section 125 or 132. Refer to Fee Schedule for any additional charges with these Plans.

Note: The Premium Reimbursement Account and TaxSaver Account allow employees to use pre-tax dollars to pay for their supplemental insurance policies. Major medical premiums are not eligible for reimbursement if employee is actively working.

Cafeteria Plan

You must have a cafeteria plan in place to allow employee pre-tax contributions to the FSA. Please select one of the following:

☐ I currently have a cafeteria plan with Further. Please update my documents.
☐ I currently have a cafeteria plan with another vendor.
☐ I want Further to setup a cafeteria plan. Continue to the eligibility section below.

Eligibility Required for Plan documents *(generally matches that of the health plan.)*

Employees must work at least _____ hours per week to be eligible

Benefits will begin on: (select **only** one):

☐ First of the month following date of hire

☐ Date of hire

☐ First *day* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other

☐ First of the *month* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other

V. FLEXIBLE SPENDING ACCOUNT ADMINISTRATIVE INFORMATION (continued)

Terminations *(applies to Medical FSA only)*

Allowing continuation on an after-tax basis is mandatory.

Do you also wish to allow continuation on a pre-tax basis, taken from the employee's last paycheck, with the employee's written permission? ☐ Yes ☐ No (default)

Minimum and Maximum Employee Contribution Limits

	Minimum	Maximum	
Medical FSA	$_____	$_____	**(IRS maximum is $2,650)**
Dependent Care FSA	$_____	$_____	**(IRS maximum is $5,000)**

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

If yes, indicate which accounts and amount of contribution: *(select **all** that apply)*

☐ Medical $_____ per participant at the start of the plan year.
☐ Dependent Care $_____ per participant at the start of the plan year.

Note: The employer can contribute up to $500 to all eligible workers without the employee contributing. When employer is contributing an amount over $500, the employer's contribution cannot exceed the employee's election.

Grace Period

The grace period only applies to Medical and/or Dependent Care FSAs. It is the additional time period in which members can incur out- of-pocket expenses in the new plan year if money is left over from the previous plan year. Claims incurred during the grace period may be submitted until the end of the runout period. A grace period is not recommended for dependent care FSA. You may choose grace period or rollover, but not both.

The grace period can be up to two months and 15 days from the end of the plan year. The grace period cannot exceed the runout period end date for a Medical FSA. A grace period is not recommended if you currently offer an HSA or if you are considering adding one in the future.

Would you like to add a grace period to the end of the plan year for **Medical FSA**? ☐ Yes ☐ No

If yes, please indicate your grace period end date __ __ /__ __ /__ __ __ __

Would you like to add a grace period to the end of the plan year for **Dependent Care FSA**? ☐ Yes ☐ No

If yes, please indicate your grace period end date __ __ /__ __ /__ __ __ __

Rollover

You have the option to allow employees to carry over up to $500 from the current plan year to their FSA for the following plan year. The rollover amount does not count towards the $2650 FSA contribution limit. Without the rollover or grace period, balances at the end of the plan year are forfeited. You may choose rollover or grace period, but not both. Indicate what happens to unused balances at the end of the plan year:

☐ Roll over balance up to $500 to subsequent plan year
☐ No balance rolls over

Runout Period

The runout period is the deadline for participants to submit claims for the previous plan year. All eligible claims must be received by the end of the runout period. *The suggested runout period selected for a Medical FSA is 3 months from the end of the plan year. A runout period always begins at the end of the plan year, and if a grace period is selected, it runs concurrently with the grace period.*

If you selected **Medical FSA**:

Please indicate the length of the runout period for active Medical FSA employees: _____ (months)
(Length of runout period must be indicated in whole and/or half month increments. Half months equate to 15 days.)

Please indicate how you would like runout to apply to terminated employees *(select **only** one)*
☐ The runout period noted above begins at termination date *(recommended)*
☐ Same as active employees

If you selected **Dependent Care FSA** please indicate the length of the runout period: _____ (months)
(Length of runout period must be indicated in whole and/or half month increments. Half months equate to 15 days. Runout for terminated and active employees is the same for dependent care.)

VI. FLEXIBLE SPENDING ACCOUNT OPTIONAL FEATURES

Reimbursement Options

You may select any of the features listed below that best meet your needs and those of your participants *(see section XIII for more information and definitions):*

☐ **Option #1 (debit card)**- participants will automatically be issued a debit card. Participants have the option to discard their debit card and enroll in crossover, if they choose.

☐ **Option #2 (medical crossover)**- participants will be automatically enrolled in medical crossover. They may opt out of the crossover feature and elect a debit card, if they choose. **Additional fees apply with this option; please refer to the pricing sheet.**

Copay amounts

The copay amounts provided below will allow these amounts to auto-substantiate when the debit card is used. Documentation will not be required for reimbursement.

Please indicate the health plan copay amounts below or attach a separate spreadsheet indicating the copay amounts:

Medical: _____ _____ _____ Vision: _____ _____ _____

Drug: _____ _____ _____

VII. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

☐ Online Group Service Center. Employer will enroll participants online using the Online Group Service Center at **hellofurther.com**

☐ Electronic file
(Electronic enrollment file format requirements will be provided via email following the approval of the plan design guide.)

