Allegiance℠ by Cigna Healthcare

New Group? ☒
Current Health Group? ☐
Health Group # _____
Joint ☐. Carrier FF ☐

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-Mail Address _____

Payroll Department: _____

PR Phone: _____

PR E-Mail Address _____

Person Authorized to amend Plan:

_____
(Print Name) (Title)

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)

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

Will Allegiance be processing runout for the current Plan Year?
☐ Yes, beginning _____
(Month / Day) (May 1)

Will you transfer carryover balances from the previous Plan Year?
☐ No
☐ Yes, Transfer Date: _____
(Month / Day/Year) (mm/dd/yyyy)

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 **(self-employed partners not eligible)**
☐ 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

☐ Same as Group Health Plan 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 Health FSA employer contributions shall be posted 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. 20.)
☐ Health Savings Account (Q. 25.)
☐ Dependent Care Flexible Spending Account

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 employer a*dministers* premiums)?

☐ Yes, include insurance premium language in flex documents
☐ No, do not include premium 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. HEALTH FSA BENEFIT LIMITATIONS (Not to exceed IRS maximum for the applicable benefit calendar year.)

☐ $_____ shall be maximum participant election to Health FSA (including Employer Contribution if any).
Additional Option:
☐ Require minimum election of _____.

21. HEALTH FSA USE IT-OR-LOSE IT
(choose one of the following options):

☐ **Option 1: Keep regular 12 month plan year. (select one below).**

☐ No carryover allowed.

☐ Allow maximum carryover for Health FSA.
Carryover default amount is 20% of the IRS maximum benefit. **Carryover only accounts are billed as active participants.*
Additional Carryover options:
☐ Require re-enrollment in order to carryover balance.
☐ Require minimum carryover balance of _____.

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

☐ Add 2 ½ months to our Health FSA

☐ Add 2 ½ months to our Dependent Care FSA.

If Grace Period is adopted, claims must be filed within: _____ days following the grace period.

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. CLAIMS FOR REIMBURSEMENT MUST BE FILED WITHIN:

_____ days following each Plan Year for active participants.

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

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

24. 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.

25. 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 <u>HEALTH SAVINGS ACCOUNTS</u> (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 HSA expenses may only be submitted for
☐ The participant.
☐ The participant and all dependents.

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

☐ Yes – At <u>annual renewal</u>, 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. DO YOU HAVE ANY EMPLOYEES IN THE STATE OF MASSACHUSETTS?

☐ Yes
☐ No

30. OPEN ENROLLMENT OPTIONS

☐ Online enrollment using Allegiance system.
☐ Online enrollment using Allegiance health plan system.
☐ Enrollment through employer and send a file to Allegiance.
Open enrollment period established by administrator in a nondiscriminatory manner.

31. PAY CYCLE

Prior to each payroll, we will:
☐ Upload a payroll contribution file to the Allegiance system.

☐ Auto post active elections in the system each pay period, Receive the payroll deduction notification seven business days prior to our scheduled payroll date. We will make 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 the total payroll deductions equal the annual election.

Please attach the payroll calendar that shows dates payroll deductions occur.

32. HOW DO YOU WANT TO FUND YOUR PLAN?

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

33. HOW WILL MID-YEAR CHANGES BE SUBMITTED?

☐ Employer processes changes on Employer Portal.
☐ Employer sends changes on Allegiance file format.
☐ Vendor sends eligibility file on Allegiance file format.
Vendor name: _____
☐ From Allegiance Health.
Notes: _____

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

☐ Yes (all participants will receive two cards).
☐ No
FSA STORE-Eligible Over-the-Counter Products (OTC)
(See the Debit Card Implementation Agreement for details)
☐ Yes
☐ No

35. DELIVERY OF INDIVIDUAL ENROLLMENT CONFIRMATION LETTERS (Select method)

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

36. DELIVERY OF FLEX PLAN DOCUMENTS (Select method)

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

37. 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

38. ARE THERE SEPARATE DIVISIONS IN THIS COMPANY?
NOTE: Please attach additional affiliated Employer information)

☐ No ☐ Yes

_____
(Company Name)
_____
(Street Address)
_____
(City) (State) (Zip)
_____
(Tax ID Number)
_____
(Entity)
Track account separately? ☐ Yes ☐ No

39. <u>HEALTH FSA COBRA</u> SERVICES TO BE ADMINISTERED BY ALLEGIANCE?

☐ No
☐ Yes

40. BROKER NAME & ADDRESS

_____
(Name)
_____
(Company)
_____
(Address)
_____
(City) (State) (Zip)
_____
(E-mail Address) (Telephone)

41. FEES

	FEES	
Initial Set-Up Fee	_____	
Per Participant/Month	_____	☐E-Price
Minimum Monthly Fee	_____	
COBRA Services	_____	

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

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 September 2024)

Allegiance℠
by Cigna Healthcare

CORPORATE HEADQUARTERS
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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

Allegiance℠ by Cigna Healthcare

PAYROLL DEDUCTION INFORMATION

Employer Name: _____

PAYROLL ROUNDING INFORMATION			
Rounding of Payroll Deductions: *(Indicate the rounding method for uneven deductions. Example: $1,000/elections/26 payrolls = $38.4615)*	☐ Standard Rounding	☐ Adjust First Period	☐ Adjust Last Period
	☐ Round Up	☐ Adjust First Period	☐ Adjust Last Period
	☐ Round Down	☐ Adjust First Period	☐ Adjust Last Period

