

TOTAL ACCESS FSA CLIENT IMPLEMENTATION KIT

What's inside:

- Total Access FSA Questionnaire
- Medical and Dental Benefits Form
- Payroll Calendar
- ACH Direct Debit Form (with Instruction Sheet)
- mbi ACH Direct Deposit Form (with Instruction Sheet)
- mbi Questionnaire

What to do:

- [] Print out this entire document.
- [] Complete the **Total Access FSA Questionnaire**. On this questionnaire, you will provide:
 - Contact information
 - Eligibility rules for your FSA plans
 - The FSA plan types (health care, dependent care, transit and parking) that you will sponsor. You may choose any or all of the plans.
 - The minimum and maximum contribution amounts for the Health Care and Dependent Care FSAs. The Transit and Parking maximums are set by law at \$105 and \$205 per month, respectively.
 - Your choice to offer the Total Access FSA Card. The card, administered by MBI, enables plan participants to purchase goods and services for any of the four plans using a debit card. This eliminates the need to submit claim forms and provides immediate reimbursement and convenience for participants.

N/A Complete the **Medical and Dental Benefits Form**. On this form, you will need to include all the specific information for your medical and dental plans. (You can also attach a copy of your schedule of benefits instead of completing the form.) Be sure to include a copy of your Plan Document and Summary Plan Description with the completed form and/or your schedule of benefits.

[] Circle the dates on which payroll is scheduled on the **Payroll Calendar**. Multiple calendars are provided in case you have different pay cycles for different employee groups.

[] Complete the **Benergy OS Direct Debit Form**. This enables Benergy OS to automatically debit funds from an employer account to pay reimbursements to plan participants. On this form, you will provide corporate account information. With this direct debit arrangement in place, employees may choose to have Benergy OS directly deposit reimbursements into their personal bank accounts for convenience.

[] If you choose to offer the Total Access FSA Card, you must complete two forms:

1. The **mbi ACH Direct Debit Form**. Because the funds for each plan participant's transactions are debited automatically from an employer account by MBI, you must provide corporate account information.
2. The **mbi Questionnaire**.

[] When all of these documents are completed and signed, please mail them to: **Town & Country Insurance Agency**
Benergy OS FSA Implementation
353 South Potomac Street
Waynesboro, PA 17268
(fax: 516-414-5122)
PO Box 1764
Jonesboro, AR 72403

Upon receiving this documentation, Benergy OS will create the enrollment and communications materials necessary for you to begin open enrollment. **If you have questions, send an e-mail to fsa@benergyos.com.**

Benergy **OS** OUTSOURCING STRATEGIES

TOTAL ACCESS FSA QUESTIONNAIRE

You must complete the following questionnaire in its entirety to have Benergy OS implement Total Access FSA for your organization for the upcoming Plan Year.

Contact and Internet Resource Information

Name of Organization:	City of Jonesboro		
What is your Organization's website address:	www.jonesboro.org		
Address:	PO Box 1845, Jonesboro, AR 72403		
Contact Person:	Suzanne Hackney		
Telephone Number:	870-933-4640	E-mail Address:	shackney@jonesboro.org
Additional Internet Resources:			
Group Number:			

Broker Contact (if applicable)

Name of Brokerage Firm:	Town & Country Insurance Agency, Inc.		
Broker Producer:	Richard Darouse	Broker Account Manager:	Madonna Lee
Address:	PO Box 1764, Jonesboro, AR 72403		
Telephone Number:	870-932-7448	E-mail Address:	mlee@townandcountryinsurance.com

Employee Portal

Do you currently use Benergy™ for your employee communications portal? Yes No

If so, please provide the following:

Website address: **www.jonesboro.mybenergy.com**

Employee's User ID: **cojemp**

Password: **benefits**

TOTAL ACCESS FSA APPLICATION

I. GENERAL INFORMATION

- A. Full legal name of company: City of Jonesboro
- B. Employer ID #: 71-6013749
- C. Company address: PO Box 1845
Jonesboro, AR 72403
- D. **Plan Administrator/Contact**
Name: Patsy Bishop
Title: HR Tech
Phone number: 870-933-4640
Fax number: 870-933-4652
E-mail address: pbishop@jonesboro.org
- E. Payroll cycle: semi-monthly (24/year)

