



## Enrolling a Flexible Benefit Plan Frequently Asked Questions

### What Do I Need to Do for Open Enrollment?

We recommend the Plan Coordinator do the following before the employee meeting date:

- Design your plan and adopt your Plan Document. (A FlexMagic consultant will assist you in this process) Read your document.
- View the Flexible Benefit Plan Educational Flash Program
- Read the Enrollment Packet (which is your Summary Plan Description) and Election Form
- Copy & Insert the Customized Information & Rules Page into each Enrollment Packet
- Read the entire Frequently Asked Questions Guide

The adopted plan design (e.g. dollar amounts allowed in the Health Care Spending Account, maximum insurance premium dollar amounts, eligibility requirements, salary adjustment schedule, reimbursement schedule etc.) determines the rules for the entire plan year. These design features will be noted in the plan document.

Each year you may re-evaluate the plan and redesign it to fit the changing needs of your employee population. Now you are ready to hold your employee meeting.

### Employee Meetings

The Employee Meeting is crucial to the success of the plan. The function of the meeting is to explain the Flexible Benefit Plan to employees and to encourage participation in the plan. Your plan is only as good as its enrollment. Employees need the opportunity to understand how the plan can work to their advantage. In the first year of the plan, it is suggested to make the meeting mandatory for all eligible (and soon to be eligible) employees. Employee participation in the plan depends largely on employer enthusiasm and promotion of the benefits under the plan.

Open Enrollment generally starts with the employee meeting and continues for one to two weeks. Enrollment may be open longer if there are multiple locations. Enrollment must be completed and all election forms signed & dated prior to the start of your plan year.

At the meeting, the Plan Coordinator needs to:

- Distribute Enrollment Packets with Election Forms and a copy of the Information & Rules Page to each benefit eligible employee.

*Note: The first year, every eligible employee needs to receive an Enrollment Packet whether or not he/she chooses to participate in the Plan. The Enrollment Packet is your Summary Plan Description and must be distributed to all benefit eligible employees at least every five years (see Summary Plan Description Information).*

- If possible, have employees view the educational program, Mr. Money and the FlexMagic Bunny Show. Our clients report a 40-50% increase in Plan usage as a result of using this educational tool.

- Guide the employees through the enrollment packet page by page, especially the worksheets and the estimated tax savings page. Review the election form and explain how to complete the form with your employees.
- Guide the employees through the rules of your plan as stated on your Information & Rules page.
- Allow time for questions & answers. Refer to IRS Publications 502 Medical and Dental Expenses and 503 Child and Dependent Care Expenses to answer employees' specific questions. You may also call or e-mail us. We always welcome your communication.

*Note: In general an employee cannot change or revoke a Flexible Benefit Plan election once the benefit period has except with an eligible status change election. The exception is contributions to the Health Savings Account Trust contributions which can change monthly.*

## **How Do I Process Employee Elections?**

### **Initial Election**

Once you have reached the end of your open enrollment period, you should have an election form from each employee (1st Plan Year) or from those in the Flexible Spending Accounts and/or those who changed an insurance election choice (2nd year & each year thereafter).

### **Election Form:**

The following is an explanation of the Election Form and how it needs to be filled out.

#### Employee Identification

Make sure you have all the information your company needs to identify the employee. You may not need the employee number or date of birth. However, all eligible dependents should be listed.

#### Boxed Elections

##### **1. Part I – Insurance**

If you are offering before-tax health premiums, each employee should complete Part I or the Part I Waiver. This choice will remain in effect from Plan Year to Plan Year until it is revoked. The employee can only change the election at next year's open enrollment or because of an eligible status change.

##### **2. Part II - Spending Accounts**

Check the employee's math and number of pay dates for accuracy. Contact the employee if there is a discrepancy in the calculations to determine the correct election amount. Those not participating should check the Part II Waiver.

#### Purpose Section

Make sure plan year dates are entered and accurate. New hires will have the same plan year-end date but a different start date. All values are prorated for new hires and election changes during the plan year.

