CHECKLIST
Section 105 - Health Reimbursement Arrangement (HRA)

EMPLOYER INFORMATION

1. EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER (Plan Administrator)

Name: _____

Address: _____

_____

City **State** **Zip**

Telephone: _____ **Fax:** _____

HR Contact: _____ **PR Contact:** _____

Email Address: _____

2. EMPLOYER'S TAXPAYER IDENTIFICATION NUMBER: _____

3. TYPE OF ENTITY

- **a.** ☐ **Corporation (including Tax-exempt or Non-profit Corporation)**
- **b.** ☐ **S Corporation (2% Shareholders & family not eligible)**
- **c.** ☐ **Limited Liability Company**
- **d.** ☐ **Non-Profit Organization**
- **e.** ☐ **Sole Proprietorship**
- **f.** ☐ **Partnership**
- **g** ☐ **Governmental Entity**

PLAN INFORMATION

4. PLAN NAME: _____

5. EFFECTIVE DATE

- **a.** ☐ **This is a new HRA effective as of** _____ **(hereinafter called the "Effective Date").**
- **b.** ☐ **This is an amendment and restatement of a previously established HRA of the Employer which was originally effective** _____ **. The effective date of this amendment and restatement is** _____**.**

6. HRA PLAN YEAR: _____ (ie: January 1 to December 31)

HEALTH INSURANCE RENEWAL MONTH: _____ (ie: January 1 to December 31)

7. IS THIS A SHORT PLAN YEAR?

- **a.** ☐ **No.**
- **b.** ☐ **Yes, dates of short plan year:** _____ (ie: January 1, 2019 to June 30, 2019)

If this is a short plan year and there is a HRA deductible:

- a. ☐ No carryover deductible
- b. ☐ Allow carryover deductible – *Must include a report from health insurance plan for deductible expenses prior to the start of the short plan year for the HRA.*

IS THIS A MID-YEAR TAKEOVER?

- **a.** ☐ **No.**
- **b.** ☐ **Yes, Takeover date:** _____ (ie: January 1, 2019)

8. NUMBER assigned by the Employer

- **a.** ☐ **501**
- **b.** ☐ **502**
- **c.** ☐ **503**
- **d.** ☐ **Other:** _____

9. CLAIMS ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
(If none is named, the Employer will serve as the Claims Administrator.)

- **a.** ☐ **Employer (Self-Administered. Use Employer address and telephone number).**
- **b.** ☐ **Allegiance**

ELIGIBILITY REQUIREMENTS

10. ELIGIBLE EMPLOYEES

- **a.** ☐ **All Employees who satisfy GROUP HEALTH PLAN eligibility requirements.**
- **b.** ☐ **All Employees EXCEPT:**
  - **1.** ☐ **Union Employees**
  - **2.** ☐ **Non-resident aliens**
  - **3.** ☐ **Commissioned Employees**
  - **4.** ☐ **Leased Employees**
  - **5.** ☐ **Part-Time Employees scheduled to work less than _____ hours per week.**
  - **6.** ☐ **Other:** _____

11. ARE DEPENDENTS COVERED?

☐ **No**

☐ **Yes -** *If HRA deductibles/maximums need to be tracked for #15 & #17 below, you must provide dependent information on the enrollment form.*

12. DEPENDENT DEFINITION. Default language in the Plan Document for the definition of dependent includes older children referenced in IRS Notice 2010-38 (April 27, 2010), which allows the expenses of adult children, up to age 26, to be reimbursed through their parents' Health Reimbursement Arrangement.

