Allegiance℠ by Cigna Healthcare

CIGNA CHECKLIST
Section 105 - Health Reimbursement Arrangement

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. ☐ Professional Service Corporation
c. ☐ S Corporation
d. ☐ Limited Liability Company that is taxed as:
   1. ☐ a Partnership or Sole Proprietorship
   2. ☐ a Corporation
   3. ☐ an S Corporation
e. ☐ Sole Proprietorship or Non-profit Corporation
f. ☐ Partnership (including Limited Liability)
g ☐ Governmental Entity
h. ☐ Other _____

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Heath Reimbursement Arrangement.

PLAN INFORMATION

4. PLAN NAME: _____

5. EFFECTIVE DATE

a. ☐ This is a new Health Reimbursement Arrangement effective as of _____ (hereinafter called the "Effective Date").

b. ☐ This is an amendment and restatement of a previously established Health Reimbursement Arrangement of the Employer which was originally effective _____(hereinafter called the "Effective Date"). The effective date of this amendment and restatement is _____.

6. PLAN YEAR: _____(ie: January 1 to December 31)
If applicable- **Deductible year (plan year):**_____ **Open Enrollment Month:**_____
Renewal Month:_____

7. IS THIS A SHORT PLAN YEAR?

a. ☐ **No.**
b. ☐ **Yes, dates of short plan year:** _____ (ie: July 1, 2024 to December 31, 2024)
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.*

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. ☐ Use name, address and telephone number below:

Name: _____
Address: _____

_____
City State Zip

Telephone: _____

ELIGIBILITY REQUIREMENTS

10. ELIGIBLE EMPLOYEES

a. ☐ N/A. No exclusions.
b. ☐ The following are excluded (select all that apply):
   1. ☐ Union Employees
   2. ☐ Non-resident aliens
   3. ☐ Salaried Employees
   4. ☐ Hourly Employees
   5. ☐ Leased Employees
   6. ☐ Part-Time Employees scheduled to work less than _____ hours per week.
   7. ☐ 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. 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. ☐ Other: _____

14. 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. ☐ Other: _____

BENEFITS

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

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

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
f. ☐ Prescription co-pay amounts
g. ☐ Medical insurance premiums
h. ☐ The following types of medical expenses ONLY: _____
i. ☐ Other: _____

16. 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. 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 _____

18. CLAIM Payout:

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

19. 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.

20. 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.

HRA REIMBURSEMENT PAYMENT ISSUED TO:

a. ☐ Participant
b. ☐ Provider (This option requires a hold harmless agreement)
☐ Debit Card for RX only

20.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.
☐ Debit card for RX only

21. CLAIMS FOR REIMBURSEMENT MUST BE FILED WITHIN:

_____ days following each coverage period.

22. 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:_____

OTHER PLAN INFORMATION

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

If b. is selected, FMLA will not apply.

a. ☐ Yes.
b. ☐ No.

24. IS THE PLAN SUBJECT TO COBRA?

If a. is selected, COBRA will not apply.

a. ☐ No.
b. ☐ Yes.
Is Allegiance your current COBRA administrator?
a. ☐ Yes.
b. ☐ No. We have our own HRA COBRA administration.
c. ☐ No. We would like a quote for HRA administration.

20a. Allegiance offers HRA COBRA administration. After one (1) year of claims experience, we can calculate a HRA per month premium for an additional fee. Do you want Allegiance to administer your COBRA Services?

a. ☒ Yes. I understand that the HRA COBRA premiums for the first year will be free.
b. ☐ Yes. The first year HRA monthly premium amount for HRA COBRA is $ _____.
c. ☐ Yes. Other
d. ☐ No.

25. How would you like to fund HRA reimbursements? FUNDING FROM THE PLAN SPONSOR will occur

a. ☐ A request for funding will be sent on the 15th and 30th of each month
Can Allegiance electronically withdraw funds?
☐ No
☐ Yes (if yes, please complete, sign and initial the attached ACH Debit Authorization Form)
b. ☐ Send an advance – Allegiance will release funds on the 15th & 30th up to the advanced amt.
(To set up this process, please contact the HRA funding specialist in Allegiance flex accounting at 1-877-424-3570 ext 4601.)

25a. HRA Funding Notifications- sent to you by

a. ☐ E-mail address: _____ Attn to: _____.

or

b. ☐ Fax Number: _____ Attn to: _____.

Comments: _____

26. INSTANT PASSWORDS for participant website access (when applicable):

a. ☐ Yes

b. ☐ No

27. **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: _____

28. FEE SCHEDULE

Initial Set-Up Fee $_____

Annual Enrollment Fee $_____

Each Participant per Month $_____

Minimum Monthly Fee $_____

COBRA Services Fee Schedule

Initial Set-Up Fee $_____

HRA COBRA calculation Fee $_____

Annual Enrollment Fee $_____

COBRA fee Per Event Fee $_____ or PPPM $_____

29. BROKER/AGENT

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 June 2024)

Allegiance℠ by Cigna Healthcare

DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

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 Institution
_____	_____
Primary Contact	City/State
_____	_____
Authorized Signature	Date
_____	_____
Account Number	Routing and Transit Number

Please attach a copy of a voided check or bank note to confirm banking information noted above.

Confirmed date that Claims Based Funding should start_____

Claims payments releasing daily.