The BESTflex℠ Plan

AnswerBook

Your guide to our Section 125 Flexible Spending Account (FSA) administration.

Employee Benefits Corporation

Answer Book Contents (click below)

Welcome to the BESTflex℠ Plan Answer Book!

The information in this book is intended to answer general questions about your BESTflex Plan administration and may not provide exact or detailed information for specific situations. For help with detailed questions, please contact us to ensure a proper answer or result.

This book is not intended to replace your established procedures, but to supplement them. You are encouraged to develop and establish procedures that address your in-house processes regarding the handling of the BESTflex Plan, group insurance, and other related benefits issues.

The Answer Book is based upon our interpretation of the Internal Revenue Code (IRC), Department of Labor (DOL) regulations, and guidance from our legal counsel. At any point you may wish to seek legal advice from your own legal counsel.

About the BESTflex Plan and Employee Benefits Corporation

The BESTflex Plan is made up of four parts, with each part providing tax savings for different types of expenses. Employee Benefits Corporation administers your BESTflex Plan and is available throughout the year to offer you and your employees assistance.

About the BESTflex Plan

The BESTflex Plan is a Section 125 Cafeteria Plan that, in accordance with IRS guidelines, provides **pre-tax reimbursements for eligible health care and daycare expenses** through flexible spending accounts (FSAs), individually billed insurance premiums through the individual billed insurance premium account (IND), and pre-tax group insurance premium payments.

Based on health care expenses that are not covered by regular health insurance, dependent care expenses and ---health insurance premiums billed at home, participating employees choose how much of their pay to place in the BESTflex Plan. When their gross pay is taxed, the money they elected to place into the BESTflex Plan is not counted as taxable income so they pay less taxes. Each time they pay out of pocket for an eligible expense, they submit a claim and the BESTflex Plan provides a reimbursement.

The BESTflex Plan is made up of four parts, with each part covering different types of expenses. **Group Insurance Premiums** covers the money that is already withheld each pay period to pay for medical or other group insurance premiums. With the BESTflex Plan, this withholding becomes an automatic, pre-tax deduction. The **Health Care FSA** reimburses health care costs and the **Dependent Care FSA** reimburses dependent care expenses. The **Individual Premium Account** reimburses insurance premiums that an employee purchases on their own, other than medical insurance. These are all pre-tax accounts.

We provide you with all the necessary documents for your BESTflex Plan.

About Employee Benefits Corporation

We are a third-party benefits administrator that provides your company's benefits administration. We manage your company's FSAs under the BESTflex Plan and process your participants' claims.

We began administering Section 125 cafeteria plans in 1989 and expanded into other related areas, including Section 105 health reimbursement arrangement (HRA) administration and COBRA administration.

The BESTflex℠ Plan

Our Website and Your Online Account

About Our Website | www.ebcflex.com

Our website and your online account are there to provide you the information and account details you need to manage your BESTflex Plan.

You can securely log into your employer account to view a variety of detailed account information, download forms and reports specific to your plan design, update your contact information, and more. It's a convenient, one-stop shop for your BESTflex Plan needs, and always available.

Without registering or logging in, you can also view news updates, product information, and general Employee Benefits Corporation information. All of this information starts on our home page, which is available at **www.ebcflex.com.**

Employee Benefits Corporation's Website In Detail

Website Address

Our website is located at **www.ebcflex.com**.

Your Online Account

Your online account lets you monitor your account activity, review invoices and payments, download forms and materials, enroll and remove plan participants, manage online enrollment, and generate important reports. Not only is it a convenient way for you to manage your BESTflex Plan, but also a safe way. Your online account is a secure portal that keeps your participants' protected health information private, as required under the Health Information Technology for Economic and Clinical Health Act.

You can access your online account at any time. We send you your user ID and secure password as part of your BESTflex Plan setup.

Please contact Client Services if you did not receive your login credentials.

Main Features of Your Online Account

- **Administration**
  The ***View Account Settings*** page allows you to review the set-up of your account. You can view your payroll and billing schedules, payment methods, and the individuals set as contacts for each plan and division in your company, if any.
- **Invoices**
  The ***Invoices*** page lists the different types of invoices your company receives for any and all plans, including administrative fees and reimbursement funding requests Please see **BESTflex Plan Invoices** for more information.
- **Plan Information**
  Your company's plan design information is readily available, whether you want to print copies of *My Company Plan* or you simply need a reminder of your plan's eligibility requirements. Please see **Important BESTflex Plan Documents** for more information.
- **Resources**
  In the ***Resources*** section, you can download forms and materials, knowing that they are relevant to your BESTflex Plan design. You simply select the appropriate plan type to view a list of available materials, forms and reports. Please see **Important BESTflex Plan Documents** for more information.

- **Renewal Activities**
  The ***Renewal*** section becomes available when your BESTflex Plan approaches its renewal date. Once available, you can use *Activate BESTflex Plan Online* to confirm your BESTflex Plan's renewal, inform us of your current number of eligible employees, and even make changes to your plan design. Please see **BESTflex Plan Renewal** for more information.

- **Manage Participants**
  Manage Participants lets you enroll or terminate participants in the middle of your plan year online, conveniently, securely, and with no faxing required. It validates your data and provides you with a confirmation of the change online quickly. Your participant's record is updated automatically and you can print a copy for your records.

Please see **New Hires** and **Termination of Participants** for more information.

How To: Log into Your Online Account

In order to maintain the security of your account, we send your user ID and secure password as part of your BESTflex Plan setup. Once you have your user ID and secure password, you can log in at **www.ebcflex.com.**

How To: Use the Secure File Uploader

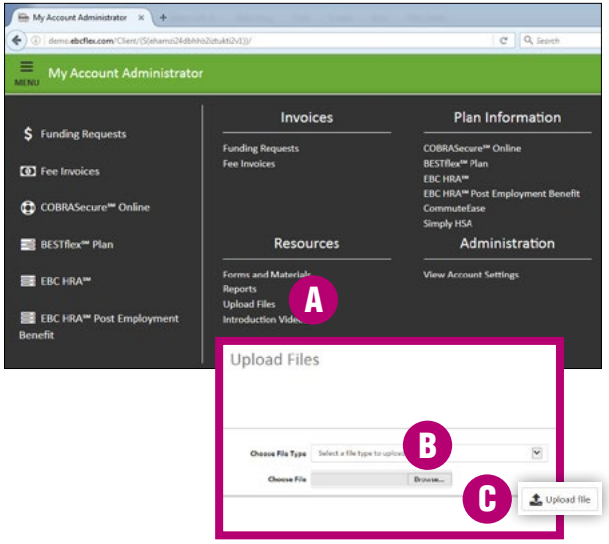
Use these instructions to submit files using our secure file uploader:

1. Save the file you would like to upload on your computer
2. Log into your online account
3. When the page opens, locate ***Upload Files*** from the ***Resources*** column in the menu **[A]**
4. Select the type of file you would like to upload from the drop-down list **[B]**
5. Click ***Browse*** to locate the file saved on your computer
6. Click ***Upload file*** **[C]**

Participant Online Accounts

Participants also have online access to their BESTflex Plan account. The participant online account offers convenient access to account details, including FSA balances, the status of claims and reimbursement payments, and the plan design details of their BESTflex Plan.

Participants can also download a copy of *My Company Plan*, authorize direct deposit of their reimbursement payments, manage their account user name and password, and update their contact information.



The secure upload area is located in the Resources section of the Menu.

Participant Online Account Activation Instructions

Participants follow these steps to activate their online account.

1. Using a web browser, go to **www.ebcflex.com**.
2. Click ***Log In*** > ***Participants*** to register the account.
3. Provide additional information for first-time user login.

After following the activation instructions, participants will receive their password via email within minutes. Then, they can log on and securely access their account information.

Important BESTflex Plan Documents

About Important BESTflex Plan Documents

We provide you the documents you need to operate your BESTflex Plan and meet ERISA and tax code requirements. It is important to know where these documents are at all times, as they contain important information that you or your participants may need to reference.

Important BESTflex Plan Documents In Detail

Plan Document

The *Plan Document*, which incorporates the *Plan Adoption Agreement* by reference, is the legal outline of your plan and must be followed. This document supersedes the *Summary Plan Description* (SPD) or any other reference materials you may receive.

Keep your *Plan Document* available and use it as a reference tool. Any time you make a change to your plan, re-sign the last page of the *Plan Document* as evidence of your adoption of the restated plan.

Your participants must be provided with a copy of the full *Plan Document* upon request. Your current *Plan Document* is available for download through your online account.

BESTflex Plan Adoption Agreement

The *BESTflex Plan Adoption Agreement* goes hand in hand with your *Plan Document*. This agreement explains the specific design of your plan. It lists the accounts that are available and the parameters of the plan.

Plan eligibility requirements and other plan specifics are established in the *Plan Adoption Agreement*. If you amend your plan after adoption, keep the amendment with your *Plan Document* and adopt the amended plan by signing the restated adoption agreement found at the end of your *Plan Document*.

Summary Plan Description

The *Summary Plan Description* (SPD) is the participant's guide to the BESTflex plan. It explains how the plan works and the guidelines and rules for participating in and using the plan. Participants may use this as a reference throughout the plan year.

The SPD is available in employers' and participants' online accounts. You must distribute a copy of the SPD (including *My Company Plan*) to each plan participant within 90 days of enrollment.

My Company Plan

My *Company Plan* goes hand in hand with the *Summary Plan Description* (SPD). You must provide a copy of *My Company Plan* to participants. The most up-to-date version of *My Company Plan* is always available in your online account, even when you make changes to your plan.

Summary of Benefits and Coverage (SBC)

The Summary of Benefits and Coverage (SBC) is a required document for non-excepted Health Care FSAs. Most Health Care FSAs qualify as excepted benefits and are not required to distribute an SBC. Please review your BESTflex *Plan Document* to determine if your Health Care FSA is an excepted benefit. If you have a non-excepted Health Care FSA and have questions about preparing your SBC, please contact Client Services.

BESTflex plan sponsors who have non-excepted Health Care FSAs must distribute SBCs to eligible employees at open enrollment, upon request, at application for coverage, following a material modification of the plan, and following a request based on HIPAA special enrollment.

If the SBC is provided in paper format, it must be printed double-sided to ensure it does not exceed four pages.

Important BESTflex Plan Documents Online

How To: Download Documents From Your Online Account

The current version of these – and many other – documents are available for download in your online account.

1. Log into your account at **www.ebcflex.com**
2. Click ***Forms & Materials*** **[A]** in the menu
3. Select the BESTflex Plan Product **[B]**

To view and download a form, click the title of the form **[C]**.

Important documents can be downloaded from the Forms & Materials section.

How To: Download My Company Plan

You can always download a copy of *My Company Plan* from your online account. Start by clicking the product link under ***Plan Information*** in the menu.

Select the appropriate product, then scroll down and click *Download My Company Plan*.

The BESTflex℠ Plan

BESTflex Plan Invoices

About BESTflex Plan Invoices

Throughout the administration of your BESTflex Plan, you will receive invoices that request the funds needed to administer your BESTflex Plan and pay your participants' reimbursements.

You can pay your invoices via check, auto-debit, and automated clearing house (ACH). We also offer comprehensive invoice information on your online account management portal.

BESTflex Plan Invoices In Detail

Monthly Administration Fee Invoices

We charge a monthly administration fee for services provided to participants. See the ***Fees*** section of your Service Agreement for the amount.

On the 15th of each month you will receive an invoice for that month's fees. This invoice must be paid in order for us to continue to process claims and distribute reimbursements to your participants. The payment is due on the last day of the month. Failure to pay this fee could result in claims and checks not being processed for your participants and the possible termination of your plan.

Employee-Paid Monthly Administration Fees

You can have your participating employees pay the monthly administration fee. If you split the monthly Permitted Elections fee amongst your participants, they will be notified of the payment requirement under ***Administration Fees*** on their copy of *My Company Plan.*

Your employees can provide written authorization by writing the amount that will be withheld from their paycheck on the ***Enrollment Form*** or you can send us a written notification that you have collected each employee's authorization by a different method.

You will be billed for these fees on your regular ***Monthly Administration Fee Invoice***.

Payroll Deduction Invoices

You can choose to forward your participants' payroll-deducted dollars to us with each pay period. You establish the schedule (monthly, bi-weekly, etc.) for the collection of your participants' payroll-deducted dollars, and we send you a ***Payroll Deduction Invoice*** requesting the funds according to that schedule.

For more information on Payroll Deduction Billing and the options we offer, please see **Reimbursement Funding.**

How To: Reconcile Your Billing for Payroll Deductions

Participants may experience changes during the plan year that affect their payroll deductions. If your company remits payroll deductions to us, your billing for payroll deductions may also change. When you receive your billing statements:

1. First, compare your billing statement to your payroll deductions.
2. Then, note any changes, terminations or leaves of absence, including the date the payroll is affected, on the billing statement. If changes occurred, please make sure to complete the appropriate form (e.g., *Termination Form, Permitted Elections Change Form, Leaves of Absence Form*, etc.) and send it to us prior to or with the billing payment.

We cannot process your payment if the amount you send is different than the amount billed, unless you indicate on the remittance the details of the changes. If you do not detail the changes, we cannot determine what amount of the payment should be applied to a participant.

Medical Excess Invoices

Medical excess can occur when Payroll Billing is your claims funding method and can occur any time claims submitted exceed the funds available to pay them.

Our system automatically identifies medical excess as soon as it occurs and a ***Medical Excess Notification*** is emailed to the primary contact, or other designee, for your company. At the same time, a ***Medical Excess Invoice*** is published to the ***Invoices*** section of your online account.

You should review your ***Medical Excess Invoice*** upon notification.

For more information, please see **Medical Excess.**

Claims Register Invoices

You can choose to forward your participants' payroll-deducted dollars to us only when they are needed to fund reimbursements during a particular period of time. You establish the schedule (weekly, twice-weekly, or daily) for the collection of funds needed to pay participants' reimbursements. We send you a ***Claims Register Invoice*** according to that schedule to request the funds.

For more information on Claims Registers and other options, please see **Reimbursement Funding.**

How To: Submit Payment to Employee Benefits Corporation

You simply submit a copy of the billing statement, the dollar amount, and any appropriate form(s), if changes are made.

Until we receive your first payment, your account will be on hold, meaning participants' claims will be processed but not paid. Once we receive payment, we will begin paying reimbursements.

Any payroll-deducted amounts for Group Medical Premiums should be sent directly to the appropriate insurance carrier.

Submitting payments in a timely manner helps to ensure the success of your plan.

Payment Methods

Auto-Debit*: You transfer your payment by allowing us to automatically debit your bank account. Auto-debit is a convenient alternative to traditional payment methods that ensures we receive your payment on time. Before each auto-debit, you will receive a billing statement that indicates the date and amount of the transfer.

You can sign up for auto-debit by submitting an *Auto-Debit Authorization Form.*

Check: You submit payment in the form of a check.

Automated Clearing House (ACH)*: You set up this electronic payment method to transfer funds to us through your bank.

