Health Care Spending Account

Plan Administrator Guide

gms health insurance

Introduction

We've been taking care of Canadian families since 1949 – before the introduction of publicly funded Medicare was available. When access to basic healthcare became available to everyone, we stepped in to bridge the gap between publicly funded healthcare and the needs of Canadians.

We introduced insurance coverage for health care related costs not paid for by government such as prescription drugs, ambulance services and private duty nursing. These core benefits are still the building blocks of the plans we offer today.

Our goal is to offer Canadians choice and real value in health and travel insurance.

Healthy and happy people create thriving communities, which is why we aim to put wellness first. Our group plans make sure the health and wellness of employees is taken care of so they can focus on what matters most to them.

With one of our extensive group benefits plans, you can provide your employees with the health insurance and benefits they need to remain productive. An attractive employee benefits plan can also help recruit and retain the best staff.

This guide outlines the product and service options available when adding a Health Care Spending Account to a GMS benefits plan and tells you how to get started.

Health Care Spending Accounts

A Health Care Spending Account (HCSA) is a great way to introduce flexibility and choice to your benefits plan and expand the type of expenses your plan currently covers. You as the employer allocates a fixed amount of money to each eligible employee. These amounts can then be used to reimburse employees for benefits or expenses not paid in full by provincial health insurance plans or other benefit plans sponsored by the employer or another insurance carrier.

Any non-taxable expense that qualifies under a traditional health and dental plan; or as a medical expense under the Canadian Income Tax Act can qualify for coverage under an HCSA. Employees can use their HCSA to pay for deductibles, co-insurance, individual health plan premiums and amounts over and above existing coverage limits.

HCSA also covers a wider range of dependents compared to health and dental plans. In addition to a spouse and/or children, employees can also claim for extended family members, if they qualify as a dependent under the Canadian Income Tax Act. To confirm dependent eligibility or eligible medical expenses, please visit the Canada Revenue Agency (CRA) and enter Medical Expense Tax Credits into the search window.

What's the difference between HCSA and Cost Plus?

You can use both options to top up existing benefit plan coverage but they're managed differently.

Health Care Spending Account: Set it and forget it

HCSAs are pre-set accounts not so different from a bank account. You set an alloted amount of money in them for each employee to use throughout the year. Once you set the alloted amount and general rules, we will track and monitor each employee's account throughout the year on your behalf.

Cost Plus: One-off claims

Cost Plus is a service that enables you as an employer to reimburse the cost of eligible medical expenses listed under Canada Revenue Agency tax rules. You provide payment to us for the cost of the eligible medical expense(s), administration fees, and applicable taxes.

Unlike the HCSA there are no accounts to track and/or manage. It is up to you to approve and submit claims as needed to us to adjudicate and process for payment.

Allotment Amounts

HCSA allotment amounts must be set before the start of the policy year, as outlined by the CRA.

Setting HCSA Allotment Amounts

Before your benefits reset each year, you must confirm the allotment amount for each employee class. This is the case even if the amounts remain unchanged from the previous year.

Multiple Classes

All employees of the same class must be offered equivalent benefits. You don't have the option to allocate different allotment amounts within the same class but do have the option to create multiple classes with different allotment amounts (E.g. Owner & Managers – Class A, All other Employees – Class B).

When an employee is moved to a different class, the HCSA allotment amount will change based on allotment provided to that class. The employee's claim total to date will follow and be deducted from their new allotment amount.

Renewal

Updates to allotment amounts must be provided before your benefits reset each year as HCSA changes can't be backdated, as per CRA guidelines. A delay in submitting a request to update existing HCSA information may result in the denial of any increases or decreases to the allotment amounts.

No Carry Forward vs. Credit Carry Forward

The CRA requires HCSA allotment amounts to only be available to an employee for a period. At the end of that time, the employee forfeits any remaining balance in their HCSA account ("use it or lose it" concept).

No Carry-Forward

Under this option, employee accounts are given their annual allotment amount beginning of the policy year. If an employee has unused HCSA funds remaining in their account at the end of the policy year, the amount is not carried over. Unused funds are forfeited.

Example of policy year January 1 to December 31:

Claim/Activity	Date	Amount	HCSA Balance
Allotment Credit	January 1, 2020	+$1,000	$1,000
Vision Claim	March 10, 2020	-$200	$800
Dental Claim	May 1, 2020	-$75	$725
Year-End Balance	December 31, 2020		$725 balance will be forfeited
Allotment Credit	January 1, 2021	+$1,000	$1,000 (no unused funds from previous years are carried forward)

Credit Carry-Forward

Under this option, employee accounts are given their annual allotment amount beginning of the policy year. If an employee has unused HCSA credits remaining in their account at the end of the policy year, this amount is carried over to be used with the following year's allotment. Claims submitted in the new policy year would be paid using the carry-forward amount first. Unused credits can only be carried forward once, which means credits are available for a period of 24 months. Unused credits remaining at the end of the 24-month period are forfeited.

Example of policy year January 1 to December 31:

Claim/Activity	Date	Amount	HCSA Balance
Allotment Credit	January 1, 2020	+$1,000	$1,000
Vision Claim	March 10, 2020	-$200	$800
Dental Claim	May 1, 2020	-$75	$725
Year-End Balance	December 31, 2020		$725 balance will be carried forward to use in 2021
Allotment Credit	January 1, 2021	+$1,000	$1,725 ($725 from 2020 + $1000 for new allotment)
Medical Equipment Claim	March 1, 2021	-$500	$1225
Year-End Balance	December 31, 2021		$1,000 balance from 2021 carried forward to use for 2022 but $225 carried forward from 2020 forfeited

Who's eligible for coverage under an HCSA?