II. PLAN INFORMATION

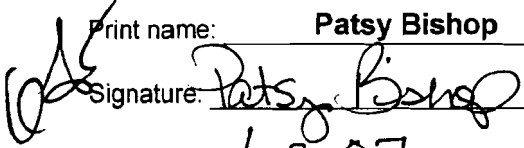
- A. First Plan Year: 01/01/07
- B. Flexible Spending Accounts to be offered (please check):
 Health Care [] Transit
 Dependent Care [] Parking
- C. Total # of eligible employees: 450

III. ADMINISTRATIVE INFORMATION

- A. Minimum check amount: \$25
- B. Expense reimbursements are to be issued: Weekly or Daily X
(Daily reimbursement require ACH Direct Debit and ACH Direct Deposit)
- C. Banking arrangements: ACH Direct Deposit

IV. PLAN ADMINISTRATOR'S SIGNATURE

Print name: Patsy Bishop

Signature:  Patsy Bishop

Date: 1-5-07

Health Care Plan

Minimum employee contribution

Annual \$ _____

Maximum employee contribution

Annual \$ _____

Dependent Care Plan

Minimum employee contribution

Single or married filing a joint return:

Annual \$ 100

Married filing a separate return:

Annual \$ 100

Maximum employee contribution

Single or married filing a joint return:

Annual \$ 5000

Married filing a separate return:

Annual \$ 2500

Transit Flexible Spending Account

Would you like to offer a Flexible Spending Account for Transit to your employees? Yes No

Parking Flexible Spending Accounts

Would you like to offer a Flexible Spending Account for Parking to your employees? Yes No

Claim Deadline

Claim deadline: Specify date (MM/DD): March 30

Would you like to offer the 2 1/2 month Grace Period? Yes No

Reimbursement Options

Reimbursements are to be issued: Weekly Daily (requires ACH Direct Debit and ACH Direct Deposit)

Would you like to offer the Total Access FSA Card reimbursement option to your employees? Yes No

If Yes, please complete the attached mbi Application & mbi ACH Direct Debit Form

Benergy Total Access FSA Portal

Provide the exact company name that you would like your employees to use as a prefix in your Benergy web address when accessing their FSA accounts online (e.g., **acme**.mybenergy.com).

jonesboro.mybenergy.com

(no spaces or characters)

Additional Plan Highlights

Benergy OS will generate extensive benefit summaries for each of your FSA plans for use in the web portal and other communications. If there are special features of your plans that should be communicated, please use the spaces below to provide them. You can also add any required disclaimers in the footer section of the benefits summary.

Headline:

Body:

Which FSA plans does this highlight apply to? Health Care Dependent Care Transit Parking

Headline:

Body:

Which FSA plans does this highlight apply to? Health Care Dependent Care Transit Parking

Optional Footer (to add any Disclaimers & Exclusions)

Which FSA plans does this footer apply to? Health Care Dependent Care Transit Parking

Which FSA plans does this footer apply to? Health Care Dependent Care Transit Parking

Sample Plan Documents

If you would like us to send you sample plan documents, please select from the following:

Premium Savings Plan Document and Form Cafeteria Plan Document Flexible Benefits Plan SPD

N/A FOR NOW

Benergy OS OUTSOURCING STRATEGIES
MEDICAL AND DENTAL BENEFITS FORM

Please enter all specific information for your medical and dental plans below. (You can also attach a copy of your schedule of benefits instead of completing this form.) Benergy OS is not responsible for the content provided on this form or in your Plan Document. The Plan Document that we provide is a template or "model" plan document for you to use and should be thoroughly reviewed by your legal counsel. (The template Plan Document and SPD can be found in the eTools section of Benergy™ Central under Total Access FSA.)