Direct Payment*: For claims payments, you authorize us to cut checks or to initiate ACH deposits from your account to your employee's account for the amount of their claim reimbursement.

For your administration fees, you authorize a regularly scheduled withdrawal to be made from your checking account. The amount debited from your account will be equivalent to the dollar amount of your fees.

*Must be arranged in advance. Contact Client Services for details.

BESTflex Plan Invoices Online

How To: Access Funding Requests and Invoices Online

1. Log into your online account at **www.ebcflex.com**
2. Click ***Funding Requests*** or ***Fee Invoices*** under ***Invoices*** in the menu.

These pages list the different types of invoices your company receives for any and all plans, including administrative fees and claim funding. The ***Invoice PDF and Details Report***, which you can access by clicking the associated links on the right side of the specific link item, offer additional detail.

If you have multiple products or multiple divisions under your plan, your invoices may be consolidated to include multiple fees. If you select an invoice that has been consolidated:

1. You can click the icon under ***Invoice*** to view the consolidated invoice in PDF format.
2. The ***Details Report*** will show each fee that makes up the consolidated invoice

The BESTflex℠ Plan

Reimbursement of Claims

About Reimbursement of Claims

After BESTflex Plan participants incur eligible expenses, they can submit claims for reimbursement from their Health Care flexible spending account (FSA), Dependent Care FSA, or Individual Billed Insurance Premium Account (IND). Participants submit their claims using our *Claim Form* and must attach third-party documentation that verifies the expenses' eligibility under the plan by indicating the date(s) of service, type of service, amount of the expense and the provider's name.

This section covers manual reimbursement, using a paper *Claim Form.* For information on using the Benefits Card instead of manual reimbursement, see **The Benefits Card and the Health Care FSA.**

Reimbursement of Claims In Detail

Eligible Expenses

The BESTflex Plan covers a variety of expenses. Prescription medicines, dental expenses, vision expenses – including contact lens solution, contact lenses, over-the-counter medications, and prescription eyeglasses – day care expenses, co-payments, and health plan insurance premiums are just a few of the common expenses on which the BESTflex Plan saves participants money.

A list of eligible expenses is available at **www.ebcflex.com/EligibleExpenses**.

When to Submit Claims

Once a participant incurs an expense, they may file a claim. The expense must be incurred in the plan year, or applicable grace period, for which reimbursement is requested.

Submitting Paper Claims

We explain to participants how to submit paper claims in the *Summary Plan Description (SPD).* We make the latest version of the SPD available to you and your participants online each plan year. Printed copies of materials can be ordered at an additional cost.

Our *Claim Form* also includes an instructions sheet to help participants submit accurate information and get their reimbursements as fast as possible.

Documentation for Expenses

All documentation for each expense submitted for reimbursement must be attached to the *Claim Form*. Each FSA requires special information, which must be included in the expense documentation.

The Health Care FSA requires:

- Documentation from a third-party provider, showing the date(s) of service, type of service, amount of the expense, and the provider's name (additional information may be requested).

The Dependent Care FSA requires:

- Documentation from the daycare provider, showing the dates of care, the charges, and the daycare provider's signature or name, or
- The dependent care provider's signature directly on the *Claim Form.*

The Individual Premium Account requires:

- Documentation from the insurance provider showing the type of policy, who is covered by the policy, the period of coverage, and the premium amount, or
- Documentation from the insurance provider showing the type of policy, who is covered by the policy, and a receipt showing the amount paid and the date paid.

Product Linking

Product linking is a feature that allows your participants to submit one claim and have the expense be correctly reimbursed from the EBC HRA and BESTflex Plan Health Care FSA. When a participant submits a request for reimbursement, the eligible amounts are paid first from the EBC HRA. Any remaining unreimbursed amounts will then be paid from the Health Care FSA.

The participant has the flexibility to decide when to use product linking and how Health Care FSA dollars are used. If EBC HRA claims are electronically received from the insurance company, employees can select an automatic option.

Claim Processing Time

We processes participants' claims within two business days after receipt. BESTflex Plan participants who have an email address on file will receive an email notification when we have processed each of their claims.

We issue reimbursement payments once the necessary funding is available.

Forms of Reimbursement

We provide reimbursement payments using paper checks or direct deposit.

Participants can sign up for direct deposit in various ways:

- Complete and submit a *Direct Deposit Authorization Form*
- Provide the required financial information while completing their enrollment
- Use the ***Account Settings*** section of their online account to provide the required financial information

FAQs

Q. What happens when a participant needs a reimbursement check reissued?

A. In the event that a BESTflex Plan participant does not receive a reimbursement check and requests that it is reissued, we will first run a check trace to ensure that it was correctly mailed. If it was, a $25.00 stop-payment fee will be assessed before a new reimbursement check is sent.

Your participants can sign up for direct deposit to eliminate the possibility of losing a physical reimbursement check and having to pay the $25.00 stop-payment fee for a reissued check.

Q. What happens if a claim or a portion of a claim is denied?

A. In the event that a claim is excluded or denied, a letter will be sent to the participant's home listing the reason for nonpayment of the claim. If applicable, the claim may be resubmitted with the requested information.

The BESTflex℠ Plan

Online and Mobile Claims

Online and Mobile Claims

In addition to submitting a paper *Claim Form*, participants can file claims through their online account at **www.ebcflex.com** or via our mobile app.

Online Claims

Online Account

Participants can file claims through their online account. They simply log in to their account at our website, **www.ebcflex.com** to access the claim filing feature.

Claims History

Participants can also view a list of the claims they've filed, sorted by year, and click each claim to expand it and view its details. This makes it easier to find a claim, see whether each expense was approved, and find the associated reimbursement.

How To: File a Claim Online

1. Log in to **www.ebcflex.com** as a participant
2. Click *Menu > Submit a New Claim* **[A]**
3. Complete the short web form and upload the scanned documentation **[B]**
4. Review, submit, and print your confirmation
5. Accept the ***Terms and Agreement***
6. Review and print your claim confirmation

Complete the Online Form

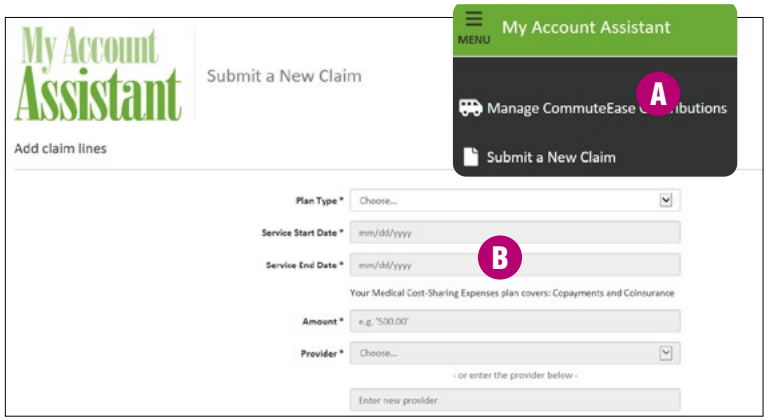
Participants complete the short claim form and, when finished, click ***Save***. They can add multiple expenses to their claim by clicking ***Add another claim line*** below the form.

EBC HRA note: If their insurance carrier submits their claims automatically, the EBC HRA will not be listed under Plan Type.

Attach Documents

Attaching supporting document(s) requires participants to scan and upload an invoice, receipt, or ***Explanation of Benefits*** (EOB) that shows the expense is eligible for reimbursement.

They click ***Upload document(s) from computer*** to bring up the file browser, then locate the scanned document(s) on their computer.



Shown: The online claim form

Once uploaded, they will see a graphic showing the document is attached to the claim. Participants can click the file name to view the document, or click ***X*** to remove it.

File Formats
Scanned documentation must be less than 4 MB in size and in one of the following formats:

.jpg / .jpeg / .gif / .pdf / .png / .tiff / .tif

When participants have completed the claim form and attached any scanned documentation, they click ***Next***.
Note: Please do not file a claim for an expense already paid for with the Benefits Card, if applicable.

Review claim, demographic, and financial information
If a participant needs to make a change, they can click ***Edit***. They can also click the file name of an uploaded document to view it, or click the ***X*** to remove it and upload a new one. When finished reviewing, they click ***Finish***.

Mobile Claims

My Mobile Account Assistant

Participants can also file claims and attach receipts using a mobile device. Participants complete a few lines on a simple form, attach their receipt using their device's camera and tap ***Submit***.

Participants can also review their BESTflex℠ Plan or EBC HRA℠ account balances and claims payment history at any time – including Benefits Card transactions.

Our mobile app, **My Mobile Account Assistant,** is available for Apple iOS and Android devices. Download the app at the iTunes Store and Google Play.

Manage Benefits Card Transactions

Benefits Card Transactions Screen
Participants who use the Benefits Card are also able to submit documentation using the app when requested. A badge will appear over the Benefits Card icon indicating the number of transactions requiring documentation.

Participants click on the Benefits Card icon to view transactions. They can view all transactions or just those requiring additional documentation. They can click on a row to view additional information.

The BESTflex℠ Plan

Reimbursement Funding

About Reimbursement Funding

The decisions you make regarding how your claims are funded and reimbursed affects the frequency with which your participants receive payments.

We offer several options. You can fund reimbursements via **Payroll Deductions**, where you forward participants' payroll-deducted dollars with each pay period. Funding via **Claims Registers** allows you to forward participants' payroll-deducted dollars only when they are needed to fund reimbursements that have accumulated during a predetermined period of time. **Direct Payment** allows us to issue reimbursement checks straight from your checking account.

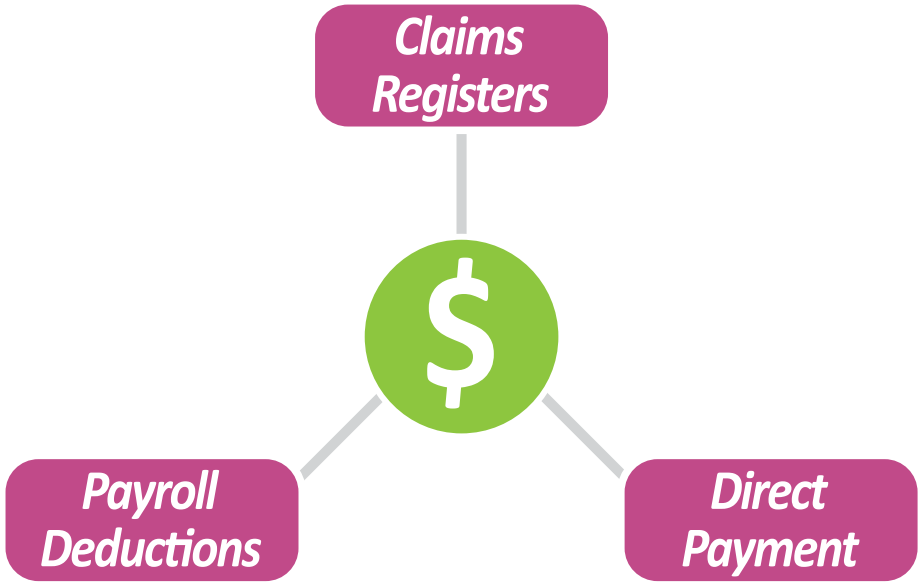
Each option has unique attributes that may make your decision easier.

Reimbursement Funding In Detail

Funding via Payroll Deductions (Payroll Deduction Invoices)

Payroll Deductions

When you fund your participants' reimbursements via payroll deductions, you forward participants' payroll-deducted BESTflex Plan contributions to us with each pay period.



The decisions you make regarding how your claims are funded and reimbursed affects the frequency with which your participants receive payments.

This is generally a simple and straightforward method of funding participants reimbursements. However, because participants in the BESTflex Plan are allowed to use the full amount of their Health Care flexible spending account (FSA) election starting on the first day of their plan year, you may have to submit additional funds when the payroll-deducted dollars do not cover the total amount to be reimbursed. For more information on this topic, see **Medical Excess.**

When funding by payroll deductions, you can provide funds via check or auto-debit.

Payroll Deduction Schedules

You establish the schedule (monthly, bi-weekly, etc.), based on the dates your company pays employees, for the collection of your participants' payroll-deducted dollars. We give you the opportunity to update your payroll schedule for each new plan year, if necessary.

Funding via Claims Registers (Claims Register Invoices)

Claims Registers

When you fund your participants' reimbursements via Claims Registers, you hold participants' payroll-deducted BESTflex Plan contributions and only forward them to us when they are needed to fund reimbursements for a particular period of time. You establish the schedule for the collection of funds needed to pay participants' reimbursements, with each schedule affecting the number of days it could take for participants to receive their payments.

We request funds according to your chosen schedule by providing Claims Register Invoices.

Three Claims Register Schedules

You can choose from weekly, daily, and twice-weekly Claims Register Invoices when you fund reimbursements via Claims Registers.

1. Weekly Claims Register Invoices (Monday)

Under this schedule, you receive a Claims Register Invoice on Monday and reimbursements are issued when we receive the required funds.

If you submit the requested funds by check:

We receive claims and process them within two business days. We then email a notification to your participants that their claim is processed. Each Monday, you receive email or fax notification when a Claims Register Invoice is available for review online. You review the register and send us a check to fund your claims for that week. Once we receive your check, we issue participant payments the next business day. Using check payments to fund claims could extend the time it takes your participants to receive reimbursement payments.

If you submit the requested funds using auto-debit authorization:

We receive claims and process them within two business days. We then email a notification to your participants that their claim is processed. You receive email or fax notification every Monday when a Claims Register Invoice, detailing the claims processed the prior week, is available for review online.

In place of you sending us a check to fund your claims, we auto-debit your account on Thursday and issue participant payments the same day.

With Weekly Claims Register Invoices and auto-debit as your funding method, participant payments are issued in 7 to 11 business days from the date the claim was received. There is no delay in claim payments and participants know when their payments are issued based on the day of the week they submit their claim.

2. Twice-Weekly Claims Register Invoices (Mondays and Thursdays)

Under this schedule, you receive a Claims Register Invoice every Monday and Thursday, and we issue reimbursement payments to participants two times a week.

Twice-Weekly Claims Register Notification requires auto-debit authorization as your claims funding method. You receive email or fax notification and review your Claims Register Invoice online twice per week on Mondays and Thursdays. Your participants' reimbursement payments are also paid twice per week.

If you choose Twice-Weekly Claims Register Invoices, claims are processed within two business days of our receipt of the claim. You review claims registers on Monday and Thursday. We auto-debit your account on the following Thursday and Tuesday and issue participant payments the same day. With Twice-Weekly Claims Register Notification, it takes between 7 to 9 business days from the day the claim was received to issue participant payments.

3. Daily Claims Register Invoices

Under this schedule, you receive a Claims Register Invoice and we issue reimbursement payments to participants daily.

Choosing Daily Claims Register Notification requires auto-debit authorization as your funding method. Claims are processed within two business days and you receive email or fax notification and review your Claims Register Invoice online daily. We auto-debit your account on the following business day and issue participant payments the same day.