☐ **Check here if you <u>do not</u> want to allow adult children to be covered under your Health Reimbursement Arrangement.**

13. THE FOLLOWING AFFILIATED EMPLOYERS will adopt this Health Reimbursement Arrangement as Participating Employers (if there is more than one, or if Affiliated Employers adopt this after the date the Adoption Agreement is executed, attach a list to this Adoption Agreement of such Affiliated Employers including their names, addresses and taxpayer identification numbers):

- **a.** ☐ **N/A**
- **b.** ☐ **Name of Affiliated Employer (s):** _____
  Address: _____
  _____
  City **State** **Zip**
  TIN: _____
- **c.** ☐ **Divisions Needed?** _____

14. CONDITIONS OF ELIGIBILITY

Any Eligible Employee will be eligible to participate in the Health Reimbursement Arrangement upon satisfaction of the following:

- **a.** ☐ **Date of Hire (No service required)**
- **b.** ☐ **_____ years after date of hire**
- **c.** ☐ **_____ months after date of hire**
- **d.** ☐ **_____ days after date of hire**
- **e.** ☐ **Same as Employer's Group Medical Plan.**
- **f.** ☐ **Other: _____**

15. EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee who has satisfied the eligibility requirements will become a Participant on:

- **a.** ☐ **the day on which such requirements are satisfied.**
- **b.** ☐ **the first day of the month coinciding with or next following the date on which such requirements are satisfied.**
- **c.** ☐ **the first day of the calendar quarter coinciding with or next following the date on which such requirements are satisfied.**
- **d.** ☐ **the first day of the pay period coinciding with or next following the date on which such requirements are met.**
- **e.** ☐ **the first day of the Coverage Period coinciding with or next following the date on which such requirements are satisfied.**
- **f.** ☐ **Same as Employer's Group Medical Plan.**
- **g.** ☐ **Other: _____**

BENEFITS

16. THIS ARRANGEMENT SHALL REIMBURSE: (select all that apply)

- **a.** ☐ **Co-payments under the Employer's group medical plan (must provide EOB)**
- **b.** ☐ **CO-INSURANCE under group medical plan (must provide EOB)**
- **c.** ☐ **All out of pocket expenses on the Employer's group medical plan (must provide EOB)**
- **d.** ☐ **Deductibles under the Employer's group medical plan (add deductible amounts in the table below)**
  - ☐ **Prescriptions included in deductible**

  Please note the name of the Group Health Insurance plan if checking any boxes under a. b. c. or d.

  _____
- **e.** ☐ **All medical expenses within the meaning of Code Section 213 (d), (except insurance premiums).**
- **f.** ☐ **Prescription co-pay amounts (not included on EOB)**
- **g.** ☐ **Medical insurance premiums**
- **h.** ☐ **The following types of medical expenses ONLY: _____**
- **i.** ☐ **Other: _____**

17. MAXIMUM BENEFIT PER COVERAGE PERIOD (complete table below):

	Per Participant	Per Participant & Spouse/Dependent		Per Family	
		Each	Maximum	Each	Maximum
Insurance Deductible (if d. is checked above)	$	$	$	$	$
Member's responsibility before HRA pays (HRA DEDUCTIBLE) ☐ Yes ☐ No	$	$	$	$	$
PERCENTAGE HRA PAYS:	%	%	%	%	%
Total HRA Benefit	$	$	$	$	$
ADDITIONAL BENEFIT INFORMATION					

17.a PRORATE FOR MID-YEAR HIRES?

- **a.** ☐ **No.**
- **b.** ☐ **Yes.**
  - ☐ **Monthly**
  - ☐ **Quarterly**
  - ☐ **Percent Define Date: _____**

17.b IS YOUR HEALTH INSURANCE WITH ALLEGIANCE?

a. ☐ Yes.

☐ Do you want to implement Joint Processing?

a. ☐ Yes.

b. ☐ No.

b. ☐ No. Current Carrier Name: _____

18. IF THE EMPLOYER MAINTAINS A HEALTH FLEXIBLE SPENDING ACCOUNT, WHICH PLAN SHALL PAY EXPENSES FIRST?

a. ☐ N/A. The Employer does not maintain a Health Flexible Spending Account and/or Cafeteria Plan.

b. ☐ This Plan (Heath Reimbursement Arrangement).

Automatically roll the HRA out of pocket amount to an existing Flexible Spending Account @ ABPM

☐ YES

☐ NO

c. ☐ The Health Flexible Spending Account under the Employer's Cafeteria Plan.

