NORTHEAST BENEFITS MANAGEMENT, LLC

Application for BEB HRA Claims Administration & Document Preparation

Employer Information

Legal Company Name (including punctuation)	Tax ID

Employer/Corp Entity: ☐C Corp. ☐S Corp. ☐Partnership ☐Government / Church ☐Non-profit ☐Sole Proprietor ☐ Other

☐Limited Liability (Taxed as) ☐C Corporation ☐S Corporation ☐Partnership

Please notify us of any changes to entity type or ownership that occur (or are anticipated) during the plan year.

An employer may provide tax-free benefits to employees, former employees, retirees, and their spouses or covered tax dependents. Because self-employed individuals are not "employees," an employer may not provide tax-free benefits to self-employed individuals (i.e., sole proprietors, partners, and greater than 2% Subchapter S corporation shareholders & applicable family members).

Mailing Address	City	
Address 2	State	ZIP
Physical Address (if different)	City	
Address 2	State	ZIP
Phone (area code) – Main company line – not a toll-free number		

Which pre-tax benefits are currently offered to your employees?*

☐ Medical ☐ Dental ☐ Vision ☐ Health Care FSA ☐ Health Savings Account (HSA)

☐ Dependent Care FSA ☐ Parking/Transit Account

*If you deduct insurance premiums pre-tax, the IRS requires a Section 125 plan. Contact us at (802) 865-0239 / info@nbmus.com to learn more

Are any of the following plans currently available?

☐ HRA (please provide a copy of your SPD) ☐ EAP

Would you like to receive a proposal for Health Care FSA, Dependent Care FSA, or HSA? ☐ Yes

Do you have any affiliated employers?

No ☐ *If yes, please complete page 5*

Name(s) of Owner(s), if applicable: _____

Will owners be participating in the HRA? Yes ☐ No ☐ If yes, names? _____

Total Number of Employees: _____ **Number of Benefit-Eligible Employees**:_____
(Numbers should include affiliated employers, if any)

Plan Contacts

Plan Admin. (general questions regarding the plan)	Email	Phone
Funding Contact (funding requests)	Email	Phone
Billing Contact (invoices/payments)	Email	Phone
HIPAA Contact (title only)		
Broker	Email	Phone
COBRA Administrator (name & address)	Email	Phone

Underlying BRS Blue Edge Business Health Plan (Select all that apply)

Co-pay 1 ☐ Co-pay 2 ☐ CDHP 1 ☐ CDHP 2 ☐

Standard BEB HRA Options (Select A, B, C, or D)

Our Difference

We provide significant value through live benefits administrators, cloud-based portal technology, a mobile app, seamless claims integration, and the option to use a debit card.

We also provide all necessary documents, including the Summary Plan Description (SPD), to ensure everything is clear and compliant.

A. ☐ **100% HRA with No Threshold**

☐ Include an Rx Debit Card (pays 100%)

Reimbursement will include all eligible BCBSVT BEB out-of-pocket expenses.

B. ☐ **Any other percentage HRA with No Threshold**

☐ Include an Rx Debit Card that pays:
☐ 50%
☐ 100%

Reimbursement will include all eligible BCBSVT BEB out-of-pocket expenses.

C. ☐ **100% HRA after a $1,700/$3,400 threshold (HSA compatible)**

Reimbursement will include all eligible BCBSVT BEB out-of-pocket expenses.

(Rx reimbursed to the employee, no debit card)

D. ☐ **50% HRA after a $1,700/$3,400 threshold (HSA compatible)**

Reimbursement will include all eligible BCBSVT BEB out-of-pocket expenses.

(Rx reimbursed to the employee, no debit card)

For A-D, please include the maximum reimbursement benefit amounts:

Required: Maximum HRA benefit for Single: $_____ 2 Person: $_____ Family: $_____

Custom HRA Plan Design

(Additional pricing will apply. NBM will provide a separate quote.

Custom plan designs are any deviation from the standard options. A custom plan would reimburse any expenses other than eligible BCBSVT expenses. Other examples include 213d, multiple HRA plan designs, and the addition of an HCFSA. **Please outline your design below.**

_____

_____

_____

HRA Eligibility

HRA eligibility must match the medical plan eligibility indicated on the BCBSVT BEB Group Enrollment Agreement

Hours per week (for example, working 30 or more hours): _____

Entry Date (for example, eligible first of the month coincident with **or** next following 30 days of employment): _____

Rehires (if eligibility is different from new hires):_____

Run-Out (Refers to the date after the plan year's end when the HRA will continue to reimburse expenses from the previous plan year.)

