Resolution No. T-2017-12-012R

A RESOLUTION AUTHORIZING THE CUNNINGHAM TOWNSHIP SUPERVISOR TO SIGN A CONTRACT FOR FLEXIBLE SPENDING ACCOUNT FOR HEALTH INSURANCE COVERAGE WITH KEY BENEFIT ADMINISTRATORS

WHEREAS, Cunningham Township provides health insurance benefits to the Township Supervisor, Township Assessor and the eligible employees of those offices; and

WHEREAS, it is in the best interests of the Township to provide the most health and cost-effective plan for employees; and

WHEREAS, establishing a Flexible Savings Account for the Township will allow employees to save on their health care costs; and

NOW, THERFORE, BE IT RESOLVED by the Township Board of the Town of Cunningham, that the Township Board authorizes the Township to Sign a contract for Flexible Spending Account for Health Insurance Coverage with Key Benefit Administrators.

APPROVED, this 18th day of December 2017 by the Township Board of Cunningham Township, County of Champaign, State of Illinois.

_____ _____

Township Clerk Chair

Flexible Benefits Plan Implementation Packet

Township of Cunningham

Section 125 Flexible Benefits Plan
Implementation Packet

Thank you for your interest in the employee benefit plan administration services offered by Key Benefit Administrators (KBA).

This packet contains all of the necessary information in order for KBA to install and begin servicing your plan. For assistance completing any of the enclosed paperwork, please contact our KBA Flex Account Manager:

Tirice Weddle
317-284-7151 or 800-558-5553 ext 7151
Tweddle@keybenefit.com

All of the items included in this packet are used to build your plan and process the claims to your specific plan design. Please review carefully. **Please return the complete packet with the authorized signature on the pages designated. Please include a check covering the Plan's Installation fee (outlined in the attached Administrative Services Agreement), payable to KBA.** We are unable to begin building your plan until the Installation Fee and all applicable signatures have been received.

In order for your Employees to receive their Flex Debit Cards timely, it is REQUIRED that KBA receive the implementation packet and Enrollments no later than the 15th of the month prior to the effective date.

Regular Mail:	**Overnight Delivery:**
FlexPro™ Key Benefit Administrators, Inc. P.O. Box 55210 Indianapolis, IN 46205	*FlexPro*™ Key Benefit Administrators, Inc. 8330 Allison Pointe Trail Indianapolis, IN 46250

Email: flexpro@keybenefit.com

KBA looks forward to providing your organization world-class service and support for years to come!

Sincerely,

FlexPro, Key Benefit Administrators, Inc.

KEY BENEFIT ADMINISTRATORS

Administrative Services Agreement of a Plan Supervisor of Flexible Benefits Plan

I. Plan Installation/Takeover – One Time Fee	**$250.00**		
➢ Expert Plan Consultation & Design Assistance by ECFC Certified Flexible Compensation Specialist and/or Benefit Consultant.			
➢ Plan Document & E-file Summary Plan Description			
➢ Key Benefit Administration Manual			
➢ Employee Information Enrollment Packet (E-file)			
II. Monthly Administration Services: [1]	**$5.25 per participant**		
Includes:	**Subject to a minimum monthly charge of $50.00**		
➢ Participant claim processing.			
➢ All checks and correspondence sent to employer for distribution to Plan Participants.			
➢ Toll-Free Phone/Fax for Participant and Employer			
➢ Benefits Card® Flex Card: **(ONLY where applicable)**			
• Point-of-Purchase Access to FSA Account			
• Compliance with IRS guidelines on debit card usage			
➢ Online Account Management Services:			
• FSA Balance Inquiries, Scheduled Employee Emails			
• Transaction History, Statements on demand			
III. Annual Service Fee (at renewal):	**$250.00**		
➢ Renewal Setup			
• Information Packets, E-file packets only (see additional services for hard copy information packet)			
• FSA Participant Set-Up, E-file election remittance only (see additional services for hard copy enrollment forms submitted)			
IV. Additional Services, as requested:		**YES** (Please check one)	**NO**
➢ Participant Direct Mail Service - checks and correspondence sent directly to Participant's Home, Per Participant per month	**$0.50**	☐	☑
➢ Participant Direct Deposit Option – Deposits made directly to employee's bank account. Charge is per participant per month but can be combined with Direct Mail or stand alone.	**$0.50**	☑	☐
➢ Employee Information Packets – hard copies sent to employer, per packet, per year.	**$1.00**	☐	☑
➢ Hard copy enrollment forms returned to KBA for data entry – Per participant, per enrollment form	**$2.00**	☐	☑
➢ Form 5500 Preparation, fee per Form 5500	**$300.00**	☐	☑
➢ Additional On Site Enrollment Meetings, Per Site, Per Day	**$250.00**	☐	☑

