



Section 105 Health Reimbursement Arrangement Kaiser Permanente Plan Application Small Group



Company Name & Address: _____ _____ _____		Contact Name: _____ Telephone #: _____ Fax#: _____ Email: _____	
Brokerage Firm _____		Consultant's Name _____	
Tax I.D. #: _____ Total # of Employees: _____ Existing HRA Plan Number: _____ <small>(i.e. 501, 502 etc.): complete for takeover plans only</small>	Business Form: Non-Profit <input type="checkbox"/> C Corp: <input type="checkbox"/> Sub S Corp: <input type="checkbox"/> Partnership: <input type="checkbox"/> LLC/LLP: <input type="checkbox"/> Government <input type="checkbox"/>		

HRA PLAN DESIGN & OPTIONS

Kaiser Plan (Select One)	HRA Bridge (Select One)	HRA Base Benefit Amount	HRA Coverage Levels & Tracking (Select One)
Effective Date: ___/___/___ <input type="checkbox"/> Ded/Co HMO \$1000/\$2000/\$3000 <input type="checkbox"/> Ded/Co HMO \$1200/\$2400/\$3600 <input type="checkbox"/> Ded/Co HMO \$1500/\$3000/\$4500 <input type="checkbox"/> Ded/Co HMO \$2000/\$4000/\$6000 <input type="checkbox"/> Ded/Co HMO \$2500/\$5000/\$7500 <input type="checkbox"/> Ded/Co HMO \$3000/\$6000/\$9000 <input type="checkbox"/> Ded/Co HMO \$4000/\$8000/12000 <input type="checkbox"/> Ded/Co HMO \$5000/\$10000/\$15000 <input type="checkbox"/> Other _____	<input type="checkbox"/> Last <input type="checkbox"/> Middle <small>(not available with 50%)</small>	Base Benefit Amount: <input type="checkbox"/> 50% <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> Other _____	Base Benefit Applies to: <input type="checkbox"/> <u>Base HRA Amount for All (Aggregate)</u> Base Benefit amount applies to all levels of coverage. (1x HRA Benefit Amt) <input type="checkbox"/> <u>Ded/Co HMO (Embedded)</u> Base Benefit applies to: <ul style="list-style-type: none"> • Individual coverage = 1x HRA • EE + One Coverage = 2x HRA • EE + Child(ren) = 3x HRA • Family Coverage = 3x HRA <input type="checkbox"/> <u>Ded/Co HSA (Aggregate)</u> <ul style="list-style-type: none"> • Individual coverage = 1x HRA • Family Coverage = 2x HRA
Effective Date: ___/___/___ <input type="checkbox"/> Ded/Co HSA \$2500/\$5000 <input type="checkbox"/> Ded/Co HSA \$3000/\$6000 <input type="checkbox"/> Ded/Co HSA \$5000/\$10000	<input type="checkbox"/> Last		

HRA Plan Details

Eligible Expenses: Kaiser Permanente Group Medical Plan Deductible Expenses Only Plan Year: All HRA plans will run on a calendar plan year. Participants must meet their HRA deductible responsibility <u>each plan year</u> before HRA benefits will be available.	4th Quarter Deductible Credits: Only Ded/Co HMO HRA plans will allow 4 th quarter deductible credits. Claims: All HRA plans have a 90 day run out period for claims submittal. Benefit Amount: Late entries to plan will receive full HRA benefit amount (no proration).
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HRA ELIGIBILITY

<p>Eligibility waiting periods: (enter required # of days before eligible)</p> <p>New employees _____ days</p> <p><i>Note: Waiting period should mirror the Kaiser Permanente health care plan.</i></p>	<p>Eligible employees:</p> <p>Full Time only</p>	<p>Number of hours/week required for eligibility _____ hours</p> <p><i>If left blank 40 hours/week will be used. (Note: required # hours/week should mirror Kaiser Permanente health care plan.)</i></p> <p>Entry date: 1st of the month after meeting eligibility requirements unless noted otherwise here. _____</p>
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HIPAA PRIVACY CONTACT

Please name an individual or committee as the point of contact for HIPAA Privacy Concerns with whom PBS may, from time to time, discuss Protected Health Information, if necessary to adjudicate a claim under any component of this plan.

Our HIPAA Privacy Contact will be: _____

AFFILIATED EMPLOYERS

Please list the names, addresses and tax I.D. numbers of any affiliated Employers that will adopt this plan:

DISCRIMINATION TESTING INFORMATION

Section 105 plans may not discriminate in favor of highly compensated employees in terms of ability to participate or as to contributions and benefits. Planned Benefit Systems will perform the necessary discrimination tests on an annual basis to help ensure the Employer's plans are in compliance. In order to perform these tests, the Employer agrees to provide required information including but not limited to the status and benefit amounts of participating employees. Please note that 2% or more owners in Sub Chapter S corporations are not eligible to participate in Section 105 plans. Likewise, Partners in a Partnership or Limited Liability Corporation or Limited Liability Partnerships are not eligible to participate in Section 105 plans either.

EMPLOYER AUTHORIZATION

The employer must complete the PBS ACH Authorization Agreement & Administrative Agreement before HRA claims will be processed. The employer understands that Planned Benefit Systems will be preparing a Plan Document and Summary Plan Description (if elected above) for all components of the plan. The employer further understands that the plan document will allow an automated enrollment in the Premium Conversion Plan and a claims submittal period of 90 days after plan year end. The employer agrees to distribute a Summary Plan Description to each participant in the plan. It is understood that any unanswered sections of this document may result in errors in the plan produced by this form. Planned Benefit Systems, Inc. makes no representation or warranty of any kind as to the legal effect, sufficiency or tax qualification of any document utilizing PBS' format. I hereby release PBS from any and all liability attributable to any legal, tax or other defect in the requested documents.

Signature: _____ **Date:** _____

Name: _____ **Title:** _____