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Welcome to Your FSA Answer Book

The information in this book is intended to answer general questions about your flexible spending account (FSA) administration. For help with detailed questions, please contact your Client Account Representative for more information.

The answer book is based upon our interpretation of the Internal Revenue Code (IRC) and guidance from our legal counsel. At any point you may wish to seek legal advice from your own legal counsel.

About Us

In addition to offering FSAs, we also offer [health savings accounts \(HSAs\)](#), [health reimbursement arrangements \(HRAs\)](#), [lifestyle spending accounts \(LSAs\)](#), [commuter benefits](#), [COBRA](#), [billing services](#), and [compliance services](#). For more information about our other products, contact us at sales@ebcflex.com.

Online Resources

Our website and your online account give you the information you need to manage your FSA.

Our Website

Our website, www.ebcflex.com, has a variety of resources that are regularly updated for you and your employees. Our most commonly accessed resources include our blog and webinars.

Blog

Our blog, [EBC Insights](#), spans a variety of topics including important information about our products, what's going on in the benefits world, compliance reminders, and more!

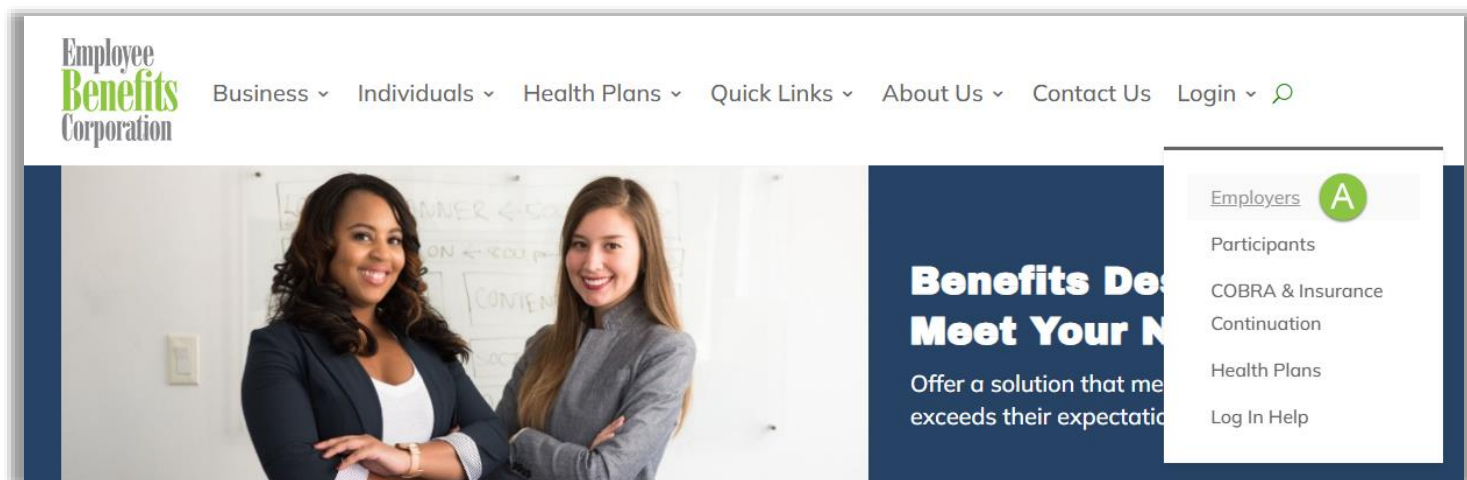
Webinars

We have a variety of on-demand [webinars](#) to engage with employers like you and share trending benefit topics and important compliance reminders.

Your Online Account

Your online account features 24/7 access to your important plan information. To access your account, visit www.ebcflex.com and log in as an employer (A).

If this is your first time logging into your online account, you will need to use the login credentials that you received during your implementation process. If you already use one of our other services, you will use the same login credentials that you normally do to log in.



Home Page

Once you're logged in, you will have access to important information and tools including:

- An overview of your EBC accounts on the home page (A).
- Additional information about your FSA(s)—access this information by clicking on the applicable plan tile (B).
- Commonly accessed resources in your *Quick Links* (C).
- Funding requests under *Funding Requests* (D).
- Administrative fee invoices under *Fee Invoices* (E).
- The contact information of your Client Account Representative (F).

My Account Summary


A Plans

COBRA COBRA <small>1/1/2016 - No End Date</small>	View Account >				
FSA Health Care FSA <small>1/1/2025 - 12/31/2025</small>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Balance</td> <td style="text-align: right;">\$4,599.92</td> </tr> <tr> <td>Participants</td> <td style="text-align: right;">2</td> </tr> </table>	Balance	\$4,599.92	Participants	2
Balance	\$4,599.92				
Participants	2				
FSA Limited Health Care FSA B <small>1/1/2025 - 12/31/2025</small>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Balance</td> <td style="text-align: right;">\$520.00</td> </tr> <tr> <td>Participants</td> <td style="text-align: right;">1</td> </tr> </table>	Balance	\$520.00	Participants	1
Balance	\$520.00				
Participants	1				
FSA Dependent Care FSA <small>1/1/2024 - 12/31/2024</small>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Balance</td> <td style="text-align: right;">\$16,599.44</td> </tr> <tr> <td>Participants</td> <td style="text-align: right;">4</td> </tr> </table>	Balance	\$16,599.44	Participants	4
Balance	\$16,599.44				
Participants	4				
HSA Health Savings Account <small>1/1/2020 - No End Date</small>	View Account >				
HRA Health Reimbursement Arrangement <small>1/1/2025 - 12/31/2025</small>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Balance</td> <td style="text-align: right;">\$34,000.00</td> </tr> <tr> <td>Participants</td> <td style="text-align: right;">13</td> </tr> </table>	Balance	\$34,000.00	Participants	13
Balance	\$34,000.00				
Participants	13				

Invoices

D Funding Requests Invoice Date: 05/16/2025	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Amount Due</td> <td style="text-align: right;">\$2,515.00</td> </tr> <tr> <td>Past Due</td> <td style="text-align: right; color: red;">\$2,515.00</td> </tr> </table>	Amount Due	\$2,515.00	Past Due	\$2,515.00
Amount Due	\$2,515.00				
Past Due	\$2,515.00				

E Fee Invoices [View Details >](#)



Benefit Plan Limits
 The Latest Limits for HSAs, FSAs, and More [Learn more](#)

C Quick Links

- [Message Center](#)
- [Reports](#)
- [Enroll Participants](#)
- [Terminate Participants](#)
- [Update Demographics](#)
- [View Participants](#)
- [Upload Files](#)

[Contact Me](#) [Follow Us](#)

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Main Menu

You can also find additional tools in the main menu of your online account.

- In the *Resources* section (A), you can find [forms and materials](#), [reports](#), a video library, communication toolkits*, and a tool for uploading files.
- In the *Manage Participants* section (B), you can enroll, terminate, and view participants.
- In the *Administration* section (C), you can view your account settings. Your account settings will give you the ability to view your payroll schedules, billing schedules, bank accounts, divisions, contacts, and billing settings.
- In the *My Profile* section (D), you can access your account security settings.

Plan Information	Balance	Participants
FSA Limited Health Care FSA 1/1/2024 - 12/31/2024	\$4,749.68	2
FSA Dependent Care FSA 1/1/2024 - 12/31/2024	\$16,599.44	4

*Our communication [toolkits](#) include a variety of resources that you can use to promote your benefits to employees. Examples of resources include email templates, presentation slides, videos, online resources, flyers, and more! These resources are great to share during open enrollment and throughout the plan year to encourage benefit enrollment and participation.

Forms and Materials

The following materials are key documents that can be found in your online account.

Plan Document

The *Plan Document* is the legal document containing details about your plan's eligibility, benefits, and operations. Your participants must be provided with a copy of the full *Plan Document* upon request.

Your *Plan Document* can be found in the main menu of your online account. You can access it by selecting *Forms and Materials* under the *Resources* section of the main menu.

Plan Adoption Agreement

The *Plan Adoption Agreement* explains the specific design of your plan. Plan eligibility requirements and other plan specifics are established in this document.

Note: Your Plan Document incorporates the Plan Adoption Agreement you signed when you set up your plan with EBC. We recommend you keep a copy of the Plan Adoption Agreement with your plan records.

Summary Plan Description

The *Summary Plan Description* (SPD) is the participant's summary of the plan. It explains in simpler terms 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.

Your *Plan Document* can be found by clicking on your FSA plan tile in your online account.