1. Fees reflected are Per Participating FSA Employee Per Month. Fees apply only to FSA participants, not to employees solely participating in the plan's pre-tax premium provision. Administration fees will be charged for 90 days past Plan termination including the grace period and run-off.
2. At least some Non-Discrimination testing is required for all entities each year. You will receive the necessary paperwork at the beginning of the plan year.
3. Many employers no longer have Form 5500 filing requirements for Flexible Benefits Plans. Effective April, 2002 only Flexible Benefit plans with 100+ participants in the Health Care FSA are subject to the Form 5500 filing requirement. Upon request of the plan sponsor, KBA will prepare the Form 5500 as appropriate.

NOTE: Additional charges may apply if we are in receipt of incorrect banking information or draft is returned as a result of insufficient funds.

Employer/Plan Sponsor: Cunningham Township Plan Year: 2018

Authorized Signature: _____ Date: _____

KEY BENEFIT ADMINISTRATORS

Section 125 Plan Adoption Agreement

The undersigned employer adopts/restates a Section 125 Flexible Benefits Plan for those employees who qualify as participants. **Please Print.**

GROUP INFORMATION

1. Name of Employer	2. Employer Federal Tax ID #	3. Business Code
Cunningham Township	37-6000533	9111

4. Mail Address	5. City	6. State	7. Zip Code
205 W. Green Street	Urbana	IL	61801

8. Physical Address	9. City	10. State	11. Zip Code
205 W. Green St.	Urbana	IL	61801

12. Primary Contact Name	13. Phone #	14. Fax #	15. Email Address
Danielle Chynoweth	217-384-4144 ext.		supervisor@cunninghamtownship.org

16. Billing Contact Name	17. Billing Contact email:	
Danielle Chynoweth	supervisor@cunninghamtownship.org	**Billing Notes**: Bills are emailed to the billing contact by the 15th of each month from FlexBilling@keybenefit.com for the upcoming month. Payment is due within 30 days. If needed, please include special instructions with the Implementation packet.

18. Decision Maker Name	19. Phone #	20. Fax #	21. Email Address
Danielle Chynoweth	ext.		supervisor@cunninghamtownship.org

BROKER/AGENT INFORMATION

1. Name of Broker/Agent	2. Agency Name	3. Broker/Agency Federal Tax ID # or SS#
Shirley Evans-Wofford	Lambent Risk Management Services, Inc.	36-4450285

4. Address	5. City	6. State	7. Zip Code
33 N. LaSalle St. Ste 1150	Chicago	IL	60602

8. Phone #	9. Email Address
312-220-9200 ext. 2568	soraya_santoyo@lambent-rms.com

OTHER PLAN INFORMATION

1. Do you have other existing Benefits Plans?

☑ Yes ☐ No

IF NO:

Next Available Welfare Plan Number (501, 502, etc.): _____

IF YES:

Plan Type	Original Effective Date	Plan Number
Premium Only Plan		
Full Flex Plan		
HRA		
HSA		

2. Plan Administrator will be the same as the Employer, unless designated otherwise below.

Type of entity (select one):

☐ Partnership* ☐ C Corporation ☐ S Corporation** ☐ Professional Corporation

☐ LLC* ☐ Non-Profit ☐ LLP* ☐ Sole Proprietorship*

☐ Other: _____ ☑ Governmental Entity

* Self-employed may not participate

** > 2% owners, their spouse, lineal ascendants and descendants may not participate

In connection herewith, the Employer makes the following statements and selections for each plan:

I. PLAN AGREEMENT:

1. The effective date shall be 01 / 01 / 2018

2. The first plan year shall begin on the effective date of the FSA and shall end 12 / 31 / 2018

3. Each subsequent plan year

Begins 01 / 01 / 2019 and ends on 12 / 31 / 2019

II. For the benefit of its employees, the undersigned Employer adopts/restates a Flexible Benefits Plan, which includes these separate optional benefits:

- ☑ Pre-Tax Premium Provision
- ☐ Individual Premium Reimbursement Provision
- ☑ Health Care Flexible Spending Account
- ☐ Dependent Care Flexible Spending Account
- ☐ Health Savings Account (if you check this benefit, please complete the HSA section at the end of this Adoption Agreement)

Are you interested in the Flexible Benefit (debit card) for your Employees? ☑ Yes ☐ No
(Note: Not all benefit types are applicable for the debit card option.)