Medical	
(Please complete a copy of this form for each of your Medical Plans.)	
Select Plan Type: <input type="checkbox"/> HMO <input type="checkbox"/> Indemnity <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> Triple Option Plan	
Contribution Information (Employee)	
<input type="checkbox"/> Employee only \$ <u> </u>	<input type="checkbox"/> Employee + family \$ <u> </u>
<input type="checkbox"/> Employee + spouse \$ <u> </u>	<input type="checkbox"/> Dependent only \$ <u> </u>
<input type="checkbox"/> Employee + children \$ <u> </u>	<input type="checkbox"/> Employee + one dependent \$ <u> </u>
<input type="checkbox"/> Employee + child \$ <u> </u>	<input type="checkbox"/> Employee + domestic partner \$ <u> </u>
<input type="checkbox"/> Employee + domestic partner/children \$ <u> </u>	<input type="checkbox"/> Employee + spouse and child \$ <u> </u>
<input type="checkbox"/> Employee + spouse and children \$ <u> </u>	
General Provisions	Benefits
<input type="checkbox"/> Annual <input type="checkbox"/> Calendar Year Deductible Is the deductible combined for in- and out-of-network services? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ <u> </u>
<input type="checkbox"/> Annual <input type="checkbox"/> Calendar Year Out-of-Pocket Maximum Is the deductible included in the out-of-pocket maximum? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the out-of-pocket maximum combined for in- and out-of-network services? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ <u> </u>
Co-payments	
Physician's Office Visit	\$ <u> </u>
Primary Doctor's Office	\$ <u> </u>
Specialist's Office	\$ <u> </u>
Routine Adult Physicals	\$ <u> </u>
Laboratory Services (Diagnostic tests, lab, x-rays)	\$ <u> </u>
Inpatient Hospital (Semi-private room, board, tests, medications)	\$ <u> </u>

Outpatient Hospital	\$ <u> </u>
Emergency Room Visit	\$ <u> </u>
	Are Co-payments waived if admitted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ambulatory Services	\$ <u> </u>
Maternity Care (Pre-natal and post-natal)	\$ <u> </u>
	<input type="checkbox"/> initial visit only <input type="checkbox"/> each visit
Well-Baby Care/Immunizations	\$ <u> </u>
Well-child Care	\$ <u> </u>
Chiropractic Care	\$ <u> </u>
Physical Therapy	\$ <u> </u>
Anesthesiology Services	\$ <u> </u>
Morbid Obesity	\$ <u> </u>
Routine Sigmoidoscopy	\$ <u> </u>
Routine Colonoscopy	\$ <u> </u>
Organ Transplants	\$ <u> </u>
Home Health	\$ <u> </u>
Hospice Facility	\$ <u> </u>
Skilled Nursing Facility	\$ <u> </u>
Outpatient Therapy	\$ <u> </u>
Allergy Testing	\$ <u> </u>
Wigs/Hairpieces	\$ <u> </u>

Durable Medical Equipment	\$ _____
Prosthetics	\$ _____

Prescription Drugs

Prescription Drug Coverage (Retail) ____ day(s) supply	\$ _____ generic
	\$ _____ brand-name
	\$ _____ non-formulary
	<input type="checkbox"/> Not Covered

Prescription Drug Coverage (Mail Order) ____ day(s) supply	\$ _____ generic
	\$ _____ brand-name
	\$ _____ non-formulary
	<input type="checkbox"/> Not Covered

Mental Health and Substance Abuse

Mental and Nervous (Inpatient)	\$ _____
	Is the number of mental and nervous days/year combined for in- and out-of-network services? <input type="checkbox"/> Yes <input type="checkbox"/> No

Mental and Nervous (Outpatient)	\$ _____
	Is the number of mental and nervous days/year combined for in- and out-of-network services? <input type="checkbox"/> Yes <input type="checkbox"/> No

Substance Abuse Treatment (Inpatient)	\$ _____
	Is the number of substance abuse treatment days/year combined for in- and out-of-network services? <input type="checkbox"/> Yes <input type="checkbox"/> No

Substance Abuse Treatment (Outpatient)	\$ _____
	Is the number of substance abuse treatment days/year combined for in- and out-of-network services? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dental
(Please complete a copy of this form for each of your dental plans.)

