isolved Benefit Services

Benefits Administration Users Guide

Contents

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COBRA Notice Administration

Welcome to expert COBRA Notice Administration with isolved Benefit Services. After receiving your contract, an Account Implementation Specialist will:

1. Gather missing information along with data on your group health plans (medical, dental, vision, flex, EAP and others. Life, long-term disability and short-term disability are not offered under COBRA and will not be requested).
2. Work with you to determine if you have individuals on COBRA we should begin to bill for COBRA coverage.
3. Set up contacts and provide introductory information with login credentials to Isolved Benefit Services website.
4. Have an Account Manager contact you to schedule your online training session.

After these important steps, the ongoing phase of your COBRA Notice Administration will begin**.**

COBRA Online (web-based)

With convenient online reporting, you can report your COBRA activity from anywhere, at any time.

- New Enrollees: You must report people once they have been added to your group health plan so isolved Benefit Services can send the General Notice of COBRA Rights and Responsibilities. Report these enrollees within 90 days of coverage becoming effective.

- Qualifying Events: You must report people who have lost coverage due to a qualifying event so isolved Benefit Services can send the Qualifying Event Notice. Report these people within 30 days of the event. Due to independent election rights, please be sure to offer all available options.

- Reports: A variety of reports are available for your convenience through COBRA Online. You must review these on a regular basis. We strongly recommend auditing these reports against the billing statement from your carrier, to make sure all new additions have been sent a General Notice, and those removed were sent a Qualifying Event Notice. All information contained in the reports is considered correct unless you notify isolved Benefit Services. Selected reports will also be sent by isolved Benefit Services on a periodic basis for your immediate review.

Your reporting responsibilities include:

- General Notice Blanket Mailing (also conducted by isolved Benefit Services for a nominal charge)
- Reporting New Insurance Enrollees, Qualifying Events and COBRA Extensions (report extension by phone)
- Auditing reports and reporting errors to isolved Benefit Services within 30 days
- Communication to carriers/insurers to add/delete members (at time of hire, qualifying event, reinstatement for COBRA and COBRA termination)
- Auditing and reconciliation of all carrier/insurer reports and statements
- Premium Collection clients must report carrier plan and rates changes to isolved Benefit Services
- Reporting the Notice of Unavailability to isolved Benefit Services by phone

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isolved Benefit Services responsibilities include:

- Generate the General Notice upon receipt of New Enrollee information
- Generate the Qualifying Event Notice upon receipt of qualifying event information
- Generate the COBRA Notice of Unavailability when reported to isolved Benefit Services
- Generate COBRA Extension Notices when reported
- Generate the Conversion and Expiration Notices near the end of COBRA coverage
- Generate the COBRA Termination Notice if COBRA terminates prior to the end of the coverage period
- Tracking of all applicable dates for Qualified Beneficiaries for compliance
- Generate periodic reports for auditing
- Accept and adjudicate COBRA elections and payments
- Provide phone and web-based support for COBRA Qualified Beneficiaries (for Premium Collection clients only)
- Maintain and update COBRA notices and compliance procedures
- Complete and accurate disclosure
- Update you when your procedures must be changed

Reports

isolved Benefit Services will provide the following reports to the parties you designate:

- COBRA Notices Mailed Report: This report is a summary of notices mailed during the period listed on the report. This report must be compared to your insurance billing statement and errors must be reported to isolved Benefit Services within 14 days.

- Daily Status Change: This report notes changes you must communicate to your carrier (new Continuees to add, COBRA terminations to delete, plan changes, etc.). **This report requires your immediate action.** Failure to respond to this report could prevent a Qualified Beneficiary from receiving needed medical care or medication.

- Participant Status Report: This monthly report is a statement of those who terminated during the period, new Continuees added during the period and those who still have time to elect COBRA. For Continuees on COBRA, a paid-through date is provided.

