



Health Reimbursement Arrangement (HRA) Plan Renewal Check List

EMPLOYER INFORMATION

Employer Legal Name _____

Federal Employer ID No. / Tax ID No. _____

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

Secondary Contact Name/Title _____ Phone _____ Fax _____ Email _____

Broker Information _____ Phone _____ Fax _____ Email _____

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 signature page to Mangrove.

****NOTE:** If the questions listed on this document are not answered, we will use the prior year's renewal documents.

ADMINISTRATION DATA

Full Plan Name: _____

State of Plan's Origin: _____

Original Plan Effective Date: _____

IRS Plan Number: _____

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).

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.

ACH DEBIT FILTER

Mangrove Benefit's ACH Debit Filter enables the employer to create, maintain and update Electronic Payment Authorizations (EPA) to filter and identify ACH Debit transactions that are approved to post to your account. Users can create, change, and delete Electronic Payment Authorizations for all accounts set up with ACH Debit Block.

Electronic Payment Authorizations identify ACH Debit transactions by Originator (Company Identification); however, the advanced functionality of ACH Debit Filters enables you to further customize the filters using additional authorization criteria including:

- Single Payment Authorization
- Recurring Payment Authorization
- Fixed Dollar Amount
- Maximum Dollar Amount
- Authorization Expiration Date

MANGROVE BENEFITS DETAILS:

Submitting Bank: M&I Bank
Routing Number: 075000051
Company ID: 1383261866

Company Name (Account Name): Metavante
Origination ID: 07500005
Tax ID: 38-3261866

CLAIMS

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.

COMPANY NAME: _____

SIGNATURE

DATE

PRINT NAME

TITLE