Number of Eligible Employees: 7

III. Benefit Selection – **Note, in order to have a Flexible Benefit plan you must offer a Group Health Plan.**

Applicable benefits to be taken pre-tax (please list carrier providing the benefits)

- ☑ Health Plan BCBS of Illinois
- ☑ Dental Plan Delta Dental
- ☑ Vision Plan (TBD)
- ☐ AD&D _____
- ☐ Group Term Life (up to $50K) _____
- ☑ High Deductible Health Plan (Qualified) BCBS of Illinois
- ☐ Other: _____
- ☐ Short Term Disability* _____
- ☐ Long Term Disability* _____
- ☐ Hospital Indemnity _____
- ☐ Cancer Plan _____

***** *Pre-taxing disability premiums will cause the disability benefits to be taxable*

Employer Contributions to the Plan: ☐ No ☐ Yes, Amount of Employer Contributions: $_____ (Max of $500 or 2 x Employees annual pledge)

Employer Contributions paid: ☐ Up front ☐ Monthly ☐ Per pay

Employer will match _____% of the amount the Employee elects for salary reduction up to $_____

Employer Contributions prorated based on date employee meets eligibility requirement: ☐ Yes ☐ No

Employer Contributions may be used for: ☐ Premiums ☐ Health Care FSA ☐ Dependent Care FSA

Employer Contributions will be included in the annual maximum.

Pre-Tax Premium deductions of Applicable Benefits

- ☑ Automatic premium deductions (Premiums will automatically be deducted on a pre-tax basis unless a Waiver of Participation form is signed) *STANDARD*
- ☐ Other: _____

Maximum Eligible Premium Reallocation: Total Premiums

Maximum Annual Individual Premium Reallocation: $ N/A

Maximum Annual Health Care FSA Reallocation: $ 2,650 — May not exceed IRS maximum of $2,650

Maximum Annual ~~Health Care~~ FSA Reallocation: (Limited Purpose) $ 2,650

Maximum Annual Dependent Day Care FSA Reallocation: $ N/A — May not exceed IRS maximum of $5,000

IV. Eligibility

"Eligible Employee" under the plan means (Check one):

A. ☐ Any employee who is anticipated to work _____ hours per week for the Employer.

B. ☑ Any employee who is anticipated to work 30 hours per week for the Employer, excluding or including those designated below:

- ☑ Employee paid by commission only
- ☐ Leased Employees
- ☑ Contract workers and independent contractors
- ☐ Employee paid by salary
- ☐ Employee covered under a collective bargaining Agreement.
- ☐ Employee paid by the hour
- ☐ Other: _____

Eligible Employees will satisfy the Plan's service requirement on: (*Check/Complete One*)

a. ☐ The first day of the month following _____ days of employment.

b. ☑ The first day immediately following 0 days of employment.

c. ☐ Other: Management: _____

d. ☐ Other: Hourly: _____

Newly hired Eligible Employees meeting the Plan's eligibility requirements may begin participation as of:

a. Individual Premium Enrollment:

N/A ☐ Upon Eligibility ☐ Annual Open Enrollment ☐ Other: _____

b. Health Care FSA Enrollment:

☑ Upon Eligibility ☐ Annual Open Enrollment ☐ Other: _____

c. Dependent Care FSA Enrollment:

N/A ☐ Upon Eligibility ☐ Annual Open Enrollment ☐ Other: _____

Terminated employees will have the following time frame to continue to incur and submit receipts.

Please note: KBA uses the date provided by the Employer as the official termination date.

			Default if not indicated:
Individual Premium:	Days to Incur following termination:	N/A	*30*
	Days to Submit following termination:	N/A	30
Health Care FSA:	Days to Incur following termination:	0	*0*
	Days to Submit following termination:	30	*30*
Dependent Care FSA:	Days to Incur following termination:	N/A	*30*
	Days to Submit following termination:	N/A	*30*

FSA Grace Period: ☐ Yes ☑ No If yes: please complete the following information:

Length of Grace Period (can be up to 2 ½ months after the end of the plan year): _____

Length of time to file a claim after the end of the "grace Period" (please mark one):

☐ 30 days ☐ 60 days ☐ 90 days

FlexPro Benefits Card

Flex card expenses incurred in the new plan year during the "grace period" will first be applied to the remaining balance in the previous plan year. Any amount left will be applied to the new plan year.