- Premium Remittance Report: Your premium remittance check will be based upon the information in this monthly report. When audited regularly, this report, used in conjunction with the Daily Status Change Report and the Participant Status Report, will prevent you from leaving someone on the plan mistakenly. This report should also be audited against your insurance billing statement every month.

Note: isolved Benefit Services will provide reports to parties you designate, including your carriers. However, your carrier may not be contractually obligated to act in response to these reports, thereby possibly leaving you responsible for any errors or omissions on the carrier's part.

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Opting out of Premium Collection

If you opt out of the Premium Collection portion of the COBRA Notice Administration, you will have some additional responsibilities:

- COBRA Continuees: You will need to report COBRA Continuees to isolved Benefit Services once the qualified beneficiary has elected and made complete retroactive premium payment towards their COBRA coverage within the proper time frames and you have reinstated them back onto the plan. isolved Benefit Services will continue to track them and send out the required additional notices until COBRA coverage expires, or until you report their termination to us.

- COBRA Terminations: Report COBRA Terminations to isolved Benefit Services after all applicable time frames are exhausted. If this is not reported, isolved Benefit Services cannot generate the required termination notice for you. If a Continuee terminates all coverage, the Conversion Notice is not required and will not be sent.

What you Should Know About COBRA

This supplement contains explanations of the following topics:

1. The Basics
2. Time Frames
3. Medicare Entitlement
4. Extensions
5. COBRA Terminating Events
6. Premiums

The information contained in this section is designed as an overview only. Many COBRA situations are unique and may require in-depth analysis. As part of your service, you have unlimited access to the nation's foremost COBRA experts. Expert assistance and more detailed information are available by calling your Customer Service Team at 866-320-3040.

Throughout this supplement, references to other relevant sections are shown in **red** text.

Forms and literature that are available to you are shown in boxes.

The Basics

The COBRA law requires the following of most employers with 20 or more employees:

General Notice of COBRA Rights: A General Notice of COBRA Rights must be sent to the employee, spouse and/or dependents (if any), within 90 days of commencement of coverage under your group health plan.

Qualifying Event Notice: When a qualifying event occurs and causes the employee, spouse and/or dependents to lose coverage, a COBRA Qualifying Event Notice must be sent. The 1999 Final IRS Regulations clarified a loss of coverage would also include any increase in premium or contribution that must

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be paid by a covered employee (or spouse or dependent child of a covered employee) as a result of a qualifying event.

COBRA Event Notice and Procedure: This also needs to be described in the SPD. Refer to **Time Frames** and **Medicare Entitlement**.

Remember this equation: **Event + Loss of Coverage = COBRA Qualifying Event**

If an event occurs without a loss of coverage, or vice versa, it is generally not a qualifying event for COBRA purposes. For example, an employee who removes himself or family members voluntarily from the group health plan does not experience a COBRA Qualifying Event. However, if the removal was in anticipation of an event (most often, divorce or legal separation), COBRA may still have to be offered. Call Customer Service at 866-320-3040. Refer to **The Voluntary Removal Form** and **Anticipated Event Notification Form.**

Notice of the Right to Convert: A Notice of the Right to Convert (Conversion Notice) must be sent to Continuees within the last 180 days of COBRA coverage, if your health plans have a conversion option. Refer to **Time Frames, Premiums** and **Extensions**.

Notice of Open Enrollment/Rate & Plan Change: As required by ERISA, when your plan goes through a change, including rates, carrier change, plan year, coverage period or open enrollment you must notify Possible Electees, Electees and Continuees of the changes and their rights during these periods. (Qualified Beneficiaries have the same rights as similarly situated non-COBRA beneficiaries, under the same terms and conditions.) A notice is available from isolved Benefit Services to assist you in these areas. For assistance, please call your Customer Service Team at 866-320-3040. Refer to **Important Insurance Notification.**

Additionally, isolved Benefit Services recommends the following for a complete compliance program:

