Assurant Health

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, John Alden Insurance Company and Union Security Insurance Company.

Section 105 Administration

Section 125 Administration

Information you'll need to complete this Service Agreement:

REVIEW ALL DOCUMENTS THOROUGHLY BEFORE BEGINNING

- An Employer Federal Employee Identification Number (FEIN)
- An Employer Executive Contact
- An Employer Administrative Contact
- An Employer's Corporate Status

For the EBC HRA℠:

- The date the EBC HRA Plan starts (Effective Start Date)
- The number of Employees covered
- The start and end dates of the EBC HRA Plan Year

For the BESTflex Plan℠:

- The date the BESTflex Plan starts (Effective Start Date)
- The total number of all Employees
- The total number of Eligible Employees

You must submit a signed and dated HIPAA Business Associate Agreement (included with this Agreement) to be compliant with HIPAA regulations

IMPORTANT: If Employee Benefits Corporation will Administer your EBC HRA , you MUST send a signed, dated and completed Auto-debit Authorization Form (enclosed with this agreement)

IN ORDER TO VALIDATE THE EFFECTIVE DATE (START DATE) OF THE PLAN, THIS SERVICE AGREEMENT MUST BE COMPLETED IN FULL, SIGNED, DATED AND BE RECEIVED BY EMPLOYEE BENEFITS CORPORATION BEFORE THE EFFECTIVE DATE.

As set forth below, the following Employer hereby adopts the following Plan(s) and engages Employee Benefits Corporation (EBC), PO Box 44347, Madison, Wisconsin 53744 4347 (telephone: 608 831 8445; toll free 800 346 2126), to provide services related to the Plan(s). The EBC HRA℠ is a Health Reimbursement Arrangement, Section 105 Plan as defined by the Internal Revenue Code. The BESTflex℠ Plan is a "cafeteria plan" as defined in Section 125 of the Internal Revenue Code.

Service Agreement

1

EBC Only

______________AH
EBC Group ID Number

____
Group ID Number

Enter Employer information.

Legal name of Company | **Federal Employer ID Number (FEIN)**

Company address | City | State | Zip

☐ Check if business address is the same as company address

Business address | City | State | Zip

Street address | City | State | Zip

Executive contact | Telephone ( ) | Extension

Administrative contact | Telephone ( ) | Extension

Administrative contact fax ( ) | Administrative contact e-mail

Determine Employer's ERISA status.

Please choose whether or not the Plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA)

Check only one:

☐ The Plan is governed by ERISA
☐ The Plan is not governed by ERISA (the Plan is a governmental plan or a church plan)
☐ The Employer cannot determine

In general, ERISA does not cover group health plans established or maintained by governmental or church controlled entities

Determine controlled groups or related companies.

Is the company above part of a controlled group or related to other companies that are part of this plan?

Check only one:

☐ Yes, attach addendum listing related employers
☐ No

The form "Addendum to the Service Agreement" is enclosed to list related employers

Indicate Employer's corporate status.

☐ C Corporation
☐ Subchapter S **
☐ Govt. Entity/School Dist.
☐ Sole Proprietor *
☐ Church Controlled
☐ Non-Profit
☐ Cooperative
☐ Partnership/LLP/LLC *

*** Special Ownership Rules** Sole Proprietors and Partners of a partnership (including members of LLPs and LLCs taxed as a Partnership) may **not** participate in the EBC HRA or the BESTflex Plan*

*** **More than 2% shareholders** in a Subchapter S Corporation, their spouses, and lineal ascendants and descendants are **not** eligible to participate in the EBC HRA or the BESTflex Plan*

Employee Benefits Corporation

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Assurant Health

The EBC HRA℠
Section 105 Administration

☒ **Elect the EBC HRA℠, Health Reimbursement Arrangement,** a Section 105 Plan as defined by the Internal Revenue Code (fill out the entire EBC HRA Section completely)

Determine if the HRA is a new HRA or a continuation.

Check only one:

☐ Entirely new HRA

☐ Continuation of existing HRA

_____ / _____ / _____
Continuation original start date (mm/dd/yyyy)

____
Continuation plan name

Name of Plan

☐ [Employer Name] Health Reimbursement Arrangement

☐ Other _____________________
Other Name

Choose your Effective Start Date.