Payroll Name: (Example: BW or BW26)	
Benefits Deduction Payroll Cycle: (Please select your payroll cycle for withholding deductions.)	☐ Weekly (52 pay periods/year) ☐ Bi-Weekly (24 pay periods/year) ☐ Bi-Weekly (26 pay periods/year) ☐ Semi-Monthly ☐ Monthly

Please complete the specific payroll benefit deduction dates in the calendar below:

20_____		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Pay Dates	1st												
	2nd												
	3rd												
	4th												
	5th												

Payroll Name: (Example: BW or BW26)	
Benefits Deduction Payroll Cycle: (Please select your payroll cycle for withholding deductions.)	☐ Weekly (52 pay periods/year) ☐ Bi-Weekly (24 pay periods/year) ☐ Bi-Weekly (26 pay periods/year) ☐ Semi-Monthly ☐ Monthly

Please complete the specific payroll benefit deduction dates in the calendar below:

20_____		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Pay Dates	1st												
	2nd												
	3rd												
	4th												
	5th												

Allegiance℠ by Cigna Healthcare

DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

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

As an authorized representative of the Employer, I understand that Allegiance Benefit Plan Management, Inc. may initiate a reversal of any entry made under this authorization if an error has been made. I understand that the financial institution at which Employer has the above account is required to provide to designated Employer representatives the procedures for resolving errors on entries made under this authorization. I understand that Allegiance Benefit Plan Management, Inc. will provide a written notice to designated Employer representative of the error within 24 hours.

The deduction amount will be communicated to the Primary Contact designated by Employer.

PLEASE PRINT

_____	_____
Employer Name	Financial Institution
_____	_____
Primary Contact	City/State
_____	_____
Authorized Signature	Date
_____	_____
Account Number	Routing and Transit Number

Please attach a copy of a voided check or bank note to confirm banking information noted above.

Confirmed date that Claims Based Funding should start_____

Claims payments releasing daily.

Allegiance℠ by Cigna Healthcare

DEBIT CARD IMPLEMENTATION AGREEMENT

This notice is confirmation that _____ has elected to implement the debit 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.

Debit Card can be used for: Medical FSA ☐ (see parameters below) Dependent Care FSA ☐

- Please review the limits of the card and choose one of the three options below. Auto-approved expenses do not require documentation to be submitted.

☐ Please use the Allegiance standard co-pays as the auto-approve standard for the debit card.

- **Options for carrier file feeds for auto-substantiation of transactions:**

☐ Medical _____
☐ Dental _____
☐ Vision _____

ALLEGIANCE STANDARD AUTO-APPROVE PARAMETER	
DESCRIPTION OF SERVICES	STANDARD CO-PAYS
Medical	$1.00 through $200.00
Prescription	$1.00 through $100.00
Dental	$1.00 through $100.00
Vision	$1.00 through $100.00

FSA Store:

TPA may receive revenue sharing fees from the FSA Store, a third party vendor, based on sales revenue from eligible products sold to Plan participants in the following amounts:

- Monthly sales revenue between $1 and $10,000 = 3% of such amount.
- Monthly sales revenue greater than $10,000 and less than or equal to $100,000 = 4% of such amount.
- Monthly sales revenue greater than $100,000 and les s than or equal to $500,000 = 5% of such amount.
- Monthly sales revenue greater than $500,000 = 6% of such amount.

SIGNED: _____ PRINTED NAME: _____

DATE: _____ TITLE: _____

Reimbursement Accounts Employer Access Form

Plan Sponsor/Employer: ________________________________

The following individuals are authorized on behalf of the plan to request and receive from Allegiance Benefit Plan Management, Inc. subject to the limitations of applicable federal regulations, access in the below categories; protected health information (PHI) on employees and their dependents; billing information; monthly reporting; and employee adding and terminating information. Such information shall only be used for legitimate plan administration payment or health care operations purposes recognized by applicable regulations, and Plan Administrator/Employer understand that use of this information for purposes other than plan administration, payment and health care operations is strictly prohibited and that civil and criminal penalties will apply to any individual who is found to have improperly used or disclosed PHI in a manner contrary to federal regulations.

Please contact your reimbursement accounts specialist with any questions or updates for your plans account access form.

KEY*	
Automatic Reports	Any report option below will include the Account Invoice, Enrollment Verification, Year-End Report and Open Enrollment Confirmation.
Funding Reports	Includes Employer Funding and Debit Card Funding
Full Access	Manage individual employee data on employer dashboard, importing/viewing new files, view plans, request reports, view/remove reports.
Reports Only Access	Request and view/remove reports.
PHI Access	Information accessible when calling or emailing Allegiance.

Please list all persons who should have online access.

Recipient Name/Title (Please Print)	Phone Number	Email Address	Email Notification of Report Availability. **Must have either Full or Reports only Access to retrieve reports.*	Access Level:
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*

Name (Print): ________________________________ Title: ______________________

Signature: ___________________________________ Date: ______________________