Extension Notice: If a Continuee experiences a Secondary Event or is deemed disabled by the Social Security Administration, he may be entitled to extend his COBRA coverage. isolved Benefit Services recommends that an Extension Notice be sent. Please contact isolved Benefit Services to report this information and process an Extension Form over the phone. Refer to **Time Frames, Premiums, Extensions** and **Medicare Entitlement.**

Time Frames

Outlined below are the time frames to which you are subject under the COBRA law. *Some of these time frames are maximums, some are minimums.* Under certain circumstances, COBRA time frames could be extended
beyond those listed. For further information in this area, please call isolved Benefit Services and request information on the following two COBRA lawsuits:

Kerr v. Chicago Transit Authority (CTA)
Sirkin v. Phillips Colleges, Inc.

1. Your company and all its locations have a maximum of 30 days from the event date to report qualifying events to isolved Benefit Services. Due to independent election rights, please be sure to offer all available options. NOTE: You have 30 days from the event date, *not the loss of coverage date.*

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Optional Qualifying Event Date Rule (OBRA 89): OBRA of 1989 amended COBRA to allow an employer to choose an optional extension of COBRA's time frames. This provision allows employers to use the loss of coverage date as the date of the Qualifying Event. **This means that a participant would receive 18, 29 or 36 months from the Loss of Coverage date instead of the Event date.** Though this OBRA provision is listed as an OPTIONAL provision, you should consider that you may set a precedent by applying it, whereby you may have to apply it in all similar situations. The other consideration regarding this OBRA provision is **checking with your carrier BEFORE you use it.** Since it is an *optional* provision and not a strict requirement under COBRA, your carrier may not have to allow the extra COBRA coverage under this provision.

2. Qualified Beneficiaries must be given a *minimum* of 60 days (from the later of the Loss of Coverage Date or the date the notice is mailed) to elect COBRA coverage.

3. According to COBRA statute, once a Qualified Beneficiary elects, he has a minimum of 45 days from the date of election to make the retroactive premium payment. This premium may be made in monthly increments. Refer to **Premiums.**

4. On each monthly premium, you must allow a *minimum* 30-day grace period from the due date (longer if the employer or active employees have a longer grace period).

5. The maximum COBRA Qualifying Events coverage periods are listed below:

36 months	**18 months**
Death of the employee	Employee's reduction of hours
Divorce or legal separation	Employee's voluntary termination
Employee's Medicare entitlement	Employee's involuntary termination
Dependent child ceasing to be a dependent child	

Bankruptcy of the employer (Title XI, U.S. Code). This provision applies generally to retirees. Please contact your legal counsel for additional assistance. Please contact Customer Service at 866-320-3040 for assistance in reporting these events.

Medicare entitlement

Medicare entitlement can be a COBRA Qualifying Event, a Secondary Event for a spouse and/or dependents (if any) or a COBRA Terminating Event. Each is explained in detail below.

Qualifying Event: The employee's Medicare entitlement can allow a spouse and/or dependents up to 36 months of COBRA coverage as follows:

1. Does the employee's Medicare entitlement alone cause the spouse and/or dependents to lose coverage? In other words, if the terms of your plan state that if John T. Employee becomes entitled to Medicare neither he nor his family is eligible for your plan.

2. If the Medicare entitlement itself does not cause a loss of coverage, you will need to wait for an event that does cause a loss of coverage. For example, if John T. Employee is entitled to Medicare, but continues to be eligible for your plan as long as he is actively at work, he and his family will not experience a loss of coverage until another event occurs.

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To report this event to isolved Benefit Services, determine what event caused the loss of coverage. If the event is death of the employee, divorce or legal separation or a dependent child ceasing to be a dependent child, 36 months of COBRA should be offered due to that event. If the event was termination or reduction of hours, the employee should receive 18 months of COBRA coverage measured from the date of termination or reduction of hours. The spouse and/or dependents should receive 36 months of COBRA coverage measured from the Medicare entitlement date **or** 18 months from the date of termination or reduction of hours, whichever is longer.

If 36 months is longer, or you would like further information in this area, please call your Customer Service Specialist at 866-320-3040.