Note: You may not choose both the Carryover and the Grace Period.

FSA Carryover (Rollover): ☑ Yes ☐ No The employee may carryover up to MAX or $500 to the next plan year.

Note: You may not choose both the Carryover and the Grace Period.

DCA Grace Period: N/A ☐ Yes ☐ No If yes: please complete the following information:

Length of Grace Period (can be up to 2 ½ months after the end of the plan year): _____

Length of time to file a claim after the end of the "grace Period" (please mark one):

☐ 30 days ☐ 60 days ☐ 90 days

FlexPro Benefits Card

Flex card expenses incurred in the new plan year during the "grace period" will first be applied to the remaining balance in the previous plan year. Any amount left will be applied to the new plan year.

Runout Period:

Plans *without* a Grace Period: Employees will have the following time frame after the end of the plan year to submit claims:

Days to Submit Claims after Plan Year-End: 90 *Default if not indicated: 90*

Status Changes:

Employees will have the following time frame after a qualifying event has occurred to submit a request for status change:

Days to Submit Request for Status Change: 30 *Default if not indicated: 30*

HEART Act

A. Health Care FSA Balance – please indicate how you will determine the Health Care FSA balance (chose one):
   - ☑ The amount contributed to the Health Care FSA as of the date of the QRD request minus any reimbursements (recommended)
   - ☐ The entire amount elected for the Health Care FSA for the plan year minus any reimbursements

B. With respect to medical expenses incurred after the date a QRD is requested, the plan may either (chose one):
   - ☑ Permit employees to continue to submit Health Care FSA claims incurred before the end of the Health Care FSA plan year (and grace period, if applicable).
   - ☐ Terminate an employee's right to submit claims.

ASSOCIATED COMPANIES

Associated Companies participating under the FSA Plan(s): Attach additional sheets, as necessary

Company Name/Address/ Phone #/Contact Person	Group Federal ID Number

HSA: If you offer a Health Savings Account (HSA), please complete the following information:

A. Plan Year – please provide your HDHP/HSA Plan Year 01 / 01 / 2018 to 01 / 31 / 2018

B. Funding – please describe how the HSA is funded (please check one)
- ☐ Employee pre-tax salary deduction
- ☐ Employer contribution
- ☑ Employee pre-tax salary deduction and Employer contributions

C. Employer Contributions to the HSA (If applicable)
- ☐ Matching contributions based on Employee pre-tax salary reduction _____%
- ☑ Fixed contribution available to all employees $2000
- ☐ Incentive contributions based on Employee participation in a program such as a wellness program, disease management, or health assessment
- ☐ Employer contributions will be made through the Flexible Benefits Plan
- ☑ An Employee must participate in the Employer HDHP to receive matching, fixed or incentive contributions
- ☑ An Employee must make HSA contributions through a pre-tax salary reduction to receive matching, fixed, or incentive contributions from the Employer.
- ☐ Other: _____

D. Choosing the Trustee/Custodian:
- ☐ Employee makes the choice
- ☐ Employer makes the choice
- ☑ Employer makes the choice (Employee must make contributions to the Employer designated Trustee/Custodian)

E. Contributions will be made:
- ☐ Up front at the beginning of the plan year
  - ☐ Repayment provision for pre-funded contributions for terminated employees will apply. Please explain the provision. _____
- ☑ Monthly
- ☐ Per pay period
- ☐ Other: _____

(Contributions for a newly eligible employee may be made the first of the month after employee becomes eligible.)

F. Limited Purpose Health Care FSA (if applicable please mark all that apply)
- ☑ Out-of-Pocket Unreimbursed dental expenses
- ☑ Out-of-Pocket Unreimbursed vision expenses
- ☑ Preventive Care Expenses
- ☑ Eligible, out of pocket, unreimbursed medical expenses that are incurred after the minimum annual deductible has been satisfied up to the maximum set by the group.