My Company Plan

The *My Company Plan* is an addendum to the SPD and should be distributed along with the SPD anytime it is shared.

The most up-to-date version of *My Company Plan* is available in your online account. You can access this document by selecting your product in the *Plan Information* section in the main menu of your online account.

Summary of Benefits and Coverage

The *Summary of Benefits and Coverage* (SBC) is a required document for non-excepted health care FSAs. Clients with a non-excepted health care FSA 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.

Your *SBC* can be found in the main menu of your online account. You can access it by selecting *Forms and Materials* under the *Resources* section of the main menu.

An Introduction to FSAs and the Flexible Compensation Plan

We offer three types of FSAs: [health care FSAs](#), [dependent care FSAs](#) and, more rarely, [individual premium FSAs](#) (called IND). Included with each FSA type is a [flexible compensation plan document](#).

Health Care FSA

With a health care FSA, your employees can enroll in either a *standard health FSA* or a *limited health FSA*. The difference between a standard health FSA and a limited health FSA is the types of eligible health expense that are covered.

- 1. Standard Health FSA Eligible Expenses**

Eligible medical, vision, dental, prescription, and over-the-counter expenses not covered by another health plan.

- 2. Limited Health FSA Eligible Expenses**

Eligible vision and dental expenses not covered by another health plan.

When an employee enrolls in a health care FSA, they can either pay for their eligible expenses using their Benefits Card or they can pay for the expenses out-of-pocket and then submit a claim for reimbursement. Claims for reimbursement can be submitted through their online account or on our mobile app, EBC Mobile.

Health Care FSA Limits

Each year, the Internal Revenue Service (IRS) announces the:

1. Maximum contribution limits for health care FSAs
2. Maximum rollover limit for health care FSAs

These limits are indexed and adjusted annually. Up-to-date limit information can be found at www.ebcflex.com/planlimits.

Uniform Coverage Rule

Under the Uniform Coverage Rule, health care FSA participants can access their full annual election amount from the first day of their plan year, regardless of how much they've contributed to date. If a participant terminates their employment mid-year after spending more than they have contributed, you cannot reimburse yourself for the excess amount spent by the employee.

Dependent Care FSA

A dependent care FSA covers day care expenses for children or other eligible dependents.

To qualify for a dependent care FSA, your employee (and their spouse, if they're married) must be working, looking for work, or be a full-time student. When an employee enrolls in a dependent care FSA, they pay for their eligible day care expenses out-of-pocket and then submit a claim for reimbursement. Claims for reimbursement can be submitted through their online account or on our mobile app, EBC Mobile.

Individual Premium FSA

An individual premium FSA (IND) covers non-medical individual insurance premiums such as dental, vision, disability, accident, cancer, or hospital indemnity coverage for your employee, employee's spouse, or employee's dependent children.

When an employee enrolls in an IND, they pay for their eligible individual insurance premiums out-of-pocket and then submit a claim for reimbursement. Claims for reimbursement can be submitted through their online account or on our mobile app, EBC Mobile.

Flexible Compensation Plan Document

EBC includes a flexible compensation plan (also known as a cafeteria plan) document for each of our FSAs. This document allows your company to deduct employees' health premiums, FSA contributions, HSA contributions, and more from their paychecks on a pre-tax basis, thereby maximizing tax savings and enhancing employee benefits.

Using FSA Funds

Once their **health care FSA** is active, participants can pay for eligible expenses either by using their Benefits Card at the point of sale or by paying out-of-pocket and submitting a claim for reimbursement. Participants with a **dependent care FSA** must pay for their eligible expenses out-of-pocket and submit claims for reimbursement.

Participants should always save their receipts or other forms of expense documents when using their FSA funds.

Benefits Card

The Benefits Card is a prepaid debit card that is mailed to participants when they first enroll. With the Benefits Card, participants can pay for eligible expenses directly from their health care FSA. They simply use their Benefits Card at the register or use it to make an online payment. Primary cardholders can also add their Benefits Card to their digital wallet and use it wherever Apple Pay, Google Pay, and Samsung Pay are accepted. Participants do not need to call to activate their card—it will work as soon as they use it.

Here are some important things to know about how the Benefits Card works:

- The Benefits Card can only be used at medical, dental, and vision provider offices, as well as retailers and pharmacies that use an inventory information approval system (IIAS). Benefits Card swipes at other retailers will decline. Visit our [Eligible Benefits Card Retailers](#) webpage for more information.
- Our Benefits Card is designed to drive the highest level of auto-substantiation possible. The Benefits Card includes:
 - Real-time claim substantiation through Inventory Information Approval System (IIAS)
 - Copay matching
 - Recurring expenses logic that learns from participant card transactions
- When the Benefits Card cannot automatically substantiate a card transaction, the participant will be asked to provide [documentation](#) for their card swipe as required by IRS guidance.
- Each Benefits Card is valid for 3 to 4 years and new cards will automatically be distributed prior to the card's expiration date.
- Participants should use the Benefits Card only for expenses incurred within the current plan year. The Benefits Card should not be used to pay for a prior year's expenses.
- If the plan has a grace period, or if the plan has rollover and the participant is hoping to be HSA-eligible in the new year, participants may want to wait until they have been reimbursed for all expenses incurred during the old plan year before using the Benefits Card for any expenses they incur in the new plan year.
- The Benefits Card is **not** available for the dependent care FSA.

Benefits Card Management

If a participant would like to order an additional Benefits Card in a dependent's name, they can request it through the mobile app, [EBC Mobile](#), or in their online account. More information about ordering an additional Benefits Card can be found in our [How do I get an additional Benefits Card video](#).

If a participant loses their card, they can lock the card in the mobile app, [EBC Mobile](#), to prevent any unwanted purchases. If they cannot find their card or if it has been stolen, they can order a replacement card. Additional information about lost or stolen Benefits Cards, can be found in our [Lost or Stolen Benefits Card Video](#).

Expense Documentation

In accordance with IRS regulations, we may request documentation to verify that a participant's Benefits Card swipes or claims are for eligible expenses. Documentation requests are sent via email or mail based on the participant's communication settings. If the participant utilizes EBC Mobile, they will also receive a push notification of the documentation request. A participant's Benefits Card is suspended if the participant does not provide adequate documentation within 90 days.

Additional information about documentation requests can be found [here](#).

Claim Reimbursement

Participants can submit claims for reimbursement from their FSA after the expense has been incurred and during the plan year or applicable grace/runout period. Participants can use the following methods to submit a claim:

- **Mobile App**
Participants can file claims using our mobile app, [EBC Mobile](#). When submitting claims through the mobile app, participants can submit images of their documentation directly through the app.
- **Online Account**
Participants can file claims and see additional claim details in their [participant online account](#).
- **Claim Form**
Participants can also file claims manually using a claim form. The claim form can be downloaded from www.ebcflex.com/forms.

Claims are processed within two business days after receipt. Participants with an email address on file will be notified via email when their claims have been processed.

It's important to note that if a participant paid for an eligible expense using their Benefits Card, they should not file a claim for that same expense.

Claim Documentation

When submitting claims for reimbursement, participants must provide documentation that verifies each expense's eligibility. The following must be included in the expense documentation:

- Date of service - both start and end dates
- Dollar amount for each line
- Name of provider
- Description of service
- Total dollar amount for the entire page

- The service provide signature for dependent care (if applicable)

To receive reimbursement from an IND, participants need to provide documentation from the insurance provider that shows the following information:

- Type of policy
- Who is covered by the policy
- Period of coverage
- Premium amount

- OR-

- Type of policy
- Who is covered by the policy
- Receipt showing the amount paid and the date paid

Approved Claims

Health care FSA reimbursement payments are issued once the claim is approved and EBC receives claim funding. Dependent care FSA and IND reimbursement payments are issued when both the necessary funding is received and EBC's records indicate that the funds have been withdrawn from the employee's paycheck. Reimbursement payments can be issued through [direct deposit](#), which is the fastest and easiest way for participants to receive their reimbursement.

A stop-payment fee will apply if a participant does not receive a reimbursement check and requests that it is reissued.

Denied Claims

If a claim is not reimbursed in full, the participant will be notified of the claim denial and denial reason. Participants may resubmit the claim with additional information or appeal the claim denial.

When a participant appeals a claim denial, an EBC employee who was not involved in the original denial will review the appeal and determine whether the appeal should be approved or denied. The participant will be timely notified of the appeal denial and denial reason. EBC follows ERISA rules for reviewing and responding to appeals.

