New Group? ☐
Current Health Group? ☐
Health Group # ________

FLEXIBLE BENEFITS PLAN

Plan Document Checklist

ABPM Rep: ID#:

1. LEGAL NAME OF EMPLOYER

____
(*Exactly* as it is to appear in legal documents with punctuation)

2. EMPLOYER'S ADDRESS

____
(Physical – address/zip code)

____
(Billing Address)

____
(City) (State) (Zip)

Telephone ______________

Fax # ______________

3. CONTACT PERSONNEL (If more than 2, please attach)

Human Resources: ______________

HR Phone: ______________

HR E-Maill Address ______________

Payroll Department: ______________

PR Phone: ______________

PR E-Mail Address ______________

Person Authorized to amend Plan:

____
Print Name) (Title)
E-Mail Address ______________

4. EMPLOYER'S TAX ID NUMBER

____

5. PLAN NUMBER (If this is the first Flex Plan, check 501)

☐ 501 ☐ 504 ☐ _____
☐ 502 ☐ 505
☐ 503 ☐ 506

6. PLAN INFORMATION

☐ New Plan
☐ Amendment and restatement

7. PLAN YEAR

Begins ______________

Ends ______________

Is first year a short Plan Year?
☐ Yes, beginning ______________
(Month / Day) (May 1)
☐ N/A

Will Allegiance be taking over the current Plan Year?
☐ Yes, beginning ______________
(Month / Day) (May 1)
☐ N/A

8. EFFECTIVE DATE(S)

Initial effective date ______________

This restatement ______________

9. EMPLOYER ENTITY

☐ Corporation
☐ S Corporation **(2% shareholders & family not eligible)**
☐ Governmental Entity or Church
☐ Limited Liability Corporation
☐ Non-Profit Organization
☐ Partnership **(self-employed partners not eligible)**
☐ Sole Proprietorship **(self-employed not eligible)**

10. ELIGIBLE CLASS OF EMPLOYEES

☐ All Employees who satisfy **GROUP HEALTH PLAN** eligibility requirements
☐ All Employees EXCEPT:
- ☐ Commissioned Employees
- ☐ Union Employees
- ☐ Leased Employees
- ☐ Part-time Employees, expected to work less than ______ hours per week
- ☐ Non-Resident Aliens
- ☐ Other exclusion ______________

CONDITIONS FOR ELIGIBILITY

11. FOR PRE-TAX GROUP INSURANCE PREMIUMS *ONLY* ELIGIBILITY is as follows:

☐ For first Plan Year only, anyone employed on the effective date of the Plan is eligible, thereafter: (Choose one from a-d below)
☐ For all years, eligibility is as follows: (Choose 1 below)

☐ Same as Group Health Plan eligibility waiting period
☐ Date of hire (No service required)
☐ ______ days after date of hire
☐ ______ months after date of hire
☐ ______ years after date of hire

12. FOR HEALTH /DEPENDENT CARE FLEXIBLE SPENDING PLANS *ONLY* - ELIGIBILITY is as follows:

☐ Same as Group Health Plan eligibility waiting period
☐ Date of hire (No service required)
☐ ______ days after date of hire
☐ ______ months after date of hire
☐ ______ years after date of hire

13. ENTRY DATE

☐ First day of pay period following date requirements were met (See #11)
☐ First day of month following date requirements were met as indicated in #11
☐ Date conditions for eligibility are met (See #11)
☐ First day of Plan Year following date requirements were met as indicated in #11

14. FAMILY AND MEDICAL LEAVE ACT. Is the Employer subject to these provisions?

☐ No (Less than 50 employees)
☐ Yes (50 or more employees)

15. **CONTRIBUTIONS. Plan will provide for**

☐ Salary reduction contributions ONLY (No Employer contribution)
☐ Employer contributions ONLY (No salary reductions)
☐ Both salary reductions AND Employer contributions

16. **EMPLOYER CONTRIBUTIONS**
For each Plan Year, Employer will contribute
☐ N/A
☐ _____% of compensation per participant
☐ $_____ per participant
☐ Discretionary amount determined by Employer

******* ALL employer contributions shall be made at the beginning of the plan year.**

AND the contributions are convertible to cash?

☐ Yes
☐ No

AND the contributions made to:

☐ All Accounts
☐ Health Flex Spending Account (Q. 21.)
☐ Health Savings Account (Q. 24.)
☐ _____

17. **FLEXIBLE SPENDING ACCOUNTS will be *ADMINISTERED by* Allegiance for: (Check all that apply)**

☐ Health Flexible Spending Account
☐ Dependent Care Flexible Spending Account

18. **INCLUDE LANGUAGE FOR PRE-TAX GROUP INSURANCE PREMIUMS IN FLEX DOCUMENTS** (even if group a*dministers* premiums)?

