

Plan Document Checklist

Sections 125 / 129



General Information – only complete Sections applicable to your Plan

Vigo County Government

PLAN FULL NAME: Flexible Benefit Plan & Section 125 **Group #:** 70000-70126 **Account #(s):** _____

Premium Only Plan // Health FSA Plan // _____ Limited Purpose FSA Plan // Dependent Care Plan // _____ HSA Plan

Employer Name: Vigo County Government **Employer Tax ID# (EIN):** 35-6000207

Address 1: Vigo County Annex, HR Dept. **Type of Business (example – Corp, Inc., LLC):** Government

Address 2: 650 S 1st Street **Phone:** (812) 462-3249 **Contact Name:** Connie Flood

City: Terre Haute **Fax:** (812) 231-5617 **Contact Title:** Human Resources Director

State Zip: IN, 47807-3438 **Email:** connie.flood@vigocounty.in.gov

Is the Plan subject to ERISA? YES NO If Yes: ERISA Plan Number: _____

Trust? (ERISA groups only) YES NO **Name of Trustee:** _____ **Title:** _____

Under which State's law is the Plan Governed? Indiana Is the Named Employer the only Employer Sponsoring this Plan?

First Plan Year Begins: July 1 YES NO-give names, full addresses & phone # of any co-sponsors:

First Plan Year Ends: June 30 _____

Second Plan Year Begins: January 1 _____

Second Plan Year Ends: December 31 _____

Is a controlled Group of Employers offering this Plan?

YES NO

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POP, HFSA, LPHFSA and DCAP Flexible Benefit Plan Eligibility Rules

Please make copies of this page if the eligibility rules are different for one or more plan(s) – circle plan (in header) the eligibility is applicable to

Are all Employees eligible for this plan? YES NO

Indicate all eligible groups:

Employees who work more than 30 hours per week

Contract Employees

Employees with more than months/days of employment

Other eligible employees:

Owners, Partners in a Partnership and 2% shareholders are NOT eligible to participate in pre-tax benefit

When does participation commence for an eligible employee?

First day of the month following eligibility

Next enrollment date following eligibility

On Plan Anniversary following becoming eligible

On the first pay-period following eligibility

First day of the month following the date of hire

Other: First day of the month following 30 days full-time employment

What is the enrollment period (You may check more than one)

Plan Year Anniversary only

Month prior to Plan Year Anniversary & 5th month mid-year

Upon becoming an eligible employee

Month prior to Plan Anniversary

Other:

FMLA Contributions

Prepayment* *prepayment must be offered if either the

Pay-as-you-go pay-as-you-go option or catch-up

Catch-up Option option is also offered

Does the Employer fund any benefits under this Plan? YES NO

Does the Plan allow for Same Sex Marriage? YES NO NO

Recognized as a legal spouse of the Participant in the jurisdiction in which the marriage occurred. Such spouse must have met all requirements of a valid

marriage contract in the state in which such parties were married

Does the Plan allow for Domestic Partners? YES NO

Please be aware – there may be tax implications for permitting Pre-tax benefits for Domestic Partners.

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When does participation commence for an eligible employee?

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____ Next enrollment date following eligibility

On Plan Anniversary following becoming eligible

____ On the first pay-period following eligibility

____ First day of the month following the date of hire

Other: _____

What is the enrollment period (You may check more than one)

Plan Year Anniversary only

____ Month prior to Plan Year Anniversary & 5th month mid-year

____ Upon becoming an eligible employee

Month prior to Plan Anniversary

Other: _____

FMLA Contributions

Prepayment* *prepayment must be offered if either the

Pay-as-you-go pay-as-you-go option or catch-up

____ Catch-up Option option is also offered

Does the Employer fund any benefits under this Plan? _____ YES NO

Does the Plan allow for Same Sex Marriage? YES NO Does the Plan allow for Domestic Partners? _____ YES NO

Recognized as a legal spouse of the Participant in the jurisdiction in which the marriage occurred. Such spouse must have met all requirements of a valid marriage contract in the state in which such parties were married. Please be aware – there may be tax implications for permitting Pre-tax benefits for Domestic Partners.