The Effective Start Date can be a date other than the start date of the normal, 12-month Plan Year (Short Plan Year).

The Effective Start Date is the date the Plan starts with Employee Benefits Corporation

The Plan Year runs for 12 months but can start on any day within that Plan Year; it always starts on the Effective Date and if less than 12 months, it is termed a Short Plan Year

_____ / _____ / _____
EBC HRA Effective Start Date (mm/dd/yyyy)

Is this a mid-year takeover?
☐ Yes ☐ No

The Service Agreement and Plan Design are invalid if the Service Agreement is signed after the Effective Start Date; Plans may not be established retroactively and participant expenses incurred prior to the Effective Start Date are not eligible

Service Agreement

2

Determine your Plan Year.

Your Plan Year is from January 1 to December 31

Your Plan Year defines the duration of your EBC HRA

If your plan design reimburses annual health insurance deductible or coinsurance expenses, it's most convenient for participants when the Plan Year matches the deductible cycle, e.g. benefits may renew on 5/1 but deductible runs from 1/1 - 12/31

Review the term of this contract.

This Service Contract shall be in effect for 1 year ("Term") and shall thereafter automatically renew indefinitely for like Terms, unless terminated as set forth in TERMINATION.

EBC HRA eligibility and participation

Employees who are enrolled in the employer's group health plan or as stipulated in any attached addendum

Choose expense reimbursement availability.

Check only one option:

☐ The annual limit is available for reimbursement at the start of the Plan Year

☐ The full annual limit is not available at the start of the Plan Year; the annual limit will be divided and EBC HRA expenses paid equally as follows:

(Check only one option): ☐ Semi-monthly ☐ Monthly ☐ Quarterly

Funds will be available at the start of the period

Choose rollover criteria.

Check only one option:

Unused EBC HRA contributions may be carried forward from year to year

☐ No dollars roll over

☐ All unused dollars roll over annually

☐ Single	☐ Limited Family	☐ Family
$ _____ Maximum lifetime cap	$ _____ Maximum lifetime cap	$ _____ Maximum lifetime cap

☐ Limited dollars roll over annually

☐ Single	☐ Limited Family	☐ Family
$ _____ Limited annual rollover amount	$ _____ Limited annual rollover amount	$ _____ Limited annual rollover amount
$ _____ Maximum lifetime cap	$ _____ Maximum lifetime cap	$ _____ Maximum lifetime cap

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Section 105 Administration

Service Agreement

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How to design your EBC HRA:

Enter the number of participants, carrier name and eligible expense types below.

Then from the following pages, choose from the EBC HRA Plan Design template(s) that describe the coverage group(s) that make up your Plan and:

1. Select the insurance plan(s)

Checkmark the box next to the insurance plan(s) you'd like to include: Single, Limited Family and/or Family.

2. Choose a deductible type or reimbursement percentage

In the case of the Deductible and Coinsurance Plan Design Template, where Limited Family and/or Family insurance plans are checked, you must also checkmark the box next to either a common family (aggregate) or individual deductible type. For Co-pays and Prescriptions, enter the percentage of each claim the EBC HRA will reimburse.

About Deductible and Coinsurance Types:

Common Family (aggregate) deductible/coinsurance *All the expenses for the family are combined to satisfy the deductible (e.g. one family member can meet the entire family deductible)*

Individual Deductible/Coinsurance with a Family Maximum *Individual family member satisfies individual deductible; expenses for other covered family members are combined to satisfy the remainder of the deductible*

3. Choose a plan design

Checkmark the box next to only one Plan Design from the 3 choices offered (1, 2 or 3 tiers).
See About EBC HRA Plan Designs below.

4-5. Enter the payment amount (From Amount - To Amount for Deductible, Coinsurance, Vision, Dental and Section 213)

6. Enter the % the EBC HRA will pay (0-100%)

To build your Plan, you may need to use more than one Plan Design Template

About EBC HRA Plan Designs:

1-Tier Plan Design: This EBC HRA plan design reimburses a % of each eligible claim

2-Tier Plan Design: This design offers first and second payment options each having variable maximums and percentages

3-Tier Plan Design: Fine tune reimbursements using variable maximums and percentages

Design your Plan.

