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 Accrue Health ("Accrue"), 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 Accrue 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.

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: _____

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 Eligible Employees	Enrolled in ICHRA	Waiving ICHRA

Contribution Strategy:

Please select your ICHRA contribution strategy:

____ Fixed Rate ____ Age* ____ Classes

____ Other (please explain)_____

_____

**Contributions by age cannot exceed a 3:1 ratio*

Will the ICHRA contribution cover: ____ Employee Premium Only ____ Employee and Dependents Premium

**Covering Employee and Dependents premium means any excess contribution after employee premium has been paid will rollover towards spouse/dependents premium unless noted.*

Maximum Monthly Amount: The maximum monthly amount to fund the ICHRA will be:

☐ Employee only: $_____

☐ Employee and Spouse: $_____

☐ Employee and Child: $_____

☐ Family: $_____

If Employee classes will be funded at different levels, please list classes here and different amounts:

Class Description	Employee	EE/Spouse	EE/Child	Family
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

Employee Payments in Excess of Funded Amount:

Any unfunded amount of premium due to Insurer will be paid as follows:

☐ Bill the Group monthly for the total balance due (all Employees and Dependents). **Group must complete a Payroll Express Master Agreement (minimum of two employees required).**

☐ Bill each Employee monthly for any balance due

Fee:

Administrative Charge: $25.00 or $2.25 per employee per month.

Blue Cross and Blue Shield of South Carolina 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, BCBSSC and Purchaser have caused their names to be signed hereto by their respective officers.

	BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
Name of Applicant (Company's Name)	
By:	By: 
(Authorized Group Signature)	Scott Graves, President
(Date)	