PAYCHEX®

Benefits Renewal Guide

Section 1: Company Information

1.1	Company Name:	
1.2	Tax ID:	

Section 2: Flexible Spending Account Changes

2.1	Please confirm if you would like to receive plan documents for your upcoming plan year. ☐ Yes ☐ No If yes, please confirm the following Is your company subject to COBRA? ☐ Yes ☐ No Is your company subject to FMLA (Family Medical Leave Act) ☐ Yes ☐ No
2.2	Would you like to make changes to your FSA plan setup for the upcoming plan year? ☐ Yes ☐ No If Yes, complete section 3. If No, skip to Section 4

Section 3: Flexible Spending Accounts (FSA)

3.1	Select type of FSA offered: ☐ Medical FSA ☐ Dependent Care FSA ☐ Limited Purpose FSA *(offered with HSA, Limited Purpose FSA design mirrors Medical FSA design unless otherwise illustrated)*
3.2	Medical FSA/Limited Purpose FSA Employee Maximum Annual Contribution ☐ $2,850 Other $_____
3.3	Dependent Care FSA Maximum Annual contribution: $5,000

FSA Plan Design Options

3.4	Will employer contribute to plan(s)? ☐ Yes ☐ No *(skip 1 & 2)* 1. Medical/Limited Purpose FSA Maximum Annual Employer Contribution $_____ 2. Dependent Care FSA Annual Employer Contribution $_____
3.5	Will a Grace Period or Rollover be offered? ☐ Yes (Select which below) ☐ No (Skip to Section 3.6) ☐ Grace Period of 2 ½ months *Allows an extension of the plan year end date in order for participants to incur services. Grace Period extension is defined as two full months ending on the 15th of the third month.* ☐ Rollover $____ or %_____ *Allows participants to roll over up to the IRS Maximum of unused funds at the end of the plan year. Only Medical/Limited FSAs that do not include a Grace period are eligible for the rollover.* Will the Rollover be offered for the previous plan year or the new plan year? ☐ Renewing Plan year ☐ New Plan Year
3.6	Indicate your co-payments for auto-approval of debit card transactions. *(Benefit Summaries, percentages, and/or deductible amount cannot be accepted. Please itemize all co-pay amounts below.)* *Separate multiple plan co-payments by commas. Specific amount must be listed individual (ranges not accepted).* Medical/Office Co-payment $_____ Vision Co-payment $_____ Dental Co-payment $_____ Emergency Co-payment $_____ Prescription Drug Co-payment _____ ☐ Our plan does not offer Co-payments

Funding and Payroll

3.7	Indicate payroll cycles(s) for withholding deductions: **Required: Include a copy of the Payroll Deduction Form for the plan year** ☐ Weekly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Monthly
	*Note: Payroll name selected above must appear verbatim on demographic file. If there are two schedules that fall under the same cycle (e.g. two Bi-Weekly), provide specific naming conventions. **PAYROLL SCHEDULE MUST BE INCLUDED – Please complete attached*****

FSA Plan Standards

- Non Discrimination Testing will be completed upon request.
- A two week open enrollment period will be offered once plan setup is complete.
- A runout period will be offered.
  - 90 days following each plan year (must be equal to or longer than Grace period, if applicable)
  - 90 days from the date of termination

- If the employer has elected the rollover, we would handle the 'standards' as listed below:
  - Medical to Medical
  - Medical to Limited
  - Limited to Limited
  - Limited to Medical (if offering both)

Section 4: Health Reimbursement Arrangement Changes

4.1	Please confirm if you would like to receive plan documents for your upcoming plan year. ☐ Yes ☐ No If yes, please confirm the following Is your company subject to COBRA? ☐ Yes ☐ No Is your company subject to FMLA (Family Medical Leave Act) ☐ Yes ☐ No
4.2	Would you like to make changes to your Health Reimbursement Arrangement plan setup for the upcoming plan year? ☐ Yes ☐ No If Yes, complete section 5. If No, plan design will remain the same for the upcoming plan year and skip to question 6.1

Section 5: Health Reimbursement Arrangement

5.1	Indicate below the expenses eligible under the HRA plan. *Note: If your plan has a threshold, only the below types of expenses will apply to the threshold and pay out for reimbursement.*		
	☐ 213D (Medical, Dental, Vision, Rx, Premiums)	☐ Dental Only	
	☐ Dental and Vision	☐ Pharmacy Only	
	☐ Medical and Pharmacy		
5.2	Does a threshold (out of pocket) dollar amount need to be satisfied before the HRA funds will be available? ☐ Yes ☐ No *(skip to section 5.6)*		
5.3	What are the threshold (out of pocket) dollar amounts at the following coverage levels? HRA Post Deductible Options will be as follows for individual/family coverage: ☐ 250/500 ☐ 1000/2000 ☐ 500/1000 ☐ 1000/3000 ☐ 500/1500		
5.4	How will the HRA funds be available to participants? ☐ 100% at the beginning of plan year or upon eligibility ☐ Monthly ☐ Quarterly ☐ Payroll Frequency (Payroll Deduction Form Required)		
5.5	How much does the employer contribute to the HRA annually? Proration of HRA funds is Monthly.	Single	$_____
		Family	$_____
5.6	If offering FSA and HRA plans, which plan pays out first to participants? ☐ FSA ☐ HRA ☐ Not Applicable		
5.7	Can the HRA funds be spent down upon termination? ☐ Yes ☐ No		
5.8	Can unused dollars be carried over and used in subsequent plan years? ☐ Yes ☐ No *(If yes):* ☐ Up to $_____ ☐ _____% of Balance		
	Whose unused dollars can be carried over and used in subsequent plan years? ☐ Active participants only ☐ All participants *(termed and active)* If a participant is no longer eligible for the HRA plan in a subsequent plan year (but are not terminated), will their balance still carry over? ☐ Yes ☐ No Does this HRA Plan require MSP Reporting ☐ Yes ☐ No		

HRA Plan Standards

- A two week open enrollment period will be offered once plan setup is complete.
- A runout period will be offered.
    - 90 days following each plan year (must be equal to or longer than Grace period, if applicable)
    - 90 days from the date of termination

Section 6: Non Discrimination Testing

6.1	Should Paychex Benefit Account Services perform Non Discrimination Testing for the upcoming plan year?
	☐ Yes ☐ No

Employer Signature

Employer Signature:	
Print:	