AMERICAN BENEFITS GROUP

CLIENT INFORMATION FORM - HRA

Company Profile

Legal Name of Organization: _____ Broker of Record: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Website URL: _____ Employer Fed Tax ID#: _____

# of Years in Business: _____ Date Established: _____

State of Incorporation: _____ # of Years at Location _____

Affiliated Employers *(list):* _____

_____ ☐ None

Organization Type *(please check)*: ☐ Privately Owned ☐ Publicly Owned

Ownership Structure *(please check):* ☐ Principal Ownership Under 25% ☐ Principal Ownership Over 25%

Type of Incorporation *(please check):* ☐ Non-Profit Organization ☐ Government Agency

☐ Partnership* ☐ Sole Proprietorship* ☐ LLC *(Limited Liability Company)**

☐ Sub-chapter "C" Corporation ☐ Sub-charper "S" Corporation* ☐ Other _____

* **Note**: Subchapter S Corporation shareholders above the 2% level **may not** participate, but they may sponsor a plan for their employees. In addition, family members and close relatives of these shareholders **may not** participate. LLC, LLP and Sole Proprietors **may not** participate, but may sponsor a plan for their employees. However, if the spouse is a bona fide employee of the firm, he or she may participate and use the benefit for the entire family.

Type of Business *(please check)*: ☐ Business to Business ☐ Business to Consumer

☐ N/A Government Agency ☐ N/A Non-Profit International Presence ☐ Yes

COBRA

Is ABG Administering your COBRA? ☐ Yes ☐ No

COBRA Administrator: _____

Mailing Address: _____

INSURANCE CARRIERS

Medical: _____

Dental: _____

Vision: _____

Form Submittal by Printed Name	Form Submittal by Signature	Form Submitted Date

Employer Plan Administrators

Administrator Access: ABG can provide a read-only access to our WealthCare Administration system for Employer Plan Administrators. Those being provided with access should either have been designated as a privacy officer, or have been cleared for access to Protected Health Information (PHI) per HIPAA requirements.

Scheduled Reports include information about account balances, debit card transactions and claim reimbursements. Scheduled reports in the system do not contain PHI or Personal Information (PI).

		Administrator Access?	Scheduled Reports?
Primary HR:	Title:	☐ Yes ☐ No	☐ Yes ☐ No
Email:	Tel:		
Payroll:	Title:	☐ Yes ☐ No	☐ Yes ☐ No
Email:	Tel:		
Billing/Finance:	Title:	☐ Yes ☐ No	☐ Yes ☐ No
Email:	Tel:		
Contact:	Title:	☐ Yes ☐ No	☐ Yes ☐ No
Email:	Tel:		
Broker Contact:		N/A	☐ Yes ☐ No
Email:	Tel:		

Nondiscrimination Testing

In order to qualify for tax-favored status, Cafeteria, Flexible Spending and Health Reimbursement benefit plans must not discriminate in favor of highly compensated employees (HCEs) and key employees with respect to eligibility, contributions, and benefits. In order to evidence compliance, annual tests must be performed and the results documented for each benefit plan.

Under the 2007 proposed regulations, Code Section 125 nondiscrimination tests are to be performed as of the last day of the plan year, taking into account all non-excludable employees who were employed on any day during the plan year. Some employers choose to perform these tests mid plan year in order to determine whether additional steps need to be taken before the end of the plan year so that the plan passes the nondiscrimination tests and preserves the tax treatment for the key and highly compensated. A second and final test would then be conducted as of the last day of the plan year.

Per your Admin Agreement:

Testing Fees for Non-Assisted Testing run by client or broker through our NDX Testing Portal:

First two NDX test sets per Plan Year ..... **Waived**

Additional NDX test sets per Plan Year $395

Testing Fees for Assisted Testing run by ABG:

Per NDX test set $495

To perform the required tests please complete the **Nondiscrimination Testing Request Form** linked here https://www.amben.com/demos/NondiscriminationTesting/ABG_NondiscriminationTestingRequestForm.pdf

IMPORTANT: If we do not receive the Nondiscrimination Testing Request Form, we will assume that you do not want to test your Plan(s) with ABG.

HRA Plan Design

Please note that your HRA must comply with the Affordable Care Act (ACA) requirements beginning January 1, 2014 as clarified on September 13, 2013 in Treasury Notice 2013-54. Your HRA can continue to reimburse all or a subset of eligible medical expenses as described under IRS Code Section 213(D) if:

1. Those eligible for the HRA are also eligible for, and enrolled in, an employer-sponsored ACA-compliant group medical coverage. Employer-sponsored ACA-compliant group medical coverage may be provided by the employer that offers the integrated HRA or employees may certify they have coverage under a spouse's or parent's ACA-compliant group medical plan.
2. The group medical plan meets the minimum value requirement.

If you are currently offering an HRA to all of your employees regardless of whether they are enrolled in an ACA compliant group medical plan you must terminate this plan or amend it so that it is only available to employees who have ACA-compliant group medical insurance with minimum value coverage. Please contact American Benefits Group immediately to discuss any changes or amendments you may need to do.

Please confirm that all employees who are eligible to participate in your HRA are:

☐ Enrolled in either your employer sponsored ACA-compliant group medical coverage
or
☐ Have certified that they have coverage under their spouses or parent's ACA compliant group medical plan

If you are currently offering an HRA to all of your employees regardless of whether they are enrolled in an ACA compliant group medical plan you must terminate this plan or amend it so that it is only available to employees who have ACA-compliant group medical insurance. Please contact American Benefits Group immediately to discuss any changes you need to do to your HRA account.