With Daily Claims Register Invoices and auto-debit as your funding method, payments are issued five business days from the day the claim was received. The Daily Claims Register Invoices option is the fastest, most efficient method of reimbursement available because we issue payments five times a week.

Funding via Direct Payment (Claims Register Invoices)

Direct Payment

When you fund your participants' reimbursements via Direct Payment, you hold participants' payroll-deducted BESTflex Plan contributions and we draw on your account to pay reimbursements. We cut participants' reimbursement checks directly from this account for participants who are reimbursed via check. We request and auto-debit funds from this account to pay reimbursements to participants who receive their reimbursements via direct deposit.

You establish the schedule for how frequently we pay participants' reimbursements.

Three Direct Payment Schedules

You can choose from weekly, twice-weekly and daily schedules when you fund reimbursements via Direct Payment.

1. Weekly Direct Payment Schedule

Under this schedule, you receive a Claims Register Invoice on Monday and reimbursements are issued Thursday.

How it works:

We receive claims and process them within two business days. We then email a notification to your participants that their claim is processed. You receive email or fax notification every Monday when a Claims Register Invoice, detailing the claims processed the prior week, is available for review online.

We auto-debit your account on Thursday for the total amount of reimbursements to be paid via direct deposit. We issue payments via direct deposit and cut reimbursement checks from your account the same day.

With Weekly Claims Register Invoices, participant payments are issued in 7 to 11 business days from the date the claim was received. There is no delay in claim payments and participants know when their payments are issued based on the day of the week they submit their claim.

2. Twice-Weekly Direct Payment Schedule

Under this schedule, you receive a Claims Register Invoice every Monday and Thursday, and we issue reimbursement payments to participants two times a week.

How it works:

We receive claims and process them within two business days. We then email a notification to your participants that their claim is processed. You receive email or fax notification every Monday and Thursday when a Claims Register Invoice is available for review online.

We auto-debit your account the following Thursday and Tuesday for the total amount of reimbursements to be paid via direct deposit. We issue payments via direct deposit and cut reimbursement checks from your account the same day.

If you choose Twice-Weekly Claims Register Notifications, claims are processed within two business days of our receipt of the claim. You review claims registers on Monday and Thursday and participants receive claims payments on the following Thursday and Tuesday. With Twice-Weekly Claims Register Notification, it takes between 7 to 9 business days from the day the claim was received to issue participant payments.

3. Daily Direct Payment Schedule

Under this schedule, you receive a Claims Register Invoice and we issue reimbursement payments to participants on a daily basis.

How it works:

We receive claims and process them within two business days. We then email a notification to your participants that their claim is processed. You receive email or fax notification and review your online Claims Register Invoice, detailing the claims processed the prior day.

We auto-debit your account the following day for the total amount of reimbursements to be paid via direct deposit. We issue payments via direct deposit and cut reimbursement checks from your account the same day.

With Daily Claims Register Notification and auto-debit as your funding method, payments are issued five business days from the day the claim was received. The Daily Claims Register Invoices option is the fastest, most efficient method of reimbursement available because we issue payments five times a week.

Changing Your Reimbursement Funding Method

Changes to your reimbursement funding method require you to provide information and authorization that we may not have on file. Please contact Client Services for additional information on when you can make these changes and to request the appropriate form.

The BESTflex℠ Plan

Medical Excess

About Medical Excess

Under the Uniform Coverage Rule, participants in the BESTflex Plan are allowed to use the full amount of their Health care flexible spending account (FSA) election starting on the first day of their plan year.

This can create a side-effect we call "medical excess."

Medical excess occurs when the dollar amount of all claims submitted are in excess of the payroll deposits available to pay them. Our administration system automatically identifies medical excess as soon as it occurs and a ***Medical Excess Notification*** is emailed to the primary contact, or other designee, for your company. At the same time, a ***Medical Excess Invoice*** is published to the ***Invoice & Payments*** section of your online account.

Medical Excess In Detail

How Medical Excess Occurs

Medical excess occurs when the dollar amount of all claims submitted is in excess of the payroll deposits available to pay them.

Available Payroll Deposits

Amount of Claims Submitted

Medical excess occurs when the dollar amount of all claims submitted are in excess of the payroll deposits available to pay them.

As an example, if Mary contributes to the BESTflex Plan Health Care FSA for only a month and requires medical care for that period, her expenses and subsequent claims submissions may be in excess of her contributions. Adding the dollar amount of all other claims submitted by participants, the total dollar amount of these claims can exceed the payroll deductions submitted to date, pushing the Health Care FSA into medical excess.

This situation is specific to a Health Care or Limited Health Care FSA only.

Medical excess can occur when Payroll Deduction Billing is the claims funding method and can occur any time claims submitted for that period exceed the funds available to pay them.

Balancing Your Account

If you fund claims by check or electronic transfer, payment for the amount shown in the *Outstanding* column is due upon receipt of the *Medical Excess Notification.* Quick payment brings your account back into balance so we can reimburse outstanding claims.

If you fund claims using direct-debit or auto-debit, we draw the *Outstanding* amount from your financial account the day after we issue the *Medical Excess Notification*. Once funds are received, we apply the funds to the excess claims and reimbursement checks are released.

Please note that if you fund claims by check or electronic transfer, even if your next Payroll Deduction payment is submitted as soon as the day following the *Medical Excess Notification*, your account will still show the excess amount as due. You can confirm this when you review your *Medical Excess Invoice* online. You must submit the outstanding amount shown on the *Medical Excess Invoice* in order to balance your account.

Medical Excess and the Benefits Card

Medical Excess can also occur when participants use their Benefits Card. As with Mary's example described earlier, the Benefits Card will continue to be accepted until the participant's election amount is met. Since the Benefits Card swipes work just like any other claim submitted, if they, along with any other claim, exceed payroll deposits available, Medical Excess will occur.

Unused Funds

Any payments you make to fund Medical Excess Invoices are added to your account balance and used to reimburse claims as needed during the plan year and during the standard 90-day runout period (consult *My Company Plan* to verify). If any of these payments remain unused, they are held for the remainder of the plan year and returned to you, along with any plan forfeitures, after the standard 90-day runout period. To request early receipt of these unused Medical Excess funds prior to receiving forfeiture payments, please contact Client Services.

Medical Excess Online

Medical Excess Notification

Our system automatically identifies medical excess as soon as it occurs and a Medical Excess Notification is emailed to the primary contact, or other designee, for your company. At the same time, a *Medical Excess Invoice* is published to your online account. You should review your *Medical Excess Invoice* upon notification.

How To: Review Your Medical Excess Invoice

If you receive a ***Medical Excess Notification***:

1. Log into your **www.ebcflex.com** account
2. Click ***Funding Requests*** under ***Invoices*** in the menu
3. Click the ***Medical Excess*** tab

The ***Outstanding*** column of the ***Medical Excess Invoice*** line shows the dollar amount of claims in excess you fund in order to balance your account.

Medical Excess Invoice Details

Clicking ***Details Report*** displays more detail.

Clicking ***Invoice PDF*** opens a copy of your ***Medical Excess Notification***.

BESTflex Plan Reports

About BESTflex Plan Reports

We generate a variety of reports for your BESTflex Plan. These reports are conveniently available to you in your online account, and help you manage your BESTflex Plan by providing important details about your participating employees, invoices, and more.

You can use the reports we offer to stay up to date on the status of your BESTflex Plan, help participants manage their flexible spending account (FSA) and perform your accounting tasks. They can highlight issues and help you guide your employees in making the most of participating in the BESTflex Plan.

BESTflex Plan Reports In Detail

Important BESTflex Plan Reports

- **Account Summary Report**
  The *Account Summary Report* provides a snapshot of your BESTflex Plan, across all participants. It includes the total annual election, total amount that has been deposited in participants' accounts, total amount of claims paid and more. It is a useful way to see participants' plan usage.
- **Check and Payment Register**
  The *Check and Payment Register Report* lists and totals the reimbursement payments your participants have received for a defined period of time.
- **Participant Data List**
  The *Participant Data List* is a listing of each participant in your BESTflex Plan. It includes important details, including the number of payroll deductions, the per-paycheck deduction and the total annual election, for each participant. This report helps you ensure at the start of the plan year that the per-paycheck deduction for each participant matches the amount you are deducting from each paycheck.

BESTflex Plan Reports Online

Downloading Online Reports

The reports as described are available for download in your online account. This is the most convenient and quick way to view data regarding your BESTflex Plan.

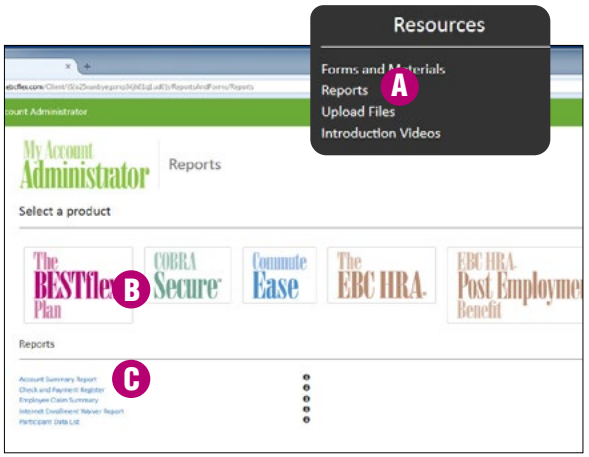
How To: Download the Account Summary Report, Participant Data List, and Check and Payment Register

1. Log into your www.ebcflex.com account
2. Select ***Reports*** from the ***Resources*** column of the menu **[A]**
3. Click ***The BESTflex Plan*** to view a list of available reports **[B]**

A list of reports **[C]** displays for your BESTflex Plan. To view the *Account Summary Report, Participant Data List,* or *Check and Payment Register,* click on its title.

How To: Download the Fee Invoice, Claims Register Invoice and Payroll Deduction Invoice

1. Log into your www.ebcflex.com account
2. Click ***Funding Requests*** or ***Fee Invoices***. Select the associated link from the list that is generated on the following page.



Reports are available for download online

How To: Use the Editing Bar When Viewing Reports from the Reports Page

The Participant Data List, Account Summary, and *Check and Payment Register* reports have several output options using the special editing bar that appears as a control at the top of each report.

The editing bar lets you perform simple functions on these reports, such as:

- Performing a text search within the report
- Selecting an output format
- Exporting the report

Some reports allow you to choose a date range for the report along the top of the editing bar using convenient, drop-down calendars.

FAQs

Q. How is the W-2 Form filled out?

A. Each participant's gross salary is reduced by the total amount that they had deducted for Group Insurance Premiums, as well as the Health Care FSA, Dependent Care FSA and Individual Billed Insurance Premium Account. Any dollar amount that was set aside in the Dependent Care FSA must be recorded in Box 10 (ten) of the W-2 Form. Any pre-tax HSA deductions from the employee and/or any employer HSA contributions to the employee must be reported in Box 12 (twelve) of the W-2 Form. Some employers are required to include the total cost of health care in Box 12, using code DD of the W-2 Form.

No other amount needs to be recorded on the W-2 Form for the BESTflex Plan at this time. Dependent Care FSA participants will need to fill out Form 2441 when they file their tax forms.

The BESTflex℠ Plan

New Hires

About New Hires

As the plan year progresses, your company may hire new employees who, based on your plan design, become eligible to participate in the BESTflex Plan. You must supply these new employees with BESTflex Plan enrollment materials and give them an opportunity to enroll in the plan for the remainder of the plan year. If they choose to participate, you send their enrollment information to us.

While you can send enrollment information by submitting a completed *Enrollment Form*, your online account and Manage Participants make it easy for you to enroll new employees **online, with no faxing or mailing required and no waiting for your form to be processed.**

New Hires In Detail

Determining a New Hire's Eligibility

Your company's eligibility requirements are defined in your plan's *Adoption Agreement* and *My Company Plan*. Once an employee has met your eligibility requirements, they may enroll in any of the available accounts.

Supplying BESTflex Plan Materials

When new hires are eligible for the BESTflex Plan, they must receive a *Summary Plan Description (SPD)*, a copy of *My Company Plan*, an *Enrollment Form*, and appendices for all features you have added to your BESTflex Plan.

If your employee chooses to waive and does not participate, they cannot enroll in the plan until the following open enrollment period or until a permitted election change event occurs. For more information, please see the section titled **Permitted Election Changes.**

How To: Enroll New Employees During the Plan Year

1. **Provide the necessary materials to the new employees.**
   Your employee can learn about the BESTflex Plan by reading the *Summary Plan Description*. It explains the basic principles of the BESTflex Plan and contains the rules an employee must understand before enrolling in the plan.

2. **Employees must complete the Enrollment Form.**
   It is very important that they correctly calculate and indicate on the *Enrollment Form* the number of payroll deductions that will occur between their effective start date and the end of the plan year. The number of pay periods is measured from their date of eligibility to the end of the plan year.

   It helps your employees if you fill out the employee's start date *(Effective Start Date)* and the number of pay periods *(Number of Pay Periods)* on their *Enrollment Form.*

3. **Return the completed Enrollment Form to us by the deadline date.**
   You can download *Enrollment Forms* from our website at **www.ebcflex.com**.

You can also complete this process online for added convenience and faster processing.

Once your employee signs up, their elections are locked in until the end of the plan year unless a permitted election change event occurs.

New Hires Online

Manage Participants

Manage Participants lets you enroll or terminate participants in the middle of your plan year online, conveniently, securely and with no faxing required. Manage Participants validates your data and provides you with a confirmation of the change online quickly. Your participant's record is updated automatically and you can print a copy for your records.

How To: Use Manage Participants to Enroll a New Hire Online

To start, log into your online account at **www.ebcflex.com**.

1. Select ***Enroll Participants*** from the from the menu under the ***Manage Participants*** column
2. Enter the employee's general and contact information
3. Enter the plan information, then click the ***Add Plan***
4. Verify the plan information is correct, then click ***Next***

5. Enter the financial account information. If the employee has chosen direct deposit, enter their account information to have their reimbursements deposited in their financial institution's account
6. The next page is a confirmation of all information that has been entered. It is also one last opportunity to make changes to the enrollment information.
   - If changes need to be made, click on ***Edit***
   - To cancel the enrollment, select ***Cancel***
   - If everything is correct, click ***Submit***
7. The final page offers a printable confirmation of the enrollment you just entered

FAQs

Q. What is the employee enrollment deadline?

A. All enrollment forms must be completed, signed and dated **before** an employee's effective start date in the plan. You can calculate this date using eligibility information on your *Service Agreement* or *My Company Plan.* **Any forms dated after the employee's effective start date will be returned.** This applies to new hires, both in the middle of the plan year and at the start of each new plan year.

Q. What needs to be sent to Employee Benefits Corporation in the case of a new hire?

A. This depends on how you enroll the new hire in the BESTflex Plan.

If you use the **Manage Participants** feature of your online account, you can enroll the participants in the middle of your plan year online, with no faxing required. Your participant's record is updated automatically with us and you can print a confirmation for your records.