3. If a family is already on COBRA coverage due to a termination or a reduction of hours, the employee's Medicare entitlement during this period could result in two occurrences:

    a. The termination of the employee's COBRA coverage.
    b. An extension for the spouse and/or dependents. Note: The employees Medicare entitlement can only be an extension if it would have caused a loss of coverage as an active employee. Refer to **Extensions** and **Terminating Events.**

Extensions

If a Continuee is on COBRA coverage due to a termination or reduction of hours, the original 18 months of COBRA coverage can be extended if a Secondary Event occurs or if an individual is deemed disabled by the Social Security Administration.

Secondary Events: If, during the 18-month COBRA period, another Qualifying Event occurs (death, divorce or legal separation, the employee's Medicare entitlement or a dependent child ceasing to be a dependent child), the original 18 months can be extended to 36 months (from the date of the original Qualifying Event). To report a Secondary Event to isolved Benefit Services, call a Customer Service Specialist at 800-300-3838.

Disability: If an individual is on COBRA coverage due to a termination or reduction of hours, all Qualified Beneficiaries may be eligible to extend their COBRA coverage up to 29 months if **ALL** of the following criteria are met:

A. The disability is deemed under Title II or Title XVI of the Social Security Act.
B. The disability began any time before the 60th day following the Qualifying Event.
C. The disability determination is reported to the employer within 60 days of the later of:

    1. The date of disability by SSA.
    2. The date of the qualifying event.
    3. The loss of coverage date.
    4. The date the Qualified Beneficiary is informed of their responsibility to notify the employer/plan administrator of this information.

D. The disability determination is reported to the employer before the end of the 18-month COBRA period.

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During months 19 through 29, the employer may charge up to 150% of the applicable group health premium for this coverage if the disabled Continuee is a part of the coverage extension. If the Continuee is deemed no longer disabled, the employer must be notified within 30 days of that determination. All Qualified Beneficiaries would no longer be eligible for the 11-month extension of coverage.

If you have a disability extension to report, please call a Customer Service Specialist at 866-320-3040. Refer to **Terminating Events.**

COBRA's Terminating Events

Under COBRA, there are ONLY five reasons for which COBRA coverage can be cancelled prior to the end of the maximum coverage period.

1. Medicare entitlement: An individual's COBRA coverage will terminate the date on which a Continuee becomes, after the date of election, entitled to Medicare. Refer to "Extensions" or "Medicare Entitlement" if the employee's Medicare entitlement is a Secondary Event for the spouse or dependents.

2. Nonpayment: If a COBRA premium is not paid in a timely manner and the proper grace period has been allowed, COBRA coverage may be cancelled. Refer to **Time Frames.**

3. End of all plans: If the employer ceases all group health plans, COBRA coverage may be cancelled.

4. Other coverage: If, after the date of election, an individual becomes covered under another group health plan.

5. Deemed no longer disabled: If an individual received the 11-month disability extension and is later deemed no longer disabled, the 11-month extension no longer applies.

The coverage of a Continuee receiving COBRA can be terminated by the group health plan for cause on the same basis that a plan terminates for cause the coverage of a similarly situated non-COBRA beneficiary.

Request for cancellation is not a listed terminating event. isolved Benefit Services suggests allowing the grace period to lapse, which gives the Continuee time to make payment, if necessary. If no payment is made by the grace date, coverage can be cancelled due to nonpayment.

Premiums

There is little formal guidance on COBRA premiums. Listed below is the information the IRS has provided to date.

- For 18- and 36-month events, the employer may charge up to 102% of the applicable group health premium.

- For the 11-month disability extension, up to 150% of the applicable premium may be charged during months 19 through 29, if the disabled Qualified Beneficiary is a part of the coverage extension.