#### Signatures

You must have the employee's signature (or electronic signature with online enrollments). The election form should be dated before the start of the plan year. Under Federal regulation the plan year enrollment must be completed prior to the start of a plan year.

The Plan Coordinator should sign on the employer signature line and date the election form prior to start of plan year. The election form is a contract/agreement between the employee and the employer for the plan year.

### Internal Use Only Section

This section can be filled out for payroll coordination. Check initial elections; write in effective date & first payroll date. If an employee should be a new hire, have an eligible status change or be terminated, the necessary information can be recorded here and given to payroll for input.

If there is an eligible status change, the employee will fill out a new election form with a new plan year start date and prorated election amounts. This information is given to payroll and to the administrator who will be setting up the accounts and reviewing the claims.

Distribute the election form copies as follows: (NOTE: No copies are needed for the employee when the online enrollment process is used as they will automatically receive an email copy of the approved election form.)

- White copy - to Employee's Personnel File
- Yellow copy - to payroll, accounting or third-party administrator
- Pink copy - to employee along with the verification memo and reimbursement materials if the election includes one or both Flexible Spending Accounts

The **Verification Memo** gives employees a few days to make any final enrollment corrections before the election information is given to payroll. This memo also confirms that open enrollment is closed and reminds the employee that no election changes are allowed following the verification deadline date. During the plan year changes are only allowed when an eligible status change occurs.

Election forms that have not been returned by the initial enrollment deadline, but returned by the final corrections deadline, can be accepted by the employer.

### **How Do I set Up the Payroll?**

It is very important for the payroll person and the Plan Coordinator to work closely together. Open enrollment must be completed prior to the start of a plan year and payroll must have enough time to make the necessary payroll adjustments based on the employee before-tax and after-tax elections.

Payroll adjustments for the first payroll of the plan year are constant for the entire plan year unless one of the following circumstances allows a new election or requires an adjustment:

1. There is an increase or decrease in the employee's share of the eligible insurance premiums (can automatically be changed without a new employee election)
2. A new hire becomes benefit eligible and elects to participate in the plan
3. An eligible status change causes a revocation or change in an election
4. An employee terminates employment
5. A Health Savings Account Trust contribution change is requested (NOTE: can be requested anytime and does not require a status change event)

All changes during the plan year are computed on a prorated basis. **Changes during a plan year must be elected prior to the effective date of the change. Example:** An employee wants to change an election upon a return to employment following a maternity leave. The requested effective date is June 1st. The employee must complete and date the new election form prior to June 1st even though the first payroll adjustment will not occur until June 15th.

## Payroll Taxes Exempted

Under a Flexible Benefit Plan the following taxes are exempted on all dollars redirected from wages to tax-free benefits:

1. Social Security contribution
2. Medicare contribution
3. Federal Withholding Taxes
4. Federal Unemployment Taxes
5. State Withholding Taxes (all states except New Jersey)
6. State Unemployment Taxes (applies to Colorado - must be verified in other states)

**Colorado:** For government employers under the Public Employees Retirement Association (PERA), contributions are exempted on both the employer and employee contributions. The Colorado Police and Fireman's retirement fund contributions are **not** exempted.

Worker's Compensation Insurance is **not** exempted in Colorado under the State Worker's Compensation Insurance Plan. Individual carriers may vary on requirements. Review this question with your Worker's Compensation Insurance broker for the requirements of your carrier.

**Other States:** The Employer should verify if State Unemployment and Worker's Compensation contributions are exempted on Flexible Benefit Plan dollars in your particular state.

## What Options Do I Have for Plan Administration?

The "administration" of a Flexible Benefit Plan refers to reimbursing the employee for dollars claimed from the chosen spending accounts. This includes adjudicating claims, tracking and reporting on the individual accounts and reconciliation with the payroll department.

There are three options available to you for administration of your plan. You can administer the plan in-house or you can outsource the plan administration through FlexMagic Consulting. Either option can be cost-effective depending on the number of plan participants. FlexMagic Consulting will assist you in determining your best option.

