HRA Data Form

**** IF SPONSORING MORE THAN ONE HRA PLAN, COMPLETE A SEPARATE FORM FOR EACH ****

PLAN ELECTIONS

Section 105 HRA Plan Name _____

Plan Beginning Date _____ Plan Ending Date _____

Plan Effective Date _____ First Year Effective Date _____

ELIGIBILITY REQUIREMENTS

The following class of employees is eligible to participate:

❑ All employees ❑ Salaried employees only ❑ Hourly employees only

❑ Other **(specify)** _____

The following employees are excluded from participation (check all that apply)

❑ No exclusions

❑ Part-time employees normally expected to work less than _____ hours per week

❑ Employees under the age of _____

❑ Union employees (unless the bargaining agreement provides for coverage)

❑ Employees with Non-Resident Alien immigration status

❑ Other **(specify)** _____

The service period employees must complete before being eligible to participate (check all that apply)

❑ For the initial Plan Year, anyone employed (in service or on the job) on the Plan Effective Date;
then for subsequent Plan Years:
❑ As of date of hire ❑ _____ days after date of hire ❑ _____ months after date of hire

❑ For all Plan Years, anyone employed (in service or on the job):
❑ As of date of hire ❑ _____ days after date of hire ❑ _____ months after date of hire

Once eligible, when employees can begin participation in the Plan

❑ On date of eligibility
❑ First day of pay period following eligibility date
❑ First day of month following eligibility date
❑ First day of quarter following eligibility date
❑ First day of Plan Year following eligibility date

OVERHEAD COVERAGE AND ELIGIBLE EXPENSES

❑ **Health/Major Medical Plan** Carrier Name: _____
❑ Deductible ❑ Co-Insurance ❑ Prescriptions ❑ Co-Pays (Office Visits/Prescriptions)
❑ Other (specify) _____

❑ **Dental/Orthodontic Plan** Carrier Name: _____
❑ Deductible ❑ Co-Insurance ❑ Co-Pays ❑ Other (specify) _____

❑ **Vision/Optical Plan** Carrier Name: _____
❑ Deductible ❑ Co-Insurance ❑ Co-Pays ❑ Other (specify) _____

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OVERHEAD COVERAGE AND ELIGIBLE EXPENSES (continued)

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❑ **Other (specify)** _____

_____

❑ **Plan is not linked to overhead coverage**

- ❑ Expenses eligible for reimbursement include all Section 213 qualified products and services
- ❑ Other (specify) _____

REIMBURSEMENT/BENEFIT TIER*

❑ Flat rate $ _____ per plan year

❑ Amount varies by coverage status

- ❑ Employee Only $ _____ per plan year
- ❑ Employee + Spouse $ _____ per plan year
- ❑ Employee + Child/ren $ _____ per plan year
- ❑ Family $ _____ per plan year

If individual HRA value is $1,000 or more for any participant, please complete the separate MSP Reporting data form

PLAN DESIGN

Dollar Amount	Participant Pays %	HRA Pays %
$0 -		

CARRYOVER*

Will there be a carryover? ❑ Yes **(specify amount below)** ❑ No

- ❑ Entire accumulated unused account balance (no cap on amount carried over)**
- ❑ Accumulated unused account balance, up to $ _____ max. amount carried over**
- ❑ Other** **(specify)** _____

The carryover portion of a participant's total HRA account balance pays at 100%

****If individual HRA value combined (after carryover) can reach $1,000 or more, complete the MSP Reporting data form***

BENEFIT ORDER

❑ HRA pays first, then FSA ❑ FSA pays first, then HRA ❑ Other _____

REIMBURSEMENT FREQUENCY

❑ Daily (claims processed and paid on the business day following the business day on which DPAS receives claim)

❑ Weekly on _____ (day of week)

❑ Monthly on _____ (day of month)

❑ Per Pay Period (Bi-Weekly or Semi-Monthly)

❑ Other _____

REIMBURSEMENT METHODS

❑ mySourceCard debit card (available only for "first-dollar" plan designs)

❑ ACH Deposit plus Direct Checks (checks mailed by DPAS direct to participants)

❑ ACH Deposit plus Employer Batch Checks (checks mailed by DPAS in bulk to Employer for signing and distribution)

❑ ACH Deposit (no Checks)

Employer Signature _____ Date _____

DataPath Signature _____ Date _____