If you submit the *Enrollment Form*, the original copy of the *Enrollment Form* should be returned to us. You should also retain or make a copy for your files and the participant's files. You can also fax the *Enrollment Form.* There is no need to follow up with the originals.

We do not need the waivers for the plan. They are for you to keep on hand to prove that you offered the benefit to all eligible employees. **We recommend that you collect waivers from all eligible employees.**

Q. Does my Health Care FSA eligibility have to be the same as my health insurance eligibility?

A. No. However, the Health Care FSA eligibility cannot be shorter than your health insurance eligibility. In addition, only those employees that are eligible for the group health insurance plan are eligible for Health Care FSA benefits.

The BESTflex℠ Plan

Permitted Election Changes

About Permitted Election Changes

In general, BESTflex Plan participants can't change their pretax plan elections after the start of the plan year, per IRS regulations. However, permitted election change (PEC) events allow BESTflex Plan participants to change their flexible spending account (FSA) elections or group insurance contributions during the plan year. Depending on the PEC event, participants may only be able to make changes to select accounts under the BESTflex Plan. Please note that the IRS allows changes to pre-tax health savings account (HSA) contributions made through the BESTflex Plan at any time during the plan year without a PEC event.

The rules regarding permitted election changes apply differently to each account under the BESTflex Plan.

Permitted Election Changes In Detail

Consistency Rules

IRS rules require PEC events be consistent with certain life event change requests. This means that in the event of marriage, divorce, death, change in dependent eligibility or the number of dependents, change in employment, or change of residence, the requested change must be on account of and corresponding with the event.

If the PEC event is the participant's divorce, annulment, or legal separation; the death of a spouse or dependent; or the dependent ceasing to satisfy eligibility requirements; the participant can only cancel health or accident insurance or reduce the Health Care FSA election for the spouse or dependent. For example, if a participant's employer carries single and family coverage, a participant who is covering her spouse and child cannot drop to single coverage when the child ceases to meet eligibility requirements. Although the participant may want to remove her spouse from coverage, that change is not consistent with the event of a dependent losing eligibility.

If a participant, spouse, or dependent gains eligibility for coverage under another employer's cafeteria plan as a result of a change in marital status or employment, the participant's election may only be decreased or cancelled if they or their covered spouse or dependent enrolls in the coverage. The employer can request proof of other coverage if desired.

If a participant's spouse loses their job, the participant is allowed to enroll their spouse in insurance coverage or increase their FSA election. Conversely, if a participant's spouse becomes eligible for benefits through new employment, the participant's change in employment event allows the participant to drop insurance coverage or decrease or revoke their FSA election.

Retroactive Health Plan Enrollment for Birth or Adoption

IRS rules require the BESTflex Plan to allow corresponding pre-tax election changes for events covered by HIPAA special enrollment, including the birth or adoption of a child. Unlike all other changes which can only be applied the later of the date of the event or the date of the request, an election change due to birth, adoption, or placement for adoption can be applied retroactively to the date of the event even if the request is made after the event (but within 30 days). Typically these rules only apply to the employer's major medical plan or other nonexcepted health plans. They do not apply to the Dependent Care FSA.

Paying for COBRA Coverage Pre-Tax

Participants who elect COBRA may be allowed to increase their pre-tax payroll deductions to pay for their COBRA coverage on a pre-tax basis. However, this is only allowed for COBRA premiums for the participant's employer, not to pay for COBRA coverage for a dependent's employer's or former employer's plan. Therefore participants may have their COBRA premiums for coverage sponsored by your company deducted on a pre-tax basis until the end of the plan year if they experience a loss of eligibility due to a reduction in hours, or a dependent loses eligibility for the health plan but remains an eligible tax dependent in the BESTflex Plan.

Permitted Election Change Requests

Generally a participant must request a change to their election no later than 30 days following the date of the PEC event, unless your plan references a different time period. This period must be at least 60 days if the PEC event is a loss of eligibility or gain of a premium subsidy under Medicaid or a state children's health insurance program (CHIP). All changes(except for health plan enrollments in the event of the birth or adoption of a child as explained above) must be made effective on the later of the date of the PEC event or the date the participant submits the request to the employer. Participants should be informed that if an FSA election is increased, they will only have access to the increased funds for expenses incurred after the change is effective.

The BESTflex℠ Plan

Leaves of Absence

About Leaves of Absence

There are several different types of leaves of absence, each of which affects BESTflex Plan participants in a different way. For instance, leaves of absence can affect a participant's eligibility under the plan and how they fund their FSAs, among other things. When an employee takes a leave of absence, you must notify us of the details by submitting a completed *Leaves of Absence Form*. The BESTflex Plan requires that you have a formal leaves of absence policy.

Leaves of Absence In Detail

Each type of leave must follow the guidelines or rules that surround that particular leave. Because of this, each leave is handled a little differently. The first step is to determine which type of leave the participant is taking. We have compiled the following information and created a **Leaves of Absence Flowchart** to help you understand the subsequent steps.

Paid Leave

This type of leave is handled as if the participant is still at work.

The participant is not allowed to make any changes to their BESTflex Plan and must continue on the plan at their current election amounts, unless the paid leave is followed by a permitted election change (PEC) event, such as an unpaid leave.

Disability payments do not constitute a paid leave. Paid leave may be covered by paid time off (PTO), sick time, vacation pay and, in some cases, severance pay.

Unpaid, Non-FMLA Leave

This type of leave takes place when a participant goes on an unpaid leave of absence that is not covered by the Family Medical Leave Act (FMLA) or when the participant does not receive their salary and you do not continue their salary.

- **Eligibility during unpaid, non-FMLA leave**
  In the case of an unpaid, non-FMLA leave, the participating employee can only make changes to their BESTflex Plan if the leave causes them to lose eligibility under the plan. If it does not cause a loss of eligibility, the participant cannot make changes to their BESTflex Plan and they must make up any payroll deductions that they miss during the leave of absence.

- **Participant loses eligibility during the leave**
  If the participant loses eligibility during their unpaid, non-FMLA leave of absence, they can choose to stop making contributions and stop their plan. This option would also cause the following:

  - The participant's plan year would end as of the date he or she began their leave
  - ALL dates of service must be incurred prior to the leave date in order to qualify for reimbursement
  - If your company is subject to COBRA you treat this as a reduction in hours allowing the participant the opportunity to continue on the plan

- **Participant remains eligible during the leave**
  Depending on your plan design, participants who remain eligible during their unpaid, non-FMLA leave of absence have as many as three options for making up their missed payroll deductions. They are:

  1. **Prepay** the deductions that would be missed during the leave (this can be done on a pre-tax basis)
  2. **Pay as you go** with after-tax contributions (participants would write a check directly to your company)
  3. **Catch up** when the participant returns from leave (this may be done on a pre-tax basis and must be agreed upon before the leave, with deductions made up within that plan year)

Unpaid, FMLA Leave

This type of leave takes place when a participant goes on a leave of absence that is covered by FMLA.

Because the leave falls under FMLA, both your company and your participating employees must follow the FMLA requirements. FMLA only covers medical-related benefits; the Dependent Care FSA is not affected. Participants under an FMLA leave have several options during their leave and when they return.

During the Unpaid FMLA leave

An unpaid FMLA leave of absence only affects the Health Care FSA. When the participant begins their unpaid FMLA leave, they must decide whether to continue their Health Care FSA coverage by selecting one of the following options. **If unpaid**

FMLA leave extends past the maximum FMLA period, the FMLA options cease and the leave should then be treated as an unpaid non-FMLA leave (see the earlier portion of this section on Unpaid Non-FMLA Leave).

- **Option 1 – Revoke the election, AND reinstate the election upon return from leave**
  This option is available only if the participant returns from leave prior to exhausting the maximum FMLA period. Claims incurred during the unpaid FMLA leave of absence are NOT reimbursable. The reinstatement of the Health Care FSA election is based on one of the two choices below:

  1. **Revoke and Prorate:** The participant will not make up deductions during the leave. The number of missed deductions will reduce the annual maximum election amount that is available to reimburse medical expenses.
  2. **Revoke and Reinstate:** The participant revokes the election during the leave and reinstates the election at the same annual maximum. The employer may adjust the participant's paycheck deductions to reflect this change.

- **Option 2 – Keep the plan open until the participant returns from leave OR exhausts the maximum FMLA period**
  The participant will make up deductions missed during the unpaid FMLA leave of absence. Claims incurred during the unpaid FMLA leave of absence are reimbursable.

  Please elect on of the payment options below:

  1. **Catch Up:** The participant will make up the required payments on a pre-tax basis when returning from the leave and within the plan year. If the pre-pay or pay as you go option is elected and the participant fails to make payments, the employer may use catch up to collect missed payments. This option may not be available if the leave crosses between two plan years.
  2. **Pre-Pay:** The participant will pre-pay the deductions that would be due while on leave. This can be done on a pre-tax basis up to the end of the plan year.
  3. **Pay As You Go:** The participant will make payments to the employer to cover deductions while on leave. This is done on an after-tax basis.

- **Option 3 – Revoke the election, and allow the plan to terminate**
  This will terminate the plan and the participant has 3 months from the date the unpaid FMLA leave of absence begins to submit claims for expenses incurred prior to the start of the leave.

Military Leaves covered by USERRA (Uniformed Services Employment and Reemployment Rights Act)

USERRA covers participants with "COBRA-like" provisions, which protect veterans' rights to health benefits while they are away from employment

Participants who leave employment for service in the military are entitled to health coverage for themselves and their dependents for a period equal to the lesser of:

- 24 months, beginning on the date the participant military leave begins

OR

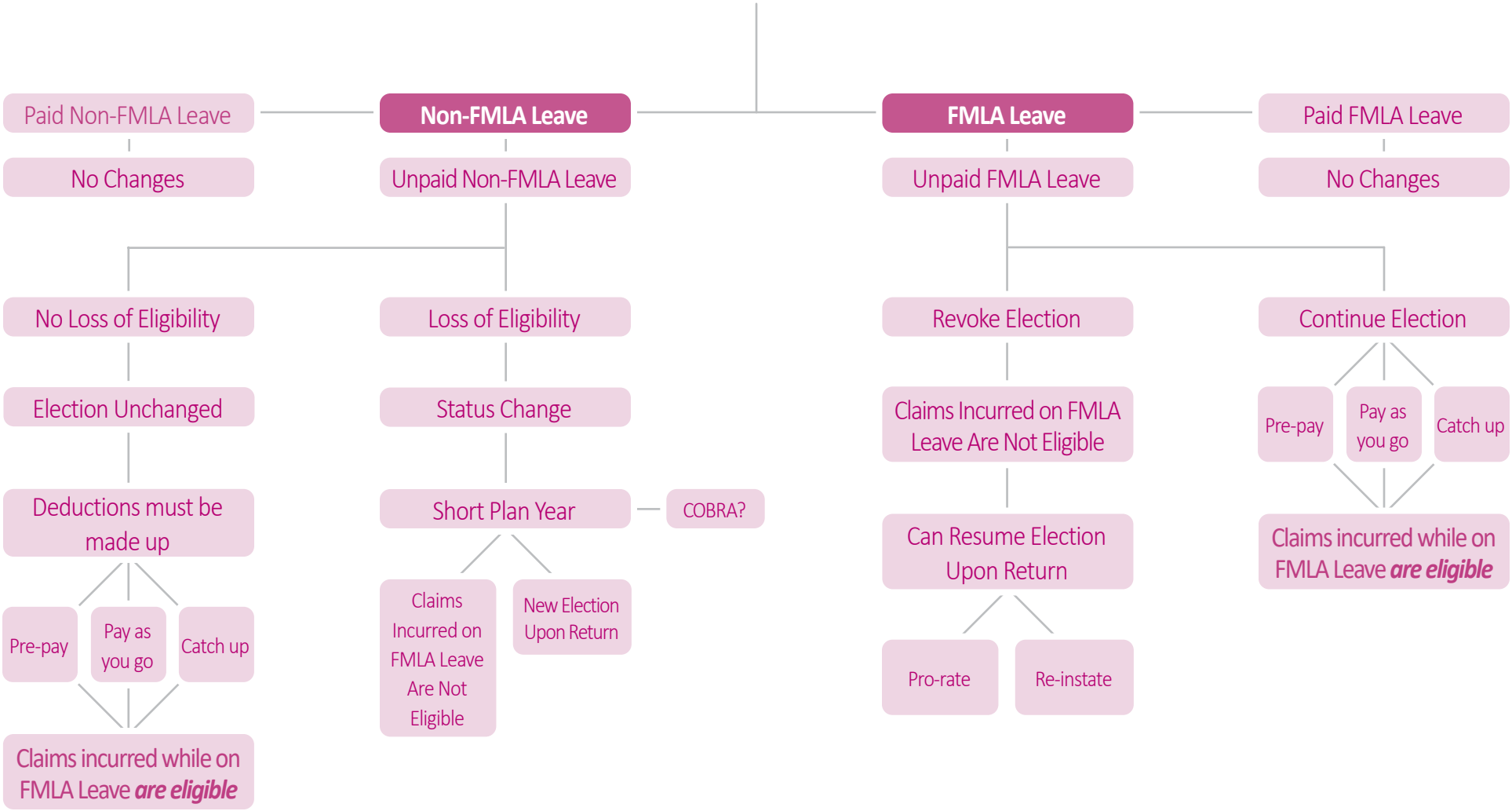
- The date the military leave begins until the day after the participant fails to apply for his or her return to employment

How To: Complete the Leaves of Absence Form

1. Complete the company and participant information at the top of the form
2. Determine the type of leave the participant is taking and check-mark the corresponding section(s)
3. Have the participant sign and date the form
4. Forward the form to us by either fax or mail

Additional forms can be downloaded from our website at **www.ebcflex.com**.

Leaves of Absence Flow Chart



The BESTflex℠ Plan

Termination of Participants

About Termination of Participants

Throughout the plan year, BESTflex Plan participants may terminate their employment with your company or otherwise lose eligibility for the BESTflex Plan and, in turn, end their participation in the plan. You must take a few steps to notify us of the terminated participant so that we may give them 90 days to submit their final claims or continue their coverage under federal COBRA or state continuation laws.

While a *Termination of Elections Form* is available to help you notify us of terminations, your online account and Manage Participants make it easy for you to terminate the participant **online, with no faxing or mailing required and no waiting for your form to be processed.**

If you are also a COBRASecure customer, please see **Joint Notification** for information on a special termination process.

Termination of Participants In Detail

Responding to a Loss of Eligibility

After a BESTflex Plan participant loses eligibility for any FSAs, you should log into your online account. Then, view or download the *Account Summary Report.*

- To learn how to access your online account, see **Our Website and Your Online Account.**
- To learn how to download the *Account Summary Report*, see **BESTflex Plan Reports.**

You should also find your payroll department's year-to-date deposit amount for the participant.

Then, compare your payroll department's year-to-date deposit amount to the deposits for the employee shown on your *Account Summary Report* to confirm that they match. If they do not match, use the most accurate amount.

