Health Reimbursement Arrangement Plan Implementation

Employer Legal Name | Federal Employer ID No. / Tax ID No.

Mailing Address | City, State, and Zip Code

Primary Contact Name /Title | Phone | Fax | Email

Secondary Contact Name/Title (if applicable) | Phone | Fax | Email

Invoice Admin Fees Contact Name | Phone | Fax | Email

Organization Type:

☐ C-Corporation ☐ Sub-Chapter "S" Corporation ☐ Sole Proprietorship ☐ Partnership ☐ LLC ☐ Other ____________________

Administration Data

Plan Year Start and End dates: From: / / To: / /

Open Enrollment Start and End dates: From: / / To: / /

Total number of employees: Total number of eligible employees:

Is this a new HRA plan or an existing HRA plan?

☐ **New Plan** - (this is the first time implementing an HRA plan)

☐ **Existing Plan** - (you had an HRA in place last year through a previous TPA) **Prior Plan Year End Date:** ____________________

****If this is an existing plan, please provide a copy of your current Plan Document and SPD****

Total number of employees participating in the prior plan year: ____________________

Will Asure COBRAsource, LLC be handling your Run-Out Period?

☐ Yes ☐ No, previous TPA is handling ☐ N/A – This is a new plan

If yes, please confirm: ☐ Run-Out Period - __________days

****To handle your run-out period, please provide us with a Year To Date Plan Summary report with your participant's election and balance information****

Full Plan Name: **State of Plan's Origin:**

Original Plan Effective Date: **IRS Plan Number:**

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Plan Design

Are all employees eligible for this plan? ____________ **If there are exclusions, please indicate:**

☐ Part-time employees who work less than _________ hours per week
☐ Employees with less than _________ months of employment
☐ Employees under the age of _________
☐ Contract employees
☐ Other _____________________________________

When does participation commence for a new eligible employee (waiting period)?

☐ None ☐ 1st month after hire date ☐ 30 days ☐ 1st month after 30 days

☐ 60 days ☐ 1st month after 60 days ☐ 90 days ☐ 1st month after 90 days ☐ Other___________________________

Are retired employees eligible to participate in this plan? ___________

If "yes", are they eligible to participate continuously under section 125 benefits, or only until the end of the plan year?

____

If you currently offer a Health FSA Plan and an HRA, claims are to be paid first out of the:

☐ Health FSA ☐ HRA

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HRA Benefits

☐ Linked HRA (Linked To Underlying Health Plan) ☐ Unlinked HRA

Linked HRA - An HRA that is connected to a major medical health plan, usually a High Deductible Health Coverage (HDHC) policy/plan. The Employee must be a Participant in the health plan to participate in its associated (linked) HRA.

Unlinked HRA/Stand-Alone HRA - HRA designed to pay for certain eligible medical expenses. Not tied to any major medical health plan.

If this is a Linked HRA, please provide the following information:

Insurance Carrier Name: ______________________________________ Group Number: __________________________

Plan Name and Description:
(i.e. HMO, PPO or POS) ____

Carrier Contact Name: ______________________________________ Phone Number: __________________________

When does the health plan renew? ____

Is the deductible plan year or calendar year? ____

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Covered expenses under the selected benefit:
(Check all that applies)

☐ Applies to the deductible credited on underlying insurer EOB –
Includes: ☐ medical expenses ☐ prescription expenses

☐ Applies to co-insurance credited on underlying insurer EOB

☐ Applies to In Network benefits ☐ Applies to Out of Network benefits

☐ Applies only to Prescriptions ☐ Applies only to Office Co-pays

☐ Other (please be specific) ______________________________

____

____

If the HRA is linked to the Health Plan Deductible, please specify the Health Plan Deductible below:

Individual: $ ____________

Family (2or >): $ ____________

Other Design (please specify):

____________ $____________

____________ $____________

____________ $____________

____________ $____________

HRA Funding & Reimbursements

Employer HRA Maximum Funding Limit (Reimbursement Cap):

Maximum Annual Individual Limit for HRA Benefits: $ ____________

Maximum Annual 2 or > Limit for HRA Benefits: $ ____________
(Generally, this max is 2 X the single limit)

Comments: ______________________________

____

HRA Reimbursement Plan Design:
(Check all that applies)

☐ 100% of claim will be paid from the HRA up to maximum limit

☐ The First $____________ is paid by the ☐Employer ☐Employee

☐ The Second $____________ is paid by the ☐Employer ☐Employee

☐ The Third $ ____________ is paid by the ☐Employer ☐Employee

☐ Other –
The ☐First ☐Second ☐Third $________ will be paid by the Employer at ________%

Comments: ______________________________

____

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When will the HRA funds be available to the employees?