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Health FSA Plan – Section 125

Plan Maximum & Minimum

Minimum annual contribution \$ _____

Maximum annual contribution \$ 2,650 _____

Frequency of Claim Payments

_____ weekly – which day of week _____

_____ bi-weekly – which day of week _____

_____ semi-monthly – dates _____

_____ monthly – what date _____

Will all Section 213 expenses be reimbursed? YES NO

If no – what specific expenses will be covered? _____

Does the plan permit OTC items to be purchased in Health FSA? YES NO

Minimum Check value \$ _____

Example – no check is to be written for less than \$5.00

Is the employer contributing to this plan? YES NO

If Yes, how much \$ _____

Frequency of contribution: _____

Health FSA Grace Period

Does the Health FSA plan have a 2-1/2 month grace period YES NO

If yes – is the Grace Period a full 2-1/2 months YES NO - _____ length of Grace Period

Health FSA Carry Over

Does the Health FSA plans permit a carry over of unused balances YES NO

If yes – how much is the carry over amount \$ _____ (maximum \$500)

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Dependent Care Plan (DCAP) – Section 129

Plan Maximum & Minimum

Minimum annual contribution \$ _____

Maximum* annual contribution \$ IRS Max _____

* IRS maximum is \$2,500 for married filing separate or \$5,000

Minimum Check value \$ _____

Example – no check is to be written for less than \$5.00

Frequency of Claim Payments

_____ weekly – which day of week _____

_____ bi-weekly – which day of week _____

_____ semi-monthly – dates _____

_____ monthly – what date _____

DCAP Spend Down

The 2007 proposed regulations provide that a DCAP may be designed to allow employees whose participation has ceased (due to termination of employment) to be reimbursed from their remaining DCAP account balances for eligible post employment expenses incurred during the remainder of the plan year. One practical problem is that the expenses incurred after termination of employment are ineligible for reimbursement unless they enable the (ex) employee and spouse to be gainfully employed. In other words, at the time the expenses are incurred, the employee and spouse must be employed, looking for work, or attending school on a full-time basis.

Do you want to allow the DCAP spend down feature? (this option is not mandatory but is an option for Plan Sponsors:

_____ Yes No

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Miscellaneous Plan Details

FSA Plan Run In

Is MedBen doing run-in on the previous LPFSA / HFSA / DCAP plan year? _____ Yes _____ No

Claims run out

All claims must be submitted within 90 * days after the close of the Plan Year in which the expense was incurred.

Terminated EE's have 90 *days from the date of termination to submit claims for expenses incurred while actively enrolled in Plan

**This is typically 90 days and is over and above any permitted Grace Period*

Payroll Frequency – Please mark all that apply

<input type="checkbox"/> weekly – which day of week _____	What date will 1 st payroll deduction occur _____
<input checked="" type="checkbox"/> bi-weekly – which day of week <u>Tuesday</u>	What date will 1 st payroll deduction occur <u>01/12/2018</u>
<input type="checkbox"/> semi-monthly – dates _____	What date will 1 st payroll deduction occur _____
<input type="checkbox"/> monthly – what date _____	What date will 1 st payroll deduction occur _____

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Premium Only Plan (POP) – Section 125

Plans to be included in Plan Document

- Plans Included: Medical Insurance
 Prescription Insurance
 Dental Insurance
 Vision Insurance
 Health Savings Account (HSA)
 Other: _____
 Other: _____
- Please mark all that apply

Coverage Tiers – Please mark all that apply

- Employee Only
 Employee Plus Spouse
 Employee Plus One Child
 Employee Plus Children
 Employee Plus Family
 Other: _____

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Additional Comments

Additional Concerns/Notes (To be completed by MedBen)

I have carefully reviewed the information listed above and the indicated attachments (if any) and certify that they reflect an accurate description of benefits and limitations under our cafeteria plan. I understand that this document does not constitute a legal plan document or summary plan description as those terms are defined in ERISA. The information provided in this checklist will be used by MedBen to draft the Plan Document. I hereby authorize MedBen to use this information in the manner described, and agree to hold harmless and indemnify MedBen for any claims or losses, which may arise from their use of this information in this manner. I further understand that any changes to the above information must be provided to MedBen in writing. Any retrospective application of any changes may assess an additional administrative fee to cover the fees for creating an amendment or recreation of the Plan Document.

Signed: *Janice A. Anderson*

Authorized Representative of the Plan Administrator

Dated: 4/14/2018

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