From here, you can notify us of the termination using the Manage Participants feature of your online account, or a *Termination of Elections Form*.

Termination of Elections Form

The *Termination of Elections Form* allows you to manually notify us of an FSA plan termination and the relevant account details. There are two variations of the form, with each applying to a different benefit setup. You can download the *Termination of Elections Form* from your online account. See **Important BESTflex Plan Documents** for more information on downloading forms.

Choosing the Proper Termination of Elections Form

- If your company has only the BESTflex Plan with us, or the participant will not be eligible for Health Care FSA continuation coverage, you will complete the *Termination of Elections Form*
- If your company has both the BESTflex Plan and COBRASecure℠, and the participant is eligible for Health Care FSA continuation coverage complete the *Qualifying Event/Termination Form* (this form will notify both plans). See **Joint Notification** for more information on this form.

How To: Complete the Termination of Elections Form

1. Fill in your company name and the date
2. Fill in the participant's name and social security number
3. Enter the exact termination date
4. List the participant's last payroll date (we track all accounts by payroll dates), as indicated in your payroll records, and fill in the dollar amount that was withheld from his or her pay for each applicable account listed on the form
5. Fill in the amount that was actually reimbursed from each applicable account; you can reference the *Account Summary Report* or your own records (if they do not match, use the most accurate amount) for this information
6. Have the participant (if possible) and a representative of the Payroll or Human Resources Department sign and date the *Termination of Elections Form*
7. Mail or fax the completed form to us

Termination's Effect on the Participant's Plan Year

When the participant becomes ineligible to participate in an FSA for any reason, such as a termination of employment or a reduction in hours, contributions to the plan stop. After the loss of eligibility, the participant can no longer incur expenses for reimbursement from the Individual Premium FSA or Health Care FSA. The participant may be eligible to continue to submit claims for reimbursement from the Dependent Care FSA for service dates through the end of the plan year.

The participant may have additional time after the loss of eligibility date during which the participant may submit previously incurred claims. Refer to *My Company Plan* for more information.

The participant may be eligible for Health Care FSA continuation coverage under COBRA. For more on COBRA continuation, see **COBRA**.

After this time period, any balance not claimed by the participant will be held in your account and, at the end of the plan year, returned to your company with any other forfeitures. For more information, see **Forfeitures**.

Termination of Participants Online

Manage Participants

Manage Participants lets you enroll or terminate participants in the middle of your plan year online, conveniently, securely and with no faxing required. Manage Participants validates your data and provides you with a confirmation of the change online quickly. Your participant's record is updated automatically and you can print a copy for your records.

How To: Use Manage Participants to Submit a Termination Online

To start, log into your online account at **www.ebcflex.com**.

1. Select ***Terminate Participants*** from the menu under ***Manage Participants***
2. Search by last name or full SSN for the person you would like to terminate and click on ***Search***
3. Click the person's name
4. Click X next to ***Terminate Plan***
5. Enter the ***Effective Termination Date*** and ***Last Payroll Date***
6. Choose the ***Last Benefit Month*** and click ***Next***
7. Review the information

   If any changes need to be made, click ***Previous***

   To cancel this termination, click ***Cancel***
8. After clicking ***Submit***, a new screen displays with confirmation of the termination. You will also receive an email confirmation.

This completes the termination process.

If your company has both the BESTflex Plan and COBRASecure, you must also link to our COBRASecure Online interface and complete the ***Add New QB Wizard*** to generate the necessary COBRA paperwork. By not completing this step, permitted election change event paperwork will NOT be generated.

FAQs

Q. What happens if a terminated participant is rehired during the same plan year?

A. Special rules apply to a participant who is rehired within 30 days. They are brought back on the plan as if they never left but must make up any missed payroll deductions. If more than 30 days have passed, the participant must wait until the next open enrollment period to re-enroll.

Q. What happens if a terminated participant has spent more FSA funds than have actually been deducted?

A. Under the Uniform Coverage Rule, Health Care FSA participants are entitled to their full, annual election from the start of the plan year – before it has all been withheld from their pay. If a participant spends more of their annual election than has been deducted and terminates employment, the employer must cover the negative balance.

Q. What happens if a participant terminates after the last payroll deduction of the plan year has been taken, but prior to the end of the plan year?

A. The termination date entered should be the date the participant loses eligibility under the plan. An employee will receive access to any grace period or rollover if they are active on the plan through continued enrollment or COBRA election as of the last day of the plan year.

The BESTflex℠ Plan

Joint Notification

About Joint Notification

Joint notification is an important topic if, in addition to administering your BESTflex Plan, we provide you with COBRASecure℠ services. When you use both services, you use a *Qualifying Event Form* to notify us of an employee's termination and the qualifying event that stems from the termination (joint notification). We will know to close any FSAs and send the appropriate COBRA notices.

Joint Notification In Detail

If we administer COBRASecure in addition to the BESTflex Plan for your company, you can use **COBRASecure Online** to notify us when a qualifying event occurs. This allows you to provide the information we need to immediately update our systems. You can access COBRASecure Online from the home page of My Account Administrator.

The preferred method to notify us of your participant's COBRA qualifying event is to use COBRASecure Online. Detailed instructions are available in the *COBRASecure Online User Guide,* which can be downloaded from your online account under *Resources > Forms and Materials*. Employers can contact Client Services with any questions regarding the COBRASecure Online interface.

You may also choose to complete a *Qualifying Event Form* to notify us of your participant's qualifying event and subsequent termination from the BESTflex Plan.

How To: Complete the Qualifying Event Form

1. Fill in your company name, the date and division, if any
2. Complete the name, social security number, gender and address of the qualified beneficiary
3. Complete the event information (check the event type, fill in the event date and the last day of plan coverage, which is usually either the end of the month or the event date)
4. Fill in the coverage information and the amount the premium would be for any plans that covered the qualified beneficiary at the time of the event
5. Complete the secondary beneficiary information if a spouse or dependents are covered by the plan
6. Mail or fax the form to us, or submit the form through your online account

Processing the Qualifying Event Form

Once we receive your completed *Qualifying Event Form*, our COBRASecure Administration team processes it and sends the necessary COBRA notifications to the participant.

Then, if the employee participated in any of the BESTflex Plan's FSAs, their FSAs are closed.

The BESTflex℠ Plan

Nondiscrimination Testing

About Nondiscrimination Testing

Nondiscrimination Testing is required by the IRS to verify the BESTflex Plan does not favor key or highly-compensated employees. You fill out the *Nondiscrimination Census Worksheet* and we perform testing on your behalf.

Nondiscrimination Testing In Detail

Nondiscrimination Census Worksheet

You fill out the *Nondiscrimination Census Worksheet*, available for download in your online account, to submit your plan and employee information to us. We use this information to complete the nondiscrimination testing on your plans. The *Nondiscrimination Census Worksheet* is long, but all of the information is needed to complete the testing. Keep your census information on file as a reference from year to year. A complete set of instructions for filling out the worksheet is provided in the *Nondiscrimination Testing Workbook*, also available for download in your online account.

If you have additional questions about completing the worksheet, please contact Client Services for assistance.

How To: Submit the Nondiscrimination Census Worksheet

You can submit your *Nondiscrimination Census Worksheet* online. Submitting your worksheet online ensures your information is safe and secure. Regular email does not protect the information you send.

1. Save the completed worksheet on your computer
2. Log into your www.ebcflex.com account
3. Locate the *Upload Files* link
4. Click ***Nondiscrimination***
5. Click ***Browse*** to locate the completed worksheet saved on your computer
6. Click ***Upload File***

Types of Tests

We complete a total of nine test using the information you submit. Each group of tests is based on different areas of the Internal Revenue Code (IRC).

Cafeteria Plan Testing (§ 125):

1. Eligibility Test
2. Contributions and Benefits Test
3. Key Employee Concentration Test

Health Care FSA Testing (§ 105):

1. Eligibility Test
2. Benefits Test

Dependent Care FSA Testing (§ 129):

1. Eligibility Test
2. Contributions and Benefits Test
3. 55% Average Benefits Test
4. 25% Concentration Test

Timing of Tests

Cafeteria plan rules require that plans be tested as of the end of the plan year. Since all component benefits must be tested along with the § 125 tests, we ask that you return your *Nondiscrimination Testing Worksheet* to us in the last quarter of your plan year. Year end testing is included in your annual fee.

Conducting preliminary testing earlier in the plan year can identify potential failure early and allows employers to address any issues during the year when corrections are easier to make. Contact Client Services if you are interested in this service. An additional charge applies.

Effects of Test Results

Since testing occurs at the end of the plan year, highly compensated employees, key employees, and certain owners may have received an entire plan year of benefits prior to the plan receiving test results. If any tests fail, the affected individual's taxable income needs to be adjusted. Under IRS rules, when testing fails, the highly-compensated and key employees must be taxed on the benefits they received from the plan in the plan year in which they received them. adjustments can be made through payroll or on the W2, but you may have limited ability to make these adjustments after the plan year ends. Our Compliance Services team requires at least 30 days to review all data, perform the testing, and send your results, so please complete and submit your worksheet allowing adequate time to receive your results.

If we have an email address on file and all of your tests pass, we send your test results via email. Otherwise, we send your test results via first class mail.

If one or more tests fail, we send your results via certified mail. This letter states which individuals need to be taxed and on what benefits. You may need assistance from your payroll vendor or tax accountant to make the adjustment to income and taxation of those benefits. This letter also explains how the test was performed and whose benefits will need to be taxed and included as taxable income.

FAQs

Q. Are there special participation rules for owners?

A. Certain types of companies have special rules regarding participation by owners. Sole proprietors and partners of a partnership (including members of an LLP or LLC that is taxed as a partnership) may not participate in the BESTflex Plan, including its pre-tax premium payments. In addition, more than 2 percent shareholders in a Subchapter S Corporation, as well as their spouses, lineal ascendants and descendants, are not eligible to participate in the BESTflex Plan, including its pre-tax premium payments.

The BESTflex℠ Plan

Forfeitures

About Forfeitures

The IRS requires that employees' unused flexible spending account (FSA) funds be returned to their employer at the end of every plan year, unless the employer has adopted the rollover for the Health Care FSA. This is known as the "use-it-or-lose-it" rule. These returned dollars are forfeitures, and they can be put toward several costs, including the administration of the BESTflex Plan. We generally return forfeitures shortly after the standard 3-month runout period ends (consult *My Company Plan*), at which time we have finalized FSA balances.

Forfeitures In Detail

Definition of a Forfeiture

Forfeitures are the dollars that represent unused elections remaining in an FSA at the end of a plan year. After the runout period that allows participants to submit claims has ended, the funds that remain in the account are forfeited to you.

Two Ways to Use Forfeitures

If your plan year ended with a positive balance, you have two options on how to use or distribute these forfeiture dollars.

The most important thing to remember is that you may not return the exact amount of funds remaining in an individual's account to that person, even as taxable income.

Option 1: Use forfeitures to help pay for your plan

Your first option is to use any forfeited monies to offset the cost of the plan. These costs can include set up fees, monthly fees, dollars used to pay for accounts that were paid out in excess of employee contributions, or any other costs associated with the operation of your plan.

Option 2: Distribute forfeitures back to employees as taxable income

If you have forfeiture dollars remaining after offsetting administrative expenses, you may distribute the money back to employees as a taxable amount in one of two ways. If you are considering one of the options below, please note that the Plan Document states that administrative fees incurred by the Plan Sponsor and Plan Administrator be deducted from the forfeited amount prior to distributing the remaining prorated amount among current plan participants.

1. You may divide the forfeited money by the number of plan participants. Each participant who was actively enrolled on the last day of the plan year would receive an equal, taxable amount based on their participation in the applicable account.
2. You may also distribute the money on a per-ratio basis or coverage level basis dependent upon each participant's contributions to the plan. This is more difficult to calculate and distribute.

Forfeitures Online

How To: Find Your Forfeiture Amount Online

After your BESTflex Plan plan year and the standard 90-day (or your) runout period have ended, you can view your final *Account Summary Report* online. This report shows the total forfeiture amount on the first page.

1. Log into your account at **www.ebcflex.com**
2. Select ***Reports*** from the menu
3. Click ***The BESTflex Plan***
4. Click ***Account Summary Report***
5. In the new window, choose the recently ended plan year and click ***View Report***

The net amount shown in the Account Balance column is the final forfeiture amount.

Please see **BESTflex Plan Reports** for more information on viewing and downloading Reports in the format of your choice.

FAQs

Q. When should we expect to receive the forfeitures, if there are any?

A. Forfeitures are returned shortly after the standard 90-day runout period for claims submission has ended and all reimbursement payments have been made.

The BESTflex℠ Plan

2-1/2 Month Grace Period

About the 2-1/2 Month Grace Period

The 2-1/2 month grace period is an optional extension to the 12-month BESTflex Plan plan year. It gives BESTflex Plan participants an extra two months and 15 days to incur expenses and be reimbursed from their FSAs. This helps them avoid forfeiting the FSA funds that they did not use during the normal, 12-month plan year. You can choose this option in your *Adoption Agreement* or amend your plan to include it during the plan year.

The 2-1/2 Month Grace Period In Detail

Definition of the 2-1/2 Month Grace Period

The 2-1/2 month grace period is an extension to the 12-month plan year that you may offer to your Health Care FSA, Dependent Care FSA and Individual Billed Insurance Premium Account (IND) participants. The grace period gives participants an additional 2 months and 15 days, which start on the day after the current plan year ends, to incur expenses and get reimbursements from the funds they have already contributed to their FSA or IND during the just-ended plan year.

The Grace Period is an extension to the plan year. The runout period simply provides time to submit claims for a plan year that has just ended.

Adding the 2-1/2 Month Grace Period

You can add the 2-1/2 month grace period to your BESTflex Plan by electing it in the *Adoption Agreement.* If you would like to add the grace period after you have already completed and submitted an *Adoption Agreement*, you must amend your plan by completing a *Certificate of Resolutions Amendment,* which you can obtain by contacting Client Services, or update your plan through *Activate BESTflex Plan* when your plan is ready to renew.

You can apply the 2-1/2 month grace period to one or both of the FSAs, and the IND.

2-1/2 Month Grace Period's Effect on Participants

Every employee under your BESTflex Plan will get an extra 2-1/2 months at the end of the plan year to spend the funds that remain in their Health Care FSA or IND. As long as participants submit timely claims for expenses incurred during the grace period, the claims will be reimbursed from any amount that remains in their FSAs of the just-ended plan year. While the "use-it-or-lose-it" rule still applies, participants have more time to use their money and avoid forfeiting it.

With respect to the just-ended and new plan years, participants need to carefully monitor the timing and order of their claims submissions during the grace period. Claims are processed on a "first-in-first-out" basis. As such, if a participant submits a claim for the new plan year and uses up any funds remaining from the previous plan year, they cannot submit claims at a later date to be applied to the previous plan year. Claims will not be reprocessed and moved to the new plan year's funds to allow for expenses to be paid with funds from the previous plan year.

