



Premium Only Plan (POP) Benefits

Getting Started Kit for Employers
1-2-3 Step Process

1. Learn how POP works

POP makes it easy to reduce taxes, save money, and attract and retain valuable employees.

Introducing The Premium Only Plan

CareFirst BlueCross BlueShield (CareFirst) is pleased to introduce the Premium Only Plan (POP). This plan makes it easy for both you and your employees to realize significant tax savings. Your company can take advantage of POP if you currently offer your employees any of the following benefits by payroll deduction:

- Health
- Dental
- Vision

Reduce your Taxes and Save Money

POP converts your employees' after-tax benefit contributions to pre-tax contributions. It's easy to set up, requires little administration and saves:

- Federal income taxes and state income taxes (in most states)—for your employees
- FICA taxes—for you and your employees

CareFirst can help you implement a POP under Section 125 of the Internal Revenue Code. When you do, your employees will be able to pay for health, dental and vision premiums on a pre-tax basis. POP enables participating employees to decrease their taxable incomes and pay lower taxes. Since FICA taxes are reduced, **your company will save the matching portion of FICA—7.65%**. That's a significant savings.

The examples below can help you determine potential savings for your employees and your company.

EXAMPLES

The following examples are for illustration purposes only.

Semi-Monthly Employee Savings

Before POP		After POP	
Gross Pay:	\$1,000.00	Gross Pay:	\$1,000.00
Pre-tax Contribution:	-0	Pre-tax Contribution:	-50.00
Taxes at 25%*:	-250.00	Taxes at 25%**:	-237.50
After-tax Health Care Premiums:	<u>-50.00</u>	After-tax Health Care Premiums:	<u>- 0</u>
Net Pay:	\$700.00	Net Pay:	\$712.50
		Net Pay Savings:	\$12.50
		Annual Savings:	\$300.00

By paying for premiums pre-tax, your employees can save \$300 a year...or more, if employees are in a higher tax bracket.

(based on 24 pays)

Employer FICA Savings

Number of Employees:	20	Employer Matching FICA	7.65%
Monthly Employee Pre-tax Contribution:	\$100	Total Monthly Employer Savings	\$153
Total Monthly Contributions:	\$2,000	Total Annual Employer Savings	\$1,836

Note: FICA has two components:

- Medicare: 1.25% of annual wages; no annual wages limit.
- Social Security: 6.4% of the annual Social Security Wage Base. This wage base changes annually.

EXAMPLES continued

Increase Your Employees Contributions by 30% and Keep Their Net Pay the Same

Before POP		After POP	
Gross Pay:	\$1,000.00	Gross Pay:	\$1,000.00
Pre-tax Contribution:	<u>0</u>	Pre-tax Contribution:	<u>65.00</u>
Taxable Income:	1,000.00	Taxable Income:	935.00
Taxes at 25%*:	-250.00	Taxes at 25%**:	-233.75
After-tax Health Care Premiums:	<u>-50.00</u>	After-tax Health Care Premiums:	<u>-0</u>
Net Pay:	\$700.00	Net Pay:	\$701.25

You can pass along a semi-monthly increase to the share of health care premiums your employees pay (if your insurance rates go up) from \$50 to \$65 without affecting your employees' spendable income.

* Assumes 15% federal income tax bracket, includes federal, FICA and income taxes in most states.

** Assumes 15% federal income tax bracket. If higher, savings are even greater. Includes federal, FICA, and income taxes in most states. Employees' W-2s will show reduced taxable wages and lower FICA taxes.

2. Determine if POP is right for your business

Answer the following questions to find out.

1. Do your employees contribute toward the cost of the group health, dental or vision insurance that your business provides to them? YES NO

If **YES**, you and your employees may benefit from implementing a POP. You can save on payroll taxes, such as FICA, and your employees can save on federal income tax, FICA tax, and state income taxes (where applicable).

If **NO**, you probably do not need to implement a POP at this time. However, you may want to introduce a POP if you will start requiring your employees to contribute toward their health insurance costs.

2. Is your business a limited liability company (LLC), partnership, sole proprietorship, or 'S' corporation? YES NO

If **YES**, you may introduce a POP for your employees. However, the following individuals are not permitted to participate in a POP:

- Any members of an LLC or LLP
- Any partners in a partnership
- The owner of a sole proprietorship
- Any shareholder of an 'S' corporation who owns at least 2% of the corporate stock and spouse/employee even if spouse is not a shareholder*

If **NO**, all employees may participate in a POP.

*Contact us regarding any other shareholder and spouse situations to determine if shareholder and/or spouse/employee may participate in a POP.

3. If you answered **NO** to number 2, is your business a 'C' corporation? YES NO
If **YES**, please keep in mind that any shareholder must be an employee to participate.

POP Set-Up Sheet

3. Complete the POP Set-Up Sheet — Please Print.

Employers: Please complete and return this **Set-Up Sheet** to the Flexible Benefits Department's address below at least 30 days prior to your requested effective date. You may either fax or mail the Set-Up Sheet (send only the bordered pages of this document) to us.

Need assistance? We're here to help. Contact us using the method most convenient for you:

Write: Flexible Benefits Department P.O. Box 8737 Wilmington, DE 19899-8737	Call: 800-559-FLEX (3539)
E-mail: flex@bcbsde.com	Fax: 302-421-8883

A. Employer Information

1. **Legal name of employer:** _____
Street Address: _____
(No P.O. Boxes, please.) _____
Phone Number: (____) _____

2. **Business entity type:** (Please check one applicable box.)