### In-House Administration System

This system is appropriate for a company with a minimum number of employees. Remember, that only employees with spending account elections need tracking through a reimbursement system. Group premiums are deducted and tracked through payroll and then paid directly to the insurance carrier.

### Third Party Administration

This option is appropriate for groups who want complete confidentiality of claims review or who are limited in staff size for internal administration of the Flexible Benefit Plan. Third-party administration services are available through FlexMagic Consulting. The Debit Card is a popular option and adds convenience for your employees by reducing the number of claims required by the IRS to be documented with the submission of receipts.

### Banking

Flexible Spending Account (FSA) dollars from Dependent Care, Health Care and Premium Reimbursement Accounts can be held in your general fund account. No special bank account is required. However, if a separate account is established, it should be under the company name, not

under the Plan name. (Example, ABC Company, not ABC Flexible Benefit Plan.)

If a trust account is established the plan is considered to be a funded plan and an audited opinion may be required. Your tax counsel and accountant can help you determine what is required in your situation.

Care must be taken to ensure that the payroll deduction amounts and the spending account amounts reconcile each pay cycle. Special care must be taken when status changes, new hires and terminations occur.

## **How Do I Track Insurance Premiums?**

When setting up your payroll system for a Flexible Benefit Plan, there must be a deduction for each insurance category or insurance company. This allows for ease of reviewing and reconciling your monthly insurance statements with your payroll reports.

### **Employer-Sponsored Group Health (Health, Dental, Vision)**

The health, dental, and vision premiums (all health related insurance) can be deducted in one column, only if the same insurance carrier is used for all premium payments. If not, it is easier to establish a separate deduction column for each premium payment to ensure proper deductions and reconciliation with premium statements. Premium dollars for group coverage are deducted and paid directly to the insurance carrier.

### **Premium Reimbursement**

If a premium reimbursement account (individual employee-owned health insurance, not part of a company group plan) is allowed, these dollars must be tracked under a separate column. These dollars are deducted from the gross wage and reimbursed to the employee with a separate before-tax payment after proof of active insurance is provided. Reimbursement to the employee for pre-payment of premiums is not allowed. **Caution:** *We do not recommend premium reimbursement as a preferred procedure. There are still unanswered questions relating to HIPAA, ERISA and some state mandates when individual health insurance premiums are reimbursed by the employer.*

### **Term Life Insurance**

**Term-Life Insurance** should have its own deduction column for payment reconciliation. You must have on file an election form for each participant if before-tax premium payments are offered. These premiums are also paid directly to the insurance carrier.

*Note: Term life premiums for the employee up to \$50,000 in death benefit are eligible for before-tax payments. If coverage is added for a spouse or dependent, the premium is considered to be a family premium and is not eligible for the before-tax payment. See current Tax Code 79 information for the correct values when figuring what portion of term-life premium can be tax free if the death benefit is over \$50,000.*

### **Disability Insurance**

Disability Insurance must be tracked separately in its own deduction column(s) to show if an employee's paying these premiums with before or after tax dollars. You must have on file an Election Form for each participant.

## **How Do I Track the Spending Accounts?**

### **Dependent Care Spending Account**

Dependent Care Spending Account dollars are tracked in a separate deduction column and the deducted value entered in the Dependent Care Benefit [DCB] box on the W-2 Form each calendar

year. These dollars are constant unless an eligible status change occurs during the plan year. The dollars deducted for dependent care expenses are reimbursed only up to the amount available in the employee's account at the time of the request. This is a *fund-as-you-go* account and requires no risk of liability to the employer.

### **Health Care Spending Account**

Health Care Spending Account deductions are also tracked separately. These dollars are constant unless an eligible status change occurs during the plan year. The full elected amount is reimbursed to the employee at any time during the plan year.

The full plan year election per employee must be available to the employee on the first allowable reimbursement date. These dollars should be considered a liability to the employer from the start of the plan year. The employee deductions are payments against the liability.

The separate deduction column allows for payroll reconciliation with you Plan administrator.