Select Plan Type: DHMO POS Indemnity PPO

Contribution Information (Employee)

<input type="checkbox"/> Employee only \$ _____	<input type="checkbox"/> Employee + spouse \$ _____
<input type="checkbox"/> Employee + child \$ _____	<input type="checkbox"/> Family \$ _____

General Provisions	Benefits
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<input type="checkbox"/> Benefit <input type="checkbox"/> Calendar Year Deductible Is the deductible combined for in- and out-of-network services? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
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<input type="checkbox"/> Benefit <input type="checkbox"/> Calendar Year Maximum Is the maximum combined for in- and out-of-network services? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
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Covered Services

Preventive Services	\$ <u> </u> Is the deductible waived for preventive services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Basic Services	\$ <u> </u> Is the deductible waived for basic services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Major Services	\$ <u> </u> Is the deductible waived for major services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Orthodontist Services	\$ <u> </u> Is the deductible waived for orthodontic services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a separate deductible for orthodontic services?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate how much per individual \$ <u> </u>
Is there a waiting period for orthodontic services?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate how long <u> </u>
Is there a separate annual/calendar year maximum for orthodontic services?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate how much \$ <u> </u>
Is there a separate lifetime maximum for orthodontic services?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate how much \$ <u> </u>

Information for Individual Completing this Form

Name

Signature

Telephone Number

E-mail Address

2007 PAYROLL CALENDAR

Circle the dates on which payroll occurs.

Applies to: All employee Groups Select groups: _____

JANUARY 2007							FEBRUARY 2007							MARCH 2007							APRIL 2007							
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	
	1	2	3	4	5	6					1	2	3															
7	8	9	10	11	12	13	4	5	6	7	8	9	10	4	5	6	7	8	9	10	8	9	10	11	12	13	14	
14	15	16	17	18	19	20	11	12	13	14	15	16	17	11	12	13	14	15	16	17	15	16	17	18	19	20	21	
21	22	23	24	25	26	27	18	19	20	21	22	23	24	18	19	20	21	22	23	24	22	23	24	25	26	27	28	
28	29	30	31				25	26	27	28				25	26	27	28	29	30	31	29	30						
MAY 2007							JUNE 2007							JULY 2007							AUGUST 2007							
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	
	1	2	3	4	5						1	2																
6	7	8	9	10	11	12	3	4	5	6	7	8	9	8	9	10	11	12	13	14	5	6	7	8	9	10	11	
13	14	15	16	17	18	19	10	11	12	13	14	15	16	15	16	17	18	19	20	21	12	13	14	15	16	17	18	
20	21	22	23	24	25	26	17	18	19	20	21	22	23	22	23	24	25	26	27	28	19	20	21	22	23	24	25	
27	28	29	30	31			24	25	26	27	28	29	30	29	30	31					26	27	28	29	30	31		
SEPTEMBER 2007							OCTOBER 2007							NOVEMBER 2007							DECEMBER 2007							
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	
						1		1	2	3	4	5	6															
2	3	4	5	6	7	8	7	8	9	10	11	12	13	4	5	6	7	8	9	10	2	3	4	5	6	7	8	
9	10	11	12	13	14	15	14	15	16	17	18	19	20	11	12	13	14	15	16	17	9	10	11	12	13	14	15	
16	17	18	19	20	21	22	21	22	23	24	25	26	27	18	19	20	21	22	23	24	16	17	18	19	20	21	22	
23	24	25	26	27	28	29	28	29	30	31				25	26	27	28	29	30		23	24	25	26	27	28	29	
30																					30	31						

**TOTAL ACCESS FSA
ACH DIRECT DEBIT FORM INSTRUCTION SHEET**

The attached ACH Direct Debit Form is required to implement Total Access FSA. By signing the form, you authorize Benergy OS, who administers the program, to debit a single account to fund reimbursements paid to participants in Total Access FSA. Failure to complete the form will result in significant processing delays.