Employees

To qualify for the HCSA benefit, all employees must meet and maintain the eligibility requirements outlined in the GMS group policy. Employees who waive health and dental coverage because they have spousal coverage are still eligible for the HCSA benefit.

Dependants

The spouse and children (also known as dependants) of an eligible employee are also eligible for the HCSA benefit. The CRA has an expanded definition of dependants eligible for HCSA benefits. The expanded eligibility includes, but is not limited to, family members who reside in Canada and who are financially and/or physically dependant on an employee.

Administration

Adding New Employees/Updating Existing Employee Records

When you add a new employee, regardless of their effective date, they will receive the full benefit allotment for the HCSA (proration is not available) once the waiting period is satisfied.

To add a new employee, or update coverage for an existing employee, submit a completed copy of the GMS Enrolment/Change Form to our office within 31 days of the eligibility date/date of change. Forms can be submitted to our office in two ways:

- Online through the Plan Admin (PA) Portal; or,
- Via mail, by printing and completing a paper copy.

Effective Date of Coverage

Employees are eligible for coverage on the effective date of the policy, or on the date in which they meet eligibility criteria as outlined in the group policy, including satisfying the waiting period, if applicable. The same applies for dependents. Claims are not payable unless GMS has the appropriate information to keep records current on employee and dependent eligibility.

Terminations

An employee's coverage ends upon termination of the HCSA benefit, upon termination of the employee's coverage under the policy, or if the employee no longer meets eligibility as outlined in the group policy.

Dependants' coverage will be terminated upon termination of the HCSA benefit, upon termination of the employee's coverage under the policy, or if the dependant(s) no longer meets the eligibility as outlined in the group policy.

To terminate the HCSA benefit under your group plan, or terminate the plan, you must provide 30 days written notice of the desired termination date.

Claims

Claim Submission

To submit a claim, your employees complete and submit a Health & Dental Claim Form. This can be done by submitting a Health Benefits & Health Care Spending Account Claim Form online at gms.ca or by mail. If mail is the chosen method, a signed and completed claim form is required for all HCSA claim submissions. Both printed and online claim forms must include copies of the original receipts along with any coordination of benefit materials from other insurers.

When a GMS Pay-Direct card is used and only part of the claim is covered, the unpaid portion has to be paid out-of-pocket. The employee can submit a claim for the unpaid portion by using our online claim form or by printing and completing a Health & Dental Claim form and mailing it to GMS. Remember, copies of receipts are needed for both online and mailed in claims.

Eligibility

Claims eligibility is determined by the conditions in the GMS group policy as well as the CRA's Medical Expense Tax Credit (METC).

Coordination of Benefit (COB) Rules

If an employee's expenses are partially covered by their health and dental plan, they have to claim through that plan first. They can then submit the balance to be paid under their HCSA benefit (HCSA's are considered last payor).

If an employee has coverage under a spousal plan or a private individual plan, all expenses must be submitted to that plan before submitting the balance to their HCSA benefit. When they submit their claim to us, we must have copies of the original receipts and the explanation of benefits statement(s) from the other insurer.

Claim Submission Period

All HCSA claims must be submitted to our office no later than 90 days after the end of the policy year in order to be eligible for reimbursement.

Terminations

Employee

When an employee's coverage is terminated, all HCSA claims must be submitted to GMS no later than 30 days following the date of termination.

Group

When a group or HCSA benefit is terminated, all HCSA claims must be submitted to GMS no later than 30 days following the date of termination.

What's Covered?

Ambulance, dental services, diabetic supplies, paramedical services, vision care and much more. Claim eligibility is determined by the health and dental policy, and also includes medical expenses as outlined by the CRA's Medical Expense Tax Credit.

What's not Covered?

Common expenses that are not eligible for coverage: athletic or fitness club fees, over-the-counter medications, vitamins and supplements.

Fees

An HCSA is pay per use, therefore there are no associated premiums. The cost depends on the total of claims submitted by your employees. Your monthly invoice will include the cost of HCSA claims plus 10% administration fee and any applicable taxes. I.E.: $100.00 HCSA claim paid to member + 10% admin fee ($10.00) = $110.00 is billed to you.

There is a minimum annual administration fee of $100.00 per group. If administration fees applied to paid HCSA claims during the policy year are less than $100.00, the difference will be calculated and applied to the first invoice issued after the annual renewal.

If you cancel the HCSA benefit mid-year or terminate your group plan mid-year, the $100 administration fee will be pro-rated.

Invoicing

There is no upfront cost to including an HCSA benefit as part of your Group Plan. The cost of any HCSA claims paid and related costs are included in your monthly invoices. Claims will be billed to you as the employer at the end of the month in which they are incurred. Each invoice includes a section specific to HCSA claims, including:

- The coverage period in which the claims were incurred
- A breakdown on claims incurred within the current coverage period, including employee name, total incurred, administrative fee, and applicable taxes

Payment options

An HCSA can be paid for by pre-authorized debit or cheque along with your health and dental premiums. Payment for HCSA claims is required within 60 days of the date of issue of the invoice. Should GMS not receive payment within 60 days, the contract is subject to restriction or termination.

Questions? We have answers.

To learn more about your HCSA, reach out to your broker, connect with our Group Administration Team by email at group@gms.ca or call our client assistance line at **1.800.667.3699**.