Note: HSA participants may NOT participate in the Health Care FSA

(**Important note**: If a Grace Period applies to your Health Care FSA, an Employee who participates in the Health Care FSA and still has a balance in his or her account at the end of the Plan Year must wait until the first of the month following the end of the Grace Period to participate in the HSA.)

G. Maximum contributions to the HSA (includes Employee pre-tax salary reduction and Employer Contributions) are:

Maximum **single** deductible limit for 2014 is $3,300.00 (indexed annually)

Maximum **family** deductible limit for 2014 is $6,550.00 (indexed annually)

H. Prospective election changes may be made to the HSA
- ☑ Monthly
- ☐ At any time

It is understood that 1) Key Benefit Administrators as the Plan Supervisor is not responsible for the tax and legal aspects of the plan; and 2) full responsibility, for the tax and legal aspects of the Plan, is assumed by the undersigned organization establishing the plan. The organization acknowledges having counseled with its legal and tax advisors with respect to the form and adoption/restatement of the plan including the selection of options.

IN WITNESS WHEREOF, the following duly elected and authorized officer of Cunningham Township
Company Name

have signed this instrument on behalf of the Employer this _____ day of _____, 20___.

Employer: Cunningham Township

Signature:_____

Printed Name/Title: Danielle Chynoweth, Township Supervisor

KEY BENEFIT ADMINISTRATORS

Payroll Information

Group Name: _____ **Plan Year**: _____

ONLY complete this page IF you are making scheduled contribution based on payroll.

Key Benefit Administrators will calculate the Year to Date Contributions, based on your payroll deductions, for your participants, using the Payroll Information provided.

- If you have more than one payroll frequency, please copy this form and fill out a separate copy for each one.
- The information on this page is required to complete enrollment processing.

Please choose one of the following scheduled deduction processes;

OPTION 1;

Please indicate the date of your first deduction for the plan year 01/15/2018 **(IRS Regulations require all deductions for a plan year be taken in that plan year.)**

Please indicate the pay frequency (Calendar occurrences such as Leap Year may affect the number of deductions in a plan year. Please double check the number indicated)

☐ Weekly (48) **please indicate skipped deductions	☐ Weekly (52)
☐ Bi-weekly (24) **please indicate skipped deductions	☐ Bi-weekly (26)
☑ Semi-monthly (24)	☐ Monthly (12)

Some Annual elections require adjustments to one of the deductions in order to match the indicated annual indicated. ($5,000.00 / 26 =$192.30769). Please choose how we should set our system to best match yours:

☐ match per pay amount ☑ match annual election

OPTION 2;

KBA will use your payroll dates circled on the calendar below to build your plan. KBA will post the employees' per pay deductions based upon the dates provided on the calendar. If regular scheduled pay dates fall on an observed holiday (highlighted in green) or the weekend, please select the date you will actually be taking the deduction. We will automatically post payroll deductions from the dates you provide.

Some Annual elections require adjustments to one of the deductions in order to match the indicated annual indicated. ($5,000.00 / 26 =$192.30769). Please choose how we should set our system to best match yours:

☐ match per pay amount ☐ match annual election

Calendar for 2017

January						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
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29	30	31				

February						
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Calendar for 2018

January						
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August						
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September						
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October						
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November						
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December						
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16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Banking Information – Checks

Group Name: Cunningham Township **Plan Year**: 2018

A. Checking Options

- ☐ Checks printed by KBA using Employer bank account, authorized signature provided by Employer.
- ☑ Checks printed by KBA using Employer bank account, sent to Employer for signature and distribution.
- ☐ Checks not printed by KBA, printed by Employer.

B. If KBA is printing the checks, where do we mail the checks and the periodic reports?

- ☐ Individual's Home Address (A fee applies for this service, please consult your fee schedule)
- ☑ Employer for Distribution

C. When would you prefer for us to run the check cycle. (This applies even if KBA does not print the checks.)

Manual Claims Reimbursement Checks:

- ☑ Weekly on (Monday, Tuesday, Wednesday, etc.)
- ☐ Monthly on ☐ 1st

D. IF KBA is printing the checks, please complete this important checking information. (Required)

- ☑ * Beginning check number_____
- ☑ * Name of person to appear on the checks (please print)_____
- N/A ☐ * Include in the "Signature Box" below, the signature to appear on the checks – Please stay inside the lines so that we may scan the signature.

