Benefits Design Guide for FSA, HRA and Commuter Spending Accounts

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Directions for producers: Please complete and submit an electronic copy to your health plan along with the new or renewal paperwork. For questions about the BenefitWallet payroll process, please contact the BenefitWallet Employer Support Team at 866.712.4551.

Health plans: Please return to the Employer Support Team at EmployerSetup.mybenefitwallet@conduent.com. Alternatively, you may fax the documents to 201.633.0134.

Health plan customer ID*	Select from drop-down menu.
Employer code (BenefitWallet assigned)	
BenefitWallet code	BFW

Section 1: Company information

Company name _____

Tax ID number (EIN) (xx-xxxxxxx) _____

Mailing address:			
City:			
State:			
Zip:			
Number of benefit eligible employees:		Number of expected enrollments:	

Accounts offered through BenefitWallet		
☐ Health Care FSA ☐ Limited Care FSA ☐ Dependent Care FSA	☐ HRA	☐ Commuter Benefits

Who will transmit the customer eligibility to BenefitWallet?				
Health Care FSA/ Limited Care FSA	Health Plan	☐	Employer/3rd Party	☐
Dependent Care FSA			Employer/3rd Party	☐
HRA	Health Plan	☐	Employer/3rd Party	☐
Commuter Benefits			Employer/3rd Party	☐

* = REQUIRED FIELD

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Section 2: Company contacts

During setup the Primary Employer Contact is assigned a User ID and granted access to the Employer Portal. The Primary Contact will then setup additional contacts with web access.

	Primary employer contact
Name:	
Email address:	
Phone number:	
BenefitWallet assigned user ID:	

	☐ Technical or secondary ☐ Employer contact
Name:	
Email address:	
Phone number:	

Additional contacts (optional)

Contact type	☐ Broker ☐ Consultant ☐ Other
Name:	
Email address:	
Phone number:	

Contact type	☐ Broker ☐ Consultant ☐ Other
Name:	
Email address:	
Phone number:	

Primary contact – The person responsible for general oversight and communication contact for the plans. This will also be the person receiving all applicable employer notifications and responsible for adding and maintaining additional authorized contacts and web users.

Secondary contact – The person would generally serve as a back-up contact for the Primary Contact. They can request to also receive applicable employer notifications.

Broker – Third party individual providing advice.

Consultant - Third party individual providing advice.

Technical contact – The person responsible for the file transmission of data, for example enrollment or payroll/ contributions.

Other contact – Please indicate what type of role the contact should be listed as.

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Section 3: Flexible Spending Accounts (FSA)

Plan year start date (MM/DD/YYYY) _____

Plan year end date (MM/DD/YYYY) _____

Co-payments: Please indicate your co-payments for auto-approval of debit card transactions. Benefit summaries, percentages, and/or deductible amounts cannot be accepted.	☐ Our plan does not offer co-payments ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Dental co-payment $ _____ ☐ Dental co-payment $ _____ ☐ Dental co-payment $ _____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Vision co-payment $_____ ☐ Vision co-payment $_____ ☐ Emergency co-payment $_____ ☐ Other, specify type and amount_____
Card package BenefitWallet assigned	☐ Standard ☐ Other, specify _____

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Section 3: Flexible Spending Accounts (continued)

Complete this section only if offering Flexible Spending Accounts through BenefitWallet.

Select type of FSA(s) offered	☐ Health Care FSA ☐ Dependent Care FSA ☐ Limited Purpose FSA

Please complete each section for each FSA that will be offered.

Plan type	Expected number of enrollments	Employee maximum annual contribution	Employee minimum annual contribution	Annual employer contribution
Health Care FSA		☐ IRS max ☐ Other $	☐ No minimum ☐ Other $	☐ None ☐ Other $
Dependent Care FSA		☐ IRS max ☐ Other $	☐ No minimum ☐ Other $	☐ None ☐ Other $
Limited Purpose FSA		☐ IRS max ☐ Other $	☐ No minimum ☐ Other $	☐ None ☐ Other $