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- The 1999 Final Regulations established guidelines for premium payments that are short by an insignificant amount. Either the plan must treat the payment as full payment or it must notify the Continuee of the amount of the deficiency to be paid and grant the beneficiary a reasonable period of time to pay the remaining amount. An insignificant premium underpayment is the lesser of 10% or $50. A 30-day grace period must be allowed for the Continuee to pay this amount. Refer to **1999 Final Regulations** and **2001 Final Regulations.**

When a Qualified Beneficiary elects COBRA coverage:

- A Qualified Beneficiary is allowed 45 days from the date of election to pay the premiums due from the Loss of Coverage Date (retroactive premium). Qualified Beneficiaries cannot be forced to pay any sooner than 45 days after the election. COBRA premiums may be paid in monthly increments.

- The IRS has issued a ruling that states you should not charge any single Qualified Beneficiary a family rate (in a two-tier plan). If you have questions about this ruling, please contact a Customer Response Specialist.

FSA Administration

Getting Started

Welcome to Flexible Spending Account Administration with isolved Benefit Services. After receiving your contract and plan design worksheet, one of our Account Setup Specialists will:

- Conduct a business call. During this call, we go over the process and any additional information that was missed on the Plan Design Worksheet. **Plan design worksheet, banking authorization, contract and payment are required before your setup process will begin.**
- Discuss funding arrangements.
- Explain the debit card process if you elect to receive this service.
- Determine who should receive our periodic reports.
- Establish and proof your account.

Upon the completion of your setup, one of our Account Setup Specialists will:

- Send you a confirmation report of the enrollments we have entered.
- Send a Welcome Letter to all of your participants.

After these two important steps, the ongoing phase of your Flexible Spending Account Administration will begin.

Your Responsibilities

Your responsibilities prior to the effective date of your plan include:

- Design your plan
- Have your Board of Directors (or equivalent) adopt the plan prior to the beginning of the plan year
- Conduct enrollment meetings (also available for additional fees from isolved Benefit Services) and forward enrollment information to isolved Benefit Services. Online enrollment and electronic data

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- transfer is also available. (Note: Flex reimbursements cannot begin without enrollment information. Delays in getting this to isolved Benefit Services may unnecessarily delay claims processing for your employees and providing debit cards.)

Your ongoing responsibilities during the plan year include:

- Provide all participants with a copy of the Summary Plan Description (It can also be made available on a company intranet)
- Complete the Nondiscrimination Test Data Request Form and forward to isolved Benefit Services so testing may be completed
- Funding of reimbursements
- Payroll deductions
- Reporting new participants, terminations and changes of elections
- Review monthly reports

isolved Benefit Services Responsibilities include:

- Conduct enrollment meetings (at additional cost)
- Provide enrollment material
- Provide Plan Document and Summary Plan Description for your plan
- Claims adjudication
- Claims reimbursement
- First level claims appeals
- Research and updates
- Provide periodic reports
- Provide web and telephone support for participants and client

Important Note: isolved Benefit Services recommends that you always send this type of information encrypted. isolved Benefit Services is HIPAA Privacy/Security/HITECH Act compliant.

Reports

isolved Benefit Services will provide the following reports to the parties you designate:

- Check Register Report: An email confirmation will be sent to you each time a claim is reimbursed to your participants. You have 24/7 access to this information. The timing of this email will depend upon the reimbursement cycle you have selected. The email requires your immediate attention, as it means funds will be accessed as indicated.
- Year-to-date Report: This report is available to you 24/7 on our website. The report shows active and terminated participants, annual elections, as well as year-to-date claims and reimbursements.

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HRA Administration

Getting Started

Welcome to HRA Administration with isolved Benefit Services. After receiving your contract, one of our Account Implementation Specialists will:

- Conduct a Business Call. During this call, we go over the process and any additional information that was missed on the Plan Design Worksheet. **Plan design worksheet, banking authorization, contract and payment are required before your setup process will begin.**
- Discuss funding arrangements.
- Explain the debit card process if you elect to receive this service.
- Determine who should receive our periodic reports.
- Establish and proof your account.

Upon the completion of your setup, one of our Account Setup Specialists will:

- Send you a confirmation report of the enrollments we have entered.
- Send a Welcome Letter to all of your participants.