18.a WILL THIS HRA PLAN HAVE A DEBIT CARD REIMBURSEMENT OPTION (Note: Debit Cards will not work for all HRA Plans)

a. ☐ Yes

☐ No debit card auto approval parameters will be set up. All transactions require substantiation.

☐ We will send auto approval parameter co-pay amounts.

☐ Set up a carrier file feed for auto substantiation of transactions.

b. ☐ No

OTHER PLAN INFORMATION

19. IS THE EMPLOYER SUBJECT TO THE FAMILY AND MEDICAL LEAVE ACT?

If b. is selected, FMLA will not apply.

a. ☐ Yes.

b. ☐ No.

20. IS THE PLAN SUBJECT TO COBRA?

If a. is selected, COBRA will not apply.

a. ☐ No.

b. ☐ Yes.

Is Allegiance your current COBRA administrator?

1. ☐ Yes, please add this HRA to our COBRA Services Contract

2. ☐ No, but please provide an HRA COBRA services quote.

After one (1) year of claims experience, Allegiance can calculate an HRA COBRA monthly premium for an additional fee.

i. ☐ I understand that the HRA COBRA premiums for the first year will be free, unless a COBRA monthly premium rate is provided. *After one(1) year, please send a notice to offer calculation of the rate oby Allegiance for year two (2).

ii. ☐ I would like the HRA COBRA premium to be "free always"

3. ☐ No, HRA COBRA services are provided

21. COVERAGE PERIOD is:

a. ☐ yearly with contributions posted monthly.
b. ☐ yearly, with full annual balance available at any time during the plan year.
c. ☐ Other _____

22. CLAIM Payout:

a. ☐ Pay up to what is accrued in the participants account.
b. ☐ Pay up to the participants annual fund balance.

23. CARRY FORWARD: Amounts not used during a Coverage Period shall:

a. ☐ Be carried forward to the next Coverage Period, in an amount up to $_____.
However, the maximum accumulation limit for a Coverage Period is $_____.
b. ☐ Be forfeited.
c. ☐ Other:_____

24. CLAIMS FOR REIMBURSEMENT MUST BE FILED WITHIN:

_____ days following each coverage period.

25. RETIREES OR OTHER TERMINATED EMPLOYEES SHALL:

a. ☐ Shall continue to be eligible for reimbursement of any remaining balances.
b. ☐ Participation ceases at termination.
A CLAIM may be submitted up to _____ days after
a. ☐ the end of the Coverage Period.
b. ☐ the termination date.
c. ☐ Other:_____

26. HRA REIMBURSEMENTS WILL BE WITHDRAWN VIA ACH DEBIT FROM THE PLAN SPONSOR.
Please complete, sign and initial the attached ACH Debit Authorization Form.

a. ☐ Daily
b. ☐ _____
c. Must coincide with FSA reimbursement schedule

27. FEE SCHEDULE

Initial Set-Up Fee	$_____	
Annual Enrollment Fee	$_____	
Each Participant per Month	$_____	☐ E-Price
Minimum Monthly Fee	$_____	
HRA COBRA calculation Fee	$_____	

28. Agent Name: _____

Agency Name: _____

Address: _____

_____

City State Zip

Agent E-Mail Address: _____ **Telephone:** _____

Fax: _____ **TIN:**_____

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 May 2023)

DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

Allegiance® a Cigna Company

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 Insititution:
Primary Contact:	City/State:
Authorized Signature:	DATE:
Account Number	Routing and Transit Number

If possible, please attach a copy of a voided check and/or bank letter to confirm banking information noted above.

Confirmed Date that Claims Based Funding should start: _____

Claims payment releasing daily.

2806 Garfield, P.O. Box 4346, Missoula, MT 59806-4346
Phone: 877.424.3570 | Fax: 877.424.3539 | www.askallegiance.com

ALLEGIANCE ADVANTAGE

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: ______________________