☐ Yes, include insurance premium payment language in flex documents
☐ No, do not include premium payment language in flex documents

PRE-TAX PREMIUM PAYMENTS may be elected for the employer major medical coverage and:

☐ Group Term Life Insurance
☐ Dental Insurance
☐ Cancer Insurance
☐ Vision Insurance
☐ Accidental Death and Dismemberment Insurance
☐ Other _____

19. **HEALTH PREMIUM PAYMENTS. Are the premium payments elected above self-insured by the Employer?**

☐ Yes Provider: _____
☐ No

20. **DEPENDENTS. Default language in the Plan Document for the definition of dependent includes older children referenced in IRS Notice 2010-38 (April 27, 2010), which allows the expenses of adult children, up to age 27, to be reimbursed through their parents' Health Flexible Spending Accounts.**
☐ Check here if you do not want to allow adult children to be covered under your Health Flexible Spending Plan.

21. **BENEFIT LIMITATIONS (Not to exceed $2550)**

☐ $_____ shall be maximum participant allocation to Health Flexible Spending Account (including Employer Contribution if any).

22. **FOR THE HEALTH FLEXIBLE SPENDING ACCOUNT, TERMINATED EMPLOYEES SHALL**

☐ Cease contributions and reimbursements upon termination (subject to COBRA limitations)
☐ Continue or cease at Participant's election.

23. **CHANGE IN STATUS:**

HEALTH FLEXIBLE SPENDING PLAN: New election due to change in status permitted?

☐ Yes ☐ No

GROUP HEALTH PLAN: Election revocation allowed for the following changes?

☐ Reduction in hours of service.
☐ Marketplace/Exchange participation.

24. **DO YOU OFFER HEALTH SAVINGS ACCOUNTS (HSA)?**
☐ No
☐ Yes
☐ HSA participants cannot have a Health FSA.
☐ HSA participants can participate in a limited FSA (answer below)

TO ACCOMMODATE HEALTH SAVINGS ACCOUNTS (HSA's), the health FSA will be LIMITED to the following expenses……(Select all that apply):

☐ N/A
☐ Dental, vision and qualifying over-the-counter expenses.
☐ Expenses in excess of HDHP deductible.

FOR
☐ All participants.
☐ Only HSA contributing participants.

AND, claims for medical expenses may only be submitted for
☐ The participant.
☐ The participant and all dependents.

25. **OPEN ENROLLMENT OPTIONS**

☐ Online enrollment reimbursement accounts only.
☐ Online enrollment using Allegiance health platform.
☐ Online enrollment using employer platform and send a file.
Open enrollment period established by administrator in nondiscriminatory manner.

26. **ARE GROUP INSURANCE PREMIUM PAYROLL reduction elections automatically taken pre-tax each plan year?**

☐ Yes – At annual renewal, employees automatically become participants in the plan for the group insurance benefits for the following year. Salaries will be automatically reduced by employer to pay for coverage.
☐ No - Participant must elect to have group insurance annually in order to have premiums taken pre-tax

27. **PARTICIPANTS WHO FAIL TO SIGN A NEW ELECTION FORM SHALL:**

☐ Be considered to have elected not to participate for upcoming Plan Year.
☐ Continue same elections as prior year ONLY for insured benefits.

28. **ALLOW QUALIFIED RESERVIST DISTRIBUTION?**

☐ No
☐ Yes.
IF YES, what amount will be available?
☐ Entire election for FSA minus reimbursements.
☐ Contributions minus reimbursements to date.
☐ Other amount: $_____ (amount not to exceed balance).

29. WILL MORE THAN ONE COMPANY BE COVERED UNDER THIS PLAN?

☐ No
☐ Yes, no signature lines are required.
☐ **Yes, include signature lines.**

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)

(Entity)

Track account separately? ☐ Yes ☐ No

30. ARE THERE SEPARATE DIVISIONS WITHIN THIS COMPANY?

☐ No
☐ Yes

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)

(Entity)

Track account separately? ☐ Yes ☐ No

(**NOTE:** Please attach additional affiliated Employer information)

31. CLAIMS FOR REIMBURSEMENT MUST BE FILED WITHIN:

_____ days following each Plan Year.

AND **for** **Terminated Employees, claims must be filed within**
(Select **one** of the following)

_____ days following Termination of Employment.
_____ days following the Plan Year.

32. PAY CYCLE

☐ Please attach the payroll calendar for the flex plan year.

Prior to each payroll, we plan to:

☐ Upload a payroll contribution file on the Employer portal (auto post by file). We don't need a payroll deduction notification.