SIGNATURE BOX

Bank Name: Cunningham Township

Bank Account Number: _____ Bank Routing & Transit Number: _____

Please note: **If the authorized signature, bank name, bank account number or account name changes, Key Benefit Administrators must be notified immediately**. Additional charges may apply if we are in receipt of incorrect banking information or draft is returned as a result of insufficient funds.

If possible, attach voided check, deposit slip or bank account verification form.

* **REQUIRED FIELDS**

Direct Deposit Set-up/Change

ELECTRONIC FUNDS TRANSFER AUTHORIZATION
FOR DIRECT DEPOSIT
EMPLOYER FORM

Direct Deposit allows employees to submit manual claims for payment directly into their bank accounts. It is a nice added feature for your employees.

How does this work?:

At your scheduled reimbursement time, the amount of the direct deposits will be automatically deducted from your designated bank account (below) and disbursed to the specific employee's designated bank account. It works much like the Flex Card purchases do now.

How will your Employees set this up?

Your employees may log into their account at www.benefitspaymentsystem.com and sign up for the direct deposit feature or KBA can supply you with Employee Direct Deposit forms.

Please complete this form if you are interested in offering Direct Deposit to your employees.

Group Name: Cunningham Township

Bank Name: _____

Bank Account Number: _____ Bank Routing & Transit Number: _____

Please note: **If the authorized signature, bank name, bank account number or account name changes, Key Benefit Administrators must be notified immediately**. Additional charges may apply if we are in receipt of incorrect banking information or draft is returned as a result of insufficient funds.

Please note: Once direct deposit is set up for you, your employees may update their direct deposit information online anytime. No need to submit a form if enrolling for the Direct Deposit feature online. A form will be provided in the Employee Information Packet (EIP) giving the employee options. Note: Claims processed before the direct deposit is set up will be paid by check.

.

As an authorized representative of the Company listed above, I hereby authorize Key Benefit Administrators to initiate variable debit entries to the Company account indicated above. This authorization will remain in effect until written notice is received by the KBA that terminates this authorization.

_____
Signature

_____
Date

Banking Information – Debit Card Funding

Group Name: Cunningham Township **Plan Year**: 2018

The authorized representative at Cunningham Township hereby authorizes FIS Benefits Payment System or FIS's agent to initiate ACH (automated clearing house) transfer entries for the following depository:

Bank Name: _____

Bank Account Number: _____ Bank Routing & Transit Number: _____

Please note: **If the authorized signature, bank name, bank account number or account name changes, Key Benefit Administrators must be notified immediately**. Additional charges may apply if we are in receipt of incorrect banking information or draft is returned as a result of insufficient funds.

A Few Notes about the KBA Online Services:

As an Employer, it is important that you have access to www.benefitspaymentsystem.com. This will allow you the ability to do many things such as checking the balance of an employee's accounts or run reports. For example, you will have the ability to run a transaction report to see the pending transactions for your employees.

Please be sure to contact your Benefit Consultant to obtain your login. All contacts and report recipients may be granted USER level access to the debit card system which will grant access to various other reports and functionality. We will be glad to complete your setup and provide you with some helpful hints on how to best use the website.

On the first day of each month, the contact will receive an Enrollee Account Balance report that shows annual contribution, contributions received year to date, and claims paid.

KEY BENEFIT ADMINISTRATORS

Reporting

Group Name: Cunningham Township **Plan Year**: 2018

1. **Daily Settlement Activity Report for debit card transactions?** This will come on a daily basis and indicate the settlement activity in total for the day including zero dollars for the settlement.
   Please Note: ACH Failures will result in a $40.00 fee per transaction.

   ☑ Yes, I would like this report. ☐ No, I do not need this report at this time.

Name: Danielle Chynoweth Email Address: supervisor@cunninghamtownship.org

Name: _____ Email Address: _____

2. **Employer Disbursement Report**:
   The Employer Disbursements Report provides transaction detail on debit card transactions, reimbursed manual claims, and refunds. The transaction data returned gives administrators a consolidated, accurate report of all spending activity for an employer group. Employers can use this report to reconcile all claim activity for a specified timeframe.

   ☐ Monthly, sent the 1st day of the month to include all transactions from the prior month.
   ☑ At time of check print.

Name: Danielle Chynoweth Email Address: supervisor@cunninghamtownship.org

Name: _____ Email Address: _____

Note: If note noted the Bank Transaction Report will match the frequency of the Manual Claim Reimbursement Report.