How to complete the form:

1. The ACH (automated clearinghouse) Direct Debit Form can only be accepted in original form.
2. Please complete the requested information.
3. If checks are drawn off this account, please submit a voided check. Otherwise, submit a deposit slip.
4. For security purposes we ask that you print the form on original Company letterhead.
5. Also, please include the signatory's business card with the form.
6. Mail the information requested to:

Benergy OS
Attn: FSA
353 South Potomac Street
Waynesboro, PA 17268

Benergy OS will notify you when settlement has been completed and employees can be loaded into the system. Please allow 5 business days from receipt of ACH until settlement is complete.

Thank you,

Benergy  **OS** **OUTSOURCING**
STRATEGIES



TOTAL ACCESS FSA
ACH DIRECT DEBIT FORM

This form can **only** be accepted in original form. Print on original Company letterhead, complete the requested information and submit with a voided check (if checks are drawn from the account) and a business card of the signatory.

HEREBY authorizes **Benergy OS** to initiate
ACH (automated clearinghouse)
transfer entries for the following depository:

City of Jonesboro
(Group/Employer name)

Employer Tax ID #: 71-6013749

Financial Institution Name: Liberty Bank of ARKANSAS

Address: P.O. Box 7514

City: Jonesboro

State: AR Zip: 72403

Routing & Transit Number: _____

Bank Account Number: _____


Information provided by: DAVID EAGLE CPA
(please print your name)

Title: CITY ACCOUNTANT

Phone: 870 933-4651 Fax: 870 933-4659

E-mail address: deagle@jonesboro.org

Signature: David W. Eagle CPA Date: 1-4-7



**TOTAL ACCESS FSA
MBI ACH DIRECT DEBIT FORM INSTRUCTION SHEET**

The Total Access FSA Card, administered by MBI, enables plan participants to purchase goods and services for any of the four FSA plans using a debit card. If you choose to offer the card to employees, you must complete the attached ACH Direct Debit Form and questionnaire. Because the funds for each plan participant's transactions are debited automatically from an employer account by MBI, you must provide corporate account information.

1. **Failure to comply with these instructions will result in significant processing delays.**
2. The ACH Authorization Form can only be accepted in original form.
3. Complete the requested information.
4. Print on original Company letterhead.
5. If checks are drawn off this account, please submit a voided check or if checks are not drawn off this account, please submit a deposit slip.
6. Submit form with a business card of the signatory.
7. Mail the information requested to:

**Benergy OS
Attn: FSA
353 South Potomac Street
Waynesboro, PA 17268**

Thank you,

Benergy OS OUTSOURCING
STRATEGIES

MBI FLEX CONVENIENCE® CARD PROGRAM
ACH AUTHORIZATION RELEASE

This form can only be accepted in original form. Print on original Company letterhead, complete the requested information and submit with a voided check (if checks are drawn from the account) and a business card of the signatory.

HEREBY authorizes **MoneyMaker Technologies** to initiate ACH (automated clearing house) transfer entries for the following depository:

City of Jonesboro
(Group/Employer name)

Financial Institution Name: Liberty BANK OF ARKANSAS

Address: P.O. Box 7514

City: JONESBORO

State: AR Zip: 72403

Routing & Transit Number:

Bank Account Number:

Information provided by: David EAGLE CPA
(please print your name)

Title: CITY ACCOUNTANT

Signature: *David Eagle CPA* Date: 1-4-7

Open Enrollment Period

Open enrollment start date:
11/15

Date the plan year begins (effective date):
01/01/07

Open enrollment end date:
12/27

Is this a short plan year? Yes No

Do you use Ready...Enroll Express or Complete? Yes No

Provide the date the full plan year begins:

Eligibility Information

Total Number of Eligible Employees:
450

Who's Eligible for Coverage?