After these two important steps, the ongoing phase of your HRA Administration will begin.

Your Responsibilities

Prior to the effective date of your plan include:

- Design your plan
- Have your Board of Directors (or equivalent) adopt the plan prior to the beginning of the plan year

Ongoing responsibilities during the plan year include:

- Provide all participants with a copy of the Summary Plan Description
- Complete the Discrimination Testing Data Request Form and forward to isolved Benefit Services so testing may be completed
- Funding of reimbursements
- Reporting new participants and terminations
- Review monthly reports

isolved Benefit Services Responsibilities include:

- Providing Plan Document and Summary Plan Description for your plan
- Claims adjudication
- Claims reimbursement
- First level claims appeal
- Research and updates
- Provide periodic reports
- Provide web and telephone support for participants

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Important Note: isolved Benefit Services recommends that you always send this type of information encrypted. isolved Benefit Services is HIPAA Privacy/Security/HITECH Act compliant.

Reports

isolved Benefit Services will provide the following reports to the parties you designate:

- **Check Register Report:** An email confirmation will be sent to you each time a claim is reimbursed to your participants. You have 24/7 access to this information. The timing of this email will depend upon the reimbursement cycle you have selected. The email requires your immediate attention, as it means funds will be accessed as indicated.

- **Year-to-Date Report**: This report is available to you to view 24/7 on our website. The report shows active and terminated participants, annual elections, as well as year-to-date claims and reimbursements.

HSA Administration

Getting Started

Welcome to HSA Administration with isolved Benefit Services. After receiving your contract, one of our Account Implementation Specialists will:

- Conduct a Business Call. During this call, we go over the process and any additional information that was missed on the Plan Design Worksheet. **Plan design worksheet, banking authorization, contract and payment are required before your setup process will begin.**
- Discuss funding arrangements (payroll deductions and fees)
- Explain the debit card process.
- Determine who should receive our periodic reports.
- Establish and proof your account.

Upon the completion of your setup, one of our Account Setup Specialists will:

- Send you a confirmation report of the enrollments we have entered.
- Send a Welcome Letter to all of your participants.

After these two important steps, the ongoing phase of your HSA Administration will begin.

Your Responsibilities

Prior to the effective date of your plan include:

- Design your plan
- Have your Board of Directors (or equivalent) adopt the plan prior to the beginning of the plan year

Ongoing responsibilities during the plan year include:

- Provide all participants with a copy of the Summary Plan Description
- Reporting new participants and terminations
- Review monthly reports

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Employee Responsibilities

- Accept Terms and Conditions via employee portal once enrolled
- Set up Beneficiaries via employee portal
- Request transfer of funds from previous custodian(optional)

isolved Benefit Services Responsibilities include:

- Providing Plan Document and Summary Plan Description for your plan
- HSA Distributions
- Research and updates
- Provide periodic reports
- Provide web and telephone support for participants

Important Note: isolved Benefit Services recommends that you always send this type of information encrypted. isolved Benefit Services is HIPAA Privacy/Security/HITECH Act compliant.

Reports

isolved Benefit Services will provide the following reports to the parties you designate:

- **Check Register Report:** An email confirmation will be sent to you each time a claim is reimbursed to your participants. You have 24/7 access to this information. The timing of this email will depend upon the reimbursement cycle you have selected. The email requires your immediate attention, as it means funds will be accessed as indicated.
- **Year-to-Date Report**: This report is available to you to view 24/7 on our website. The report shows active and terminated participants, annual elections, as well as year-to-date claims and reimbursements.

Premium Only Plan (POP) Administration

Getting Started

Welcome to POP Administration with isolved Benefit Services. After receiving your contract, one of our Account Implementation Specialists will:

1. Send your Plan Document upon receipt of contract and payment.
2. Provide assistance in the implementation process.

After these two important steps, the ongoing phase of your POP Administration will begin.

