AMERICAN BENEFITS GROUP

HRA PLAN AMENDMENT FORM

Per your organization's Section 105 Plan, as the Plan Sponsor you may amend or terminate the Plan at any time. If you wish to add or alter a parameter of your HRA plan, we ask that you use this form to indicate which changes you are looking to implement. *Only with a completed and signed Amendment Confirmation Form will ABG move forward with amending the Plan Document, Summary of Benefits of Coverage (SBC) and administrative set-up of the plan*. Many of the items below require more information in the "More Detail" box near the bottom of the form.

Please note, per your organization's signed Administrative Services Agreement, there is a $295 fee associated with amending the plan.

Employer Information

☐ Change in Employer Details (Federal Tax ID, Type of Organization, add Affiliated Co., etc.)

Description:_____

_____

_____

Group Health Insurance and Deductible Year

For any HRA that covers deductible expenses, the HRA plan year ***must*** follow the deductible year of the underlying Group Health Insurance Plan. As part of an effort to improve our records, please confirm the following:

Health Insurance Plan Year Start	Health Insurance Plan Year End
MM/DD _____	*MM/DD* _____

Health Insurance Deductible Year Start	Health Insurance Deductible Year End
MM/DD _____	*MM/DD* _____

Aggregate or Embedded Deductible?

For the new plan year, is the Group Health Insurance Plan deductible (check one):

☐ **Aggregate Deductible**
(claims for all family members contribute to meeting the total deductible on the insurance plan)

--- or ---

☐ **Embedded Deductible**
(each family member has their own deductible that is tracked separately by the insurance)

For the new plan year, is the HRA Plan Employee Responsibility (check one):

☐ **Aggregate Employee Responsibility**
(claims for all family members contribute to meeting the total employee responsibility on the HRA)

--- or ---

☐ **Embedded Employee Responsibility**
(each family member has their own employee responsibility that is tracked separately by the HRA)

Question 1: Funding Amounts & Employee Responsibility

☐ **NO CHANGE TO FUNDING OR EMPLOYEE RESPONSIBIITY:** There will be no changes to the amount of funds being made available to employees in the HRA, and there are no changes to the employee upfront responsibility (if no changes, please ***proceed to Question 2***).

--- or ---

☐ **CHANGE TO FUNDING OR EMPLOYEE RESPONSIBIITY:** There are changes to the amounts being made available to employees in the HRA, and/or there are changes to the employee upfront responsibility (if so, please select one of the four checkboxes below, and enter the values in the selected table before moving to the Question 3):

☐ **HRA Employee First** – Employee Pays Upfront, then HRA Pays Remainder

Tier	Employee Upfront Responsibility	HRA Funding Available
Single (EE Only)	$ _____	$ _____
Double (EE Plus One)	$ _____	$ _____
Family (EE Plus Family)	$ _____	$ _____

☐ **HRA Employer First** – HRA Pays Upfront ("First Dollar"), then Employee is Responsible for Remainder

Tier	HRA Pays Upfront	Employee Responsible for Remainder
Single (EE Only)	$ _____	Remainder of Deductible or OOP
Double (EE Plus One)	$ _____	Remainder of Deductible or OOP
Family (EE Plus Family)	$ _____	Remainder of Deductible or OOP

☐ **HRA Pays Percentage:** Per Eligible Claim, HRA Pays a Percentage and Employee is Responsible for the rest.

Tier	HRA Pays % of Each Claim	Employee Pays % of Each Claim
Single (EE Only)	_____ %	_____ %
Double (EE Plus One)	_____ %	_____ %
Family (EE Plus Family)	_____ %	_____ %

☐ **Other Design:** Check this box if you want to change your HRA plan design to one that is not one of the three listed above. This may mean an increase to the rate you pay for the administration of the HRA for the new plan year.

_____

_____

_____

(Form is continued on next page.)

Question 2: **Eligible Expenses and/or Cost Types**

☐ **NO CHANGE TO ELIGIBLE EXPENSES:** There will be no changes to the types of expenses allowable under the HRA (if no changes please ***proceed to Question 3***).

--- or ---

☐ **CHANGE TO ELIGIBLE EXPENSES:** There are changes to the types of expenses allowable under the HRA (if so, please check the items below before moving to Question 3). Please check ***all*** the expenses that will be covered under the HRA for the new plan year:

☐ Deductible Expenses – Major Medical (ABG will assume in-network and out-of-network unless specified otherwise)

☐ Coinsurance – Major Medical

☐ Copayments – Major Medical

☐ Other Section 213(d) Major Medical Expenses outside of your organization's Group Health Insurance Plan

☐ Vision Deductible, Coinsurance and Copayments

☐ Dental Deductible, Coinsurance and Copayments

☐ Prescriptions (Rx)

☐ Other: _____

Question 3: **HRA Coverage End Date**

An HRA should follow the underlying Group Health Insurance Plan when it comes to employee terminations. If coverage under the Group Health Insurance Plan ends on the date of termination, so should coverage under the HRA. If coverage under the Group Health Insurance Plan ends at the end of the month when termination occurs, then the HRA should do the same.

☐ **NO CHANGE TO COVERAGE END DATE:** For the new plan year, the HRA coverage will continue to end for terminated employees as it has for the current plan year (if this is the case, please ***proceed to Question 4***).

--- or ---

☐ **CHANGE TO COVERAGE END DATE:** There is a change to the when coverage ends under the Group Health Insurance Plan for terminated employees, and will change for the HRA in the new plan year. Please check one of the following before moving to Question 4):

☐ HRA Coverage will end as of the date of termination

☐ HRA Coverage will end at the end of the month in which termination occurs

(Form is continued on next page.)

Question 4: HRA Plan Year (if changing the plan year by running a Short Plan Year)

For any HRA that covers deductible expenses, the HRA plan year ***must*** follow the deductible year of the underlying Group Health Insurance Plan. Running a short plan year should only occur if necessary to align the HRA plan year with the integrated Group Health Insurance Plan's deductible year.

☐ **NO CHANGE TO PLAN YEAR:** The HRA Plan Year for my organization's HRA will remain the same (if no change to the plan year, you have completed this form).

--- or ---

☐ **CHANGE TO HRA PLAN YEAR:** There are changes to the HRA Plan Year for my organization's HRA (if so, please complete the table below):

Current HRA Plan Year		**Renewal HRA Plan Year**	
Current HRA Plan Year Start Date	Current HRA Plan Year End Date	Future HRA Plan Year Start Date (for Renewal)	Future HRA Plan Year End Date (for Renewal)
MM/DD _____	*MM/DD* _____	*MM/DD* _____	MM/DD _____

End of Form. Return the form to processing@amben.com.

Organization Name: _____ Change Effective Date: _____

Print Name: _____ Signature: _____ Date of Signature: _____
(Employer Representative)