YOU'VE GOT QUESTIONS. WE'VE GOT ANSWERS.

The FAQs on our (Public Sector) FSAs

1 **When can a client move their Benefit Accounts administration to Maestro Health™?**

A client can change administrators at the beginning of the plan year (aka renewal scenario) or in the middle of a plan year (aka takeover scenario). Due to the high volume of activity around the beginning and end of a plan year, takeovers are best done in the middle few months of a plan year. Also, a takeover scenario is not considered a "qualifying life event" that would allow members to add, drop or change their election.

2 **What happens with the previous year's balances if the client moves at renewal?**

A client has two options: First, the prior administrator can administer the runout for the existing accounts. Second, the prior administrator can send balances to Maestro Health and we will administer the runout. This requires an Excel file from the prior administrator on or within a few days of Maestro Health assuming administration.

3 **How long does it take to implement a Benefit Accounts program with Maestro Health?**

The implementation process must start no later than 60 days prior to the date Maestro Health begins administration. For a renewal scenario, this is the first day of the plan year. During a takeover scenario, this is the first day Maestro Health pays claims.

4 **How can employees file claims for reimbursement?**

The easiest and fastest way to file claims is through our employee portal or mSAVE™ mobile app. Documentation can be uploaded from a computer or captured with the camera on a smartphone.

5 **How does a client pay for claim reimbursements to employees?**

Maestro Health generates daily check and direct deposit reimbursements from an account we own to employees as part of our hassle-free administration. To fund the claim reimbursements and debit card swipes, we will initiate an ACH debit to the client-designated bank account. This process allows the client to keep their plan assets in their own bank account until they are needed to pay for claims.

6 **What kind of reports are available to clients?**

We will automatically send monthly employee account balance and claims-based funding reports via email. Additional reports are available and can be run ad hoc by the client on the employer portal.

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WE'VE GOT MORE ANSWERS.

7 **What is the difference between grace period and carryover for the Healthcare FSA?**

Grace period allows employees an additional 2.5 months to incur claims after their plan year ends. Carryover allows employees to move up to $500 from one plan year to the next. These options are mutually exclusive and optional (e.g., a client is not required to offer either).

8 **How are payroll deductions posted to the Benefit Accounts?**

Maestro Health can auto-post payroll deductions if provided with a payroll calendar and the per pay period amounts for each employee election. The client may also upload actual payroll deductions through the employer portal or send an automated data file in the Maestro Health standard file format via SFTP.

9 **How are enrollments captured and sent to Maestro Health?**

Enrollments can be captured via paper form or an electronic enrollment system. If the client is using voluntaryEDGE, Benefit Accounts can be included in the offering. Enrollments can be sent to Maestro Health as paper forms or by using our standard electronic census spreadsheet. Clients using voluntaryEDGE enrollment platform for their Benefit Accounts will automatically get connectivity for eligibility.

10 **How much can an employee contribute to their Benefit Accounts on an annual basis?**

- Healthcare FSA – $2,600 for plan years starting after January 1, 2017
- Dependent Care FSA – $5,000 ($2,500 if married & filing separately)
- Health Savings Account – $3,450 for individuals and $6,900 for families (2018 tax year); $1,000 catch-up allowed for individuals age 55 or older

11 **Are employees required to provide receipts for debit card swipes?**

We are able to automatically approve most debit card swipes (over 90% for most clients) using merchant data, copay tables and recurring expense detection. Other transactions will require the employee to submit an itemized bill. This can easily be done through our mSAVE mobile app, by simply snapping a photo of their receipt on their smartphone. If employees do not provide documentation within 60 days of a request, their card will be disabled until they resolve the claim.

12 **What customer service options are available for employees?**

Our Customer Advocates are available to answer questions via phone, Monday through Friday, 8 am – 8 pm ET. In addition to answering phone calls, they process claims and respond to inquiries that come in through our email support channel. Our service model and team structure is designed to be relational. We assign a small group of customers to small teams of Customer Advocates, allowing them to build relationships and act as extension of employers' HR teams.

Got questions? We've got answers.
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