Run out period: Please indicate how many days employees will have to file claims after the plan year end date.	☐ Standard, 90 days ☐ Other, specify _____ This deadline also applies to employees terminating mid-year.
You may select <u>either</u> grace period or rollover in accordance with your plan provisions. You cannot select both. You may select neither.	
Grace period: Allows an extension of the plan year end date in order for participants to incur services. Grace period extension is defined as two full months ending on the 15th of the third month. The run out period will need to be greater than or equal to the grace period.	☐ Yes ☐ No If yes, please select account types: ☐ Health Care FSA ☐ Dependent Care FSA ☐ Limited Purpose FSA Additional notes:
Rollover: Allow participants to roll over up to the IRS maximum of unused funds at the end of the plan year, if a grace period is not offered.	☐ Yes ☐ No If yes, please select maximum rollover amount: ☐ IRS max ☐ Other $_____ ☐ If there is a minimum rollover amount please indicate it here $_____ **Note:** If elected, rollover balance will continue in either Health Care FSA or Limited Purpose FSA as it originated. Not applicable to Dependent Care FSA. Additional notes:
Do you currently have a Health Care FSA, Dependent Care FSA, or Limited FSA? If so, complete this section to document the transition process and roles for the current administrator.	☐ Yes ☐ No If yes, will the current Third Party Administrator (TPA) complete the administration of the existing plan year, including run out and/or grace period? ☐ Yes ☐ No, (Partner) will take over the below administration effective _____ ☐ Run out* ☐ Run out and grace period* ☐ Current plan year takeover *Plan setup will not begin until current and previous plan year data is received. Additional notes:

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Section 4: Health Reimbursement Arrangements

_____ Plan year start date (MM/DD/YYYY)

_____ Plan year end date (MM/DD/YYYY)

Select type of expenses eligible under the HRA plan. If selecting more than one complete section 5 one time for each plan.	☐ General purpose health eligible expense (213 (d) expenses list) - HRA-S-GX-00 ☐ Medical expenses only - HRA-S-CX-00-0450 ☐ Medical and prescription - HRA-S-CX-00-0179 ☐ Limited purpose eligible expense (Dental & Vision) - HRA-S-VD-00 ☐ Deductible only (no debit card, streamlined claims only) - HRA-S-UX-00 ☐ Medical, dental, vision premium and parts A and D premium - HRA-S-CX-00-0538 ☐ Medical co-insurance only BW to provide plan code ☐ Other, note additional setup time required. BW to provide plan code. Detail eligible expenses below:
Expected number of enrollments:	_____
Co-payments: Please indicate your co-payments for auto-approval of debit card transactions. Benefit summaries, percentages, and/or deductible amounts cannot be accepted.	☐ Our plan does not offer co-payments ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Medical/Office co-payment $_____ ☐ Dental co-payment $_____ ☐ Dental co-payment $_____ ☐ Dental co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Prescription drug co-payment $_____ ☐ Vision co-payment $_____ ☐ Emergency co-payment $_____ ☐ Other, specify type and amount _____
How will the HRA funds be available to participants?	☐ 100% at the beginning of plan year or upon eligibility ☐ Quarterly ☐ 1st of each month (1/12) ☐ Per payroll frequency ☐ Automatic posting Additional notes:

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Section 4: Health Reimbursement Arrangements (continued)

Mid-year hire: Annual election should be available in full or pro-rated.	☐ In full ☐ Pro-rate	**Mid-Year Status Change** Change in status would update election amount in full or on a pro-rated basis	☐ In full ☐ Pro-rate
Health care payment card: You must select NO if the HRA is reimbursing deductible only expenses.	☐ Yes (not an option if employees have upfront or deductible out of pocket member responsibility before HRA pays), if yes ☐ Can be used for all eligible expenses ☐ Can only be used for prescription expenses ☐ No debit card	**If offering FSA and HRA plans, which plan pays out first to participants?** Only available if both FSA and HRA are administered by BenefitWallet	☐ FSA ☐ HRA ☐ Not applicable

Contribution level	Contribution amount	Is there an individual reimbursement limit?
Single	$ _____	No
Single plus spouse	$ _____	☐ Yes, $_____ ☐ No
Single plus dependent	$ _____	☐ Yes, $_____ ☐ No
Family	$ _____	☐ Yes, $_____ ☐ No

Run out period: Please indicate how many days employees will have to file claims after the plan year end date.	_____ days following the plan year end date This deadline also applies to employees terminating mid-year.
HRA rollover: If funds are rolling over to a subsequent plan year, the rollover will take place on Day 1 of the new plan year.	**Can unused dollars be carried over and used in subsequent plan years?** ☐ Yes ☐ No If yes, ☐ Up to $_____ ☐ _____ % of balance
	Whose unused dollars can be rolled over and used in subsequent plan years? ☐ Active participants only ☐ All participants (active and termed) **If a participant is no longer eligible for the HRA plan in a subsequent plan year (but are not terminated), will their balance still roll over?** ☐ Yes ☐ No

Date HRA was first offered to employees: If not provided, date will be defaulted to plan year start date indicated in Section 4.	
Can participants be reimbursed for expenses incurred between the original effective date of the HRA and this plan year as long as they were a participant? Example: If this is the first time offering the HRA, would the plan design X years from now pay back claims with dates of service back to the original date listed above.	☐ Yes ☐ No

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Section 5: Commuter Benefit plans

Complete this section only if offering Commuter Benefit plans through BenefitWallet.

