GETTING STARTED KIT

for Employers

1-2-3 Step Process

BlueCross BlueShield
of Delaware

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Premium Only Plan (POP) Benefits

1 LEARN HOW POP WORKS

Introducing The Premium Only Plan

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

Blue Cross Blue Shield of Delaware (BCBSD) 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

BCBSD 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.

Note: FICA has two components

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

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	– 50.00	After-tax health Care Premiums:	– 0
Net Pay:	**$700.00**	**Net Pay:**	**$712.50**
		Net Pay Savings:	**$12.50**
		Annual Savings: (based on 24 pays)	**$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.

EMPLOYER FICA SAVINGS

Number of Employees:	20	Employer Matching FICA:	7.65%
Monthly Employee Pre-tax Contribution:	$100.00	**Total Monthly Employer Savings:**	**$153.00**
Total Monthly Contributions:	$2,000.00	**Total Annual Employer Savings:**	**$1,836.00**

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:	– 0	Pre-tax Contribution:	65.00
Taxable Income:	$1,000.00	Taxable Income:	935.00
Taxes at 25%*:	– 250.00	Taxes at 25%*:	– 233.75
After-tax Health Care Premiums:	– 50.00	After-tax health Care Premiums:	– 0
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.

3. If you answered NO to #2, is your business a "C" corporation? ❑ YES ❑ NO

   If YES, please keep in mind that any shareholder must be an employee to participate.

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

3 POP SET-UP SHEET

Complete the POP Set-Up Sheet

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

Employers: Please complete and return this Set-Up Sheet to Blue Cross Blue Shield of Delaware's Flexible Benefits Department at least 30 days prior to your requested effective date. You may either fax or mail the Set-Up Sheet (pages 3 through X).

Need assistance? Contact us using the method most convenient for you:

Write: Blue Cross Blue Shield of Delaware
Flexible Benefits Department
PO Box 8737
Wilmington, DE 19899-8737

Call: 302.421.8970 (in Wilmington, DE)
800.559.FLEX (3539)
Fax: 302.421.8883
Email: flex@bcbsde.com

A. Employer Information

1. Legal name of employer: _____

   Street address (no PO boxes, please): _____

   _____

   Phone number: _____

2. Business entity type: (Please check one applicable box.)
   - ❑ C Corporation
   - ❑ S Corporation
   - ❑ Limited Liability Co. (LLC)
   - ❑ Limited Liability Partnership (LLP)
   - ❑ General Partnership
   - ❑ Sole Proprietorship
   - ❑ Government
   - ❑ Limited Partnership

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 applicable box.)
   - ❑ Weekly (52 pays)
   - ❑ BiWeekly (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 Yr.: Start Date (mm/dd/yyy): _____End Date (mm/dd/yyyy): _____

   ❑ Fiscal Plan Yr.: Start Date (mm/dd/yyyy): _____End Date (mm/dd/yyyy): _____

   ❑ Calendar Plan Yr.: Start Date (mm/dd/yyyy): _____End Date (mm/dd/yyyy): _____

   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 only one box):

   ❑ A new plan

   ❑ An amendment and restatement of a previously established Section 125 plan. List your plan year dates here: Start Date (mm/dd/yyyy):End Date (mm/dd/yyyy):

3. Plan Administrator. Below, please print the name and title of the person legally responsible for this plan. The individualmay 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**=Healt **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 Number	Full-Time Employees		**Part-Time Employees**		**Other Classes of Employees**		**Total Employees For This Plan**	
	Eligible	Participating	Eligible	Participating	Eligible	Participating	Eligible	Participating

Continued...

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 3 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: _____

_____

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:

Select one:

❑ Write check payable to BCBSD for $250. Enclose completed Set-Up Sheet (pages 3 to 7) and mail to address shown at the top of page 3 of this Set-Up Sheet.

❑ Refer to Account Executive for Special Small Group Market Funding

2. Account executive and broker information:

Account Executive: _____ Broker:_____

Name: _____ Name:_____

Address:_____ Address:_____

3. Mailing POP implementation packet:
Please indicate to whom we should send the POP implementation packet:

❑ 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 the BCBSD 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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