ALLEGIANCE FLEX ADVANTAGE

New Group ☐
Current 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

Human Resources: ______________________________

HR Phone: ______________________________

HR E-Mail 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
☐ 502
☐ 503
☐ 504
☐ 505
☐ 506
☐ _____

6. PLAN INFORMATION

☐ New Plan
☐ Amendment and restatement

7. PLAN YEAR

Begins ______________________________
(Month / Day) (January 1)

Ends ______________________________
(Month / Day) (December 31)

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 ______________________________
(Month / Day / Year) (1/1/2011)

This restatement ______________________________
(Month / Day / Year) (1/1/2011)

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 eligibility requirements
☐ Salaried Employees only
☐ Hourly Employees only
☐ 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)

a ☐ Date of hire (No service required)
b. ☐ ________ days after date of hire
c. ☐ ________ months after date of hire
d. ☐ ________ years after date of hire

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

☐ 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 and/or #12)
☐ First day of month following date requirements were met as indicated in #11 and/or #12
☐ Date conditions for eligibility are met (See #11 and/or #12)
☐ First day of Plan Year following date requirements were met as indicated in #11 and/or #12
☐ (Other) _____

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
☐ Other_____
☐ Employer pays 100% of employee's insurance premiums

AND the contributions shall be made:
☐ At the beginning of Plan Year
☐ Pro rata each pay period

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.)
☐ Employee Premiums
☐ _____

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
☐ No, do not include premium payment language

PRE-TAX PREMIUM PAYMENTS may be elected for:
☐ Group Health insurance
☐ Dependent health insurance ONLY (paid by employee)
☐ No group health insurance

SEPARATE PRE-TAX PREMIUM PAYMENTS also may be elected for:
☐ Group Term Life Insurance
☐ Disability Insurance
☐ Dental Insurance
☐ Cancer Insurance
☐ Vision Insurance
☐ Accidental Death and Dismemberment Insurance
☐ Prescription Drug Coverage
☐ Other _____

19. **HEALTH PREMIUM PAYMENTS. Are the premium payments elected above self-insured by the Employer?**
☐ Yes ☐ No

20. **May Participants seek reimbursement for individual policies through the Premium Reimbursement Plan?**
☐ No
☐ Yes, at the Administrator's discretion
IF YES, is Allegiance administering this Premium Reimbursement Plan? ☐ Yes ☐ No

21. **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.

22. **BENEFIT LIMITATIONS**

☐ $________shall be maximum participant allocation to Health Flexible Spending Account (including Employer Contribution if any).
☐ N/A –Health Flexible Spending Plan is not offered.

23. **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.
☐ N/A –Health Flexible Spending Plan is not offered

24. **HEALTH FLEXIBLE SPENDING PLAN**
New election due to change in status permitted?

☐ No
☐ Yes
☐ N/A –Health Flexible Spending Plan is not offered.

25. **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.

Allow one-time Flex rollover to H S A? (specific rules apply)
☐ Yes (if yes, must have 2 ½ month extension)
☐ No

26. **OPEN ENROLLMENT PERIOD SHALL BE**

☐ The ________day period prior to each Plan Year.
☐ Established by administrator in nondiscriminatory manner.

27. **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

28. **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.

29. **ALLOW QUALIFIED RESERVIST DISTRIBUTION?**

☐ No
☐ Yes.
IF YES, what amount will be available?
☐ Entire election for FSA, minus reimbursements.
☐ Amount contributed-to-date, minus reimbursements (default).
☐ Other-not exceeding elected amount minus reimbursements.
If other, list set amount $_____.

30. 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)

Separate bills? ☐ Yes ☐ No

31. ARE THERE SEPARATE DIVISIONS WITHIN THIS COMPANY?

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

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)

(Entity)

Separate bills? ☐ Yes ☐ No

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

32. CLAIMS FOR REIMBURSEMENT MUST BE FILED WITHIN

(Applies only to Health Care and Dependent Care reimbursements)

_____ 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.

33. PAY CYCLE (Please write the number of actual deductions taken)

Number of deductions taken each Plan Year: _____
First Pay Date: _________(required on bi-weekly pay cycles)

34. THE 2 ½ MONTH GRACE PERIOD RULE. ***(NOTE: If adopted, Allegiance will increase the 'Fee for Participant/Month' at first annual renewal by $.25 per participant.)***

☐ Keep regular 12 month plan year.
☐ Add 2 ½ month grace period to our Health Flexible Spending Account
☐ Add 2 ½ month grace period 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 not allowed to participate in the 2 ½ Month Extension.
☐ All participants can only incur expenses for dental and vision expenses to submit against prior year's fund balance during the 2 ½ month extension.

