HEALTH REIMBURSEMENT ARRANGEMENT APPLICATION/ADOPTION AGREEMENT

Administered by:
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Trust No:_____

Group No:_____

Broker/Agency:_____

Phone No:_____

Email Address:_____

It is the intention of the Employer named in this Application/Agreement to adopt the Health Reimbursement Arrangement (HRA) described below.

EMPLOYER/PLAN SPONSOR INFORMATION

Company Name (*full and complete legal business name*):	Requested Effective Date:
New or existing HRA:	If existing, please indicate the original effective date:
Street Address:	
Mailing Address:	

Company Type: □ Sole Proprietor □ Partnership □ C Corporation □ S Corporation □ Government Entity □ Non-Profit
□ Limited Liability Corporation □ Limited Liability Partnership □ Other_____

(Note: sole proprietors, partners, 2% or greater shareholders of an S corporation and members of a limited liability company generally cannot participate in an HRA)

EIN Number:	
Number of eligible employees:	SIC Code:
Telephone No:	Fax No:
Contact's Name:	Contact's Email:

Weekly Funding Reports will be emailed to the contact person unless otherwise stated.

HRA PLAN DESIGN INFORMATION:

Debit Card: □ Yes □ No

Type of HRA: □ Medical □ Dental/Vision □ Retiree Only

(Note: An HRA that reimburses medical expenses must be "integrated" with an ACA-compliant group health plan. To be integrated, this Employer must offer an ACA-compliant group health plan and the HRA must be available only to employees enrolled in an ACA-compliant group health plan, even if that group health plan is sponsored by another employer. Employees may waive this Employer's group health plan coverage if covered under another employer's ACA-compliant group health plan. If this Employer's or the other employer's ACA-compliant group health plan does not provide minimum value, HRA reimbursements are limited to deductibles, copays, and Code Section 213(d) medical expenses for non-essential health benefits. If this Employer's or the other employer's ACA-compliant group health plan provides minimum value, the HRA may reimburse any 213(d) medical expenses. If this Employer allows HRA enrollment when the employee is enrolled in group health plan coverage sponsored by another employer, the employee will be required to certify the other coverage when submitting claims for HRA reimbursement.

For a medical HRA:
Provide the name of this Employer's major medical carrier (if insured) or the plan name (if self-funded) and attach an outline of coverage from the major medical coverage:_____
Does the coverage provide minimum value? □ Yes □ No

Plan Year start date:_____ Plan Year end date:_____

HRA deductible if any:
Employee amount $_____ Family amount $_____ per person □ OR aggregate □
Annual Benefit Maximum:
Employee amount $_____ Family amount $_____ per person □ OR aggregate □
(Aggregate means 1 person in the family can meet the total family deductible or reimbursement benefit amount.)

HRA reimbursement level: □ 100% □ 80% □ 50% □ Other_____

Eligible Expenses:
□ In-Network Deductible □ Out-Of-Network Deductible
□ In-Network Coinsurance □ Out-Of-Network Coinsurance
□ Medical Copayments □ Prescription Drug Copayments
□ All eligible 213(d) expenses (Medical, dental and vision)
□ Other – Please describe here:_____

Reimbursement Guidelines: □ Always Pay Provider □ Always Pay Employee □ At Employee's Discretion
If provider reimbursement is requested, a copy of the itemized bill must be included with the EOB.

CARRYOVER PROVISION

□ Yes □ No
If "Yes" select carryover provision below.
□ All unused funds
□ _____%
□ Up to a cumulative amount of $_____ (Employee only) $_____ (Employee with family)

COBRA/FMLA

This Employer is subject to COBRA: □ Yes □ No

This Employer is subject to the FMLA: □ Yes □ No

ELIGIBILITY FOR PARTICIPATION IN THE HRA (CHECK ALL THAT APPLY)

□ Current employees and their spouses and dependent children who are covered under this Employer's major medical coverage.
□ Current employees and their spouses and dependent children who are covered under another employer's major medical coverage.
□ Other (specify):_____
If benefits are offered after termination for certain qualifying employees such as retirees, please specify the eligibility provision here:

_____

_____

*Please note: Dependent children will be covered to age 26 unless noted here:*_____

ON-LINE ENROLLMENT

Will the Employer utilize SBS's web based on-line enrollment services? □ Yes □ No
Will the Employer utilize SBS's web based on-line termination services? □ Yes □ No

SPECIAL RULES FOR EMPLOYERS WITH SECTION 125 CAFETERIA PLANS (PLEASE RESPOND, AS APPLICABLE)

This Employer sponsors a Health Flexible Spending Arrangement (FSA): □ Yes □ No
If "Yes", please note: if coverage is provided under both an HRA and an FSA for the same expense, amount available under the HRA normally must be reimbursed first. The Employer may reverse this order, if desired. The reversal is accomplished by having the plan document for the HRA specify that the HRA is available only *after* qualifying expenses exceeding the dollar amount of the FSA have been paid. To be effective for a particular year, this provision in the HRA plan document must be in place before the FSA plan year begins.
Please select on of the following:
□ Amounts available under the HRA should be reimbursed before amounts available under the FSA.
□ Amounts available under the FSA should be reimbursed before amounts available under the HRA (applicable to the first FSA plan year occurring after the HRA is effective).

In adopting the HRA, the Employer understands and agrees to the following: 1) there must be a plan in place for employees' reimbursements to be nontaxable; 2) a written plan document is required to establish the plan and the Employer will comply with the provisions of the plan document; 3) reimbursements are restricted to the eligible medical care expenses specified in the plan document; 4) the Employer must provide each plan participant and beneficiary with a Summary Plan Description that accurately describes the plan; 5) annual nondiscrimination testing is required to insure that the plan does not discriminate in favor of highly compensated individuals; 6) the plan must be designed as defined in IRS Notices 2002-21 and 2002-45 and as modified by the Affordable Care Act and the Employer assumes full legal and financial responsibilities for not having the plan design and documentation reviewed and approved by the Employer's financial and legal counsel prior to adoption; 7) an HRA must be paid for solely by employer contributions; it cannot be paid for, directly or indirectly, through employee salary reduction elections; 8) there are additional tax and legal implications for this type of plan which also should be reviewed with the Employer's financial and legal counsel; and 9) this Application/Agreement is not an insurance contract and the Employer is responsible for funding an amount equal to the actual claims paid, as well as paying an administrative fee.

Authorized Signature (Employer) Date

_____ _____