Runout and the Grace Period

The BESTflex Plan allows a specific number of days after the plan year ends to submit claims for expenses incurred prior to the end of the plan year. The runout period for your plan design is found in *My Company Plan.*

The difference between the grace period and the runout period is that during the grace period, you can incur new expenses and submit claims. During the runout period, you can only submit claims for expenses incurred during the plan year or the grace period. Expenses incurred during the runout period are lost unless a new plan year overlapping the runout period is in place.

In most instances, the grace period overlaps the runout period. After the grace period ends, you usually have roughly two weeks remaining to submit claims during the runout period. Please consult *My Company Plan* for specifics regarding the length of the runout period for your plan design.

FAQs

Q. What is the difference between the 2-1/2 month grace period and the standard 3-month runout period?

A. The 2-1/2 month grace period is an extension to the plan year. It gives your participants an extra two months and 15 days to incur and be reimbursed for eligible expenses under the plan year that just ended.

The standard 3-month runout period (consult *My Company Plan*), on the other hand, simply provides participants with time to submit claims for the expenses that they already incurred in the previous plan year. Expenses must have been incurred in the plan year that has ended in order to be reimbursed from that plan year's balance.

The 2-1/2 month grace period runs concurrently with the standard 3-month runout period.

Q. How does the 2-1/2 month grace period work with the Dependent Care FSA?

A. IRC Section 129, which created and regulates the Dependent Care FSA, limits the pre-tax benefits available per calendar year to a maximum of $5,000. Participants who take advantage of the 2-1/2 month grace period for the Dependent Care FSA should carefully manage their plan. If a participant incurs and is reimbursed for more than $5,000 in a calendar year, the amount above $5,000 may be treated as additional taxable income.

The BESTflex℠ Plan

Health Care FSA Rollover

About the Health Care FSA Rollover

The Health Care FSA rollover is an optional amendment that allows your Health Care FSA participants to rollover the balance left in their Health Care FSA at the end of the plan year into their Health Care FSA for the next plan year. Maximum rollover limits can be found at **www.ebcflex.com/PlanLimits**. This helps them avoid forfeiting the Health Care FSA funds they did not use during the normal 12-month plan year. You can choose this option in your *Adoption Agreement* or amend your plan to include it during the plan year.

Health Care FSA Rollover In Detail

Definition of the Health Care FSA Rollover

The Health Care FSA rollover allows participants to roll some of their unused balance from their prior plan year's Health Care FSA into their Health Care FSA for the new plan year, even if they do not make a Health Care FSA election for the new plan year. Maximum rollover limits can be found at **www.ebcflex.com/PlanLimits**.

Adding the Health Care FSA Rollover

You can add the Health Care FSA rollover to your BESTflex Plan by electing it in the *Adoption Agreement.* If you would like to add the Health Care FSA rollover after you have already completed and submitted an *Adoption Agreement*, you must amend your plan by completing a *Certificate of Resolutions Amendment*, which you can obtain by contacting Client Services. The plan year that you add the rollover amendment to means that each participant's Health Care FSA balance at the end of that plan year will rollover into the next plan year, up to the maximum rollover limit (e.g., amend the 2016 plan year to allow rollover into the 2017 plan year).

In addition, you cannot include both the grace period and the rollover for the Health Care FSA. If you add rollover to the Health Care FSA and currently have the grace period for it, you will also need to amend the plan to remove the grace period.

Health Care FSA Rollover's Effect on Participants

Participants in the Health Care FSA on the last day of the plan year do not forfeit that year's Health Care FSA balance, up to the rollover maximmum limit, when the plan year is over. This amount rolls over into the participant's Health Care FSA for the next plan year (minimum $1). Those participants have their new year election amount plus their rollover amount and any employer contribution to their Health Care FSA as the total available to reimburse eligible medical expenses in the new plan year. At the end of the new plan year, the participant can rollover a portion of that new plan year's Health Care FSA balance, up to the rollover maximum limit, into the subsequent plan year.

In addition, even if the participant does not elect any pre-tax amount for the new plan year, they are eligible to receive the rollover dollars from the prior plan year. In other words, they automatically have an account created for the new plan year to accept the rollover dollars that can be used to reimburse eligible medical care expenses in the new plan year.

If you offer both a standard health FSA and limited health FSA, the prior year's rollover balance rolls over into the FSA that the participant elects for the new plan year or into the same type of FSA that the participant had the prior plan year if no election is made for the new plan year.

Health Care FSA participants who want to make health savings account (HSA) contributions starting with the first day of the new plan year must either: elect a limited health FSA for the new plan year; or make no Health Care FSA election for the new plan year and have a zero dollar ($0) balance in their Health Care FSA on the last day of the plan year. Otherwise, if no Health Care FSA is elected and there is a balance on the last day of the plan year, the participant is ineligible to make or receive HSA contributions until the run out period is over and it is verified that no new plan year expenses were reimbursed using any prior year rollover dollars. If any new plan year expenses were reimbursed using rollover dollars, then the participant is ineligible to make or receive HSA contributions for the entire plan year.

When a participant's Health Care FSA is terminated mid-plan year, that participant is not eligible for rollover unless the participant elects and pays for the Health Care FSA through COBRA to the end of the plan year (see the **COBRA** section of this Answer Book).

Runout and the Health Care FSA Rollover

During your BESTflex Plan's standard 3-month runout period (consult *My Company Plan* to verify), participants can submit expenses incurred in the prior plan year and receive reimbursement for eligible medical care expenses up to their remaining Health Care FSA balance. Once the runout period is over, the prior plan year's Health Care FSA remaining balance rolls over into the new plan year, up to the rollover maximum limit, and is available to reimburse eligible medical care expenses incurred on or after the first day of the new plan year.

FAQs

Q. Is the Health Care FSA Rollover mandatory?

A. No. The employer, as plan sponsor, must elect to amend the BESTflex Plan to include the Health Care FSA rollover.

Q. Can an employer offer both the rollover and grace period to its plan participants?

A. No. The BESTflex Plan can only offer one of these plan options – or none – but not both. If an employer currently offers a grace period, they must amend their plan to remove the grace period and then add the rollover feature.

Q. Can employee salary reductions, employer contributions, or both be applied to the rollover amount?

A. Yes, both. Any funds remaining at the end of the plan year can be considered for rollover. Per the guidance, all dollars that are subject to the uniform coverage rule are available as part of the rollover.

Q. Which dollars are paid out first?

A. The ordering rules are that the dollars from the new plan year are paid out first. If a claim exceeds the new plan year's election amount, then the rollover dollars are applied. During the runout period, participants can continue to submit claims against the previous plan year for reimbursement.

Q. Does an employee have to make an election the following year to have funds roll over?

A. No. If an employer elects to have the rollover feature added to the plan, and a participant has funds remaining, a new plan year is automatically created for that participant. Dollars can roll over from year to year.

Q. If a participant terminates mid-plan year, do they get any special treatment?

A. No. A participant has their balance, including the rollover, available up to the date of termination. Per the *Service Agreement*, participants have either the standard 3-month runout period or a different runout period as specified. Any remaining funds after the runout period, including rollover funds, are then forfeited to the employer.

Q. Does the rollover apply to the Dependent Care FSA or the Individual Billed Premium Account?

A. No. Only the Health Care FSAs.

Q. Can an employer still have the grace period on the Dependent Care FSA or Individual Billed Premium Account and have rollover on the Health Care FSA?

A. Yes. Each account has its own options. The rollover does not apply to the Dependent Care FSA or the Individual Billed Premium Account, so the grace period is still available for them.

Q. Are the Health Care FSA and Limited Purpose Health Care FSA treated the same for purposes of rollover?

A. Yes. They are the same account type and are treated the same as far as the rollover is concerned.

Q. Can the carryover balances accumulate over time?

A. No.

Q. How can a participant rollover money from a standard health FSA to a limited health FSA to ensure HSA compatibility?

A. The participant must make an active election in the following plan year for the limited health FSA to trigger the rollover of dollars from the standard health FSA to the limited health FSA.

Q. If an employer runs a short plan year (January to June) and then renews for a full 12 months, would the employer be eligible to have two rollovers in the same year?

A. Yes. Both plan years would be eligible for rollover but the rollover amount cannot exceed the rollover maximum limit, found at **www.ebcflex.com/PlanLimits**, from one plan year to the next.

The BESTflex℠ Plan

5500 Returns

About 5500 Returns

A 5500 return is an information-reporting form sent to the Department of Labor's (DOL) Employee Benefits Security Administration each plan year for certain plans.

All forms 5500 and related schedules are required to be filed electronically. EFAST2 is the Department of Labor's (DOL's) name for the electronic filing protocol – Electronic Filing Acceptance System 2 – that replaces their earlier voluntary version of electronic form 5500 filing (EFAST).

As an employer, you are responsible for filing form 5500 for your ERISA retirement and welfare benefit plans. If you have 100 or more participants in your Health Care FSA at the start of the plan year, we prepare the electronic form 5500 on your behalf and allows you to review and make any necessary changes. You, or your designee, then electronically sign and submit the form 5500.

5500 Returns In Detail

Definition of the 5500 Return

A 5500 return is an information-reporting form sent to the Department of Labor's (DOL) Employee Benefits Security Administration each plan year for certain plans. If your company has over 100 participants in the BESTflex Plan Health Care FSA at the beginning of the plan year, you are required to file this form. The form must be filed as a Health and Welfare Benefit plan. If your company is a governmental entity or a church-controlled organization, you are exempt from all filing requirements.

Electronic 5500 Reporting

All forms 5500 and related schedules are required to be filed electronically. EFAST2 is the Department of Labor's (DOL's) name for the electronic filing protocol – Electronic Filing Acceptance System 2 – that replaces their earlier voluntary version of electronic form 5500 filing (EFAST).
As an employer, you are responsible for filing form 5500 for your ERISA retirement and welfare benefit plans. If you have 100 or more participants in your Health Care FSA at the start of the plan year, we prepare the electronic form 5500 on your behalf. When it is prepared, we notify you that you can review the form 5500 and make any necessary changes. You, or your designee, then electronically sign the form 5500 and submit it.

You can register for electronic credentials to through the EFAST2 website **www.efast.dol.gov.**

Click on "Register" on the left side of the web page. You will be asked to read a Privacy Statement and "Accept Agreement" before you can begin. The website will then walk you through step by step to setting up your credentials.

Due Date for the 5500 Return

The 5500 return is due seven months from the end of the plan year. Penalties may be assessed by the DOL if the return is late.

Schedule C

There is a special exemption for certain plans to no longer file Schedule C. Most Health Care FSAs are unfunded health plans that do not require the contributions to be maintained in trust due to DOL Technical Release 92-01.

If the plan sponsor files a Wrap Plan for benefits and includes the Health Care FSA in the Wrap Plan, the special exemption for Schedule C filing may be lost. If the other components of the Wrap Plan do not qualify for DOL Technical Release 92-01, the Health Care FSA may need to have a Schedule C filed.

Due to the complex nature of the Wrap Plan and the variation of benefit combinations available, Employee Benefits Corporation will not be able to assist in determining if the Schedule C is necessary under a particular Wrap Plan.

FAQs

Q. Do you need separate credentials to sign separate form 5500s for each plan you offer?

A. No. If you will be signing more than one plan form 5500 (for example if you file a separate form 5500 for your health plan, dental plan and health care FSA), you only need to receive one set of signing credentials. And can sign for multiple plans.

Q. Do you need separate credentials for each employee who might sign your form 5500s?

A. Yes, credentials are "owned" by the individual, not the organization. If more than one individual is to have signing authority, then each signer needs their own signing credentials. Likewise, if that individual leaves, or a new individual is to have signing authority, the new signer needs their own signing credentials.

Q. When you register for electronic credentials through the EFAST2 website, what type(s) of user should you select?

A. You should select "Filing Signer."

Q. What does it mean to be the Filing Signer?

A. Filing Signers can sign Form 5500 filings. Signers must ensure that the filing information is correct prior to its submission. The signer's signature indicates that to the best of the signer's knowledge and belief the filing is true, correct, and complete.

Q. Why can't Employee Benefits Corporation sign the form 5500 for the employer?

A. The employer is the Plan Sponsor for the Health Care FSA. The Plan Sponsor is responsible for signing and submitting the form 5500 timely.

Q. What if you already have a PIN and ID for electronic filing from the earlier EFAST version of electronic 5500 filing? Can you use those credentials and information for submitting your filing electronically in EFAST2?

A. No. EFAST2 is a completely separate system from EFAST. You will need to register for and obtain new electronic credentials under EFAST2.

Q. How do you update your email address or other contact information after you've registered?

A. After successfully logging into the EFAST2 website, click on the "Profile" link in the navigation bar and you will be able to change any of your contact information, including email address.

Q. Do you need new credentials every year?

A. No. Signing credentials do not expire unless they are unused for 3 years.

Q. Will a Schedule A be provided?

A. No. Schedule A is used to report premiums for an insured plan. The Health Care FSA is an unfunded health plan.

BESTflex Plan Renewal

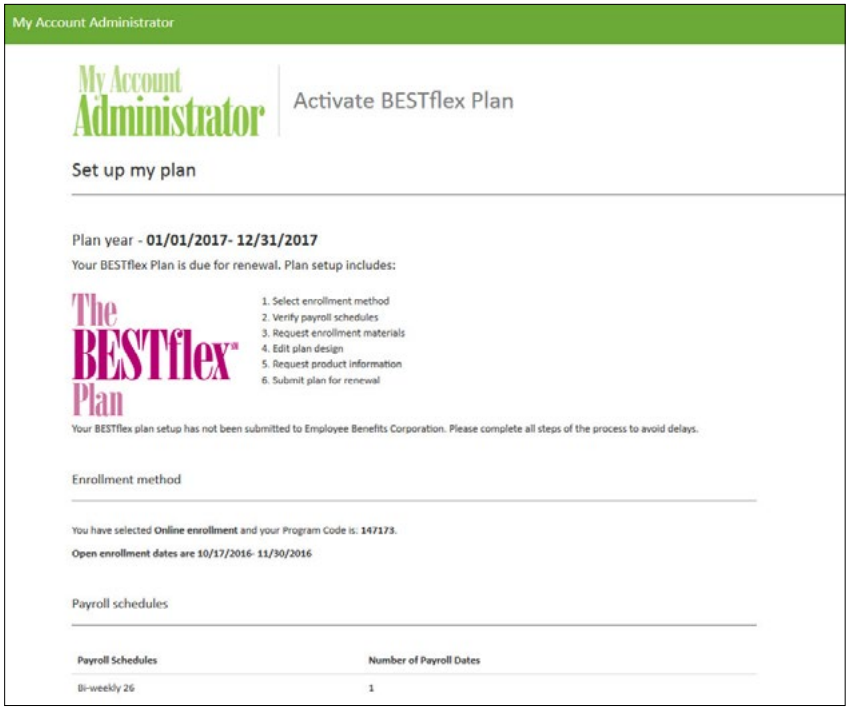
About BESTflex Plan Renewal

Toward the end of each plan year, we begin the process of renewing your BESTflex Plan.

