# Health Reimbursement Arrangement (HRA)
## *Plan Renewal Check List*

### EMPLOYER INFORMATION

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

Mailing Address ________________ City/State/Zip Code ________________

Primary Contact Name /Title ________ Phone ________ Fax ________ Email ________

Secondary Contact Name/Title ________ 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: ________________

**Would you like to offer the Benefits Debit Card?** ❑ Yes ❑ No
This card can be utilized for HRA eligible expenses at authorized merchants (no additional charge applies for employee card).

**Are there any changes being made to the HRA plan for the upcoming plan year?** ❑ Yes ❑ No
If yes, please answer the questions listed below that pertains to the changes being made and notify our office if you'd like to make any amendments to your current Plan Document/SPD (additional fee applies).

If no, please return this page along with page 5 (signature page) to Mangrove.

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

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

****NOTE: If the questions listed below are not answered, we will use the prior year's implementation documents****

## PLAN DESIGN

**Are all employees eligible for this plan?** ❑ Yes ❑ No

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?** ❑ Yes ❑ No

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

## 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?___________________

**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: ____________________________________________
____________________________________________

**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, no later than the end of the plan year. 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.

**Do you want to allow a Spend-Down feature for HRA funds upon termination?** ❑ Yes ❑ No

If you've answered "No," how much time do you want to allow terminated employees to submit claims which incurred prior to their termination date?

❑ 0 days ❑ 30 days ❑ 60 days ❑ 90 days ❑ Other: ___________ days

### Run-Out Period

The run-out period permitted under IRS Notice 2005-42 gives active employees an extended amount of time for submitting expenses for that were incurred during the coverage period (HRA plan year).

**Do you want to allow a Run-Out Period?** ❑ Yes ❑ No

If you've answered "Yes," how much time do you want to allow active employees to submit claims which incurred during the HRA plan year?

❑ 30 days ❑ 60 days ❑ 90 days ❑ Other: _______________ days

**When does the HRA participation cease for a terminated employee?**

❑ Date of termination

❑ The last day of the month following date of termination

**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.

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

**EMPLOYER'S BANKING INFORMATION**

Are funds held in an employer sponsored trust account? ❑ Yes ❑ No

Name of Bank: ______________________________

______________________________ ______________________________
Bank Address City/State/Zip Code

______________________________ ______________________________
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)***

Mangrove will use this signature when creating your check template.

**HRA Starting Check Number:** ____________________
*Please specify the check number Mangrove should use for the HRA eimbursements. 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 Mangrove 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 Mangrove. Please be sure to return this signed document and other related plan enrollment materials at least 30 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.

Mangrove will email the employer a monthly invoice. The email will contain a link, which will contain the invoice. Payment must be made payable to Mangrove 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**