# Independence Spending Account Small Market Health Reimbursement Account (HRA) Application (2023)

Instructions:

1. Complete Sections A, B, and C
2. Submit an Online Employer Portal Access Form (OEPAF) requesting access to Spending Accounts for all administrators.
3. Contact your Independence representative for assistance.
4. Submit completed, approved application to your Independence representative.

## Section A: Employer Information

| Employer Name | Tax ID | Client ID |
|---|---|---|
| Street Address 1 | Street Address 2 | |
| City | State | Zip |
| Billing Address (if different) | | |
| Telephone | Fax | |
| Payroll Location/Reporting Code (if applicable) | | |
| Number of Benefit Eligible Employees: | Estimated Enrollment: **HRA:** | |

| Employer Primary Spending Account Contact Name | Email | Phone | Fax |
|---|---|---|---|
| Street Address ☐ Same as employer | | | |
| | | | |
| Employer Contact Name | Email | Phone | Fax |
| Street Address Same as employer | | | |

## Section B: Health Reimbursement Account

(Copy Section if there is more than on HRA plan)

| HRA Plan Effective Date | HRA Plan End Date | Group #s (Add additional groups in notes section below) |
|---|---|---|

HRA Group Run-Out Period

○ 0 months ○ 1 month ○ 2 months ◉ 3 months ○ Other _____

HRA Run-Out for Terminated Employees

○ 0 months ○ 1 month ○ 2 months 3 months ○ Other _____

HRA Type – Select one and complete the corresponding section below: ○ HRA Pays First ○ Employee Pays First

**HRA Pays First**

Annual HRA Employer Contribution ($ amount not %)

| Individual | Employee + Spouse | Employee + Child | Employee + Children | Family |
|---|---|---|---|---|
| $ | $ | $ | $ | $ |

Is there a per person funding cap? ○ Yes* - Amount: $_____ ○ No

*If yes, any one person covered on a multi-person plan cannot spend more than the designated amount.

**Employee Pays First –** Employee pays HRA deductible for eligible expenses before HRA funds are used.

Annual Employee HRA Deductible ($ amount not %)

| Individual | Employee + Spouse | Employee + Child | Employee + Children | Family |
|---|---|---|---|---|
| $ | $ | $ | $ | $ |

Is there a per person deductible (embedded)? ○ Yes* - Amount: $_____ ○ No

*If yes, any one person covered on a multi-person plan must satisfy the individual HRA deductible amount before their claims will be reimbursed from the HRA.

Annual HRA Employer Contribution ($ amount not %)

| Individual | Employee + Spouse | Employee + Child | Employee + Children | Family |
|---|---|---|---|---|
| $ | $ | $ | $ | $ |

Is there a per person funding (embedded)? ◉ Yes* - Amount: $_____ ○ No

*If yes, any one person on a multi-person plan cannot spend more than the designated amount.

Can employees earn additional incentive deposits to their HRA? ○Yes ○No

Is the HRA Employer Contribution prorated monthly for employees enrolling mid-year? ○Yes ○No

Are HRA funds available annually based on employee's medical coverage tier? ○Yes ○No If no, you agree to send file for HRA Employer contribution.

Will unused HRA funds roll over from one plan year to the next? ○Yes If yes, complete table below. ○No

Should rollover funds be available prior to the end of the prior year run out (enhanced run out)? ○Yes* ○No

*If yes, incurred claims will be paid from current year HRA funds first then prior year funds, if available.

**HRA Year End Rollover**

How much of remaining employee funds should rollover to the next plan year?

○All ○_____ % ○Cap Amount ○_____ % up to cap amount ○None

| Individual | Employee + Spouse | Employee + Child | Employee + Children | Family |
|---|---|---|---|---|
| % | % | % | % | % |

Maximum Rollover Cap Amount:

| Individual | Employee + Spouse | Employee + Child | Employee + Children | Family |
|---|---|---|---|---|
| $ | $ | $ | $ | $ |

**HRA Reimbursement Options**

Eligible Expenses: (check all that apply)

| | | | |
|---|---|---|---|
| Medical | Rx | Dental | Vision |
| Deductible | Coinsurance | Copay | Other/Not covered |
| In-network | Out-of-network | | |

Should claims autopay from the HRA*? ○ Yes ○ No

Should payment be sent directly to the provider of service? ○ Yes ○ No

Will a debit card be issued with this HRA plan*? ○ Yes ○ No

If yes, please specify which expenses can be paid with the debit card: Medical Rx Dental Vision

If yes, please specify copay amounts for auto-substantiation: Medical Rx Dental Vision

*Note: A debit card is not permitted on integrated claims when autopay is selected unless the debit card is for RX only.

Will there be cost sharing of each eligible HRA claim? ○No, claims will pay 100% ○Yes, HRA will pay _____% of each claim

Are employees allowed to change autopay preferences, if applicable? ○Yes ○ No

HRA Administrative Fee: Amount $ Fee is Client-paid

Internal Use Only:
SCC Template _____ MCC Template ____

Notes:

## Section C: Signature

| Print Name | Date |
|---|---|
| | |

Signature

| Relationship to Client: | Client | Producer/Broker | Other |
|---|---|---|---|
| | | | |