The renewal process begins about 90 days before the start of your next plan year, when you can access *Activate BESTflex Plan Online***.** *Activate BESTflex Plan Online* is a feature of your online account that helps us ensure a smooth start to your next plan year. It's an easy process that lets you confirm your BESTflex Plan's renewal, set up internet enrollment, edit the dates of payroll deductions for the coming plan year and even make changes to your plan design.

Once you complete *Activate BESTflex Plan Online*, we send you an email confirming your selections. An invoice for your renewal fee is sent about 45 days before the start of your next plan year.

All renewal materials can be accessed on our portal. Should you wish to receive printed materials, you need to complete *Activate BESTflex Plan Online* and order at that time.



All renewal materials and features can be accessed through your online account.

BESTflex Plan Renewal In Detail

Timing of Your Renewal

The renewal process begins about 90 days before the start of your next plan year, when you can access *Activate BESTflex Plan Online*. You will receive an email from us describing the steps you need to take to access *Activate BESTflex Plan Online*.

If your BESTflex Plan renews on January 1, we will notify you of your upcoming renewal 120 days in advance. Updated renewal materials can be accessed on our portal 90 days prior to your renewal date.

The Renewal Process

Once you complete *Activate BESTflex Plan Online*, we provide your enrollment materials in your chosen format should you choose to order them. An invoice for your renewal fee is sent about 45 days before the start of your plan year.

Your renewal materials will be due **30 days prior to your new plan year.**

Some other things to keep in mind:

- *Enrollment Forms* **must** be completed, signed and dated before the start of your new plan year
- If you choose to receive your BESTflex Plan enrollment materials electronically, you must submit your employees' election data using the Employee Data Listing spreadsheet; we will not process paper *Enrollment Forms*
- There is no need to send us the *Enrollment Forms* for employees who waived the plan; retain these for your records
- All employees must receive a copy of the *Summary Plan Description (SPD)*
- The Renewal Fee Invoice must be paid prior to the start date of the new plan year
- If you submit payments by check, remember that we cannot begin reimbursing your participants' claims until your first payroll deductions have been received and posted
- Please contact us if you cannot meet the required deadlines

Choosing Not to Renew

If you do not plan on continuing business with us, we must be informed with a written notice 60 days prior to the end of your plan year. All termination notices received after this date are subject to a termination fee. See your *Service Agreement* for more information.

BESTflex Plan Renewal Online

Activate BESTflex Plan Online

Activate BESTflex Plan Online is a feature of your online account that helps us ensure a smooth start to your next plan year. It's an easy process that lets you confirm your BESTflex Plan's renewal, set up Internet Enrollment, edit the dates of payroll deductions for the coming plan year and even make changes to your plan design.

We urge BESTflex Plan clients to complete the process, as it will ensure that your plan is ready to go on day one.

Activate BESTflex Plan Online Process

Our *Activate BESTflex Plan Online* system guides you through the renewal process. You can keep *Activate BESTflex Plan Online* simple by continuing with your current BESTflex Plan setup, or use it as a convenient opportunity to make changes to your plan design.

Activate BESTflex Plan Online offers you several ways to modify your BESTflex Plan for the next plan year.

To simplify open enrollment for you and your employees, you can choose Internet Enrollment. This online enrollment system allows eligible employees to use our website to make their BESTflex Plan elections during open enrollment. You approve the elections before they are uploaded to our administration system, allowing you to monitor employees' enrollments and make sure only eligible employees enroll.

You can use the Payroll Schedules feature to review the schedule on which you deduct BESTflex Plan contributions from participants' paychecks. The online, 12-month calendar makes it easy to edit the dates of payroll deductions, if needed.

You can also review and make changes to your plan design, including the accounts available under your plan, the 2-1/2 month grace period, and contribution limits, among other things. Keep in mind that ***Activate BESTflex Plan Online*** is one of the best times to make plan design changes.

How To: Activate BESTflex Plan Online

When your plan is approximately 90 days from its renewal date, you will receive an email from us that describes how to access ***Activate BESTflex Plan Online***.

1. Log into your online account at www.ebcflex.com.
2. Click ***Activate BESTflex Plan*** under ***Renewal Activities*** in the menu
3. Follow the prompts to ***Activate BESTflex Plan***

You will receive confirmation via email when you complete ***Activate BESTflex Plan Online***. Depending on the options you choose, the letter may contain additional information about your renewal. Please be sure to read and save it.

Express Renew

Express Renew lets you manage your employees' entire renewal process online with just a few clicks – submitting and validating your information as you go. You can renew all your employees in one visit or over multiple sessions, whatever works for you. As you submit data, it will be validated and securely uploaded to our administration system. You will receive confirmation once you have completed the renewal process.

How To: Access Express Renew

1. Log into your online account at **www.ebcflex.com**
2. Click ***Renew BESTflex Plan Participants*** in the menu
3. Review and update your list of renewing participants

The BESTflex℠ Plan

The Benefits Card and the Health Care FSA

About the Benefits Card and the Health Care FSA

The Benefits Card is a debit card that is tied to a participant's Health Care FSA. Instead of paying out of pocket and submitting a paper claim for an expense, participants can use the Benefits Card to automatically debit their Health Care FSA. While the IRS requires that participants submit receipts to verify the eligibility of the expenses they apply to the card, many merchants can automatically verify expenses at the point of sale, minimizing the manual work behind the Benefits Card and Health Care FSA.

The Benefits Card and the Health Care FSA In Detail

The Benefits Card

The Benefits Card makes the BESTflex Plan easier to use. It's a solution to modernize and streamline the Health Care FSA administrative process. It uses a proprietary rules-based adjudication system that is tied to a stored-value MasterCard® to pay for qualified expenses (e.g., prescriptions, co-pays and deductibles) at the point of sale or service. Participants use the Benefits Card to pay for their eligible expenses, eliminating the pay-twice deterrent and helping drive up participation levels and tax savings.

Benefits Card

How the Benefits Card Works for Participants

Once an employee enrolls in the BESTflex Plan Health Care FSA, the Benefits Card is mailed directly to their home. The envelope will contain one card and a cardholder agreement. It generally arrives within 30 days after the BESTflex Plan start date.

When using the Benefits Card at the point of sale or service, it is swiped through the MasterCard machine. Participants don't have to use cash. The Benefits Card can also be used whenever there is deductible or coinsurance in place and the participant receives a patient due statement from their provider. The participant simply writes the Benefits Card number on the bill and sends it back to the provider.

Where the Benefits Card Works

The most recent IRS regulations establish strict rules regarding where the Benefits Card (and all other stored-value benefits cards) can be used. Two types of merchants are considered valid:

1. Health care, dental and vision provider offices
2. General retailers (e.g., grocery stores, discount stores, department stores, etc.) and pharmacies that automatically verify the eligibility of card transactions at the point of sale through an inventory information approval system (IIAS)

An online list of retailers that can automatically verify Benefits Card transactions at the point of sale through an IIAS is available at **https://www.sig-is.org/card-holders/store-locator**.

If a specific retailer does not meet any of these requirements, Benefits Card transactions will decline. Participants can contact our Participant Services team for help with determining whether a certain retailer is valid.

Benefits Card Receipts

After using the Benefits Card, it is important that participants retain **all** receipts because we, in accordance with IRS regulations, may request them for further verification. The Benefits Card relieves participants from having to pay out of pocket, but they may still need to send in receipts for substantiation purposes.

Receipts must be submitted in a timely fashion. Failure to submit receipts will result in a loss of card privileges and will require participants to repay 100 percent of the amounts for which no receipts are submitted. Participants may still submit paper claim forms if they do not pay for an eligible expense with the Benefits Card.

Receipt Notifications

Whenever possible, the Benefits Card tries to electronically verify participants' purchases at the cash register. However, some Benefits Card transactions require itemized receipts to be submitted in order to verify the transaction. Receipt Notifications are sent via email and used to collect those receipts and substantiate the expense. When the Benefits Card cannot verify a claim electronically or at the cash register, we send the participant a Receipt Notification email outlining the unverified expenses. The participant can submit documentation the following ways.

- Submitting documentation online by logging into their **www.ebcflex.com** and choosing *Submit Benefits Card Documentation* from the menu.
- Using the mobile app to submit a snapshot of their documentation taken with the camera on their mobile device.
- Faxing a copy of their documentation and a copy of their Receipt Notification Letter to (608) 831-4790.

In the event we do not have a valid email address, we will send the Request Notification via U.S. Mail (this may cause delays in processing participants' documentation).

How Receipt Notifications are sent

With Email on file	*No Email on file*
First Notice via email	First Notice via U.S. Mail
Second Notice via email	Second Notice via U.S. Mail
Deactivation Notice via U.S. Mail	Deactivation Notice via U.S. Mail

If there is no response to the first Request (First Notice), a second Request will be sent to the same email or the same U.S. Mail address (Second Notice). If there is no response to the second Request, the participant will receive a letter via U.S. Mail notifying them their card is deactivated (Deactivation Notice).

Receiving Receipt Notification Letters Via Email

If a participant has activated their account at our website and currently enters their Social Security Number and a PIN or enters a user name and password to view their account online, we have the email address they provided at that time. This is the email address we will use unless the participant requests us to change it.

To change the email address on file, participants can send an email to participantservices@ebcflex.com with "RR Letters Via Email" in the subject line. Participants must send this email from the email address to which they'd like us to send the Receipt Notification Letters.

Transactions That Do Not Require Receipts

There are two instances where receipts may not be required. Although a participant's expense information is submitted automatically in these situations, it is still important that he or she saves their receipts in case of a data transfer problem or other error.

- When participants use their Benefits Card at their health care provider for an office or prescription co-pay and the co-pay amount exactly matches the co-pay amount you have on file with us, receipts should not be requested
- As long as participants purchase eligible prescriptions, eligible over-the-counter items or contact lens supplies at retailers that can automatically verify the eligibility of Benefits Card transactions at the point of sale through an IIAS, receipts should not be requested. The IIAS only applies eligible expenses to the Benefits Card and requires a different form of payment for any ineligible items

Remember: if the provider cannot substantiate the expense, we are required to request receipts to verify the entire transaction. If a transaction cannot be verified or the card was used to pay for an ineligible expense, the participant will be asked to repay the plan or their card will be temporarily deactivated.

From: **notifications@ebcflex.com**
Sent: Tuesday, November 1, 2016 9:26 AM
To: cardholder@company.com
Subject: **ACTION NEEDED: Request for Benefits Card Documentation**

Sample Receipt Request Email: Watch for the email and ensure it doesn't land in your blocked email directory

Benefits Card Deactivation

If a participant uses the card to pay for ineligible items or does not substantiate card purchases, his or her card will be temporarily deactivated. It will be reinstated when the participant pays the plan for the expense or verifies that the expense is eligible with an itemized receipt or Explanation of Benefits (EOB).

Helpful Tips For Participants Before Using the Benefits Card

- Participants may be asked to document their Benefits Card purchases by providing us with receipts
- Participants will be asked to and must repay the expense amount if they make a purchase with the card and cannot provide documentation of the expense for any reason
- Participants should not submit expense documentation until requested to do so; we will send participants a list of their unsubstantiated Benefits Card purchases, which they return to us with copies of their documentation

Adding the Benefits Card to Your BESTflex Plan

You can contact our **Sales team** at **(800) 346-2126** to add this benefit during your renewal. A new contract will be sent to you for your review. You must use our auto-debit payment system and will need to allow at least 30 business days for your card to be set up and issued. We provide promotional materials for marketing the plan and additional information is available on our website at **www.ebcflex.com**.

FAQs

Q. How do we know the Benefits Card is accurate and has complete substantiation?

A. Validating that charges qualify under IRS guidelines is a critical part of our business. We have a substantiation process in place to ensure that the Benefits Card pays for only qualified medical expenses.

Q. How is the card funded?

A. Employers must use our auto-debit payment system. An *Auto-Debit Authorization Form* is available in the ***Forms & Reports*** section of your online account.

Q. How long are cards valid and can they be replaced if lost?

A. The cards renew each plan year. Claims submitted during plan runout periods will require participants to manually submit claims if your plan does not include the 2-1/2 month grace period. New cards are issued to participants 30 days prior to the card expiration date. Cardholders can call **(800) 346-2126** with questions and can also monitor their account by visiting our website at **www.ebcflex.com**.

If an eligible participant chooses not to participate in the BESTflex Plan for a renewal plan year, they should still keep their Benefits Card.

Q. Can the card be used during the runout period or during COBRA for terminated participants?

A. No. IRS regulations require that the debit card be suspended once a participant is no longer an active employee.

The BESTflex℠ Plan

COBRA

About COBRA

The **Consolidated Omnibus Budget Reconciliation Act (COBRA)** of 1985 is a federal law that requires most companies that offer group health plans to provide a temporary extension of health coverage to employees whose coverage would otherwise end. Any employee, spouse or dependent who participates in the BESTflex Plan Health Care FSA and experiences a COBRA Qualifying Event may be able to continue their Health Care FSA coverage under COBRA.

COBRA In Detail

General Purpose of COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires most companies that sponsor group health plans to offer their health plan participants, as well as the participants' families, the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under their plan would otherwise end.

COBRA's Application to the BESTflex Plan

COBRA is offered to any employee, spouse or dependent who participates in the BESTflex Plan Health Care FSA and experiences a COBRA Qualifying Event under certain circumstances.

- Termination usually begins the date the participant is actually terminated
- If the Health Care FSA is excepted from HIPAA, continuation coverage under COBRA only needs to be offered until the end of the plan year
- COBRA does not have to be offered to participants who have overspent their Health Care FSA dollars if the Health Care FSA is an excepted benefit under HIPAA

If the Health Care FSA does not qualify as an excepted benefit, normal COBRA rules apply.

Participants can choose to accept the continuation coverage or end their coverage after being offered COBRA.

See the **Non-Excepted Health Care FSA Flowcharts** to determine if any of your Health Care FSA participants have non-excepted FSAs.

Participant Elects COBRA Continuation

If the participant is offered and chooses to accept COBRA continuation coverage for the Health Care FSA:

- The participant must submit after-tax contributions to your company in a timely manner
- Your company will be billed for the participant's dollars
- The participant may elect to have the remaining Health Care FSA dollars deducted from his or her last paycheck on a pre-tax basis (this is the only time the participant may pay on a pre-tax basis)

Participant Fails to Elect COBRA

If the participant does not accept COBRA continuation coverage for the Health Care FSA:

- After the participant terminates, they have a 90-day (standard, or see *My Company Plan*) runout period to claim expenses that were incurred during his or her plan year
- After the runout period, any balance that the participant has not claimed will be held in your account and returned to you when your company's forfeitures are issued

FAQs

Q. What happens if Employee Benefits Corporation also administers my COBRA?

- Once we receive your *Qualifying Event/Termination Form* (see **Joint Notification**), we will send the COBRA notice to the participant, spouse or dependent(s)
- We will collect the COBRA enrollment form and premium payments from the participant, spouse or dependent(s) and deposit them into the Health Care FSA

Please see the *COBRASecure℠ Answer Book* for a more detailed explanation.