A participant can request a *second level* appeal if their first appeal is denied. Second level appeal decisions are made by the employer and not EBC, since the employer is the plan fiduciary.

If EBC receives a second level appeal from a participant, EBC will provide the employer with the claim and appeal details and notify the participant of the employer's appeal determination.

Funding Options

There are two ways to fund your FSA: through payroll deductions or claim deductions.

Payroll Deductions

When you choose to fund your FSA through payroll deductions, the deducted funds are sent to EBC on a per payroll or monthly basis. Claims are then paid from the pool of funds held at EBC. You will receive a Payroll Deduction Invoice prior to each payroll deduction.

We give you the opportunity to update your payroll schedule for each new plan year, if necessary. Because participants' payroll deductions may fluctuate throughout the year, complete the following steps when you receive your Payroll Deduction Invoices:

1. Compare each Payroll Deduction Invoice to your payroll deductions for that period.
2. Note any changes ([permitted election change](#), [loss of eligibility](#), or [leaves of absence](#)), including the date the payroll is affected, on the billing statement. If changes occurred, notify us of the change prior to or with your payment.

Please note that payments will not be accepted if the amount paid is different from the amount billed unless the changes are detailed on the remittance.

Claim Deductions

When you choose to fund your FSA through claim deductions, a claims register is created after claims have been approved for payment. Claim payments are made once the funds are received at EBC. If you fund your FSA with claim deductions, you will receive Claims Register Invoices.

- If you fund claims on a daily basis, you will receive a Claims Register Invoices each day. Reimbursements are issued to participants daily and they typically receive payment within 5 business days from the date the claim was approved.
- If you funds claims twice weekly, you will receive Claims Register Invoices on Mondays and Thursdays. Reimbursements are issued to participants twice weekly and they typically receive payment in 7-9 business days from the date the claim was approved.
- If you have chosen to fund claims weekly, you will receive your Claims Register Invoices on Mondays. Reimbursements are issued to participants weekly and they typically receive payment in 7-11 business days from the date the claim was approved.

FSA Invoicing and Payments

With an FSA, there are two types of invoices that you can expect: funding requests and fee invoices.

Funding Requests

A funding request is an invoice for FSA claim funding.

To access your funding requests:

1. Log in to your [employer online account](#)
2. Select your *Funding Requests* tile

The type of funding request you receive for the FSA depends on whether you pay via claim or payroll deductions, as selected on your Service Agreement.

Medical Excess Invoice

If you fund your FSA based on payroll deductions and you offer a health care FSA, you may receive a Medical Excess Invoice. This occurs when the total health care FSA claims and Benefits Card transactions exceed the funds collected through the Payroll Deduction Invoicing.

The *Outstanding* column of the Medical Excess Invoice line shows the dollar amount of health care FSA claims that are in excess of your organization's received payroll funds. Quick payment of medical excess brings your account back into balance and allows us to continue reimbursing outstanding claims.

If you fund claims using auto-debit, we will draw payment from your financial account the day after we notify you that your plan is in medical excess. We will then apply the funds to the excess claims and release reimbursement checks.

Any payments that 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 your 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, contact your Client Account Representative.

Fee Invoices

Fee invoices refer to any invoice related to your plan administration fees.

To access your fee invoices:

1. Log in to your [employer online account](#)
2. Select your *Fee Invoices* tile

Payments

To ensure secure and timely invoice payments, we recommend using one of the following methods:

- **EBC-Initiated Auto-Debit:**

This convenient option allows EBC to automatically debit your bank account for invoice payments. Prior to each debit, you will receive a billing statement detailing the amount and scheduled date of the transfer. Auto-debit helps ensure your payments are made on time without manual intervention.

- **Employer-Initiated ACH Payment:**

Alternatively, you can initiate an ACH transfer directly from your bank to EBC. This method also provides a secure and efficient way to manage your payments.

To enroll in auto-debit, please complete the **ACH Transaction Authorization Form**.

To access the ACH Transaction Authorization Form:

1. Log in to your [employer online account](#)
2. In the main menu, select *Forms and Materials* under Resources

FSA Reports

You can use the reports in your employer online account to stay up to date on the status of your plan, help participants manage their FSA, and perform your accounting tasks.

Downloading Reports

To download your reports:

1. Log in to your [employer online account](#)
2. In the main menu, click on *Reports* under Resources
3. Select FSA from the dropdown menu

When you access your reports, you may use the editing bar at the top of each report to perform a text search within the report, select an output format, and export the report. Some reports will also allow you to choose a date range for the report. Reports are updated four times a day and are available to export in several formats including CSV, Excel, HTML and PDF.

Enrolling Employees into the FSA

When an employee becomes eligible to participate in your FSA, complete the following steps:

- **Provide Plan Information**
Connect with your eligible employees and provide them with information about the plan. We recommend providing them with a copy of the plan's SPD and My Company Plan, as well as additional benefit information from the resources found in our [communication toolkits](#).
- **Share Details on Making Plan Elections**
Employees should make FSA elections before their effective start date in the plan. If their effective date starts within 30 days of their hire date, they have 30 days from their hire date to make an election. Let employees know that once they start participating in the plan, their elections cannot be changed unless a [permitted election change event \(PEC\)](#) occurs. If they choose *not* to participate in the FSA when they are first eligible, they won't be able to enroll in the FSA until the following plan year or until they experience a PEC.
- **Complete Enrollment**
Enroll new hires online as outlined below. Keep a copy of their enrollment information for your records.

Sole proprietors and partners of a partnership (including members of an LLP or LLC that is taxed as a partnership) may not participate in a flexible compensation 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 a flexible compensation plan, including its pre-tax premium payments.

Enrolling Employees Online

Enroll participants in your online account for a fast and convenient way of managing your participants.

To enroll your employees online:

1. Log in to your [employer online account](#)
2. Select *Enroll Participants* under the Manage Participants section of your main menu
3. Enter your employee's information
4. Choose FSA from the dropdown list and enter the plan information
5. Enter the financial account information

Note: If the employee has chosen direct deposit, enter their account information to have their reimbursements deposited in their financial institution's account

By enrolling your new hires online, their records are updated automatically.

Permitted Election Change Events

In general, participants can't change their FSA and flexible compensation plan elections after the start of the plan year, per IRS regulations. However, permitted election change (PEC) events allow participants to change their elections during the plan year. The rules may vary depending on the type of FSA you have, so it's important to consult your Plan Document for specific guidance.

Here are some important things to know about PEC events:

- **Consistency Requirement**

In many cases, the requested election change must be "consistent" with the PEC event. This means the change must directly relate to the event and affect eligibility for coverage.

- **Timing of Requests**

Generally, participants must request an election change within 30 days of the PEC event, unless your plan specifies a different time period. If the event involves a loss of eligibility or gain of a premium subsidy under Medicaid or a state children's health insurance program (CHIP), the timeframe must be at least 60 days.

- **Effective Date of Changes**

Most election changes must take effect prospectively (not retroactively). However, exceptions apply for events such as birth, adoption, or placement for adoption. Refer to your Plan Document for details. When an election becomes effective prospectively, it means:

- Participants that enroll mid-year following a PEC can only be reimbursed for expenses incurred after their election becomes effective.
- Increases to an FSA election apply only to expenses incurred after the change.
- If a participant decreases their FSA election, they only have access to the decreased election amount regardless of the date that the expense was incurred.
- If a participant revokes their FSA election, they will be treated the same as any other terminating participant. Please see the [Loss of Eligibility](#) section for more information.

- **Minimum Election Limits**

A participant cannot reduce an FSA election below the amount they have already contributed to the plan or less than the amount they have already been reimbursed for during the plan year.

- An exception to the general rules listed above exists for pre-tax HSA contributions. Employers must allow participants to change their HSA contribution amount at least once per month as long as the election change is prospective.

For more information about permitted election changes, review our [Annual Elections and Common Permitted Election Changes E-Book](#).

Leaves of Absence

Leaves of absence may affect a participant's eligibility under the plan, their elections, and how they pay for their benefits. The leave's impact depends on whether the leave is paid or unpaid, whether FMLA or USERRA applies, your company's leave policies, and more. **When an employee takes unpaid leave, submit a completed FSA Unpaid Leaves of Absence Form promptly to ensure their account is updated correctly.**

To download the FSA Unpaid Leaves of Absence form:

1. Log in to your [employer online account](#)
2. In the main menu, click on *Forms and Materials* under Resources
3. Select FSA from the dropdown menu

Paid Leave (FMLA and non-FMLA)

During a paid leave, the participant is treated as though they are still in active employment for FSA purposes. Their eligibility continues and therefore they typically cannot make changes to their FSA elections unless a [PEC event](#) occurs during their leave. Paid leaves may include paid time off (PTO), sick pay, vacation pay, short-term disability pay, and, in some cases, severance pay.

