(*FAMILY NAME*)

Individual Coverage Health Reimbursement Arrangement

Effective Date:

Employer / Plan Administrator

Employer Name: _____
Address: _____
_____
Phone Number: __(_____)_____-_____

Federal Employer Identification Number:

The employer named above will serve as Plan Administrator. The Plan Administrator has the authority to:

- Interpret the Plan for eligibility and benefits determinations,
- Determine Plan eligibility for individuals,
- And Terminate or Amend the Plan.

Plan Year: _____

Waiting Period:

_____ (Not to exceed 90 days from start of employment.)

Maximum Benefit:

This is the maximum amount of benefits that will be paid out during the course of the Plan Year. Employees enrolled in the Plan will be eligible to receive reimbursements from the Employer Health Care Expenses in a Plan Year or the remaining Plan Year in which they are enrolled.

Annual Maximum: $_____

Carry Over:

$_____ ☐ NO CARRY OVER OF UNUSED BENEFITS BETWEEN PLAN YEARS

This is the maximum amount of unused benefits that can be carried over from one Plan Year to the next Plan Year. Cash Outs are not permissible.

Health Care Expense:

Health Care Expense means any amount paid by a Participant, covered Dependent and/or Spouse that is an expense for individual health insurance policy premiums reimbursable under §213(d) of the Internal Revenue Code, excluding expenses reimbursed by any other health plan.

Individual health insurance policies must offer minimum essential coverage as defined by the Affordable Care Act to be eligible for Plan reimbursement. Health care sharing plans cannot be reimbursed under a ICHRA Plan.

Should the employee fail to maintain coverage that constitutes minimum essential coverage, the employee may be subject to penalties under the individual mandate provisions of the ACA, and the ICHRA reimbursements might be included in the employee's gross income.

HRA Account:

The HRA account established for each individual Eligible Employee is fully funded by the Employer, and any amounts remaining at the end of the plan year in excess of the Carry Over defined above are forfeited. Any remaining funds at time of termination are forfeited.

Eligibility and Enrollment:

Eligible Employee: An Eligible Employee will automatically become a participant in this Plan upon completion of the Waiting Period as defined above and submission of an enrollment form.

Eligible employee is actively employed on the date before the effective date, as well as any newly hired or rehired active full time employee. Part time employees, temporary employees, and employees under the age of 25 who are included on a parent's plan are not eligible to participate in the Plan.

Enrollment: An Eligible Employee must complete an enrollment form to participate in the Plan. Coverage will begin no more than thirty (30) days after the completed enrollment form is received by the employer.

Termination:

An Eligible Employee's participation in the plan shall terminate as of the earliest of:

- The date the employee ceases to be employed by the employer;
- The date of Plan termination.

Coverage following Termination of Employment: The terminated employee has a period of thirty (30) days following termination of employment for any reason to submit eligible expenses incurred prior to employment termination for reimbursement by the Plan subject to the employee's HRA balance.

Plan Records:

The employer/Plan Administrator is required to maintain records to document proper Plan Administration.

The Plan participant is required to furnish the employer/Plan Administrator with the data the Administrator reasonably requests to ensure the proper administration of the Plan, with documentation of items such as proof of relationship as needed.

Expense Reimbursement

The following must be observed for eligible reimbursement of Health Care Expenses:

- Participant must submit a completed REIMBURSEMENT REQUEST FORM no later than thirty (30) days after the close of the Plan year –OR- no later than thirty (30) days after the termination of employment.
- The REIMBURSEMENT REQUEST FORM must include the following:
    - Name and address of the participating employee;
    - Name of the person who incurred the expense (employee, spouse, or eligible dependent);
    - The name and address of the health care provider or organization to whom the health care expense was paid or is to be paid and the amount of the payment;
    - Type of eligible expense;
    - Copy of receipt or bill.

HEALTH EXPENSE REIMBURSEMENT FORM

Employee Information		
Name:		SSN:
Street Address:		
City:	State:	Zip:

Reimbursement Information	
Provider Name:	Date of Expense:
Patient Name:	Total Reimbursement:
Type of Expense:	

Authorization		
By signing below, I request reimbursement for the described expense and I represent that the information I provided in this request is true and complete and further certify that I have health insurance that meets minimum essential coverage.		
Name: (Please Print)	Signature:	Date:

(ATTACH RECEIPT)