Participants are employees who meet the eligibility requirements of the EBC HRA; the number of participants is used to calculate your monthly administrative fee

Estimate the number of participants in the EBC HRA (Assurant Health strongly advises not to allow for reimbursement of expenses other than deductible expenses):

____
Participants

Enter the Health Plan carrier name: **Assurant Health**
Carrier name

Design Your Plan: Eligible Expense Type

Enter the eligible expense type:

☐ Deductible (The health plan deductible amounts must be a minimum single deductible of $1500)

☐ Coinsurance

☐ Dental

☐ Vision

☐ All Section 213 expenses

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Design your Plan: Deductible Template

☐ Not elected

Section 105 Administration

Service Agreement

1. Select your insurance plan(s) and enter the total deductible amount	3. Choose ONLY ONE EBC HRA design (Choose ONLY ONE Plan Design Template below)	4. Enter From Amount	5. Enter To Amount	6. Enter % HRA pays

☐ **Single**

$____________
Enter total deductible

☐ **Family**

$____________
Enter total deductible

2. You must choose ONE of the deductible types below:

Option 1:

Common Family (aggregate) deductible *All the expenses for the family are combined to satisfy the deductible (e.g. one family member can meet the entire family deductible)*

☐ Common family (aggregate) deductible

Option 2:

Individual Deductible with a Family Maximum *Individual family member satisfies individual deductible; expenses for other covered family members are combined to satisfy the remainder of the deductible*

☐ Individual deductible with a family maximum

$____________
Enter individual cap

Important Note:

If you have set an individual cap (Option 2 above) DO NOT USE THE FAMILY TOTAL DEDUCTIBLE AMOUNT AS THE *TO AMOUNT* in the last tier of the Plan Template.

YOU MUST USE THE INDIVIDUAL CAP AMOUNT AS THE TO AMOUNT in the last tier of the Plan Template as in the example below

☐ 1-Tier Plan Design

		From Amount	To Amount	% HRA pays
Single	Pays	$	$	%
Family	Pays	$	$	%

☐ 2-Tier Plan Design

		From Amount	To Amount	% HRA pays
Single	First Tier	$	$	%
	Second Tier	$	$	%
Family	First Tier	$	$	%
	Second Tier	$	$	%

☐ 3-Tier Plan Design

		From Amount	To Amount	% HRA pays
Single	First Tier	$	$	%
	Second Tier	$	$	%
	Third Tier	$	$	%
Family	First Tier	$	$	%
	Second Tier	$	$	%
	Third Tier	$	$	%

EXAMPLE:

The Plan uses a $2000 single deductible and a $4000 family deductible. *The individual cap is $2000.* The EBC HRA reimburses the last $2000.

You could enter this plan design into the 2-Tier Template as shown to the right:

☐ 2-Tier Plan Design

		From Amount	To Amount	% HRA pays
Single	First Tier	$ 0.00	$ 2000.00	0 %
	Second Tier	$ 2001.00	$ 4000.00	100 %
Family	First Tier	$ 0.00	$ 2000.00	0 %
	Second Tier	$ 2001.00	$ 4000.00	100 %

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Design your Plan: Coinsurance Template

☐ Not elected

The EBC HRA℠
Section 105 Administration

Service Agreement

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1. Select your coverage level	
☐ **Single**	$________ Enter coinsurance amount
☐ **Limited Family**	$________ Enter coinsurance amount
☐ **Family**	$________ Enter coinsurance amount

2. Check the box below

☐ Coinsurance

Option 1:

Common Family (aggregate) coinsurance *All the expenses for the family are combined to satisfy the deductible (e.g. one family member can meet the entire family deductible)*

☐ Common family (aggregate) deductible

Option 2:

Individual coinsurance with a Family Maximum *Individual family member satisfies individual coinsurance; expenses for other covered family members are combined to satisfy the remainder of the coinsurance*

☐ Individual coinsurance with a family maximum

$ ________
Enter individual cap

Important Note:

If you have set an individual cap (Option 2 above) DO NOT USE THE FAMILY TOTAL COINSURANCE AMOUNT AS THE *TO AMOUNT* in the last tier of the Plan Template.