Unpaid FMLA Leave

This section applies to the health care FSA and does not apply to the dependent care FSA. You may handle your dependent care FSA according to the [Non-FMLA Unpaid Leave section](#) below.

When a health care FSA participant begins their unpaid FMLA leave, they should choose one of the following options:

- **Suspend the account during the unpaid FMLA leave**
Claims incurred during the unpaid FMLA leave are not reimbursable. When the participant returns to work after their leave, they choose to reinstate their coverage as follows:
 - **Prorate election upon return**
The participant will not make up missed deductions and their new election will be reduced by the missed deductions.
 - **Reinstate election upon return**
The participant's annual election amount will be the same as it was before they took leave. Their payroll deductions will increase upon returning from leave to make up for the missed deductions.
- **Keep the account active during the unpaid FMLA leave period**
Claims incurred during the unpaid FMLA leave are reimbursable. The participant may pay their FSA contributions using one of the following methods:
 - **Pre-Pay**
The participant pre-pays the FSA deductions they will miss during their leave through salary deduction. If the leave spans two plan years, you may treat the pre-payment for FSA coverage during the current plan as pre-tax. However, you must treat the pre-payment for FSA coverage during the next plan year as post-tax.
 - **Pay As You Go**
The participant will make periodic (usually monthly) payments on a post-tax basis to the employer while on leave. If the employee stops paying during their leave, the employer may use the catch up method to collect missed payments as described below, or they may terminate the coverage due to non-payment.

- **Catch Up**

The participant will make up their missed payroll deductions when they return from leave through salary deduction on a pre-tax basis.

- **Revoke the election and close the account for the rest of the plan year**

Only claims incurred prior to the unpaid FMLA leave will be reimbursable. The participant will have the mid-year plan termination runout period as reflected on your *My Company Plan* to submit those claims.

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 an unpaid FMLA leave transitions to an unpaid non-FMLA leave. What happens to FSA elections during a non-FMLA unpaid leave depends on whether the participating employee loses eligibility under the plan and your company's internal policies.

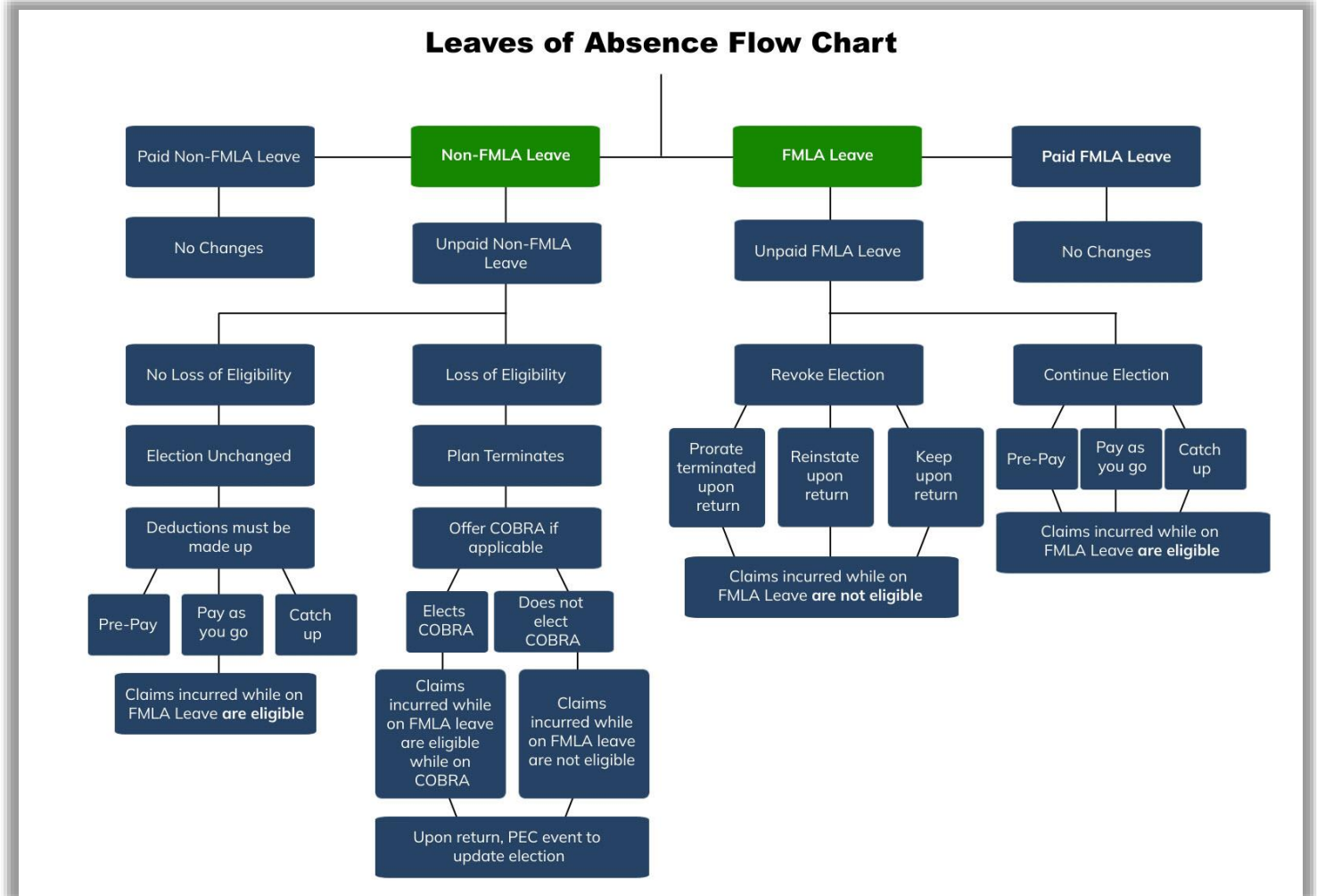
If the participant loses eligibility during their non-FMLA unpaid leave:

- Their participation in the FSA terminates.
- They can only be reimbursed for claims incurred prior to their termination.
- If COBRA applies to your FSA, the reduction in hours would be a COBRA qualifying event and you would offer COBRA due to the employee's reduction in hours unless the account was overspent.
- If the employee does not elect COBRA (or your company is not subject to COBRA), the employee can reactivate their benefits once they regain eligibility when they return from the unpaid leave so long as they request reactivation within 30 days of returning from their unpaid leave. If they reactivate their FSAs, their new election is for the whole plan year, and it must factor in their previous claims and payroll deductions. Because of this, a participant cannot request an FSA election which is less than the amount they have already contributed to the plan or less than the amount they have already been reimbursed for the plan year. The participant's FSA will only be eligible to reimburse expenses incurred prior to and after the leave, but not during the unpaid leave.

If the participant does not lose eligibility during their non-FMLA unpaid leave:

- They cannot change their health care FSA election unless they have another PEC event which allows them to do so.
- They can reduce or revoke their dependent care FSA election if their leave causes them to no longer have eligible dependent care expenses.
- Participants must pay their premiums according to your internal policies, which may include the Pre-Pay, Pay As You Go, and Catch Up options described above for FMLA leaves.

Leaves of Absence Flowchart



Uniformed Services Employment and Reemployment Rights Act (USERRA) Unpaid Leave

USERRA, also known as military leave, has COBRA-like provisions which protect health benefits for military service members. Participants on military leave can continue their FSA coverage for up to 24 months. For more details about the duration of FSA coverage during military leave, review your company's USERRA policy, talk with your employment counsel, or reach out to us.

Note: Qualified Reservists can elect to receive a distribution of unused amounts from their health care FSA if they meet specific criteria. This option is available to members of a reserve component who are ordered or called to duty for a period of 180 days or more, or for an indefinite period. To be eligible, the Reservist must request the distribution during the period that begins on the date of the order or call to active duty and ends on the last day of the plan year in which the order or call to active duty occurred.

Loss of Eligibility

Participants may lose FSA eligibility if their employment is terminated or their work hours are reduced. If a participant loses their FSA eligibility, you should stop their pre-tax contributions and notify us promptly. EBC is not responsible for any claims paid before we receive your notification. If the participant has a Benefits Card, we will suspend the card once we are notified of their loss of eligibility.