Your Responsibilities

- Adopt plan
- Enroll participants
- Convert payroll
- Distribute SPD
- Perform nondiscrimination testing

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isolved Benefit Services Responsibilities

- Providing Plan Document for your plan
- Provide you with telephone support
- Provide updated documents

What you should know about Flexible Compensation

Cafeteria Plans allow both the employer and the employee a chance to realize tax savings by setting aside pre-tax dollars to pay for medical or dependent care expenses. The plans are governed by federal law (Employee

Retirement Income Security Act and the Internal Revenue Code). As such, there are some important points you should be familiar with.

Annual Elections

Flexible Spending Accounts (FSAs) require participants to make an election (a dollar amount) for the plan year prior to the start of the plan year (or, prior to effective date, if they become eligible to participate after the start of the plan year). **The IRS establishes a cap for salary reduction contributions to a health FSA.**

Changes: Generally, annual elections cannot be changed. However, the occurrence of certain life events may allow a participant to change an election.

- Change in marital status such as death of spouse, divorce, legal separation and annulment.
- Change in number of dependents including birth, death, adoption and placement for adoption.
- Employment status. Any of the following events that change the employment status of the employee, the spouse or dependents of the employee: a termination, a strike or lockout, a return from an unpaid leave of absence and a change in worksite.
- Dependent ceases to satisfy the eligibility requirements due to attainment of age, student status or any similar circumstance.
- Residence. A change in the place of residence of the employee, spouse or dependent. The relocation would need to cause a loss of coverage under the plan to allow the election change.
- Adoption assistance. For purposes of adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding must occur.

Any change in election made in conjunction with one of these events must be reflective of the change. In other words, if there is a change in the number of dependents due to birth, the election should increase, not decrease.

Report all changes in annual elections to Infinisource.

Limits

Dependent Care FSA - Federal law sets a limit on how much money can be set aside in a Dependent Care FSA. Additionally, your plan document sets limits as well. Your plan may allow elections up to the federal

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limit, or your plan may have a lower limit. Your participants will need to know about these limits in order to plan for their annual elections.

Health FSA - While federal law does not set a limit on how much money can be set aside in a Health FSA, your plan document may set these limits. Your participants will need to know about these limits in order to plan for their annual elections.

Health FSA Claims

Claims are based upon the date the expense was incurred (the date the service was provided). isolved Benefit Services will review each claim to determine when the expense was incurred, if the expense is eligible, if sufficient documentation has been provided and if the participant has enough funds in the account to reimburse the claim.

Documentation: The following items are required to document each claim:

- Date of service (must be within the plan year)
- Name of provider
- Name of person for whom service was provided
- Amount
- Description of service provided

Generally, these items can be found on an itemized receipt from a provider.

Appeals: Your plan document and Summary Plan Description outline an appeal process for claims. isolved Benefit Services will adjudicate claims based upon the documentation requirements above. Participants whose claims are denied may appeal. First level appeals are handled by isolved Benefit Services; second level appeals will be directed to the plan sponsor.

Eligible/ineligible expenses: To view the most recent list of Eligible & Ineligible Expenses, review our information on our FSA Resource Center.

Allowable expenses must be considered for medical care. The definition of medical care would need to include amounts paid *"for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."*

Medical care must be "for the diagnosis, cure, mitigation, treatment, or prevention of disease." *Diagnose* means using any procedure to find out whether an individual has a disease or dysfunction. Hearing, vision and blood tests are examples of diagnostic tests. *Cure* means a medical treatment or drug used to restore health such as using chemotherapy to cure cancer. *Mitigation* must make a medical condition less harsh or severe,
such as a wheelchair if a participant has multiple sclerosis or a seeing-eye dog for a blind person. *Prevent* requires that the care involve the prevention of possible disease, illness or defect.

Expenses are to be confined strictly to expenses incurred for the prevention or alleviation of a physical or mental defect or illness. The following are specific examples the IRS provides to satisfy this requirement: (1) X-rays; (2) hospital services; (3) medicine and drugs; (4) nursing services; (5) ambulance service; (6) artificial teeth and limbs.