Run-Out: ☐ 90 Days following the end of the plan year (standard option) ☐ Other: _____

Run-Out for Terminated Employees

Note: The HRA will reimburse terminated employees for expenses incurred on or before their termination from the plan if received within this time frame.

☐ 90 days after termination (standard option) ☐ Other: _____

Other HRA Details

Will the HRA benefits be prorated for employees enrolling mid-year?

☐ No (Participants will receive the full benefit regardless of enrollment date)
☐ Yes (If yes, benefits will be prorated by the number of months enrolled)

Do you have a previous HRA with a rollover funds provision?

☐ No ☐ Yes (After run-out has ended, forward the rollover report from the prior carrier)

Will the HRA plan provide coverage for Domestic Partners?

☐ No ☐ Yes (Employers must tax employees with domestic partners enrolled in their HRA)

Employers often use HRA COBRA rates related to the non-tax-dependent domestic partner to determine the fair market value for the coverage period.

Important Compliance Requirements

BEB medical plans and HRAs are subject to the following

PCORI

Under the Affordable Care Act, certain health insurance policies and self-insured health plans (including HRAs) are subject to a fee. This fee supports the Patient-Centered Outcomes Research Institute (PCORI). It should be reported annually on the 2nd quarter IRS Form 720, Quarterly Federal Excise Tax Return, and paid by July 31 of the following calendar year after the policy year ends.

Do you want NBM to prepare signature-ready PCORI and Form 720 documents? ☐ Yes (additional charges apply) ☐ No

HRA Nondiscrimination Testing

Self-insured medical insurance must pass nondiscrimination testing to avoid favoritism towards highly compensated or key individuals.

Do you want NBM to perform the HRA nondiscrimination testing? ☐ Yes (additional charges apply) ☐ No *

Medical Nondiscrimination Testing

Self-insured medical insurance is subject to nondiscrimination testing, which prevents plans from discriminating against highly compensated individuals or otherwise key to the business.

Do you want NBM to perform the Medical nondiscrimination testing? ☐ Yes (additional charges apply) ☐ No *

HRA COBRA Calculation

HRAs are considered medical plans and are subject to COBRA. A separate calculation of HRA COBRA rates is needed.

Do you want NBM to perform HRA COBRA calculations? ☐ Yes (additional charges apply) ☐ No

* Checking "No" will result in a Hold Harmless letter, as testing is required under Code Section 105(h).

Employer Banking Information

HRA funding will be transferred from the bank account you provide. You will be notified electronically of the weekly funding required to process claims. Additional processing dates may be added if you offer debit cards.

Bank Name	Bank Address
Bank Phone	Account Type
Routing Number	Account Number
Person Authorizing	Phone Number

Authorizations

Thank you for your business!

We hereby authorize Northeast Benefits Management, LLC ("NBM") to withdraw the necessary amount for our Health Reimbursement Arrangement, HSA accounts, and other fees. It is our sole responsibility to ensure that the payments are accurately debited from our bank account. We must verify that there are no account blocks before the plan's start date and promptly notify NBM of any changes in our banking information.

I hereby authorize Northeast Benefits Management, LLC to provide reimbursement account services based on the information provided on this form. I understand that any changes made to our plan design after the initial implementation, whether made by me (plan sponsor) or mandated by the DOL or IRS, may result in additional fees. Finalization of this application is contingent upon receipt of a signed Administrative Services Agreement, which will be provided separately.

Signature	Date

Contact Us

Northeast Benefits Management, LLC
620 Hinesburg Road, Suite 120
PO Box 2363
South Burlington, VT 05407-2363

Tel: (802) 865-0239
Email: info@nbmus.com

Affiliated Employer(s) (If applicable)

Legal Company Name (including punctuation)	Tax ID	
Mailing Address	City	
Address 2	State	ZIP
Physical Address (if different)	City	
Address 2	State	ZIP
Phone (area code)		

Employer Entity taxed as (check one): ☐C Corporation ☐S Corporation ☐Partnership ☐Government or Church ☐Non-profit ☐ Other

☐Limited Liability - Taxed as (check one) ☐C Corporation ☐S Corporation ☐Partnership

Name(s) of Owner(s) if applicable:_____

Will owners be participating in the HRA? Yes ☐ No ☐ If yes, names? _____

If there are more employers, please attach additional pages.