If you have an FSA eligibility file feed, please ensure changes are communicated to EBC through your file feed. If you do not have an FSA eligibility file feed, please terminate your participants through your online account.

To terminate your participants through your online account:

1. Log in to your [employer online account](#)
2. Select *Terminate Participants* under the *Manage Participants* section of your main menu
3. Enter the participant's last name or full SSN and click *Search*
4. Select the participant's name and check the box next to *Terminate Plan*
5. Enter the last day of coverage for the plan participant and the last payroll date in which you will be taking a deduction for the plan

If a participant loses their FSA eligibility, it's important to note the following.

Health Care FSA:

- Expenses incurred after the date of eligibility are not eligible for reimbursement unless the participant is eligible for and elects [COBRA](#).
- Participants can continue to submit claims for eligible expenses incurred before the loss of eligibility during the runout period identified in your My Company Plan.
- You may not recoup funds from the participant if their FSA is overspent due to the [Uniform Coverage Rule](#).
- If your company uses [Payroll Deduction Billing](#), any balance not claimed by the participant will be held in your account and returned to your company with any other [forfeitures](#) following the end of the plan year.

Dependent Care FSA:

- Eligible expenses incurred after the loss of eligibility can be reimbursed through the grace period, if applicable. This allows participants to spend down their remaining balance.
- Participants can continue to submit claims for expenses incurred before the loss of eligibility during the runout period identified in your My Company Plan.

Individual Premium FSA

- Expenses incurred after the date of eligibility are not eligible for reimbursement unless the participant is eligible for and elects [COBRA](#).
- Participants can continue to submit claims for eligible expenses incurred before the loss of eligibility during the runout period identified in your My Company Plan.

Termination and Rehire

If a terminated participant is rehired within 30 days, they are brought back on the plan as if they never left. However, they will need to make up any missed payroll deductions. Generally, if more than 30 days have passed, the participant

must wait until the next open enrollment period to re-enroll in any FSAs. Please review your Plan Document to determine the specific restrictions regarding terminations and rehires.

Health Care FSA Continuation Under COBRA

COBRA is a federal law requiring most companies to offer group health plan continuation when a participant terminates employment, when a participant reduces their hours and loses eligibility for the plan, and for certain other events.

Most health care FSAs are “excepted” and therefore qualify for special COBRA rules. A health care FSA is “excepted” if (1) employees eligible for the health care FSA are also eligible for the employer’s major medical plan, *and* (2) any employer contributions do not exceed the greater of \$500 or a dollar-for-dollar match of the employee’s contribution.

The following are special COBRA rules for excepted health care FSAs:

- If the health care FSA is **overspent** (i.e., the total amount that could be charged in COBRA premium through the end of the Plan Year is greater than the balance in the participant’s health care FSA as of the date of the qualifying event), **the participant does not need to be offered COBRA for the health care FSA**. If your plan has rollover, please see [Special Rollover Issues](#) below for more information.
- If the health care FSA is **underspent** (i.e., the total amount that could be charged in premiums through the end of the Plan Year is less than the balance in the participant’s account as of the date of the qualifying event), **COBRA only needs to be provided until the end of the current health care FSA plan year**. If your plan has rollover, please see the Special Rollover Issues below for more information.

If the health care FSA is a **non-excepted benefit**, COBRA must be offered to all health care FSA participants for the usual 18, 29, or 36-month continuation period.

Former participants who elect health care FSA continuation coverage under COBRA are able to submit expenses incurred during the active COBRA period for reimbursement. If COBRA terminates before the plan year ends, the health care FSA terminates on the last day of the last month of COBRA coverage.

Special Rollover Issues

When determining whether COBRA needs to be offered for an excepted health care FSA, rollover amounts should be included when determining the participant’s balance. Rollover amounts should not be included when calculating the COBRA premium.

If your plan requires a participant to make a new election to get rollover, a participant on COBRA will not get any rollover amounts because they can’t make an election for the new year for excepted benefits.

If your plan does not require a participant to make a new election to receive rollover, a participant on COBRA with a balance at the end of the plan year will stay in the FSA. They can use the remaining balance with no premium for the following plan year, just like active employees. They continue to have access to the rollover balance through the end of their COBRA coverage period.

Determining the COBRA Premium

If there are no employer contributions to the health care FSA, then the COBRA premium through the end of the Plan Year is simply the amount that the participant has not yet contributed to the plan plus a 2% COBRA administrative fee.

If your plan includes employer contributions, the calculation is more complex. To determine the COBRA premium through the end of the Plan Year, you will first need to determine how much of the annual employer contribution has been accrued on the date of the COBRA Qualifying Event. Your internal policy will determine how your employer contribution is accrued. Any portion of the employer contribution that has not yet been accrued will be added to the amount that the participant has not yet contributed to the plan. Then the 2% COBRA administrative fee is added to that amount.

The monthly COBRA amount is then determined from there. You may choose to split the COBRA premium through the end of the Plan Year evenly among the remaining months or offer a pro-rated COBRA amount for the month in which they lose coverage and then split the remainder evenly among the remaining months.

Alternative methods exist for determining COBRA FSA premiums for dependent events. If desired, you may explore other methods with your COBRA administrator or benefits advisor. If EBC is your COBRA administrator, please review your COBRA Answer Book for more information.

Please note that EBC is not responsible for determining the COBRA premium for your health care FSA.

Paying COBRA Premiums

In most cases, COBRA premiums are paid on an after-tax basis. If your company uses [Payroll Deduction Billing](#), we will continue billing and collecting deductions in the same manner as if the plan participant was still actively employed.

In the following rare cases, COBRA premiums may be paid on a pre-tax basis:

- If a health care FSA participant knows they will experience a loss in eligibility under the health care FSA in the future and wants to pay COBRA premiums pre-tax in advance of the event, you may permit them to do so. If a plan participant does this, please ensure that when you enter their Loss of Eligibility date that you are entering the last date of the last month of COBRA coverage that the individual has paid for.
- If the loss in eligibility under the health care FSA is due to a reduction in hours, the employee can request that deductions continue pre-tax through payroll to pay their COBRA premiums.

Loss of Eligibility

If a participant loses eligibility for the health care FSA and should be offered COBRA, you will need to inform your COBRA administrator.

When EBC Administers your COBRA

If we administer your COBRA and a participant loses eligibility for an FSA(s), follow the steps listed in the [Loss of Eligibility section](#) above. Then, go to the COBRA section of your online account and complete the *Add New QB Wizard* to generate the necessary COBRA paperwork. You will need to select the health care FSA along with any other plans the QB should be offered, and you will have to indicate the monthly rate. Detailed instructions on how to do this are available in the COBRA Answer Book, which is available in your online account.

EBC will terminate the QB's health care FSA when payment is not received or once the COBRA coverage period has ended, unless COBRA coverage is extended due to the plan not requiring a new election to receive rollover. In this case, you will need to complete the steps listed in the [Loss of Eligibility section](#) above once the QB's COBRA coverage period ends.

When EBC Does Not Administer your COBRA

If your participant loses eligibility for an FSA(s), follow the steps listed in the [Loss of Eligibility](#) section. Then, notify your COBRA administrator. Please notify EBC if a QB elects COBRA for the health care FSA so that we can reactivate their health care FSA.

If a QB's health care FSA should be terminated due to nonpayment or loss of COBRA eligibility, you should follow the steps listed in the [Loss of Eligibility](#) section.

If COBRA coverage for the health care FSA is extended because your plan does not require a new election to receive rollover, you will need to complete the steps listed in the [Loss of Eligibility](#) section once the QB's COBRA coverage period ends.

Nondiscrimination Testing

Nondiscrimination testing helps you ensure that your plan does not impermissibly favor highly compensated and key employees. Nondiscrimination is included with your flexible compensation plan service at no additional cost.

Each year, we will send you an email to ask you to complete and upload the Nondiscrimination Census Worksheet available in your online account. This worksheet provides us with your plan and employee information, which we use to complete the nondiscrimination testing on your plans. It is your responsibility to return the worksheet to ensure your plan's nondiscrimination testing is completed.

Visit our [Nondiscrimination Testing website](#) for frequently asked questions, instructions for testing, and information about test results.

Forfeitures

Under IRS rules, unused funds in a health care FSA at the end of the plan year or grace period must be forfeited to the plan, unless the plan includes a [rollover](#) provision. The forfeited amounts are known as plan forfeitures.

If you have [Payroll Deduction Billing](#), we generally return forfeitures shortly after your runout period ends, when we finalize FSA balances.