YOU MUST USE THE INDIVIDUAL CAP AMOUNT AS THE TO AMOUNT in the last tier of the Plan Template as in the example below

3. Choose ONLY ONE EBC HRA design (You may choose ONLY ONE Plan Design Template)

☐ 1-Tier Plan Design

		4. Enter From Amount	5. Enter To Amount	6. Enter % HRA pays	7. Apply Rollover
Single	Pays	$	$	%	☐
Limited Family	Pays	$	$	%	☐
Family	Pays	$	$	%	☐

☐ 2-Tier Plan Design

		4. Enter From Amount	5. Enter To Amount	6. Enter % HRA pays	7. Apply Rollover
Single	First Tier	$	$	%	☐
	Second Tier	$	$	%	☐
Limited Family	First Tier	$	$	%	☐
	Second Tier	$	$	%	☐
Family	First Tier	$	$	%	☐
	Second Tier	$	$	%	☐

☐ 3-Tier Plan Design

		4. Enter From Amount	5. Enter To Amount	6. Enter % HRA pays	7. Apply Rollover
Single	First Tier	$	$	%	☐
	Second Tier	$	$	%	☐
	Third Tier	$	$	%	☐
Limited Family	First Tier	$	$	%	☐
	Second Tier	$	$	%	☐
	Third Tier	$	$	%	☐
Family	First Tier	$	$	%	☐
	Second Tier	$	$	%	☐
	Third Tier	$	$	%	☐

EXAMPLE:

The Plan uses a $1000 single and $2000 family coinsurance. The EBC HRA reimburses the first $500.

You could enter this plan design into the 2-Tier Template as shown to the right:

☐ 2-Tier Plan Design

		4. Enter From Amount	5. Enter To Amount	6. Enter % HRA pays	7. Apply Rollover
Single	First Tier	$ 0.00	$ 500.00	100 %	☐
	Second Tier	$ 501.00	$ 1000.00	0 %	☐
Limited Family	First Tier	$	$	%	☐
	Second Tier	$	$	%	☐
Family	First Tier	$ 0.00	$ 1000.00	100 %	☐
	Second Tier	$ 1001.00	$ 2000.00	0 %	☐

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The EBC HRA℠

Section 105 Administration

Design your Plan: Dental Template

☐ Not elected

1. Select your insurance plan(s)	3. Choose **ONLY ONE** EBC HRA design (You may choose ONLY ONE Plan Design Template)		4. From Amount	5. To Amount	6. % HRA pays
☐ Single	☐ **1-Tier Plan Design**				
☐ Family	Single	Pays	$	$	%
	Family	Pays	$	$	%
2. Check the box below	☐ **2-Tier Plan Design**				
☐ Dental	Single	First Tier	$	$	%
		Second Tier	$	$	%
	Family	First Tier	$	$	%
		Second Tier	$	$	%

EXAMPLE:

The Plan provides $500 single and $1000 family. The EBC HRA reimburses 100% of submitted Dental expenses.

☐ **1-Tier Plan Design**				
Single	Pays	**$ 0.00**	**$ 500.00**	**100 %**
Family	Pays	**$ 0.00**	**$ 1000.00**	**100 %**

Service Agreement

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Design your Plan: Vision Template

☐ Not elected

1. Select your insurance plan(s)	3. Choose **ONLY ONE** EBC HRA design (You may choose ONLY ONE Plan Design Template)		4. From Amount	5. To Amount	6. % HRA pays
☐ Single	☐ **1-Tier Plan Design**				
☐ Family	Single	Pays	$	$	%
	Family	Pays	$	$	%
2. Check the box below	☐ **2-Tier Plan Design**				
☐ Vision	Single	First Tier	$	$	%
		Second Tier	$	$	%
	Family	First Tier	$	$	%
		Second Tier	$	$	%

EXAMPLE:

The Plan provides $500 single and $1000 family. The EBC HRA reimburses 100% of submitted Dental expenses.