3. **Enrollee Account Balance Report**:
   The Enrollee Account Balance report provides administrators with a list of all participants detailing: Account Status, Annual Election, Contributions Year to Date (Employee and Employer), Deposits, Total Year to Date Disbursements, Plan Forfeiture Balance, and Balance Due. Administrators should use this report to track total fund contributions versus total disbursements to provide Employer groups with a complete plan fund summary. This report should be run monthly. When selecting report criteria for this report, administrators may choose all account statuses or any combination of Active, Terminated, Temp Inactive, and Permanently Inactive.

Name: Danielle Chynoweth Email Address: supervisor@cunninghamtownship.org

Name: _____ Email Address: _____

Employer Online Access to Request Form

Group Name: Cunningham Township **Plan Year:** 2018

Please give the following contact(s) access to view our Employees' Accounts online accounts.

Danielle Chynoweth
Name

supervisor@cunninghamtownship.org
Email

217-384-4144
Phone

Soraya Santoyo (Broker, Lambent Risk Management)
Name

soraya_santoyo@lambent-rms.com
Email

312-251-2568
Phone

I give permission for the employer contact(s) named above to have access to the FlexPro online system to view the Accounts of the Participants in our Section 125 Flexible Benefits Plan. I understand that I will need to notify FlexPro/Key Benefit Administrators immediately if the employer contact(s) terminates employment or should no longer have access to view Accounts of the Participant enrolled in the plan. Upon receipt of a termination notice, FlexPro will remove employer contact access privileges.

AUTHORIZED SIGNATURE

Township Supervisor
TITLE

Danielle Chynoweth
PRINTED NAME

DATE

Co-Payment – Outline of Benefits

Group Name: Cunningham Township **Plan Year:** 2018

If applicable to your plan, providing KBA with your **MEDICAL PLAN SCHEDULE OF BENEFITS/BENEFIT SUMMARY** will help to increase automatic transaction approval at time of purchase/service and decrease substantiation requests. KBA will build your plan to automatically approve claims that match your plan co-pays (IRS guidelines, as outlined in Revenue Ruling 2003-43, allow automatic adjudication in the exact amount of the applicable medical plan co-pays.)

PLEASE NOTE: We will replicate the information from your current plan year if no new information is provided.

- ☐ This option does not apply to this plan.
- ☑ See attached schedule of benefits. Please provide a clear copy of your benefit summary.
- ☐ See benefit information noted below.
- ☐ We are making medical plan changes and our new Schedule of Benefits is not available at this time. Please build our plan with the current plan co-pays. When our new Schedule of Benefits is available we will provide the new information so our plan can be updated. The Employer is responsible to provide benefit changes to KBA.
- ☐ This is not applicable to our plan design.

IMPORTANT: If your benefits change anytime throughout the year, it is important that you provide updated co-pay information to KBA so that we can update our system and provide the most efficient auto-approval process as possible.

Please initial:_____

You may complete the form below or provide a copy of your schedule of benefits.

Merchant	**Generic Co-Pay**	**Brand Co-Pay**	**Formulary Co-Pay**
Pharmacy Co-Pay:			
Mail Order Rx Co-Pay:			
Provider	**In-Network**	**Non-Network**	
Physician Co-Pay:			
Dental Co-Pay:			
Vision Co-Pay:			
Chiropractic Co-Pay:			
Emergency Room:			
Urgent Care:			
Other Co-Pay			
Other Co-Pay			
Other Co-Pay			
Other Co-Pay			
Other Co-Pay			

Note: Debit card groups with no indicated co-pays will be set to default template at amount .01. Substantiation will be required on all transactions.

Group Name: Cunningham Township **Plan Year:** 2018

Reimbursement for Orthodontia Services

Most orthodontia payments are paid on a monthly basis through the length of the service. Occasionally Orthodontists will give the patient the opportunity to pay for the services at a discount if they pay the entire amount up front. A representative from the IRS has informally stated that it may be permissible to accept full payment of orthodontia up front provided the patient has paid up front. Our standard procedure is to process orthodontia receipts on a monthly basis. If you would like us to change that procedure for your Flex participants who pay for the orthodontia services up front, you will need to complete this form. Please keep in mind that you, as the employer, are at risk for the participant's full annual pledge. Unless we receive this signed form from you, we will continue to process your participant's orthodontia services on a monthly basis.

Orthodontia Services will be processed in the manner indicated below until the direction from the Internal Revenue Service changes or the company revokes this option in writing.