<input type="checkbox"/> C Corporation	<input type="checkbox"/> General Partnership
<input type="checkbox"/> S Corporation	<input type="checkbox"/> Limited Partnership
<input type="checkbox"/> Limited Liability Company (LLC)	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Limited Liability Partnership (LLP)	<input type="checkbox"/> Government

3. **Are you a not-for-profit business entity?** YES NO

4. **Principal business activity:** _____
Principal Product or Service: _____
Business Code Number (6 digits): _ _ _ _ _ _

5. **Employer Identification Number (EIN):** _ _ - _ _ _ _ _
List your Social Security Number if you are a sole proprietor: _ _ - _ - _ _ _ _

6. **Number of employees** _____ as of: _____ (date)

7. **Payroll cycle**—please check one:

- Weekly (52 pays)
 Bi-Weekly (26 pays)
 Semi-Monthly (24 pays)
 Monthly (12 pays)

8. Are you affiliated with any subsidiaries or other business entities? YES NO

If YES, please answer the preceding questions (1-7), using a separate sheet for each subsidiary or business entity.

9. Contact Information:

Name: _____ Title: _____

Mailing Address: _____

Phone: _____ Fax: _____

E-mail: _____

B. Plan Information

1. Plan year

Please indicate your choice (check only one box) of POP Plan Year from the options listed and defined below. Then fill in the Start and End Dates for the option you marked.

Short Plan Year: Start Date: ____ / 01 / 200__ End Date: ____ / 30 or 31 / 200__

Fiscal Plan Year: Start Date: ____ / 01 / 200__ End Date: ____ / 30 or 31 / 200__

Calendar Plan Year: Start Date: 01 / 01 / 200__ End Date: 12 / 31 / 200__

Definitions

Short Plan Year: Any plan year containing 11 or fewer months.
You may need to select a Short Plan Year for your initial POP plan year so that in all following years your plan years coincide with those you now use for your health insurance plan(s).

Fiscal Plan Year: Any plan year containing 12 months but not beginning in January.

Calendar Plan Year: Any plan year that uses the calendar year.

2. Plan type

Please select the plan type (check one):

A new plan

An amendment and restatement of a previously established Section 125 plan. List your plan year dates here: *Start Date:* _____ *End Date:* _____

3. Plan Administrator

Below, please print the name and title of the person legally responsible for this plan. The individual may be a corporate officer of a corporation, a partner in a partnership, the owner of a sole proprietorship, etc.

Name: _____ Title: _____

C. Benefit Information

1. Choose your company's POP benefit plans

My company's POP will cover the following benefit plans:

Benefit Plans	Type of Benefit H=Health D=Dental V=Vision	Name of Insurance Company	Legal Name of Benefit Plan	Number of Tiers	Annual Plan Renewal Date	Are any affiliated companies participating? If yes, provide legal name of parent, subsidiary or affiliate below:
1.						
2.						
3.						
4.						
5.						

2. Plan participation

For each plan listed above, provide the employee counts as requested.

Count each employee only once. Employee counts are as of _____ (date).

Eligible = Eligible to participate in benefit plan. **Participating** = Participating in benefit plan.

Benefit Plan #	Full-Time Employees		Part-Time Employees		Other Classes of Employees		Total Employees for this Plan	
	Eligible	Participating	Eligible	Participating	Eligible	Participating	Eligible	Participating
1.								
2.								
3.								
4.								
5.								

3. Plan eligibility and eligibility waiting periods for new hires

For the first benefit plan you listed in answer to section C.1. shown on the preceding page (page 5 of this Set-Up Sheet), please answer each question below by checking the boxes or by printing your answer on the lines provided. *Please Note:* If you listed more than one plan in section C.1., and the information requested in this section is not identical for all plans, please provide the answers to the following questions on a separate sheet of paper for those other benefit plans.

- a. Are full-time and part-time employees eligible to participate in the plan?
Full-Time: YES NO **Part-Time:** YES NO

- b. What is the minimum number of hours per week your employees are required to work?
Full-Time: _____ **Part-Time:** _____

- c. Are any classes of employees not eligible to participate in the plans? YES NO
If YES, please list them below.

- d. What is the waiting period (number of days or months) following date of hire that an employee must wait before participating? _____

- e. Which day of the month—the 1st or the 15th—can an eligible employee starting participating?
1st: YES NO **15th:** YES NO

D. Other Information

1. Payment method:

- Free with a CareFirst BlueCross BlueShield or CareFirst BlueChoice insurance plan

2. Account executive and broker information:

<u>Account Executive:</u>	<u>Broker:</u>
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____

3. Mailing POP implementation packet:

Please indicate to whom we should send the POP implementation packet by checking the appropriate box.

- Employer Account Executive Broker

4. POP set-up sheet submitted by:

- Employer Account Executive Broker

E. Signature and Date

The individual *with the legal authority to contract on behalf of your organization* must sign this Set-Up Sheet. He or she may be a corporate officer of a corporation, a partner in a partnership, the owner of a sole proprietorship, etc.

The undersigned employer hereby:

Certifies that:

- a. All foregoing information is accurate and complete, and
- b. A *Premium Only Plan (POP)*, as defined under Section 125 of the Internal Revenue Code, shall be established according to the information provided.

Agrees to:

- a. Abide by the requirements set forth in the plan document for the *Premium Only Plan*.
- b. Provide any information required by CareFirst's Flexible Benefits Department in the future in a timely manner as required for continued compliance with Section 125 and any other applicable laws and regulations.

Signature

Today's Date

Please print the above person's name and title below:

Name: _____

Title: _____

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