VIII. FSA PAYROLL INFORMATION

Further is required to post payroll deduction information throughout the year for all employees choosing to participate in the plan. Funds should **not** be sent with any deduction information.

You have the option to send your enrollment deduction data to Further in the following three ways (select one):

☐ **Online Group Service Center (recommended)**: You can create and upload a file directly in the Further system or manually enter contribution amounts.

☐ **Electronic File**: This option requires employers to create a file using Further format requirements. (Contact the group leader line for file format requirements.)

☐ **Paper Report**: This option is a report that the employer creates each payroll date and sends to Further via fax or mail. This option may only be used for employers with fewer than 50 participants. **Additional fees apply. Please refer to the pricing sheet.**

IX. CLAIM REIMBURSEMENT PROCESSING

You will receive an automated e-mail notification with the claim reimbursement totals. Sign into the Online Group Service Center to view and print your complete invoice detail under Claim Reimbursement Invoices.

Automated Clearinghouse Information ***(completion of this section is mandatory)***

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **claim reimbursements** made to our employees. The following bank account information is provided to Further for initiation of this procedure.

Bank Name _____

Type of Account: ☐ Checking ☐ Savings

Bank ABA Number _____

(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip)

Bank Account Number _____

X. ADMINISTRATIVE FEES

You will receive an automated e-mail notification when your detailed billing information is available and another e-mail notification two business days in advance of the scheduled ACH transaction confirming the amount of funds to be transferred. Sign into the Online Group Service Center to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **Administrative Fees.** The following bank account information is provided to Further for initiation of this procedure.

Please select **one:**

☐ **Use same bank account as indicated for claim reimbursements; OR**

☐ **Use bank account information indicated below:**

Bank Name _____

Type of Account: ☐ Checking ☐ Savings

Bank ABA Number _____

(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip)

Bank Account Number _____

(Funds will be drawn from your bank account on or after the 20th of each month.)

XI . PLAN DOCUMENTS

Will Further be preparing your Plan Document and Summary Plan Description (SPD)?

☐ Yes (Plan Documents and SPDs will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.)

☐ No (If no, please forward a copy of your plan documents to Further.)

XII. ADMINISTRATIVE TIPS AND DEFINITIONS

ONLINE ACCESS: hellofurther.com

With Further, your employees have access to a powerful tool for managing their FSA. By registering with hellofurther.com, your employees can:

- Enroll in direct deposit
- View recent claims or reimbursement requests
- Create and view a customized statement
- Manage their personal profile

You can also access forms and enrollment materials at **hellofurther.com.**

LOCATIONS: Multiple Further locations are available for 51+ groups only. If you want multiple Further locations, please complete and attach the Locations Addendum (F8928). Locations must be the same across all products administered by Further. If you wish to have different ACH accounts by location, please complete the Group ACH Authorization Agreement Form (X9055).

COORDINATING WITH AN HSA: For participants that have an FSA and an HSA, the FSA provides reimbursement for permitted benefits such as vision and dental care benefits until the health plan deductible is met. Once the health plan deductible is met, all Section 213(d) expenses, excluding deductible expenses, are eligible for reimbursement.

This affects only those participants who are eligible to contribute to their HSA. Participants who are not eligible to contribute to an HSA will have a general purpose (Full) FSA.

Please note: If the HSA is not administered by Further or the health plan is not with Blue Cross and Blue Shield of Minnesota, the group is required to manually notify Further which employees are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (F8978) to Further to indicate that the deductible has been satisfied prior to receiving reimbursement for 213(d) eligible expenses.

COORDINATING WITH AN HRA:

* If the HRA allows reimbursement for health plan eligible expenses only, the HRA is primary and the FSA is secondary.

* If the HRA allows all 213(d) expenses to be reimbursed, the FSA is primary and the HRA is secondary because unused FSA funds are forfeited if not used for the applicable plan year.

ACCOUNT FEES: For participants who have an HRA stacked with a Further FSA, only one monthly participant fee will apply. Participant fees are billed monthly via mail and are payable by check or ACH. You will receive one bill for the entire group including the billed amount for each location (if applicable).

PLAN DOCUMENTS: Further will be preparing your Plan Document and Summary Plan Descriptions (SPD). The documents will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.

REIMBURSEMENT OPTIONS:

DEBIT CARD: This feature allows a participant to use a debit card to access their medical FSA at point of service. Members with an FSA and an HSA will be automatically issued a debit card.

MEDICAL CROSSOVER: Eligible health expenses (i.e. deductible and/or coinsurance) as indicated on the health plan Explanation of Benefits will be electronically transferred to Further. Claims will be processed and reimbursed according to the participant's available balance.

Please note: Crossover is not appropriate for participants who have secondary health coverage. Contact Further for a list of partners where crossover is available.

XIII. SIGNATURES

It is agreed that necessary information concerning current and future employees or employees and/or their dependents who participate in this Plan and employees whose participation is to be changed or discontinued, shall be provided to Further on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE,TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signature _____ Date_____

Printed Name _____ Title _____

XIV. OFFICE USE ONLY

Further Group Number _____

Market Segment _____

Health Plan Account Manager _____

Distribution Partner _____

Distribution Partner Account Manager _____

Sales Exec _____

Further Account Manager_____

Client Manager _____

Enrollment Specialist _____