☐ Full Annual HRA Funds will be available at the beginning of the plan year or upon eligibility

☐ First of each month (employer contribution / 12 months)

☐ Customized – List the contribution dates:

____

____

Do you allow your employees to roll over any unused HRA funds to the subsequent plan year? ☐ Yes ☐ No

If yes, what is the allowed roll over amount or percentage?

☐ Full Unused Amount

☐ Up to $ ____________________

☐ __________________________%

Do you allow employees to elect a *one-time rollover* of their unused HRA dollars into a Health Savings Account? ☐ Yes ☐ No

Spend-Down Feature

Spend-Down Feature – 2002 IRS Guidance permits an employer to design an HRA so that terminating employees can use up their HRA account balance until exhausted. Employees can spend down an account balance by getting reimbursed for expenses incurred after employment terminates. Cash Outs are not allowed. Some employers may not want a spend-Down feature – unused funds are forfeited. Whether or not an HRA has a spend-down feature, COBRA must be offered.

Can the HRA funds be spent down upon termination? ☐ Yes ☐ No

If you've answered no to the spend-down feature question, how long of a run-out period (extends the time for submitting expenses that were incurred during the coverage period) would you like to allow terminated employees to have to submit claims that incurred prior to their termination date?

☐ NO Run-out Period ☐ _____________ months (i.e. 3 months)

For active employees, would you like to offer a run-out period?

☐ NO Run-out Period ☐ _____________ months (i.e. 3 months)

When does the HRA participation cease for a terminated employee?

HRAs & COBRA:

An HRA is a group health plan generally subject to the COBRA continuation coverage requirements. If an individual elects COBRA continuation coverage, an HRA complies with these COBRA requirements by providing for the continuation of the maximum reimbursement amount for an individual at the time of the COBRA qualifying event and by increasing that maximum amount at the same time and by the same increment that it is increased for similarly situated non-COBRA beneficiaries (and by decreasing it for claims reimbursed). Premiums are determined under the existing rules in §4980B. In Rev. Rul. 2002-41, Situation 1, a qualified beneficiary who chooses to elect COBRA continuation coverage may only elect the HRA in conjunction with the major medical plan. However, a qualified beneficiary may choose to elect COBRA continuation coverage for only the major medical plan.

Employer is entitled to bill COBRA participant 1/12 of the HRA maximum benefit listed above (+2% optional surcharge) unless rollover election is selected. With a rollover option an actuary must be retained to determine COBRA premium.

Asure COBRAsource, LLC will write checks off of the employer's assigned account (specified below). After each scheduled check run, Asure COBRAsource, LLC will email the contacts listed below, the check run register.

Employer's Banking Information:

Are funds held in an employer sponsored trust account? ___________ Name of Bank: ____

Bank Address: ____City/State/Zip:____

Name on Account: _______________________________________ Account Number: ____

Bank Routing No. (MICR) (Ex: 123456789): _____________________ Bank Routing No. (Bank Info) (Ex. 111-42-348): ___________________

Authorized Signature(s) to use on Checks:
(Please sign in the box with **BLACK** ink)

Asure COBRAsource, LLC will use this signature when creating your check template.

HRA Starting Check Number: ______________
(Please specify the check number CSI should use for the HRA reimbursements. 500 will be used if a number is not specified)

Please provide a **voided check (or copy of one if returning by fax or email) from the bank account you want Asure COBRAsource, LLC to utilize for your HRA reimbursements. This account should be a general operating account. **

Manual Claims Reimbursement Frequency:

☐ Daily (as claims are processed) ☐ Weekly (Mondays)

Which Reimbursement Options would you like to offer to your employees:

☐ Check ☐ Direct Deposit

Who within your organization would you like to receive our funding reports for Manual Claim Reimbursements and Debit Card Settlement Funding?

_____________________________________ _____________________
Name Email

_____________________________________ _____________________
Name Email

_____________________________________ _____________________
Name Email

☐ **I have reviewed the information provided herein and have verified that it is accurate and complete.** As information changes, it is the responsibility of the employer to communicate the changes in a timely manner to Asure COBRAsource, LLC, Inc. Please be sure to return this signed document and other related plan enrollment materials at least **45** days prior to the desired renewal plan start date. For optimal enrollment numbers, please allow for a two-week open enrollment period for your current or prospective plan participants to enroll in this plan. HRA Participant Kits, will be provided to the employer via email within 10 business days upon receipt of this document.

Asure COBRAsource, LLC, Inc. will email the employer a monthly invoice. The email will contain a link, which will contain the invoice. Payment must be made payable to Asure Employer Services by the invoice due date. A late fee will apply if payments are not received by the invoice due date.

COMPANY NAME: ____

SIGNATURE: ______________________________ **DATE:** __________________

PRINT NAME: _____________________________ **TITLE:** _________________

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