☐ **1-Tier Plan Design**				
Single	Pays	**$ 0.00**	**$ 500.00**	**100 %**
Family	Pays	**$ 0.00**	**$ 1000.00**	**100 %**

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Design your Plan: IRC Section 213 Expenses

☐ Not elected

The EBC HRA℠
Section 105 Administration

Service Agreement

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1. Select your insurance plan(s) and enter the total deductible amount	3. Choose ONLY ONE EBC HRA design (You may choose ONLY ONE Plan Design Template)		4. From Amount	5. To Amount	6. % HRA pays
☐ Single	☐ **1-Tier Plan Design**				
☐ Family	Single	Pays	$	$	%
	Family	Pays	$	$	%
2. Check the box below	☐ **2-Tier Plan Design**				
☐ All Section 213 Expenses	Single	First Tier	$	$	%
		Second Tier	$	$	%
	Family	First Tier	$	$	%
		Second Tier	$	$	%
	☐ **3-Tier Plan Design**				
	Single	First Tier	$	$	%
		Second Tier	$	$	%
		Third Tier	$	$	%
	Family	First Tier	$	$	%
		Second Tier	$	$	%
		Third Tier	$	$	%

EXAMPLE:

The Plan provides $2000 single and $4000 family amounts. The EBC HRA reimburses 100% of all claims up to the specified amounts

☐ **2-Tier Plan Design**				
Single	First Tier	$ 0.00	$ 2000.00	100 %
	Second Tier	$	$	%
Family	First Tier	$ 0.00	$ 4000.00	100 %
	Second Tier	$	$	%

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Assurant Health

☐ **Elect the BESTflex℠ Plan,** a "cafeteria plan" as defined by Section 125 of the Internal Revenue Code (fill out the entire BESTflex Plan Section completely)

☐ **Do not elect the BESTflex℠ Plan**

Determine if the Plan is a new Plan or a continuation.

☐ Entirely new Section 125 Plan

☐ Continuation of existing Section 125 Plan

_____ / _____ / _____

Continuation original start date (mm/dd/yyyy)

The BESTflex℠ Plan

Section 125 Administration

Name your BESTflex Plan.

☐ [Employer Name] Flexible Compensation Plan

☐ Other ______________________

Existing name

Choose your Effective Date (start date).

Your Effective Date can be a date other than the start date of the Plan Year (Short Plan Year).

_____ / _____ / _____

The BESTflex Plan Effective Date (start date with EBC) (mm/dd/yyyy)

The Service Agreement and Plan Design are invalid if the Service Agreement is signed after the Effective Start Date. Plans may not be established retroactively and participant expenses incurred prior to the Effective Date are not eligible

The Plan Year runs for 12 months but can start on any day within that Plan Year; it always starts on the Effective Date and if less than 12 months, it is termed a Short Plan Year

Service Agreement

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Determine your Plan Year.

Check only one option:

To have the BESTflex Plan use the calendar year as the Plan Year, check the box below.

☐ Use calendar year starting January 1

Your Plan Year is from January 1 to December 31

To have a **custom BESTflex Plan Plan Year**, check the box below.

☐ Custom Plan Year: _____ / _____ _____ / _____

Plan year start date (mm/dd): Plan year end date (mm/dd):

The Plan Year defines the duration of the BESTflex Plan

Add a Grace Period to your Plan.

Check only one option:

☐ YES, add 2-1/2 month Grace Period

☐ NO, do not add 2-1/2 month Grace Period

For takeovers of existing plans, will Employee Benefits Corporation administer the Grace Period for the prior plan year (additional fees will apply)? This is recommended to ensure proper payment of the participant's claims.

☐ Yes

☐ No

Employers may amend their plan document to add a grace period of 2 months and 15 days to their plan, allowing participants to use funds remaining in their BESTflex Plan Health Care FSA during this period

This does not effect the runout period

Eligible expenses are reimbursed from Health Care FSA funds remaining unused at the end of the immediately preceding Plan Year

Any unused balance remaining in the Participant's Health Care FSA after Grace Period ends are forfeited

Review the term of this contract.

This Service Contract shall be in effect for a 1 year ("Term") and shall thereafter automatically renew indefinitely for like Terms, unless terminated as set forth in TERMINATION.

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Assurant Health

The BESTflex℠ Plan

Section 125 Administration

Service Agreement

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Skip if only electing the Premium Only Plan; go to "Choose your BESTflex Plan benefits."

Calculate FSA eligibility.