Select type of Commuter Benefit offered	☐ Parking benefit ☐ Transportation benefit

Please complete each section for each benefit that will be offered.

Plan type	Expected number of enrollments	Employee maximum monthly contribution	Employee minimum monthly contribution	Monthly employer contribution
Parking benefit		☐ IRS max ☐ Other $	☐ No minimum ☐ Other $	☐ None ☐ Other $
Transportation benefit		☐ IRS max ☐ Other $	☐ No minimum ☐ Other $	☐ None ☐ Other $

Note: Accounts are funded as contributions are taken from participant paychecks.

Debit cards: **Will the group offer a debit card for the Commuter Benefit(s) elected?** If members are not using a debit card for the Transportation benefit, they will only be able to submit manual claims for Vanpool expenses. IRS section 132(f) rules specify that transit reimbursement is only qualified under a bona fide reimbursement arrangement if a voucher or similar item is not "readily available" for direct distribution by the employer. If the employer is able to purchase qualified transit passes, vouchers, or terminal-restricted debit card, then such items are considered readily available, meaning cash reimbursement is not allowed. As such, manual claims are only permissible for Vanpool and qualified Parking expenses.	☐ Yes ☐ No
Run out period: Per IRD guidelines members have 180 days to submit expenses that are incurred during the plan year, after the end of the plan year and after termination.	180 days
Rollover: Per IRS guidelines any funds remaining in the account must rollover.	Yes
Do you currently have a Commuter Benefit plan? If so, complete this section to document the transition process and roles for the current administrator.	☐ Yes ☐ No If yes, will the current Third-Party Administrator (TPA) complete the administration of the existing plan year, including run out? ☐ Yes ☐ No, ☐ Run out ☐ Current plan year Takeover – current administrator:_____ Contact: _____ What date should BenefitWallet expect to receive plan year rollover funds from the prior administrator effective _____
Merchant category network	☐ Parking ☐ Transportation

Section 6: Program fees

Below is a list of the program fees. All fees are employer paid for FSA and HRA. Fees will not be waived for retroactive terminations.

Fees	Amount
FSA/HRA monthly service fee	Select from drop-down menu.
Note: Minimum monthly fee of $100 applies.	

Section 7: Employer signature

Primary contact signature: Electronic signature acceptable	
Print:	
Title:	
Date:	

ACH Authorization Form on next page is required to complete the setup

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ACH Authorization Form

Please complete and return to EmployerSetup.mybenefitwallet@conduent.com or fax to 201.633.0134.

Employee claims payments: debit card transactions and direct deposit payments will be settled directly with the bank account ("Account") at the depository financial institution provided to below ("Depository").

BenefitWallet will initiate an ACH from your bank account equal to the total check, direct deposit and/or debit card transactions that occur each business day.

- For debit card transactions, funds will be pulled by The Bancorp Bank with originating company ID: **1050006509**.
- For manual or online claims, checks will be issued from a BenefitWallet account with an originating company ID: **1CIBWFSA01**.

I hereby authorize BenefitWallet to initiate debit/credit entries to the Account for:

☐ Manual/Online claims (each business day or as they occur. The Reimbursement claims include, but are not limited to, manual/online transactions.)

I hereby authorize The Bancorp Bank to initiate an debit/credit entries to the Account equal to the total debit card transaction amount. To support The Bancorp Bank process, this account must be a checking account.

☐ Debit card transactions (each business day or as they occur; required to indicate approval when debit card is issued)

Please attach a voided check (or photocopy of a check with your banking information) and inform the banking institution that you have authorized these ACH debits to occur. Should filters not be established with the banking institution, ACH errors may occur and could delay plan set up processes.

Depository name _____ Branch _____

Address _____ Phone _____

City _____ State _____ Zip _____

Routing number _____ Account number _____

This authorization is to remain in full force and effect until BenefitWallet has received written notification from an authorized representative of its termination in such time and in such manner as to afford BenefitWallet, The Bancorp Bank, and Depository a reasonable opportunity to act on it.

I acknowledge that the origination of ACH transactions to the account must comply with the provisions of U.S. law.

Employer name _____ Tax ID# _____

Employer code _____ Print name _____

Date _____ Signature _____