☐ Auto post each pay period, receive the payroll deduction notification seven business days prior to our scheduled payroll date. We will send any corrections needed within four business days of the notification.

Important note: Enrollments are entered as an annual amount. Payroll deductions are rounded. The last payroll in a plan year is adjusted so that the total payroll deductions equal the annual election.

33. USE IT-OR-LOSE IT (choose one of the following):

☐ **Keep regular 12 month plan year.** (select one below).

☐ No carryover allowed.

☐ $500 carryover for Health Flexible Spending Account allowed.

☐ **2 ½ Month Grace Period (extends plan year 2 ½ months)**

☐ Add 2 ½ months to our Health Flexible Spending Account

☐ Add 2 ½ months to our Dependent Care Flexible Spending Account.

If Grace Period is adopted, claims for reimbursement must be filed within:

_____ days following the grace period.

If you offer Health Savings Accounts (HSA Q.24.**)**
the 2 ½ Month Extension is limited to (choose one)

☐ H S A participants are <u>not</u> allowed to participate in the 2 ½ Month Extension.
☐ All participants can only incur dental and vision expenses during the 2 ½ month extension.

34. DEBIT CARDS. Is Employer electing the Debit Card?
(Debit cards can be used for all benefits offered.)

☐ Yes (all participants will receive two cards).
☐ No

35. <u>FLEX COBRA</u> SERVICES TO BE ADMINISTERED BY ALLEGIANCE?

☐ No
☐ Yes

36. BROKER NAME & ADDRESS

(Name)

(Company)

(Address)

(City) (State) (Zip)

(E-mail Address) (Telephone)

37. FEES

	FEES
Initial Set-Up Fee	_____
Re-Enrollment Fee	_____
Per Participant/Month	_____
Minimum Monthly Fee	_____
COBRA Services	_____

Following each month of service, Allegiance withdraws fees electronically by ACH.

38. DELIVERY OF INDIVIDUAL PARTICIPANT WELCOME PACKETS (Select method)

☐ Mail to participants individually at $2.00 per packet.
☐ Email all enrollment confirmation materials to the employees.

39. DELIVERY OF FLEX PLAN DOCUMENTS (Select method)

☐ E-mail documents directly to contact person using Docusign.
☐ E-mail documents directly to contact person.

40. HOW DO YOU WANT TO FUND YOUR PLAN?

☐ Allegiance withdraws funds based on claims experience electronically by ACH.
☐ Reimbursements made directly from employer bank account.

41. DO YOU HAVE ANY EMPLOYEES IN THE STATE OF MASSACHUSETTS?

☐ Yes
☐ No

42. REPORT RECIPIENTS/TIMELINES:

REPORT	RECIPIENT	DATE/FREQUENCY
Acct Balance		
Payroll Notice		
Claims Notice		
Billing Notice		

These documents are being printed by Allegiance Benefit Plan Management, Inc., at the direction of the Employer named on the checklist form, under the supervision of an attorney. It is understood that Allegiance Benefit Plan Management, Inc., is not engaged in the practice of law. Any unanswered questions may result in errors in the Plan produced by using the information from this worksheet. I understand that in preparing the document requested, Allegiance Benefit Plan Management, Inc., is utilizing information shown on this checklist to produce legal documents using a format which has been designed by Allegiance Benefit Plan Management, Inc., with advice and assistance of its attorneys. Allegiance Benefit Plan Management, Inc., has made NO REPRESENTATION OR WARRANTY OF ANY KIND, expressed or implied, including no warranties of MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, nor is any opinion, expressed or implied, rendered by its attorneys as to the legal effect, sufficiency or tax qualification of any document utilizing Allegiance Benefit Plan Management, Inc., format. It is understood and agreed that the documents must be reviewed and approved by the Employer's tax and legal counsel and that neither Allegiance Benefit Plan Management, Inc., or its attorneys and accountants are acting as legal or tax advisors to the Employer. I hereby RELEASE Allegiance Benefit Plan Management, Inc., and its attorneys from any and all liability attributable to any legal or other defect in the requested documents.

The cafeteria plan rules (Treasury regulations) require that a signed Plan Document must exist prior to providing benefits. A draft document will be provided to you for signature, based upon the benefit design indicated in this checklist. By your signature below, you certify that the benefit design above is correct and accurate. Allegiance will process claims based upon this design until a signed plan document is received. If modifications are made to this design after claims have been processed, which require Allegiance to reprocess claims, a fee of $20 per claim reprocessed will be assessed.