35. DEBIT CARDS. Is Employer electing the Debit Card?

☐ Yes - **If you haven't already, please complete Debit Card Employer Acknowledgement attached *(required).***
☐Health ☐Dependent care
☐ No

36. FLEX COBRA SERVICES TO BE ADMINISTERED BY ALLEGIANCE?

☐ No
☐ Yes - Please contact your broker or Allegiance Rep to add COBRA services to your Plan.

37. BROKER NAME & ADDRESS

(Name)

(Company)

(Address)

(City) (State) (Zip)

(E-mail Address)

Telephone: ____________

Fax: ____________

Federal Tax ID# ____________

38. FEES

	ABPM	AGENT*	TOTAL
Initial Set-Up Fee	_____	_____	$_____
Annual Re-Enrollment Fee	_____	_____	$_____
Fee for Participant/Month	_____	_____	$_____
Minimum Monthly Fee	_____	_____	$_____
Debit Cards	_____	_____	$_____
COBRA Services Fee	_____		

***In order for agent commission to be paid, the amount must be indicated in the fee schedule above.**

39. DELIVERY OF INDIVIDUAL PARTICIPANT WELCOME PACKETS **(Select method)**

☐ Mail to participants individually at $.75 per packet.
☐ Mail all welcome packets to the employer at employer's address.

40. DELIVERY OF FLEX PLAN DOCUMENTS **(Select method)**

☐ E-mail documents directly to contact person. ***(Preferred)***
☐ Mail documents via US Postal Service directly to contact person.

41. HOW DO YOU WANT TO FUND YOUR PLAN?

☐ Hold your own funds in bank account.
☐ Allegiance holds your funds. (Choose delivery method below)
☐ Funds sent to Allegiance by check.
☐ Funds sent electronically by ACH.

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

☐ Yes
☐ No

43. ELECTRONIC BILLING:

☐ E-Mail my bill to:____________

44. INSTANT PASSWORDS for participant website access:

☐ Yes
☐ No

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 July 2010)

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, defined by Code § 125 414(q) to mean an employee who earns in excess of $110,000 in the prior plan year or, if elected by the employer, who was in the 20% top-paid group; or,
- A spouse or dependent (within the meaning of Code § 152) of an individual described above.

KEY EMPLOYEE:

- An officer of the Employer with annual compensation greater than $160,000 (as indexed for cost-of-living adjustments); or
- 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).

ALLEGIANCE
FLEX ADVANTAGE™

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

Group funding options for Flex plans @ Allegiance Benefit Plan Mgmt, Inc.

____ I would like to set up my own checking account.

Please fill out attached information for the account. Allegiance will issue checks on this account M-F and follow your request for check registers. You will hold all payroll contributions. A contribution spreadsheet or the adjusted Allegiance billing will need to be sent to Allegiance each pay period to update participant balances on the system.

_____ I would like to send my payroll contributions to Allegiance each pay period.

Allegiance will pay claims daily up to the amount funded. If claims being paid exceed funds received a request for funding will be sent and claims will be pended until funds are received. Funds may be sent via ACH or paper check, a contribution spreadsheet, adjusted Allegiance billing or contribution import file that matches the funds sent must also be included each pay period.

____ I would like to send advance funds to pay claims daily.

You may advance a bulk amount each month or every 2 months (etc.) depending on claim payout. Allegiance will issue checks on these funds daily and request additional funds when claims requested exceed balance in account. Claims will pend until funds are received. Funds may be sent via ACH or paper check. A contribution spreadsheet or the adjusted Allegiance billing will need to be sent to Allegiance each pay period to update participant balances on the system.

We will provide the banking information after this form has been received.
For questions regarding banking information please contact Allegiance @
1-877-424-3570 xt 4525 Stacy Wilkey

Employer

____

Signed by

____

Send to: Allegiance Benefit Plan Management—PO Box 4346—Missoula, MT 59806
Note: Documentation must be received before the implementation date.

ALLEGIANCE
FLEX ADVANTAGE™

TO: ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.

FROM: ____

RE: FLEX DEBIT CARD IMPLEMENTATION REQUEST

This notice is confirmation that ______________________ has elected to implement the Flex Debit Card option 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.

- Plan participants will now have two reimbursement options. One option is traditional paper claim filing; the other option is through use of the Flex Debit Card. IRS regulations require ALL claims be substantiated (paper claims and card transactions) which, in most cases, require the plan participant to provide documentation of expenses after using the Flex Debit Card.

- Participants will receive a cardholder agreement that they must read and adhere to. 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 plan participants or their spouses do not provide appropriate documentation; and the participant will be required to reimburse the plan**. Unsubstantiated claims not reimbursed by participants will be charged to the employer as experience losses during year-end plan reconciliation.**

- The total dollar amount of daily card transactions will be debited from an account identified on the Medibank (mbi) Authorization Form. Employer will have sufficient funds available at all times to cover card transactions.