*Note: Once the initial elections are entered into payroll, taxes are recalculated and account tracking is set up. The first payroll of the Flexible Benefit Plan Year is ready. Values will remain the same for the entire plan year, except under certain circumstances. (See "When are Election Changes allowed during the Plan Year"). Periodically, the employee should receive status reports disclosing the claims, payments and balance of the account(s).*

### **How Often are Employee Status Reports Required?**

Employee account balance reports are recommended at least twice a year, but preferably on a quarterly basis. Both a calendar year-end and a plan year end report are required under Federal regulations.

### **How do Corporate Structure Changes Impact a Flex Plan?**

Flexible Benefit Plan Coordinators need to be aware that changes in their company's corporate structure **during** a Plan year can produce some unanticipated and unwanted results. If you know of any forthcoming mergers, acquisitions, changes from C Corporation to S Corporation structures or even significant expected layoffs, please notify FlexMagic Consulting. We will help you determine what effect, if any, the change will have on Flexible Benefit Plan compliance issues.

### **What Compliance Reporting is Required?**

At the beginning of your first plan year and at the end of each plan year, the employer has to complete several reporting requirements.

### **Plan Document**

Employers do not file the plan document with any government agency. However, the plan document must be signed and kept with other important company documents. All employers must have a written plan document if they have adopted a Flexible Benefit Plan. This Document, once adopted, governs the operations of the plan.

FlexMagic provides plan documents and summary plan descriptions as "models." The company legal counsel should review and approve them.

## Summary Plan Descriptions

ERISA and COBRA regulations require employers to provide each eligible employee with information on his/her rights and rules under the plan.

*Note: If you are a public sector employer, you may not be required to follow ERISA regulations.*

The SPD (Summary Plan Description) has been incorporated into three pieces of the enrollment materials:

- Enrollment Packet
- Flexible Benefit Plan [FBP] Information & Rules Page
- Claim Reimbursement Materials

The enrollment packet and Information & Rules page is provided to each eligible employee during the open enrollment period for the first plan year. The third piece of the SPD is in the reimbursement materials (Claims Denial Appeal Procedures Section). This information is needed only by those employees who elect to participate in a Spending Account (Dependent Care or Health Care).

The enrollment packet along with the Information & Rules Page must be given to all benefit-eligible employees. The SPD must be given to the employees within 120 days after the start of the Plan year or 90-days after becoming a participant in the Plan.

The SPD must be updated and distributed at minimum every fifth year. If there have been material modifications to your plan a new copy must be provided to eligible employees. It must be distributed at least every 10 years when no changes have been made.

### ***Non-English Speaking Employee Requirements***

*If there are less than 100 employees and 25% are literate in the same non-English language, there must be a disclaimer in the SPD referring them to a person who can explain the information contained in the SPD. If there are more than 100 employees and 10% or 500 are literate in the same non-English language, there must be a disclaimer in the SPD referring them to a person who can explain the information contained in the SPD.*

## 5500 Form Reporting

The 5500 Form has temporarily been discontinued for Flexible Benefit Plan with fewer than 100 Health Care Spending Account participants. This change was effective in 2002. However, 5500 Forms are still required when there are 100 or more Health Care Spending Account participants. It must be filed within seven months after the end of the plan year.

## How Long Must I Keep Records?

At the end of each Flex Plan year, it is prudent to store that year's documents and records in one place. Include:

- Completed and signed plan document adoption agreement.
- Set of all forms used for the plan year

- 502 and 503 IRS Publications
- Employee claim forms & substantiation along with your accounting records (unless stored for you by your third-party administrator – FlexMagic)
- Non-Discrimination test results
- Employer copy of the 5500 Form (if applicable\_

In the event of an IRS audit of your Flex Plan, all pertinent records will then be easily accessible.