HRA Plan Design

Plan Effective Date: _____

This Plan is: ☐ An entirely new plan ☐ A continuation (amendment or restatement) of an existing plan*
*If so, what was the effective date of the original plan? _____

Who was previously administering the Plan? _____

What is the 3 digit ERISA plan number assigned to this plan? _____

Who will be responsible for processing run-out claims: ☐ Previous Administrator ☐ ABG

☐ Check here if this is a short plan year: Start Date: _____ End Date: _____

☐ Check here if this is a mid-year takeover: Start Date: _____ Take-over Date: _____ End Date: _____

Participation in the Health Reimbursement Arrangement Begins (*please check*):

☐ As of date of hire

☐ From date of hire: ☐ 30 days ☐ 60 days ☐ 90 days

☐ First of the month following: ☐ DOH ☐ 30 days ☐ 60 days ☐ 90 days

☐ Other *(please explain)*: _____

Please indicate which employees will be eligible for the HRA:

☐ All Benefit Eligible employees

☐ Health Plan participants only

☐ HSA Plan participants only

☐ Retirees only

☐ Other *(please explain)*: _____

Minimum hours per week worked to participate _____

Linked HRA

Is this HRA linked to a Health Plan? ☐ Yes, please attach a Summary Plan Description for this Health Plan ☐ No

What is the name of your Plan? _____

Is this Plan a High Deductible Health Plan (HDHP)? ☐ Yes ☐ No

Does the deductible run on a calendar year? ☐ Yes ☐ No, indicate the month when the deductible renews: _____

Do you want to want to run a short plan year so that the HRA year coincides with the Linked Health Plan year? ☐ Yes ☐ No

For a linked HRA, please indicate annual amounts:

	DEDUCTIBLE	ER CONTRIBUTION
Single:	$_____	$_____
2 Person:	$_____	$_____
Family:	$_____	$_____

Notes: _____

Is there a prescription deductible that the HRA will be funding? ☐ Yes ☐ No

If Yes, is the deductible embedded in the Medical Deductible? ☐ Yes ☐ No

Indicate annual RX deductible amounts:

	DEDUCTIBLE	ER CONTRIBUTION
Single:	$_____	$_____
2 Person:	$_____	$_____
Family:	$_____	$_____

Notes: _____

Non-Linked HRAs and HRAs linked to a non-HDHP Health Plans

What coverage tiers are you offering?

☐ Employee only ☐ Employee plus one ☐ Family ☐ Flat Rate

☐ **HRA Plan where the HRA Reimburses eligible expenses first:**

Employee only	***Employee plus one***	***Family***	***Flat Rate***
Employer will pay first	Employer will pay first	Employer will pay first	Employer will pay first
$ _____	$ _____	$ _____	$ _____
Employee will pay second	Employee will pay second	Employee will pay second	Employee will pay second
$ _____	$ _____	$ _____	$ _____

Notes: _____

☐ **HRA Plan where the Employee Reimburses eligible expenses first:**

Employee Only	***Employee plus one***	***Family***	***Flat Rate***
Employee will pay first	Employee will pay first	Employee will pay first	Employee will pay first
$ _____	$ _____	$ _____	$ _____
Employer will pay second	Employer will pay second	Employer will pay second	Employer will pay second
$ _____	$ _____	$ _____	$ _____

Notes: _____

HRA Plan Design Continued

How are the funds in the HRA made available to your plan participants?

- ☐ 100% at the beginning of the plan year
- ☐ Posted monthly on the first of each month
- ☐ Posted quarterly on the first of each quarter
- ☐ The employer and employee are responsible for a percentage of each expense (the total should equal 100%)

The employee is responsible for: ☐ 25% ☐ 50% ☐ 75% ☐ Other (please specify) _____

The employer is responsible for: ☐ 25% ☐ 50% ☐ 75% ☐ Other (please specify) _____

Will the funds be pro-rated for new hires based on the plan entry date? ☐ Yes Monthly ☐ Yes Quarterly ☐ No

Do you offer an FSA plan? ☐ Yes ☐ No

If yes, the HRA will pay for all eligible expenses first and the FSA will pay second. If the benefit order is different please note here and describe _____

What expenses can the HRA benefits be used for and do you allow them to be paid for with the ABG Benefits Card
(The card is not suitable for plans which require employees to pay the first portion or their deductible, or for plans which are required to reimburse non-RX deductible expenses.)

Expense	Card	Documentation Required To Substantiate Claim
☐ Deductible Expenses	☐	☐ Yes ☐ EOB
☐ Co-pays	☐	☐ Yes ☐ EOB
☐ Co-Insurance	☐	☐ Yes ☐ EOB
☐ Dental	☐	☐ Yes
☐ Vision	☐	☐ Yes
☐ Over-the-counter	☐	☐ Yes
☐ RX	☐	☐ Yes
☐ Other	☐	☐ Yes

Run Out Period for End of Plan Year – How may days after the end of the Plan Year will employees have to submit claims incurred during the plan year?

☐ 3 months ☐ Other: _____

Participation in the HRA terminates: ☐ Date of Termination ☐ Last day of the month in which termination occurs

Number of days after termination to submit claims incurred prior to termination?

☐ 90 days ☐ Other (please specify) _____

COBRA

Please note that Health Reimbursement Arrangements are governed by ERISA; HIPAA and COBRA regulations. With a COBRA qualifying event an HRA participant must be offered COBRA on their HRA benefit.

What are the COBRA premium rates for your HRA?

Employee Only _____ *Employee plus one* _____ *Family* _____ *Flat Rate* _____

☐ The COBRA premium rate is a bundled rate for both the Integrated Health Plan and the HRA.

☐ There will be separate premium for the Group medical plan and the integrated HRA.