You can find your total forfeiture amount in your Account Summary Report, which is available the month following the end of your runout period. The net amount shown in the account balance column is your final forfeiture amount.

Health Care FSA Forfeitures

By law, health care FSA forfeitures **cannot** be returned to plan participants based on their individual claim experience. To remain compliant with applicable tax and benefits regulations, we recommend that you use your forfeitures in the following ways. We recommend you complete these steps in the order they are listed below.

1. **Offset Plan Year Losses**

Use forfeitures to offset any losses you experienced during the plan year as a result of providing reimbursements in excess of the amounts contributed through salary reductions.

2. **Cover Administration Costs**

Use remaining forfeitures to offset any eligible plan administration expenses, such as setup fees or monthly service fees.

3. **Allocate Remaining Funds**

Use any remaining forfeitures to enhance participant benefits (e.g. additional FSA amounts) on an equal or pro rata basis, return funds to participants on an equal or pro rata basis, or pay for plan administration costs in subsequent plan years*.

Note: If providing increased benefits or compensation, you must determine whether to allocate on an equal basis or on a pro rata basis (based on each participant's FSA election). You may not return the exact amount of funds remaining in an individual's account to that person.

4. **Special Considerations for Non-ERISA Plans**

Non-ERISA plans sponsored by state/local governments, churches, or church-controlled organizations should consult with legal counsel to determine whether local laws require special use of forfeitures.

**An equal basis typically means dividing the forfeitures equally among the plan participants in the plan year in which you receive the forfeitures. A pro rata basis typically means dividing the forfeitures among plan participants based on the ratio of each participant's health care FSA election to the total amount of health care FSA elections.*

Dependent Care FSA Forfeitures

By law, dependent care FSA forfeitures cannot be returned to the plan participant based on their individual claim experience. Dependent care FSA forfeitures should follow the same steps as health care FSAs above with the exception that dependent care FSA forfeitures can be retained by the employer since dependent care FSAs are not subject to ERISA.

Individual Premium FSA Forfeitures

By law, individual premium FSA forfeitures cannot be returned to the plan participant based on their individual claim experience. Individual premium FSA forfeitures should follow the same steps as health care FSAs above.

Grace Period, Rollover, and Runout

Your plan design likely contains grace period, rollover, and/or runout provisions. Each of these features is designed to help relieve the burden of having unused funds forfeited at the end of the plan year. See your My Company Plan document for your specific plan design.

Grace Period

A grace period is an additional period of time (typically 2 months and 15 days) following the end of the plan year where participants can incur claims.



Rollover

An FSA with rollover allows you to carry up to a specified amount of unused funds from one plan year to the next plan year. Rollover funds are not included in a participant's annual maximum contribution amount, so any funds rolled over will be in addition to their election amount for the new plan year.

The maximum amount eligible for rollover is adjusted each year by the IRS. For the current limit, visit www.ebcflex.com/PlanLimits.

You have two options for setting your plan's rollover maximum:

- **Set to the IRS statutory maximum:** This option automatically adjusts your plan's rollover limit each year based on IRS updates.
- **Set a fixed rollover:** This option allows you to choose a specific rollover maximum (e.g., \$500) that will stay the same from year to year unless you amend your plan.

Your rollover options include several design features, each with their own benefits and drawbacks. An overview of these features can be found below. For details on your plan's specific features, see your *My Company Plan*.

Note: You cannot have both a grace period and rollover for your health care FSA.

Standard Rollover

A health care FSA with a standard rollover allows participants to carry over unused funds to the new plan year without making a new election. If a participant has at least \$1 remaining in their health care FSA on the last day of the plan year, they will automatically be enrolled in the health care FSA in the new plan year with that balance.

The benefit of a standard rollover is:

- Participants with a remaining balance can keep their funds to use on future plan year expenses.

The drawbacks of a standard rollover are:

- Participants that are automatically enrolled in a standard health FSA in the new plan year due to rollover are generally ineligible to make HSA contributions for the entire new plan year.
Note: *Participants that spend their remaining FSA funds on prior plan year expenses by the end of the runout period can become eligible to contribute to an HSA starting the first day of the month following the end of that runout period.*
- Participants who are on COBRA on the last day of the plan year can continue the plan in the next plan year for no additional cost.
- Employers subject to COBRA must offer COBRA coverage at no cost to participants with accounts that only contain rollover dollars.
- Employers can forget to terminate the health care FSA for plan participants who only have accounts that contain rollover dollars since there are no current payroll deductions.
- Employers that are terminating a health care FSA for plan participants with accounts that contain only rollover dollars will need to contact EBC directly (outside of the file feed).

Require New Election Rollover

Your health care FSA can be designed so that health care FSA funds roll over to the new plan year only if the participants make a new plan election.

The benefits of this plan design are:

- Participants can be HSA-eligible on the first day of the new plan year (unless they actively elect to participate in a standard health FSA for the new plan year).
- Participants who are on COBRA on the last day of the plan year cannot continue the plan in the next plan year unless they make a new election in the new plan year (see the [COBRA section](#) for more information).
- Employers can rely on payroll deduction records to remind them to terminate the health care FSA.

The drawback of this plan design is:

- Participants with remaining balances will forfeit their funds if they choose to not make a new election in the new plan year.

Minimum Balance Rollover

Your health care FSA can be designed so that participants are required to meet a minimum rollover balance before funds can be rolled over from one plan year to the next.

The benefits of this plan design are:

- Participants with balances that exceed the minimum can retain their funds for future plan year expenses.
- Participants who are on COBRA on the last day of the plan year need to meet the minimum balance in order to continue COBRA for no additional cost in the upcoming plan year.

The drawbacks of a minimum balance are:

- Participants that are automatically enrolled in a standard health FSA in the new plan year due to rollover are generally ineligible to make HSA contributions for the entire new plan year.
Note: *Participants that spend their remaining FSA funds on prior plan year expenses by the end of the runout period can become eligible to contribute to an HSA starting the first day of the month following the end of that runout period.*

- Participants who are on COBRA on the last day of the plan year whose balance exceeds the minimum can continue the plan in the next plan year for no additional cost.
- Employers who are subject to COBRA must offer COBRA coverage at no cost to participants with accounts that only contain rollover dollars.
- Employers can forget to terminate the health care FSA for plan participants with accounts that only contain rollover dollars since there are no current payroll deductions.
- Employers that are terminating a health care FSA for plan participants with accounts that only contain rollover dollars will need to contact EBC directly (outside of the file feed).

FSA Plan Type Settings

For plans that support both a standard health FSA and a limited health FSA—and do **not** use the require new election feature—plan sponsors must decide how rollover amounts will be handled for participants who do **not** make an election for the next plan year. There are two available settings:

1. Same Plan Type

Under this setting, rollover amounts will carry over into the **same type** of health care FSA the participant had in the prior year. This means a standard health FSA will roll into a standard health FSA and a limited health FSA will roll into a limited health FSA.

Benefit:

- Participants can continue using the plan for the same types of expenses in the new plan year.

Drawback:

- Participants with a **standard health FSA** that contains only rollover dollars are generally **ineligible to contribute to an HSA** for the entire new plan year. However, if they spend all remaining funds on prior plan year expenses by the end of the runout period, they may become HSA-eligible starting the first day of the month following the end of that period.

2. Auto-Convert for HSA Eligibility

With this setting, rollover amounts automatically convert to a **limited health FSA** for participants who do not make a new election.

- If **EBC administers your HSA**, auto-conversion occurs when the participant enrolls in EBC's HSA for the new plan year.
- If you use a **different HSA administrator**, auto-conversion occurs when the participant does **not** make any health care FSA election for the new plan year.

Benefit:

- Participants can be **HSA-eligible on the first day** of the new plan year (unless they actively elect a standard health FSA).

Drawback:

- For plans with a different HSA administrator, participants who do not make a new election will have their rollover amounts moved into a **limited health FSA**, even if they do not intend to use one or contribute to an HSA.

Runout

A runout period is a specified amount of time following the end of your plan year where participants can still submit claims for eligible expenses incurred during the plan year and/or grace period (as applicable). The runout period for your company's plan design is found in your *My Company Plan*.

Runout and the Benefits Card

When the Benefits Card is used during the runout period, it will not reduce the prior year's FSA balance *even if the Benefits Card is used to pay for an expense incurred in the previous year*. Participants that are interested in reducing their prior year's FSA balance should submit online claims for expenses incurred in the previous year.