Select employee group(s) that apply:

All employees - Definition optional (750 characters maximum):

Full-time employees - Definition optional (750 characters maximum): *To include Aldermen, City Attorney, Mayor, and City Clerk. (All elected officials)*

Part-time employees - Definition optional (750 characters maximum):

When Can an Employee Participate?

Select one:

First day of employment

First of the month after 60 days of employment

First of the month following date of employment

First of the month after 90 days of employment

First of the month after 30 days of employment

Other - Please specify:



SUMMARY OF PRICING

Assumptions

Because pricing depends on employee headcount, it is important to verify our assumptions:

- Number of employees: **455**
- Number of benefit user groups for Benergy: **2 (1 New Hire & 1 Non New Hire)**

PRODUCT	SERVICE	DESCRIPTION	1 ST YEAR FEES
<input checked="" type="checkbox"/> Benergy Enhanced Communications Required Component	Set-up Fee		
	Implementation	T&C launches portal for you	\$500
	Ongoing Fee		
	Communications Portal	Charges based on # of employees (<500 ee's)	\$400 monthly
<input type="checkbox"/> Ready...Enroll Complete Optional	Set-up Fee		
	Configuration	Configuration of benefits plans	\$1000
	Data	Employee data uploads and election data output to carriers	Included
	Ongoing Fee		
	Annual enrollment plus year-round service	Per Employee Per Month (PEPM)	\$1.25 (\$568.75)
<input checked="" type="checkbox"/> Total Access FSA Flexible Spending Accounts Estimated Tax Savings Mthly \$780 Optional	Set-up Fee		
	Configuration	Configuration of FSA	\$100
	Ongoing Fee		
	Monthly Fee (Per Participant per Month)	Health & Dependent Care FSA Accounts Current Participants: 109	\$5 (\$545)
<input checked="" type="checkbox"/> Real Value Statements Optional	Annual Fee (based on 455 statements)		
	Configuration	Publishing Statements	\$1650

Above prices based on Town & Country Insurance Agency, Inc. continuing as broker of record on Group Dental and \$40,000 Group Term Life.

QUOTES

Ceredian

Set-up fee - \$750.00
Renewal fee - \$398.00
\$4.60 per participant per month (23 – 34% participation)
Debit Card - \$1.50 per participant per month
2 1/2 month extension fee - \$4.00 per participant per month
Total cost per participant per month = \$10.10
Enrollment kits – Electronic no additional cost
 Paper \$.95 per kit
Enrollment reports – Included
Enrollment Changes Report – Included
Custom Reports - \$140.00 per hour
Employee Education meetings - \$500.00 per day plus travel
EOB/Account Statements to Employees - Provided

Infinisource

Set-up fee - \$50.00
Renewal Fee - \$525.00
\$5.25 per participant per month
Debit Card - \$2.00 per participant per month (\$5.00 for additional cards)
Total cost per participant per month = \$7.25
2 1/2 month extension fee - annual fee of \$250.00
Enrollment kits - Electronic no additional cost
 Paper \$.95 per kit
Enrollment Reports - included
Enrollment Changes Report - included
Custom Reports - May incur additional costs
Employee Education meetings – Power point presentation included. On site presentations at additional cost
EOB/Account Statements to Employees - Provided

Total Access FSA (Benergy)

Set-up fee - \$600.00

Renewal fee - \$100.00

\$5.00 per participant per month plus \$400.00 monthly base

Debit Card - Included

Total cost per participant per month = \$5.00

2 1/2 month extension fee - Included

Enrollment kits - Electronic no additional cost

Paper no additional cost

Enrollment Reports - Included

Enrollment Changes Reports - Included

Custom Reports - Not available

Employee Education meetings - Will attend local meetings or will be teleconferenced into meetings

EOB/Account Statements to Employees - Provided quarterly