Upon the recommendations of our tax counsel the following suggestions apply:

- Tax returns and W-2's should be kept forever. The IRS can audit a company for "Gross Omission of Income" for six years. However, if fraud is found, there is no time limit on the review.
- Under ERISA Guidelines, 5500's (if required) should be kept for six years

*Note: The employer should follow the advice of its own tax counsel.*

## **What Year-End Procedures are Required?**

### **Employee Statements**

Each employee must receive a calendar year-end statement of how much has been deducted in each before-tax category. This report can be as simple as copying the employee's Flexible Benefit Plan accounting sheet and then including the value of the before-tax employee-paid insurance premiums from the payroll report. If you are reimbursing on the paycheck then generally all the information is provided on the pay stub. Employees need to know these tax-free dollars to assist with year-end tax preparation. The report must be provided by January 31st each year.

If your plan year ends at a time other than December 31st, you must provide a plan year-end statement as well as the calendar year-end statement.

### **W-2 Forms**

Before-tax dollars expensed through the Flexible Benefit Plan are never taxed and most are not reported on the W-2 Form, with the exception of the Dependent Care benefit dollars and the Health Savings Account Trust contributions. Effective soon premium dollars will also be reported on the W-2.

The DCAP (Dependent Care Assistance Plan, IRS Code Section 129) dollars paid by the employee with before-tax Flex Plan dollars are reported in a box marked "DCB" (Dependent Care Benefits) on the W-2 Form. Additional dollars paid by the employer as a before-tax dependent care subsidy are also shown in this box. Total dollars cannot exceed \$5,000 per calendar year for single or married employees filing a joint return. The maximum for a married employee filing a separate return is \$2,500 per calendar year per spouse.

The DCB reported value could be the amount deducted from the gross wages or the value of the actual amount of care expenses incurred during the calendar year. It does not matter when the expense is paid, only when the care expense is incurred. It is assumed that the deducted value is the incurred value.

The reported amount may be different from the plan year amount when a plan year spans two calendar years.

## **How Does the 90-Day Run-Out Period Work?**

The document allows a 90-day run-out-period after the end of each plan year. During this time employees can submit claims for either the Dependent Care or Health Care Spending Account. The service, however, must have been incurred prior to the end of the plan year (or during the 2 ½ month grace period following the end of the plan year – if the grace period was adopted by the employer) and during the time the employee was actually enrolled and active in the plan.

Example: The Company is on a calendar Plan year. Using the years 2010 and 2011 for our example, an employee had a porcelain crown put on Dec. 17, 2010. He submits the bill to his dental insurance. On Feb. 5, 2011, he receives his insurance Explanation of Benefits that says the insurance will pay \$450 and the employee owes \$450. On Feb. 6, 2011, the employee submits his signed Claim Form along with a copy of the Explanation of Benefit. He receives a reimbursement of \$200 from his Health Care Spending Account; which is the remaining balance available for the 2010 plan year. His 20105 Health Care Spending Account is now at a \$0 balance.

## **How Does the 2 1/2 Month Grace Period Work?**

The employer can choose to offer a 2 ½ month grace period following the end of the plan year for employees to incur expenses and make a claim against the previous plan year dollars. This helps to reduce forfeiture of funds by allowing a “grace period” following the end of the plan year. Claims must still be submitted within the 90-day run-out period under the plan document and the employer can decide to offer the Grace Period or not.

## **Is IRS Publication 502 accurate regarding Flexible Benefit Plan Expense Reimbursement?**

IRS Publication 502 is primarily designed for use by people who itemize medical expenses which exceed 7.5% of adjusted gross wages on a federal tax return.

While many pages of the publication pertain to the Flexible Benefit Plan Health Care Spending Account much of the information in this publication does not apply. For example: the publication references health premiums as eligible expenses – which they are for income tax deduction purposes. However, health insurance premiums cannot be reimbursed through the Health Care Spending Account; only out-of-pocket health care expenses can be reimbursed through this account. The publication says that expenses are deductible when paid – which is true for the federal tax deduction when filing medical expenses on a tax return; however, under the Flexible Benefit Plan rules expenses must be incurred during the plan year (or during the grace period – if adopted by the plan) in order to be eligible for reimbursement. When the expense is actually paid does not matter.

Please call FlexMagic Consulting if you have specific questions on allowable expenses.