Runout and the Grace Period

When a participant incurs an expense during the grace period and submits a claim for reimbursement during the runout period, the claim is first applied to the prior year's FSA balance. Only after those funds are exhausted will claims be reimbursed from the new plan year's balance. Participants should submit claims from the previous year *before* they submit claims incurred during the grace period. Doing this ensures that participants don't exhaust their prior year's balance on expenses incurred during the grace period.

For example, assume a participant has a \$500 FSA balance on December 31. The participant incurred \$500 worth of pre-surgery claims in December but did not submit them for reimbursement. The participant then has surgery during their grace period in January and submits their surgery claim for reimbursement, reducing their previous year's FSA balance to \$0. If the participant were to try and submit their pre-surgery claim, it would be denied because their previous year's FSA balance was used on their surgery expenses. If the participant had submitted the pre-surgery claims first, the FSA balance would have been reduced to \$0 by the pre-surgery claims, and the participant could apply their surgery claim to the new plan year's balance and have it reimbursed.

Therefore, you should encourage participants to wait until they have been reimbursed for all prior year expenses before submitting claims (or using the Benefits Card) for expenses incurred during the grace period.

Runout and Rollover

Although the runout period is not affected by rollover, claims submitted for prior plan year expenses during the runout period can eliminate or reduce the amount of their rollover. Rollover amounts, therefore, are not final until after your plan's runout period is over.

Forms 5500

Plan sponsors of ERISA plans* are responsible for filing Forms 5500 as applicable for their employee benefit plans. If our records indicate that you are an ERISA plan sponsor and that you have 100 or more participants in your health care FSA at the start of the plan year, we prepare the electronic Form 5500 for your review and signature unless:

- It is reasonable to conclude the health care FSA is part of a wrap plan based on information provided by your company or your company's previous Form 5500 filing history;
- We prepared a Form 5500 for the health care FSA for the prior plan year and your company did not file the form 5500 that we prepared; or
- You have directed us not to prepare a Form 5500 for the health care FSA.

We will send you an email in advance of the Form 5500 filing deadline, which is seven months after the end of the plan year (e.g., July 31 for a calendar year plan), to explain the next steps in the Form 5500 process for your health care FSA. The primary contact at your organization may electronically sign and submit the Form 5500. If another designee is responsible for signing and submitting the Form 5500, please inform your Client Account Representative. In order for your company to sign a Form 5500 for your health care FSA, the person signing will need their own signing credentials. If the person signing does not already have Form 5500 signing credentials, instructions for obtaining credentials can be found here: <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/efast2-credentials> (if this site is unavailable, we recommend searching the Internet for "EFAST2 credentials").

**If your company is a governmental entity or a church-controlled organization, you are exempt from Form 5500 filing requirements.*

Summary Annual Report

Employers that are required to file a Form 5500 must provide plan participants with a summary annual report (SAR), which is a summary of the information contained in the Form 5500. The SAR must be provided within 9 months of the close of the plan year. EBC creates and provides SARs to employers when we create the Form 5500 for health care FSAs. The employer is responsible for distributing the SAR to plan participants.

Schedule C Requests

If your company files a Form 5500 for a wrap plan, you may determine that you need a Schedule C from EBC for the health care FSA. Please note we cannot make this determination for your company. Please reach out to your Client Account Representative if you require Schedule C information to file a Form 5500 for your wrap plan.

Informing EBC of Changes

Please contact us if you experience any of the following changes: a contact information change, banking change, employer information change, plan change, and/or a merger and acquisition.

Contact Changes (includes Broker Contact Changes)

Complete an Update Contacts Form to add or remove contacts, change a contact's permissions, or update a contact's information. Be sure to complete this form as soon as possible when a contact with permission to view personal information for plan participants leaves so that we can quickly deactivate their login and remove their access to sensitive personal information. To find the form:

1. Log in to your [employer online account](#)
2. Select *Forms and Materials* in the main menu
3. Download the *Update Contacts Form* in the *Employer Administration Documents* section
4. Email the completed form to your Client Account Representative

To identify the current contacts on your account with EBC:

1. Log in to your [employer online account](#)
2. Select *View Account Settings* in the main menu
3. Review your list of contacts, their contact type, and whether they are able to receive or view PHI
4. View the contact details we have for the individual by selecting *View Contact Details*

Banking Changes

Complete an ACH Transaction Authorization Form to add, remove, or change your banking information to pay fees or claims funding. To find the form:

1. Log in to your [employer online account](#)
2. Select *Forms and Materials* in the main menu
3. Download the *ACH Transaction Authorization Form* in the *Employer Administration Documents* section

Employer Changes

Complete an Update Employer Information Form to change your company's legal name, FEIN, address, and phone number so that your plan documents contain accurate information. To find the form:

1. Log in to your [employer online account](#)
2. Select *Forms and Materials* in the main menu
3. Download the *Update Employer Information Form* in the *Employer Administration Documents* section

Plan Changes

Notify your Client Account Representative about changes to your FSA(s) and/or flexible compensation plan. Plan changes that occur mid-year are subject to a \$50 fee. Plan changes include (but are not limited to) changing plan years, adding pre-tax HSA contributions, changing the FSA design, adding or changing employer contributions, adding or changing cash-in-lieu provisions, and more. Most plan changes require completion of a plan amendment form that details the plan changes.

Mergers & Acquisitions

When you know your company is going to be involved in a business transaction like a merger or acquisition, notify your Client Account Representative so that we can provide options for your plan administration.

Renewal

During your plan renewal, you will need to complete the following:

- Communicate plan changes to EBC and amend your plan as appropriate
- Confirm with EBC that you want to continue services for the next plan year
- Communicate the plan to your employees
- Sign updated plan documents (if applicable)
- Distribute plan materials to your employees

We've put together the following steps to guide you through your plan renewal.

Step 1: Receive and Review the Renewal Email Communication

EBC will send you an email 90-120 days prior to your plan's renewal date. The email contains information about:

- Activating your plan for the next plan year
- Verifying your payroll schedule for the next plan year if you have an FSA
- Educating your employees using materials provided by EBC
- Enrolling employees in the FSA
- Signing your plan document for compliance purposes
- Distributing plan materials to your participants
- Reviewing your authorized PHI users (i.e., people you authorize to receive personal information related to your plan participants)
- And more!

Step 2: Identify Necessary Updates to Your Plan

The following are examples of benefit changes that may require updates to your plan:

- **Offering an HSA:** If you offer a health care FSA and want to add an HSA to your benefit plan, you will most likely need to update your health care FSA plan design and your flexible compensation plan documents. It's important to note that when adding an HSA to your benefit plan, timing plays a significant role. Most updates to your design and documents can be made for the following plan year, but some updates must be made for the current plan year. The chart below shows which amendments should be made for the current and following plan years:

Amendments to the current plan year	Amendments to the following plan year
Remove the grace period (if applicable)	Add an HSA-compatible limited health FSA
Add/update rollover provisions so rollover is HSA-compatible	Add pre-tax HSA contributions to your flexible compensation plan
	Remove a standard health FSA

- **Changing your medical insurance renewal date:** If you change your medical insurance renewal date, we recommend you amend your flexible compensation plan document accordingly and consider whether you want to also adjust the plan year for your FSA.

- **Changing the waiting period on your medical insurance:** To continue maintaining a non-excepted health care FSA, ensure that the waiting period on your medical insurance is no longer than the waiting period for your health care FSA. This may require amending the eligibility provisions for your health care FSA.
- **Adding or removing benefits with pre-tax premiums:** We recommend you update your flexible compensation plan document to contain an accurate list of benefits with pre-tax premiums.
- **Adding/removing/updating FSA(s):** If you'd like to make changes to your FSA, you will need to notify EBC and make amendments to your flexible compensation plan. Examples of changes include adding a new FSA, eliminating an FSA, changing the FSA minimum or maximum contribution amount, changing the plan year, changing the runout period, changing grace period or rollover provisions, changing eligibility requirements, and more.
- **Adding/removing/updating employer contributions:** Any changes to employer contributions will need to be updated in your flexible compensation plan documents.
- **Adding/removing/updating cash-in-lieu provisions:** Any changes to cash-in-lieu provisions will need to be updated in your flexible compensation plan documents.

Step 3: Determine How Updates Will Be Made

Many updates can be made when you use the *Active BESTflex Plan Online* feature in your online account during the renewal process. If you'd like to make an update to your plan that isn't covered in the online renewal process, reach out to your Client Account Representative for more information.