The BESTflex℠ Plan

HIPAA

About HIPAA

HIPAA is the **Health Insurance Portability and Accountability Act of 1996.** This legislation was passed to help govern the portability of health care coverage, especially in the area of preexisting conditions, and to create a more consistent health care delivery system. There are two sections of HIPAA that affect the BESTflex Plan Health Care FSA. We work with you to make sure your plan remains in compliance with the relevant HIPAA requirements.

HIPAA In Detail

HIPAA's Four Primary Sections

In order to understand HIPAA, it is important to understand that HIPAA is broken down into sections and that each section covers a different aspect of the act. The main sections of HIPAA include:

- HIPAA portability, special enrollment and nondiscrimination requirements for group health plans
- Insurance market rules
- Administration simplification
- Other requirements, such as special rules for Multiple Employer Welfare Association (MEWA), abuse and fraud

HIPAA's Effect on the BESTflex Plan

HIPAA protects welfare benefit plans that provide or pay for medical care and are a group plan. There is one section of HIPAA that impacts the Health Care FSA plans: the **administrative simplification rules.** Prior to the ACA, HIPAA Portability Rules and Certificates of Creditable Coverage also applied. This rule will have an impact on the BESTflex Plan Health Care FSA.

The BESTflex Plan allows health or dental insurance benefits to be funded with pre-tax dollars. These benefits may be subject to HIPAA on their own. However, it's the payment for medical care through the Health Care FSA that makes the plan subject to HIPAA.

There can be instances where the BESTflex Plan Health Care FSA may meet certain exceptions to HIPAA. For example, your plan may require only minimal compliance with the portability rules, but require full compliance with the administrative simplification rules. We will work closely with you to ensure that your plan is in compliance with HIPAA.

You should discuss HIPAA's impact on your other benefits with your insurance carrier or other benefits administrator.

Penalties for Non-Compliance with HIPAA

The IRS, Department of Labor (DOL) and Department of Health and Human Services (HHS) jointly enforce HIPAA's requirements. Each governing body regulates different areas of HIPAA and can impose fines, penalties or imprisonment.

The IRS regulates the **non-compliance rule** regarding HIPAA's Preexisting Condition Exclusions (PCE), **special enrollments** and **nondiscrimination requirements**. The IRS can impose an excise tax of $100 per day for each individual for whom a failure occurred on the sponsoring employer.

The DOL regulates compliance with the same items as the IRS. Additionally, they can bring a civil action against the employer or insurance carrier to enforce HIPAA.

After passage of the Health Information Technology for Economic and Clinical Health Act (HITECH), HHS may now impose greater penalties based on four tiers. The tiers range from $100 to $50,000 per violation, with an annual cap of $1,500,000 on the penalty amount that may be assessed. HHS also maintains the right to impose criminal penalties, which could result in imprisonment.

HIPAA's Enforcement Policy

Rules that will dictate the procedures to enforce HIPAA's Administrative Simplification rules have been established. These include processes for investigations, subpoenas and Administrative Law Judge hearings. The enforcement of

Privacy and Security will be broken down and handled by two separate organizations. Office for Civil Rights (OCR), a branch of HHS, is responsible to enforce the Privacy Rules and the Centers for Medicare and Medicaid Services (CMS) is responsible for the enforcement of EDI and Security.

OCR and CMS will be looking for voluntary compliance with these regulations and will provide assistance when requested.

Portability Requirements Under HIPAA

The portability requirements are broken down into three main categories: Preexisting Condition Exclusions (PCE), special enrollments and nondiscrimination requirements.

Special enrollment rights allow employees, their spouses and their dependents to enroll for certain events, including loss of coverage under another plan, marriage, birth and adoption. These special enrollment rights also apply to COBRASecure-qualified beneficiaries.

The **nondiscrimination rules** limit the use of certain factors that a health plan may impose on its participants in regards to eligibility, premiums, or contributions. These factors include such things as health of the individual, medical history, genetic information and receipt of medical care.

The Portability Requirements' Effect on the BESTflex Plan Health Care FSA

Certain types of plans are exceptions to HIPAA's rules. In the case of the BESTflex Plan Health Care FSA, nondiscrimination rules do not apply and the plan will be an excepted benefit when both the following conditions are met:

1. Maximum Benefit Condition

The Maximum Benefit Condition requires that the Health Care FSA annual election does not exceed two times the employee's salary reduction amount for the plan year or, if greater, the amount of the salary-reduction election for the Health Care FSA, plus $500. To fail the Maximum Benefit condition, the employer must be contributing dollars into the Health Care FSA. Plans that are solely funded by employee salary reductions will always pass this test. The Maximum Benefit Condition is applied on an individual basis.

One way to approach the Maximum Benefit Condition is to think of it as a two-step test. Step one is to determine if there is an employer contribution and whether it exceeds the employee salary reduction amount. If yes, then the second step is to determine if the employer contribution is more than $500.

Examples of Health Care FSA plan designs that meet the Maximum Benefit Condition:

Example 1
The employer matches the employee salary reduction on a one-to-one ratio. The employer contributes $600 and the employee deducts $600 from their pay. The annual election of $1,200 is not more than twice the salary reduction amount. It is exactly twice the employee's salary reduction amount.

Example 2
The employer contributes less than $500 and the employee contributes less than the employer. The employer contributes $400 and the employee contributes $300. The annual election is more than twice the employee's salary reduction. However, the amount is not the employee's salary reduction plus at least $500.

Example of a Health Care FSA plan design that does not meet the Maximum Benefit Condition:

Example
The employer contributes $800 and the employee salary deducts $600. The annual election is $1,400 which is more than two times $600. In addition, the $1,400 election exceeds the $600 reduction by more than $500.

2. Availability Condition

The Availability Condition requires that participants in the Health Care FSA have other group health plan coverage available from the employer. Other coverage cannot be other Excepted Benefits. Coverage is based on a class by class basis. Since a requirement to be eligible for the Health Care FSA is to be eligible for group health plan coverage, this rule will always be met.

Examples of Health Care FSA plan designs that meet the Availability Condition:

Example 1
Employer A offers all full time employees the Health Care FSA and the Group Health Insurance Plan and both plans have the same waiting and eligibility periods.

Example 2
Employer B offers all employees the opportunity to enroll in the Health Care FSA and the Group Health Insurance Plan.

*Examples of Health Care FSA plan designs that do **not** meet the Availability Condition and violate the ACA:*

Example 1
Employer Y offers full time employees a Group Insurance Health Plan and offers all employees, including part time, the Health Care FSA. Part time employees do not have the Group Insurance Plan Available and therefore fails this condition.

Example 2
Employer Z offers all employees the Health Care FSA on date of hire and the Group Health Insurance Plan after a 90-day waiting period. If an employee enrolls in the Health Care FSA and terminates prior to eligibility for the Group Health Insurance Plan, the employee would fail the Availability Condition.

Example 3
Employer A does not offer its employees a group health plan. If an employee enrolls in the Health Care FSA, that FSA would fail the Availability Condition.

Administrative Simplification Provisions

There are three parts to the Administrative Simplification provisions. They are:

- Privacy Standards
- Security Standards
- Electronic Data Interchange (EDI) Requirements

Organizations that Must Comply with the Administrative Simplification Provisions

Covered Entities, defined as health care providers (insurance companies, carriers), health care clearing houses and health plans (self-insured health plans), must comply with these provisions. The Covered Entity for the BESTflex Plan Health Care FSA is the health plan itself. Since the plan cannot act on its own, the plan administrator or sponsor will act on behalf of the plan.

Purposes of the Privacy Standards

The privacy standards were created to:

- Prohibit plans (including the BESTflex Plan Health Care FSA) from using or disclosing protected health information (PHI) for purposes other than treatment, payment and operations
- The scope of any PHI disclosure must be limited to the minimum necessary for treatment, payment and operations; procedures must be established by you and Employee Benefits Corporation to comply with this requirement
- The health plan must explain individual rights in the form of a privacy notice
- Covered entities must establish privacy procedures to ensure compliance; this includes designating a privacy officer, training staff, creating a process to file complaints and developing a system of punishing those who violate the established rules

The privacy standards protect all PHI in oral, written, electronic and non-electronic formats.

The Privacy Officer

The **Privacy Officer** is someone who you designate to be responsible for compliance with HIPAA. The Privacy Officer is the point of contact if a complaint regarding PHI is filed or if we need to contact the plan regarding a participant's PHI. The Privacy Officer is also responsible to ensure that there is adequate separation maintained between you and the plan.

Types of Information That May Be Considered PHI

PHI is any information that can be used to identify an individual within a group health plan. The following are examples of PHI, but, remember, there may be other items that could be PHI.

- Participant's name
- Social Security Number
- Address information, including all geographic subdivisions smaller than state (street address, city, county, zip code)
- Elements listing dates (except year) that are related to a participant, including birth date, dates of service, date of death, all ages over 89 (including the year) and any elements that could be used to create a category of "age 90 or older"
- The participant's phone number
- The participant's fax number
- The participant's email address
- Medical record numbers
- Medical information regarding services, diagnoses, dates of service
- Reimbursement information on claims
- Payment information
- Treatment information
- Account numbers
- Web addresses (URL)
- Certificate/license numbers
- Vehicle identifiers, serial numbers, license plate numbers
- Finger and voice prints
- Full face images and photos
- Genetic information

Obligations with Respect to PHI Use

You must agree to certain provisions with respect to the use and disclosure of PHI. Those conditions are:

- Not to use or disclose PHI other than as permitted by law
- Ensure that any agents and subcontractors with whom you share PHI agree to the same restrictions and conditions that apply to you (this includes us, brokers and insurance agents)
- Not to use or disclose PHI for employment-related or your employee benefit plan-related actions, unless authorized by the individual
- Not to use or disclose PHI in connection with any of your other benefit or employee benefit plans, unless authorized by the individual
- Track any PHI use or disclosures
- Make PHI available to that individual in accordance with HIPAA's access requirements
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA

- Make internal practices, books and records – those that relate to the use and disclosure of PHI and are received from the plan – available to the HHS Secretary for the purpose of determining the plan's compliance with HIPAA
- If feasible, return or destroy all PHI that you receive from the plan and maintain in any form, and retain no copies of such PHI when it is no longer needed for the purpose of disclosure; if not feasible, limit further uses and disclosures

Purpose of Security Standards

The security standards were created to:

- Protect information that is maintained or transmitted electronically
- Establish safeguards to ensure the integrity and confidentiality of information
- Protect against threats to the security of or unauthorized access to the information

The security standards protect PHI in electronic formats only.

The Security Officer

The **Security Officer** is someone who you designate to be responsible for compliance with HIPAA's Security Standards. This person ensures that your systems are secure from threats and unauthorized access to or unauthorized use of information.

Complying with the Security Standards

You can begin by appointing a Security Officer who can examine your systems for security issues. A simple step, such as establishing password protection, is a great place to start.

Also, when you send electronic files that contain PHI to us, only use the secured link on our website. To use our secured link, you must log into your **www.ebcflex.com** account. Never use regular email to transmit PHI. It is not a secure and safe method.

How To: Securely Submit Electronic Data to Employee Benefits Corporation

Use these instructions to submit files using our secure file uploader:

1. Save the file you would like to upload on your computer
2. Log into your **www.ebcflex.com** online account
3. Open the menu and click ***Resources > Upload Files***
4. Select the type of file you would like to upload from the drop-down list
5. Use the ***Browse*** button to locate the file saved on your computer; the file path will appear next to the button
6. Click ***Upload file***

Electronic Data Interchange Requirements

HIPAA's EDI requirements standardize the way electronic data is transmitted to and from certain administrative and financial organizations. They also protect the privacy and security of the data. This rule does not affect most BESTflex Plan Health Care FSA claims since most are submitted by paper.

However, the EBC HRA and some BESTflex Plan Health Care FSAs submit their claims or other information, such as eligibility, electronically. Health plans that do not send information electronically using the EDI requirements must still be capable of receiving information using the EDI standards.

Employers who use our administration services are in full compliance with these requirements. Our Information Technology (IT) department has already established these processes.

How We Help You Comply with HIPAA's Requirements

We update our documents to contain any necessary HIPAA language, and has created internal procedures to comply with HIPAA. The following documents have been updated or created to comply with the various requirements:

Updated Documents

- *Plan Document*
- *Summary Plan Description (SPD)*
- *Enrollment Form*
- *Claim Form*

Documents Created to Comply with HIPAA

- *Business Associate Agreement*
- *Notice of Privacy Practices Template*
- *Participant Authorization Form*

Business Associate Agreement

The *Business Associate Agreement* is a contract between the plan (you) and Employee Benefits Corporation. The agreement was signed when the *Service Agreement* was completed. This agreement will hold us to the same high standards that the plan must establish to protect PHI.

Notice of Privacy Practices Template

The *Notice of Privacy Practices* explains to participants the HIPAA requirements that relate to the use and disclosures of PHI by the plan and any agents of the plan, including us.

A *Notice of Privacy Practices Template* is available for download in your online account. The employer is responsible to distribute copes of the *Privacy Notice* to participants in the Health Care FSA. This *Notice of Privacy Practices Template* may be amended or changed as the plan or plan's legal counsel may advise. The company's information and logo may also be added to customize the document.

The employer is responsible to notify plan participants of the availability of the *Notice of Privacy Practices* and how to obtain one at least once every three years if no changes were made requiring distribution at an earlier time.

See **Important BESTflex Plan Documents** to learn how to download forms and materials through your online account.

Participant Authorization Form

If the participant would like other individuals, such as a spouse, to have access to the plan, a *Participant Authorization Form* should be completed. This form is available to download at **www.ebcflex.com**

FAQs

Q. Is there a special exception for the BESTflex Plan Health Care FSA under the Administrative Simplification provisions?

A. No. Unlike the portability regulations, no special exception exists. In fact, the Department of Health and Human Services (HHS) published a FAQ specifically to inform the public sector that there are no exceptions for the BESTflex Plan Health Care FSA (available at **http://answers.hhs.gov/**). **It states:** A "group health plan" is a covered entity under the Privacy Rule and the other HIPAA, Title II, Administrative Simplification standards. A "group health plan" is defined as an "employee welfare benefit plan," as that term is defined by the Employee Retirement Income Security Act (ERISA), to the extent that the plan provides medical care. See 42 USC § 1320d(5)(A) and 45 CFR 160.103. Thus, to the extent that a flexible spending account or a cafeteria plan meets the definition of an employee welfare benefit plan under ERISA and pays for medical care, it is a group health plan, unless it has fewer than 50 participants and is self-administered. Employee welfare benefit plans with fewer than 50 participants and that are self-administered are not group health plans. Flexible spending accounts and cafeteria plans are not excluded from the definition of "health plan" as excepted benefits. See 45 CFR 160.103, paragraph (2)(i) of the definition of "health plan."