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Dependent Care FSA Claims

Claims are based upon the date the expense was incurred (the date the service was provided). isolved Benefit Services will review each claim to determine when the expense was incurred, if the expense is eligible, if sufficient documentation has been provided, if the participant has contributed enough funds and if the participant has a balance in the account to reimburse the claim.

Documentation: Participants should use one of the following methods to submit claims:

- Complete the FSA Request for Reimbursement Form and have the dependent care provider sign and date. Submit to isolved Benefit Services for reimbursement.

- Complete the FSA Request for Reimbursement Form and attach supporting documentation which must include provider name and address, dependent name(s), dates of service and amount of expense.

Appeals: Your plan document and Summary Plan Description outline an appeal process for claims. Isolved Benefit Services will adjudicate claims based upon the documentation requirements above. Participants whose claims are denied may appeal. First level appeals are handled by isolved Benefit Services; second level appeals will be directed to the plan sponsor.

Eligible/ineligible expenses: This is a sample listing of eligible and ineligible expenses. These items are subject to change in accordance with IRS guidance.

Examples of Eligible Expenses

- Care for your child(ren) who are under the age of 13, your spouse or other dependent(s) who are physically and/or mentally incapable of self-care.
- Dependent care expenses that are incurred while you (or your spouse, if applicable) are working, looking for employment or attending school full-time.

Examples of Ineligible Expenses

- Meals
- Activity fees
- Late charges
- Activity supplies
- Transportation
- Field trips
- Overnight camps

Nondiscrimination Testing

isolved Benefit Services makes available the following nondiscrimination testing required under the Code (collectively referred to as the “Nondiscrimination Tests”) with respect to the Plan (s) (to the extent isolved Benefit Services provides related administrative services):

(a.) Key Employee Concentration Test required under Code §125.

(b.) The 55% Average Benefits Test required under Code §129.

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(c.) The 25% Shareholder Concentration Test required under Code §129.
(d.) The Highly Compensated Individual Eligibility and Benefits Test required under Code § 105.

To the extent necessary, isolved Benefit Services will prompt Employer to complete the Nondiscrimination Tests. Employer will complete the Nondiscrimination Tests and isolved Benefit Services will notify Employer if, based on isolved Benefit Services interpretations, any of the tests fail to pass. The results will be based on information received from Employer and/or any information obtained and maintained by isolved Benefit Services in the course of performing services required. isolved Benefit Services will conduct additional Nondiscrimination Tests required under Code §125, §105 and/or §129 only upon Employer's written request.

What if a plan is discriminatory? If your plan is found to be discriminatory, you have several options:

- Change elections: Your plan document from isolved Benefit Services allows you to make election changes for your participants to make the plan nondiscriminatory. Generally, this means reducing the elections of highly compensated employees.
- Revoke elections: You may need to revoke or reduce elections of highly compensated employees.
- Tax the benefits: If you are unable to change or revoke elections to make the plan nondiscriminatory, you will simply need to tax the benefits for the highly compensated employees. Non highly compensated employees will continue to enjoy the pre-tax benefits of your FSA.

Time Frames

- Plan Year: You establish your plan year listed in your plan document. All expenses must be incurred (service provided) during the plan year to be eligible for reimbursement.
- Run-out period: Your plan document will establish a run-out period. This is a period following the end of the plan year during which participants can submit eligible expenses from that plan year.
- Claims appeals: When a claim cannot be processed, isolved Benefit Services will:
  - Try to resolve the claim through phone contact to the participant for up to 12 calendar days.
  - If still unresolved, a Notice of Extension will be sent to the participant. The participant will have 45 days to respond.
  - If no response is received within 45 days, a Notice of Claim Denial will be sent to the participant. This notice gives the participant 180 days to file an appeal.

If the appeal claim is also denied, a notice of claim appeal denial will be sent to the participant. Second level appeals are directed to the plan sponsor.

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