Step 4: Choose Your Open Enrollment Period

Once you have confirmed any changes to the current plan design and if anything will be changing for your upcoming plan year, you will want to choose an open enrollment period for your FSA. This usually will be the same open enrollment period for your other pre-tax benefits. When deciding on your open enrollment period, please keep in mind that FSA elections for the new plan year must be made prior to the first date of the new plan year.

Step 5: Complete Online Renewal

Complete your renewal with EBC by using the *Activate BESTflex Plan Online* feature in your online account. This online renewal feature is available up to 14 days prior to your renewal and lets you set up online enrollment, easily edit your payroll dates, and make select changes to your plan design.

Step 6: Enter Employees' FSA Elections

Submit your employees' FSA elections using one of the following methods: our online enrollment system, the express renew tool, or by uploading a participant data spreadsheet.

Online Enrollment

If you choose online enrollment, your employees can make their FSA elections online. Once they have made their FSA elections, an employer contact must review and approve the elections. The participants will then be enrolled with the approved election amounts.

To implement online enrollment, complete the following steps.

1. Log in to your [employer online account](#)
2. Select *Activate BESTflex Plan Participants* in the *Renewal Activities* section of the main menu

Express Renew

Express Renew lets you manage your employees' entire renewal process online. You can renew all your employees in one visit or over multiple sessions. 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.

To access Express Renew, complete the following steps.

1. Log in to your [employer online account](#)
2. Select *Renew BESTflex Plan Participants* in the main menu
3. Review your list of existing participants, indicate whether they elected in the upcoming year and, if so, enter their election(s)

Spreadsheet Submission

To access the Participant Data Spreadsheet, complete the following steps.

1. Log in to your [employer online account](#)
2. Select *Forms and Materials* in the main menu
3. The Participant Data Spreadsheet is located in the *Getting Started with Open Enrollment* section

Once you have completed the spreadsheet, please save the file and upload it to your online account. You can upload the spreadsheet using the Upload File feature available in the main menu of your online account.

You will receive confirmation once your Participant Data Spreadsheet has been processed.

Step 7: Distribute Plan Materials to Participants

To maintain compliance with ERISA, it is recommended that you distribute plan materials to participants in a timely manner. Employees who elect to participate in your FSA(s) should receive the current SPD along with the My Company Plan appendix.

The SPD for the new plan year becomes available on the first date of that plan year. The updated My Company Plan appendix is available up to 120 days before the start of the new plan year.

Your SPD will be updated annually to reflect any plan changes, legal updates, or improvement for clarity. For this reason, we recommend distributing the SPD to FSA plan participants each year.

You may distribute SPDs electronically if permitted by ERISA. Otherwise, you can distribute them in paper form. For more information, see the [Guidelines for Distributing ERISA-Required Documents](#).

Plan Compatibility

Participants can maximize their savings by pairing their FSA with an HSA or HRA. As the employer, you are responsible for updating your flexible compensation plan to allow for pre-tax employee HSA contributions and employer contributions. Please reference the [Informing EBC of Changes](#) section for instructions on how to update your plan.

Limited Health FSA and HSA Eligibility

Participants can maximize their savings by contributing to both a limited health FSA and HSA through EBC. The Benefits Card can be loaded with both balances. To ensure participants maximize their savings potential, the Benefits Card will automatically draw funds from the limited health FSA first for any eligible dental and vision expenses that the participant has throughout the year, since any unused funds in this account will be forfeited at the end of the year.

If the participant still has any eligible dental and vision expenses after all of the limited health FSA funds have been used, the Benefits Card will automatically start drawing funds from the HSA. The Benefits Card will also automatically draw funds from the HSA for any medical expenses.

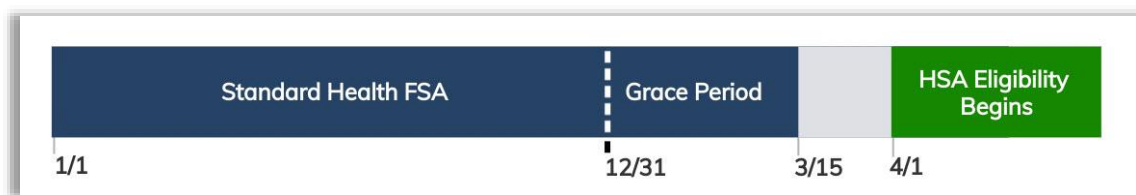
Standard Health FSA and HSA Eligibility

Participants cannot be enrolled in a standard health FSA *and* an HSA in the same plan year. Because of this standard health FSAs with grace period or rollover can delay or prevent a participant from being HSA-eligible in their upcoming plan year.

Standard Health FSA with Grace Period

If your health care FSA has a grace period feature, and a participant has unused health care FSA funds on the last day of the plan year, the participant will be unable to make or receive contributions to their HSA until the month following the end of the grace period.

For calendar year plans, the earliest that a participant with funds in their health care FSA on December 31 would be eligible to contribute to their HSA would be the following April 1st, as shown below.



Participants who are interested in a seamless transition from a plan year with a standard health FSA to a new plan year with an HSA must have a \$0 balance* in their standard health FSA on the last day of the prior plan year.

Standard Health FSA with Rollover

If your health care FSA has a rollover feature, a participant will be unable to make or receive contributions to their HSA for the entire following plan year *unless*:

- The participant had a \$0 balance* in their standard health FSA on the last day of the prior plan year.
- The participant submits claims for prior year expenses by the end of the prior plan year's runout period and does not use their Benefits Card during the runout period (HSA eligibility would begin on the first day of the month following the end of the runout period).

- The participant elected a limited health FSA for the new plan year.
- Your plan has the Require New Election rollover feature.**
- Your plan has the Minimum Balance rollover feature and the participant has a balance less than the minimum balance.**
- Your plan has auto-convert set up.**

**The account balance in the standard health FSA must be \$0 at the end of the business day on the last business day of the plan year. Claims that are in house waiting to be processed, claims in the system pending payment, Benefits Card transactions that are in transit or waiting for additional documentation are not taken into consideration. The account balance truly must be \$0 and not waiting to be paid to bring it down to \$0. The only way to ensure account balances are \$0 is to get claims in early.*

***See the [Grace Period, Rollover, and Runout](#) section for more details about these plan features.*

FSAs and HRAs

At EBC, if you have an FSA and HRA, your plans will have a product linking feature that allows your participants to submit one claim and have the expense be correctly reimbursed from the HRA and health care FSA. When a participant submits a request for reimbursement, the eligible amounts are paid first from the 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 HRA claims are electronically received from the insurance company, employees can select an automatic option.

Additional Compliance Notes

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy and security of certain health information maintained by group health plans, including health care FSAs. EBC supports HIPAA compliance for health care FSAs as follows:

- EBC's FSA Service Agreement contains a Business Associate Agreement (BAA) that requires EBC to comply with HIPAA's privacy and security standards for business associates.
- EBC provides you with a template Notice of Privacy Practices (NPP). It is available for download in your online account. If you choose to use the template NPP, you will need to customize it as indicated and distribute it to your plan participants at least once every three years unless a change to your privacy practices occurs earlier.
- EBC's standard plan documents contain HIPAA-specific provisions.

ERISA

Private sector employers are subject to the Employee Retirement Income Security Act (ERISA). Public sector employers (e.g., school districts, governmental entities) and church-controlled entities are not subject to ERISA. If an organization is subject to ERISA and sponsors a health care FSA, the health care FSA is an ERISA plan. EBC supports ERISA compliance for health care FSAs as follows:

- EBC provides a flexible compensation plan document that contains health care FSA plan details. It can be found in your company's online account as described earlier in this guide.
- EBC provides a summary plan description (SPD) and My Company Plan. It can be found in the online accounts for your company and its participants. **EBC does not mail or email the SPD and My Company Plan to your company's plan participants.** For information about how you can furnish the SPD and My Company Plan to your plan participants, see the [Guidelines for Distributing ERISA-Required Documents](#).
- EBC provides [Form 5500 services](#) as described earlier in this guide.
- EBC follows ERISA's claim and appeals procedures.

Tax Reporting

We recommend that you confirm with your payroll team or vendor that they are correctly reporting benefits and deductions under the flexible compensation plan. For example:

- Each participant's gross salary is reduced by the total amount that they had deducted for their group insurance premiums, FSA, and other flexible compensation plan benefits.
- Any dollar amount that was set aside in the dependent care FSA must be recorded in Box 10 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 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.

EBC does not provide tax advice or perform tax reporting for companies.