INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENT
ADMINISTRATIVE SERVICES AGREEMENT

This Individual Coverage Health Reimbursement Arrangement ("ICHRA") Administrative Services Agreement ("Agreement"), effective _____, is between _____ on behalf of itself and its Health Reimbursement Arrangement Plan ("Group"), and Planned Administrators, Inc. ("PAI"), a division of Blue Cross and Blue Shield of South Carolina, a South Carolina mutual insurance corporation.

Financial and Administrative Terms:

These Financial and Administrative terms apply throughout this Agreement. Capitalized terms used throughout the Agreement shall have the same meaning as provided in the Exhibit A (Administrative Services Terms and Conditions "Terms and Conditions") or Exhibit B ("Plan of Benefits"), as applicable, unless a different meaning is plainly required by the context. In case of a conflict between the terms of this Agreement and the terms of the Terms and Conditions or Plan of Benefits, this Agreement shall control.

Classification Requirements:

1. Group has established, or intends to establish, an ICHRA Plan for Group's eligible employees.
2. Subject to Exhibit A, Terms and Conditions, and Exhibit B, the Plan of Benefits (all of which are hereby incorporated into this Agreement), Group desires to retain PAI to provide certain administrative services with respect to the ICHRA Plan.
3. Group hereby agrees to the terms and conditions contained in the Terms and Conditions and may be amended from time to time.
4. The ICHRA furnished to Plan Participants will be a premium-only Individual Coverage HRA, intended to assist Employees and Dependents in purchasing health coverage through the Individual ACA issuers.
5. The ICHRA Plan imposes the following requirement for an Employee to qualify as an Eligible Employee OR a Dependent to qualify as an Eligible Dependent:
    - Enrolled in Individual Health Insurance Coverage or Medicare (Parts A and B, or Part C)
    - If Applicable, Dependents are eligible for coverage under this Plan until the Dependent turns age 26
6. Qualified Medical Expenses eligible for reimbursement under the ICHRA Plan are limited to Premiums for Individual Health Insurance Coverage or Medicare only. Such expenses will be reimbursable Directly to the health insurance carrier or other entity accepting premiums for the coverage, provided that the Participant completes and submits a certification, in a form and manner provided by the Claims Administrator, authorizing the ICHRA Plan to make such premium payments, or to the Participant where required.
7. The Employer is solely responsible for payroll deduction arrangements with the employee.
8. The monthly invoice should be reviewed and verified for accuracy. Any changes must be communicated to the agent immediately.
9. Employee terminations must be submitted in the month in which they occur. No retroactivity will be allowed.

Employer Information

Name of Applicant: _____
(Company's Legal Group Name)

Address: _____
(Street) (City) (State) (ZIP)

Federal Tax Identification Number: _____

Identify How Taxes are Filed: ☐ C-Corp ☐ LLC ☐ Partnership ☐ S-Corp ☐ Sole Prop ☐ Non-Profit

S-Corp, Sole Prop and Partnership Owners are not eligible to participate in ICHRA reimbursement. Consult your tax professional with any eligibility questions.

List all owners here (required):

1. _____

2. _____

3. _____

Point of Contact for Employer – Benefit Coordinator:

Name: _____

Phone: _____

Email: _____

Agent Contact Information:

Name: _____

Agent Number: _____

Phone: _____

Email: _____

Chamber Name: _____ **Chamber Agent Code:** _____

Prior Carrier: _____

ICHRA Plan Year:

The current HRA Plan Year will begin on _____ and end on December 31, _____.

Each subsequent HRA Plan Year will begin on January 1 and end on December 31.

Participation:

Total Employees	Total Eligible	Total Eligible Enrolling

HRA Contribution Strategy

The strategy you choose will determine how contributions are distributed to your employees.

☐ Flat Amount – Employees and Dependents: $_____
Contribution applies to the whole family premium.

☐ Fixed Rate – Employees only: $_____
Contribution applied to the employee's premium only.

☐ Fixed Rate – Employees and Dependents:
Enter a separate dollar amount for employee, spouse and dependent's HRA contribution.
(No Rollover will occur. Dependent contribution applies to all dependents with a premium.)

Employee: $_____ Spouse: $_____ Dependents(s): $_____

☐ Aged Tiered – Fixed Rate Employee only:
Enter a separate dollar amount for ages 16-65+ on an excel spreadsheet. No rollover will occur to Dependents. 3:1 ratio cannot be exceeded. Submit with ASA.

☐ Age Bands – Employees only:
Contribution applied to the employee's premium only.

Age Band	Amount ($)	Age Band	Amount ($)

Contribution by Class

If Employee classes will be funded at different levels, please list classes here and different amounts. Only permitted classes will be allowed.

☐ Flat Amount – Employees and Dependents:
Contribution applies toward the whole family premium.

☐ Fixed Rate – Employees only:
Contribution applies toward the employee's premium only.

Class Description	Amount ($)

Employee Payments in Excess of Funded Amount:
Any unfunded amount of premium due to Insurer will be billed to the Group monthly for the total balance due (all Employees and Dependents). **Groups must complete a Payroll Express Master Agreement and submit with ASA.**

Fee:

Administrative Charge: **$18.50 per employee per month.**

Electronic Funds Transfer Authorization:

Account Name: _____

Financial Institution: _____

Bank Account Number: _____

Routing Number (i.e., 123-456-789): _____

Account Type: ☐ Checking ☐ Savings

☐ I authorize Planned Administrator's Inc. to draw bank drafts on the above listed bank account for the Individual Coverage Health Reimbursement Arrangement (ICHRA). Payment will include the ICHRA contribution and monthly administration fee. This authorization will remain in effect until I notify Planned Administrator's Inc. in such a time as to afford reasonable time to act upon it.

_____ _____
(Print Name) (Authorized signor on the Account)

_____ _____
(Title) (Date)

Planned Administrator's Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

IN WITNESS WHEREOF, PAI and Purchaser have caused their names to be signed hereto by their respective officers.

_____ **Planned Administrator's Inc.**
Name of Applicant (Company's Name)

By: By:

_____ _____
(Authorized Group Signature) George Stiles, President

_____
(Date)