☑ Please do **NOT** accept claims for up-front payment of Orthodontia Services. Payments should only be made as expenses are actually incurred and/or on a monthly basis.

☐ Please accept claims for **up-front** payment of Orthodontia services. We understand that a participant in our company's Health Care FSA may pay up-front for Orthodontia Services for himself/herself or one of his/her eligible dependents, the participant may file for reimbursement for the total amount he/she paid (up to the amount available in the participant's Health Care FSA).

What is Nondiscrimination Testing?

The IRS requires that Section 125 Flexible Benefit Plans pass a series of nondiscrimination tests each year. These tests were designed to ensure that plans are not discriminating in favor of Highly Compensated Employees (HCEs) or KEY Employees regarding eligibility for pre-tax contributions and actual benefits provided. To determine if a Plan is nondiscriminatory, testing is performed on an annual basis. At the beginning of each plan year, you will receive the Nondiscrimination Testing Request for Information Form and Worksheet for completion. Once the information is completed and returned to KBA the testing will be run within a few weeks.

There are three Nondiscrimination Tests that are run:

1. **25% Key Employee Concentration Test:*** This test requires that pre-tax contributions by KEY employees must not collectively exceed 25% of the total value of your flexible benefits plan.

   An employee will be considered to be a KEY employee when he or she meets one or more of the following:
   a. More than 5% owner during prior or current plan year
   b. Officer earning more than $170,000 in 2014/2015 (as indexed)
   c. More than 1% owner earning more than $150,000 2014/2015 (as indexed)
   d. Employee/spouse of a sole proprietor

   Government Entities – the definition of "Key employees" excludes officers or employees of government entities. Therefore, the Key Employee Concentration Test does not apply to the Flexible Benefits Plan maintained by government entities.

2. **55% Average Benefit Dependent Care Test:*** This test requires that the average dependent care benefit for non-highly compensated employees be at least 55% of the average dependent care benefit for highly compensated employees.

   An employee will be considered a Highly Compensated employee when they meet one or more of the following:
   a. Highly compensated employee earning more than $115,000 during the preceding year (2014/2015).
   b. An officer during the current or preceding plan year
   c. More than 5% owner in the current or preceding year
   d. A spouse or tax dependent of an individual described above

3. **5% Shareholder, 25% Dependent Care Test:*** Participants who are more than 5% shareholders AND have a Dependent Care Account cannot receive more than 25% of the Plan's total Dependent Care benefit.

What else will I need?

In addition to the names of the Key and Highly Compensated employees, you will also be asked for:
- The total number of eligible employees (regardless of whether or not they participate in the Flex Plan).
- The total benefits. These are the total annual cost of insurance plans for which employees make pre-tax contributions, plus the annual value of Flexible Spending Account Plans. You may provide the information to us by either the "Total Monthly Nontaxable Benefits" dollar amount or the employee's pre-tax premium contributions and the Employer's corresponding share of the premiums.

What happens when you pass the Nondiscrimination tests?

If you pass, you will be sent a copy of the Nondiscrimination test along with a letter from us.

What happens when you fail one or more of the Nondiscrimination tests?

If you fail any one of these tests, you will receive a letter with your test results and suggested revisions to bring your plan into compliance.

Additional Definitions that may be helpful

Officer – An officer of the employer should include all elected and appointed officers who actually have authority to manage the business. An employee with the title but not the authority of an officer is not considered to be an officer. Similarly, an employee who does not have the title but has the authority of an officer, is an officer for purposes of this test. Every employer should have at least one "officer."

Compensation – An employee's compensation includes his or her salary reductions under a Flex Plan (may include pre-taxed HSA), Transportation Plan, 401(k) Plan, etc. As an example, Sue makes $100,000 per year. She contributes $2,000 toward her Health Care FSA and $6,000 toward her 401(k). She has a taxable income of $92,000. When determining if Sue is a Highly Compensated Employee (HCE), we will look at her entire compensation of $100,000.

Excluded Employees (applies only to the §129 Dependent Care Test) – Excluded employees are those employees who have compensation less than $25,000, are under age 21, have not completed a year of service, or are part of a collective bargaining agreement.

* **Note: Depending on the company entity there may be restrictions on how (or if) Key employees can participate in the Flex Plan. This applies to S-Corps, LLCs, LLPs, Partnerships and Sole Proprietors.**