FLEXIBLE SPENDING ACCOUNT (FSA)
DIRECT PLAN DESIGN GUIDE

Horizon | MyWay℠

Please complete this form and return to Horizon 45 days before your effective date so we can properly administer your plan.

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

I. EMPLOYER INFORMATION

Employer's Name _____

Employer's Street Address _____

City _____ State _____ ZIP Code _____

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

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

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

Number of Employees Eligible for Plan: _____

HR Contact:
(Responsible for signing the Plan Design Guide and approving the plan design)

Name _____ Title _____

Phone Number ( ) _____

Email Address _____

Finance Contact:
(Has access to all plan information when calling Horizon and will automatically be granted full access to the Spending Account Employer Portal)

Main Contact Person _____ Title _____

Phone Number ( ) _____

Email Address _____

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

Additional Contact Person _____ Title _____

Phone Number ( ) _____

Email Address _____

Additional Contact Person has access to when contacting Horizon:

☐ All plan information OR ☐ Claim billing information

* Log in to the Spending Account Employer Portal to grant access to additional users or to add contacts.

II. AGENCY/BROKERAGE INFORMATION

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

Agent/Broker Code_____ Agent/Broker Phone _____

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

Agency/Brokerage Code _____ Agency/Brokerage Phone _____

Agency/Brokerage Tax ID _____-_____

Agency/Brokerage Address _____

III. TRANSFER OF ADMINISTRATION

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

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

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

IV. HEALTH PLAN ADMINISTRATIVE INFORMATION

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

Health plan carrier _____

Health Plan Group Number _____ Health Plan Account Manager _____

Group size: (check one)

☐ SHBP ☐ Public

☐ Small (2-50) ☐ Labor

☐ Mid (51-99) ☐ Large / National / Jumbo (100+)

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

V. FLEXIBLE SPENDING ACCOUNT ADMINISTRATIVE INFORMATION

Plan Year

FSA start date _____ FSA end date _____

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

☐ Medical Flexible Spending Account

☐ Dependent Care Flexible Spending Account

Cafeteria Plan

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

☐ I currently have a cafeteria plan with Horizon. Please update my documents.

☐ I currently have a cafeteria plan with another vendor.

☐ I want Horizon to setup a cafeteria plan. Continue to the eligibility section below.

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

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

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

☐ First of the month following date of hire

☐ Date of hire

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

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

VI. FLEXIBLE SPENDING ACCOUNT ADMINISTRATIVE INFORMATION (continued)

Terminations *(applies to Medical FSA only)*

Allowing continuation on an after-tax basis is mandatory.

Do you also wish to allow continuation on a pretax basis, taken from the employee's last paycheck, with the employee's written permission?

☐ Yes ☐ No (default)

Minimum and Maximum Employee Contribution Limits

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

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

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

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

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

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

Grace Period

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

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

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

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

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

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

Rollover

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

☐ Roll over balance up to $500 to subsequent plan year

☐ No balance rolls over

Run-out Period

The run-out period is the deadline for participants to submit claims for the previous plan year. All eligible claims must be received by the end of the run-out period.

The suggested run-out period selected for a Medical FSA is 3 months from the end of the plan year. A run-out period always begins at the end of the plan year, and if a grace period is selected, it runs concurrently with the grace period.

If you selected **Medical FSA**:

Please indicate the length of the run-out period for active Medical FSA employees: _____ (months)

(Length of run-out period must be indicated in whole and/or half-month increments. Half months equate to 15 days.)

Please indicate how you would like run-out to apply to terminated employees *(select **only** one)*

☐ The run-out period noted above begins at termination date *(recommended)*

☐ Same as active employees

If you selected **Dependent Care FSA** please indicate the length of the run-out period: _____ (months)

(Length of run-out period must be indicated in whole and/or half-month increments. Half months equate to 15 days. Run-out for terminated and active employees is the same for dependent care.)

VII. REIMBURSEMENT

Choose one:

☐ **Debit Card** – Employees use the debit card to pay for expenses just as they would use a bank debit card. All participants will be issued one debit card. A debit card for dependent(s) may be requested online.

Note: If you offer an HRA with an FSA, the debit card is not available for members with stacked accounts.

☐ **Autopay –** Eligible health plan expenses (i.e. deductible and/or coinsurance) as indicated on the health plan Explanation of Benefits will be automatically reimbursed according to the participants available account balance.

All employees can request reimbursement through our secure online member service center at horizonblue.com/employers or by fax or mail.

Copay amounts

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

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

Medical: _____ _____ _____ Vision: _____ _____ _____ _

Drug: _____ _____ _____

VIII. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

☐ Employer can enroll participants using the group portal.

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

IX. FSA PAYROLL INFORMATION

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

We offer three options for sending us your payroll deduction data:

☐ **Spending Account Employer Portal (recommended)**: You can create and upload a file directly in the Horizon system or manually enter contribution amounts.

☐ **Recurring Contributions:** This option allows employers to enter in their payroll contribution data at the beginning of the plan year through the Spending Account Employer Portal and employee contribution amounts will automatically post to their accounts on the specified payroll date.

☐ **Electronic File**: This option requires employers to create a file using Horizon format requirements. This option is required for employers with 50 or more employees and is recommended for all employers. (Contact the group leader line for file format requirements.)

X. ADMINISTRATIVE FEES

You will receive an automated email notification when your detailed billing information is available and another email notification two business days in advance of the scheduled ACH transaction confirming the amount of funds to be transferred. Sign in to the Spending Account Employer Portal to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information

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

Please select **one:**

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

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

Bank Name _____

Type of Account: ☐ Checking ☐ Savings

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

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

XI. PLAN DOCUMENTS

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

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

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

XII. CLAIM REIMBURSEMENT PROCESSING

You will receive an automated email notification with the claim reimbursement totals. Sign in to the Spending Account Employer Portal to view and print your complete invoice detail under Claim Reimbursement Invoices.

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

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

Bank Name _____

Type of Account: ☐ Checking ☐ Savings

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

Bank Account Number_____

XIII. ADMINISTRATIVE TIPS

ONLINE ACCESS: horizonblue.com/employers

With Horizon, your employees have access to a powerful tool for managing their FSA. By registering with horizonblue.com/employers, your employees can:

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

You can also access forms and enrollment materials at **horizonblue.com/employers.**

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

COORDINATING WITH AN HRA:

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

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

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

XIV. SIGNATURES

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

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

Signature _____ Date_____

Printed Name _____ Title _____