

Health Reimbursement Arrangement Application/Adoption Agreement



Administered by:
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Trust No: _____

Group No: _____

Broker/Agency: _____

It is the intention of the Employer named in this Application/Agreement to adopt the Internal Revenue Service Notice 2002-45 Health Reimbursement Arrangement (HRA) described below.

Employer/Plan Sponsor Information

Company Name: _____ Requested Effective Date: _____

Street Address: _____

Mailing Address: _____

Company Type: Sole Proprietor Partnership C Corporation S Corporation **EIN:** _____

Number of eligible employees: _____ **SIC Code:** _____

(Note: the 'self-employed', including 2% or greater shareholders in an S Corporation cannot receive tax-free reimbursements from an HRA)

Telephone Number: _____ Fax Number: _____

Contact's Name: _____ Contact's E-mail: _____

Name of Medical Carrier: _____ (Attach benefit outline)

The employer hereby adopts the Plan. In doing so, the Employer understands and agrees to the following: 1) the Internal Revenue Service requires a legal plan document for a Code Section 105(h) Health Reimbursement Arrangement and the Employer will comply with the provisions of the plan document; 2) if any person has a right to receive cash or another taxable or nontaxable benefit under the HRA, other than the reimbursement of medical care expenses, then all of the reimbursements to all of the participants in the HRA will be taxable; 3) there must be a plan in place for employees' reimbursements to be nontaxable; 4) if the Plan discriminates in favor of 'highly compensated' individuals, these people could be taxed on all or part of their reimbursements; 5) the Plan must be made clear to eligible employees, plan participants, and beneficiaries, each of whom must receive a Summary Plan Description; 6) there are additional tax and legal implications for this type of medical reimbursement plan which should be reviewed with the Employer's financial and legal counsel; and 7) 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.

This application cannot be processed without medical benefit plan design information from the Carrier and the Client's HRA documentation. Benefits will be adjudicated in accordance with this documentation.

Authorized Signature (Employer): _____ Date: _____

Incurred expenses to be reimbursed under the HRA:

- Major medical plan Deductible - Specify: In-Network Deductible Out-of-Network Deductible
(Attach plan design)
- Major medical plan Coinsurance - Specify: In-Network Coinsurance Out-of-Network Coinsurance
(Attach plan design)
- Any medical care expenses covered by the Major Medical Plan which are subject to the Plan's deductible, coinsurance, etc.
(Attach benefit outline)
- Dental Expenses (if applicable, attach Plan design)
- Vision Expenses (if applicable, attach Plan design)
- All medical care expenses which are deductible on an Individual's federal tax return under Internal Revenue Code '213(d)

Will SBS be crediting deductibles from a previous medical plan? Yes No

If Yes, EOBs from the medical plan must include year to date deductible amounts.

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.

Benefit Reimbursement: In Network Only In Network and Out of Network

Benefits Period: Calendar Year Plan Year

Automatic Claim Crossover? (Limited to groups with medical coverage through SBS) Yes No

Funding Method: MICR (Fee Applicable) ACH Processing (Over)

Annual Maximum Reimbursement Amount(s):Annual Maximum Reimbursement Amount(s): **Single:** \$ _____ **Family:** \$ _____HRA deductible amount (if any): **Single:** \$ _____ **Family:** \$ _____
(amount the individual must meet before HRA benefits are reimbursed)

HRA reimbursement percentage: 100% _____ 80% _____ 50% _____ Other _____

Please explain any other benefit options included such as co-pay reimbursements (specify amounts per type: office visit, pharmacy, emergency) or if 213(d) expenses allowed, please attach plan design.

Carryover of Unused Amount from Previous Year: Yes No

If "Yes," describe carryover provision below

 All _____ % Up to a cumulative amount of \$ _____ (Employee Only) \$ _____ (Employee with Family) Other (specify): _____**COBRA**

My Company (including members of a controlled group or a successor resulting from consolidation, merger, or similar restructuring, or mere continuation) maintained a group health plan and normally employed 20 or more common law, full-time employees and part-time employees (counted as fractions) on at least 50 percent of its typical business days during the preceding calendar year:

 Yes No*If you checked 'Yes' to the above statement, the HRA is subject to COBRA.***Eligibility for Participation in the HRA (check all that apply)** Current employees and their spouses and dependent children who are covered under the Major Medical Plan All employees and their spouses and dependent children → Hours for Eligibility: _____ Waiting Period _____
Maximum Age Limit for Child Dependent: _____ Maximum Age Limit for Student: _____**ALTHOUGH NOT REQUIRED, even if COBRA coverage (if applicable) is not elected, HRA coverage may be continued for formerly covered -** Terminated employees and their spouses and dependent children: only until the unused reimbursement amount remaining at termination is exhausted with increases in the amount available for reimbursement after termination*Maximum Reimbursement Amount available after termination is to be reduced for any administrative costs of continuing the coverage -* Yes No Retired employees and their spouses and dependent children: only until the unused reimbursement amount remaining at retirement is exhausted with increases in the amount available for reimbursement after retirement*Maximum Reimbursement Amount available after retirement is to be reduced for any administrative costs of continuing the coverage -* Yes No Spouses and dependent children of deceased employees: only until the unused reimbursement amount remaining at the time of the employee's death is exhausted with increases in the amount available for reimbursement after the death of the employee*Maximum Reimbursement Amount available after the employee's death is to be reduced for any administrative costs of continuing the coverage -* Yes No No formerly covered employees, spouses, or dependents Other: (specify) _____**Special Rules for Employers with Section 125 Cafeteria Plans (please respond, as applicable)****An HRA must be paid solely by the employer and cannot be provided pursuant to a salary reduction election or otherwise under a Section 125 Cafeteria Plan. However, employers can provide both types of plans (i.e., an HRA and a Section 125 Plan).****Does your Company Sponsor a Premium Only Plan (POP) -** Yes No **If 'Yes',** please note: the salary reduction election form must indicate that salary reduction elections are used only to pay for the Major Medical Plan.**Does your Company sponsor a Health Flexible Spending Account (FSA)? -** Yes No **If 'Yes',** please note: if coverage is provided under both an HRA and an FSA for the same expense, amounts available under the HRA normally must be reimbursed first. You 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 one 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)