- If the Employer chooses to use own bank account, a $1.00 ACH Debit Card processing fee will be charged against their account at the time of set-up.

- Employer will inform terminated employees that the card will be inactivated. At their discretion, the employer may wish to collect the card along with other employer-related credit cards and keys.

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

☐ I have reviewed the recommended parameters and would like to have these set for our card as well.

☐ I have reviewed the recommended parameters and would like to make changes to them (please attach).

We would like to elect: **Spouse cards** ☐Yes ☐No **Dependent Cards** ☐Yes ☐No

*A separate enrollment form will be needed for spouse and/or dependents to enroll. This will be e-mailed to you when your debit card plan is set up. *

SIGNED: __________________________ PRINTED NAME: ________________________

DATE: ________________ TITLE: ________________________

Send to: Allegiance Benefit Plan Management—PO Box 4346—Missoula, MT 59806
Note: Documentation must be received before the implementation date.

IIAS ACCEPTABLE MERCHANT CODES				
GROUP:	ALLEGIANCE GENERAL	MAXIMUM	MAXIMUM	
MERCHANT	DESCRIPTION	TRANSACTION	TOTAL	AUTOMATICALLY
TYPE CODE		AMOUNT	AMOUNT	APPROVED
2833	Medicinal Chemicals and Botanicals			NO
2834	Pharmaceutical Preparations			NO
2835	In-Vitro and N-Vitro Diagnostics			NO
3827	Opticla Instruments and Lenses			NO
3842	Orthopedic and Prosthetic Appliances			YES-WHOLE $ <30
3851	Eyeglasses and Eye Safety Shields			YES-WHOLE $ <30
4119	Ambulance Services			YES
5047	Den/Lab/Med/Opthalmic Hospital Equip & Supp			NO
5048	Opthalmic Supplies			NO
5975	Hearing Aids			YES
5976	Orthopedic Goods, Prosthetic Devices			YES
8011	Doctors NEC			YES-WHOLE $ AMTS BETWEEN 5 & 100 &/OR EQUAL TO
8021	Dentists, Orthodontists			YES-WHOLE $ <30
8031	Osteopathic Physicians			YES-WHOLE $ AMTS BETWEEN 5 & 100 &/OR EQUAL TO
8041	Chiropractors			YES-WHOLE $ AMTS BETWEEN 5 & 100 &/OR EQUAL TO
8042	Optometrists, Opthalamologists			YES-WHOLE $ AMTS BETWEEN 5 & 100 &/OR EQUAL TO
8043	Opticians, Optical Goods & Eyeglasses			YES-WHOLE $ <30
8044	Opticla Goods and Eyeglasses			YES-WHOLE $ <30
8049	Chiropodists, Podiatrists			YES-WHOLE $ AMTS BETWEEN 5 & 100 &/OR EQUAL TO
8050	Nursing and Personal Care Facilities			NO
8052	Immediate Care Facilities			YES-WHOLE $ AMTS BETWEEN 5 & 100 &/OR EQUAL TO
8059	Nursing & Personal Care Facilities			NO
8062	Hospitals			YES-WHOLE $ <30
8063	Psychiatric Hospitals			YES-WHOLE $ <30
8069	Specialty Hospitals, except Psychiatric			NO
8071	Medical and Dental laboratories			YES-WHOLE $ <30
8072	Dental Laboratories			NO
8082	Home Health Care Services			NO
8093	Specialty Outpatient Facilities, NEC			NO
8099	Medical Services & Health Practitioners, NEC			YES-WHOLE $ AMTS BETWEEN 5 & 100 &/OR EQUAL TO

Above are the general guidelines set up for substantiating claims per IRS regulations, which states that all claims must be substantiated. The guidelines are set up for each merchant code. We can adjust the maximum transaction amount, maximum total amount, or change the parameters to fit your needs. When choosing the parameters, please keep in mind the purchases that could be made at the merchant codes. The asterisked (*) merchant codes are those that are more generalized and could allow purchases outside the regulations. These purchases could include cosmetics, food products, toiletries, tobacco, novelty items, apparel, furniture, electronics, household items, sports equipment, and appliances. The choice of the parameters directly affects the documentation requirement for the reimbursed claims. If a YES choice is made for auto approving the claim, this means that no documentation will be requested from the participant. Also if you choose not to have a maximum transaction amount or a maximum total amount on a merchant code, the card swipe will allow any amount. Keeping this in mind, the asterisked merchant codes are more of a risk to the employer since they can allow purchases outside the guidelines and you might want to choose more conservative parameters. Once you have reviewed the merchant codes and made the appropriate changes, please return the list prior to the group setup to Allegiance Benefit Plan Management or email to swilkey@askallegiance.com or jlanger@askallegiance.com