Authorized signer:____________________________**Date**: ______

(Revised August 2016)

1. Total number of Employees: ________
2. Total number of Employees eligible to participate: ________
3. Highly Compensated Employees:

____
____
____
____
____
____
____
____

4. Key Employees:

____
____
____
____
____
____
____
____

DEFINITIONS:

HIGHLY COMPENSATED EMPLOYEE (HCE):

- An officer; or
- A shareholder owning more than 5% of the voting power or value of all classes of stock of the Employer; or
- Highly compensated based on compensation level, to mean an Employee who earns in excess of $115,000 in the prior Plan Year or, if elected by the Employer, who was in the 20% top-paid group; or
- A spouse or dependent of an individual described above.

KEY EMPLOYEE:

- An officer of the Employer with annual compensation greater than $165,000 (as indexed for cost-of-living adjustments)
- A more-than-5% owner of the Employer; or
- A more-than-1% owner of the Employer with annual compensation in excess of $150,000 (not indexed).

CORPORATE HEADQUARTERS
PO Box 4346
Missoula, MT 59806
(406) 721-2222 or (877) 424-3570
Fax (406) 523-3149 or (877) 424-3539
www.allegianceflexadvantage.com

OREGON OFFICE
PO Box 2930
Tualatin, OR 97062
(503) 885-1888
Fax (503) 885-1988

DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

Allegiance® a Cigna Company

Please complete the following form and return with one of the following documents:

- Voided Check **OR**

- Letter from your bank with your account and routing number listed as well as contact information for the representative at the bank.

I have attached either a voided check or a letter from our bank that states our account number, routing number and bank contact.

___________________________ authorizes Allegiance Benefit Plan Management, Inc. to initiate electronic withdrawal from our checking account in conjunction with services provided pursuant to the Administrative Services Agreement between Allegiance Benefit Plan Management, Inc. and ___________________________. This authority will remain in effect until cancelled in writing or until the termination or expiration of the Administrative Services Agreement.

On behalf of ___________________________ I understand that Allegiance Benefit Plan Management, Inc. may initiate a reversal of any entry made under this agreement if an error has been made. I understand that the financial institution at which I have the above account is required to provide me the procedures for resolving errors on entries made under this agreement. I understand that Allegiance Benefit Plan Management, Inc. will provide a written notice to me of the error within 24 hours.

The deduction amount will be communicated to the Primary Contact.

PRIMARY CONTACT:	AUTHORIZED SIGNER:
EMAIL ADDRESS:	AUTHORIZED SIGNATURE:
PHONE NUMBER:	DATE:

Allegiance
a Cigna Company

DEBIT CARD IMPLEMENTATION AGREEMENT

This notice is confirmation that ______________________________ has elected to implement the debt card option for our reimbursement accounts as of: _______ . As sponsor/plan administrator of the plan, we understand:

- Successful implementation and efficient administration is directly related to employer understanding and support of the process, clear and appropriate employee communications, and timely submission of plan year enrollment.

- Each participant will receive two cards; the second card may be signed and used by the spouse or dependent at the discretion of the participant.

- Plan participants will now have two reimbursement options: traditional claim filing and the debit card. IRS regulations require claims be substantiated.

- Participants will receive a cardholder agreement. Employees will certify, upon enrollment and through each use of the card, that they will use the card only for eligible expenses, that any expense paid by the card has not been reimbursed nor will the employee seek reimbursement under any other plan. Participants and their spouses will retain documentation for all expenses for submission to claims processor.

- Cards will be inactivated if a plan participant or their spouse does not provide appropriate documentation; and the participant will be required to reimburse the plan. Unsubstantiated claims not reimbursed by a participant will be charged to the employer as an expense which is offset by the gain realized when the reimbursement is removed from the plan during year-end plan reconciliation.

- Employer will have sufficient funds available at all times to cover card transactions.

- Employer will inform terminated employees that the card will be de-activated. The employer is encouraged to collect the card as part of the exit interview.

- **Please review the limits of the card and choose one of following:**

  - ☐ Please use the Allegiance standard co-pays as the auto-approve standard for the debit card.
  - ☐ Please use our actual co-pays as the auto-approve standard (please attach).
  - ☐ Please set us up for claims exchange/joint processing, and limit debit card functionality to Rx only.

- ☐ Please set up a carrier file feed for auto-substantiation of transactions.

ALLEGIANCE STANDARD AUTO-APPROVE PARAMETERS

DESCRIPTION OF SERVICES	STANDARD CO-PAYS
Medical	$5.00 through $100.00 in $5.00 increments
Prescription	$5.00 through $100.00 in $5.00 increments
Emergency	$50.00 through $200.00 in $5.00 increments
Dental	$5.00 through $100.00 in $5.00 increments
Vision	$5.00 through $100.00 in $5.00 increments

SIGNED: ______________________________ PRINTED NAME: ______________________________

DATE: ______________________________ TITLE: ______________________________