For the Health Care and Dependent Care FSAs, Employees must meet the following hourly requirement and waiting period:

For Payroll Deducted Medical Premiums and/or Cash in Lieu of Medical Premiums of the BESTflex Plan, an employee must be eligible for coverage under the terms of the applicable underlying plans

Hourly requirement:

____
Minimum hrs/wk

Waiting period

Check only one option:

Eligible Employees shall begin to participate as of the first Entry Date after they complete the waiting period defined in this section

☐ First of month after: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ______________ Describe other

☐ From date of hire: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ______________ Describe other

☐ Date of hire

☐ Other ______________

Describe other

Add Employees.

______________ Total number of Employees

______________ Number of eligible Employees

***Eligible Employee** means an Employee that meets FSA Eligibility defined in this Agreement or one who qualifies for payroll deducted Group Premiums*

Choose your BESTflex Plan benefits.

Payroll deducted Group Premiums, Flexible Spending Accounts or Premium Only Plan

Choose all that apply:

☐ Medical Insurance
☐ Dental Insurance
☐ Disability
☐ Vision Care
☐ Group Term Life Insurance (up to $50,000/employee only)
☐ Accidental Death and Dismemberment Insurance
☐ Cancer Insurance
☐ Health Savings Account (HSA)
☐ Other insurance ______________

Describe other insurance

Choose Premium Only Plan:

☐ Premium Only Plan (No FSAs)
Go to "Cash in lieu of medical premiums amount."

Choose Flexible Spending Accounts:

☐ Health Care FSA
☐ Dependent Care FSA
☐ Limited Health Care FSA (only available if offering an HSA)

Skip this section if electing Premium-Only Plan.

For the Dependent Care FSA annual IRS maximum limits apply

Set your Flexible Spending Account annual limits.

Set the Health Care FSA limits.

$ ______________
Annual Health Care FSA limit amount

☐ No annual Health Care FSA limit amount

$ ______________
Annual Limited Health Care FSA limit amount

☐ No annual Limited Health Care FSA limit amount

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Assurant Health

Skip this section if electing Premium-Only Plan.

Determine employer contributions.

Choose only one option:

In addition to employee salary reduction contributions the employer shall

- ☐ Make NO contributions to the BESTflex Plan
- ☐ Make contributions to the BESTflex Plan

Contributions can be used for:

- ☐ Health Care FSA
- ☐ Dependent Care FSA
- ☐ Limited Health Care FSA

Plan Year maximum amount must include Employer contribution

$ ____________ Amount

____________ Terms

Employer will submit payment for above contribution:

- ☐ One time (at beginning of Plan Year)
- ☐ Per pay period

Set cash in lieu of medical premiums amount.

Choose only one option:

Employer will pay cash to employees who waive health coverage

- ☐ Yes

$ ____________ Amount

____________ Terms

- ☐ No

Skip this section if electing Premium-Only Plan.

Review employee enrollment education options.

May choose more than one type of enrollment.

Employee Benefits Corporation can provide enrollment assistance and education for your employees for a smooth implementation of your flexible spending accounts. We also offer automated enrollment services through the use of our telephone and internet enrollment systems. See your Fee Sheet. We will contact you for meeting dates and times as well as automated enrollment data requirements. Please indicate your enrollment preference below:

Billed separately and subject to change

Employee Education:

- ☐ Employee Group Meetings by Employee Benefits Corporation
- ☐ Individual Enrollment Sessions by Employee Benefits Corporation
- ☐ Self-Education

Enrollment Options:

- ☐ Employee Benefits Corporation Internet Enrollment System
- ☐ Employer's Internet Enrollment System
- ☐ Automated Telephone Enrollment
- ☐ Paper Enrollment

If Internet or phone option is chosen, Employer will be required to provide an electronic census in a designated format

The BESTflex℠ Plan
Section 125 Administration

Service Agreement

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The EBC HRA℠
Section 105 Administration

The BESTflex℠ Plan
Section 125 Administration

Service Agreement

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Skip this section if electing Premium-Only Plan.

Choose administration services.

Enter payroll information.

Payroll frequency (24, 26, 52 etc.)	Number of payroll deductions in the first Plan Year (24, 26 etc.) *	First payroll deduction date for this benefit (mm/dd/yyyy)
		/ /

If the Plan uses a short Plan Year enter the number of payroll deductions from the Effective date to the end of the Plan Year

Who will hold the employee payroll deducted Health Care FSA/Dependent Care FSA dollars?

Employee Benefits Corporation holds the funds

☐ Employee Benefits Corporation auto-debits payroll deduction amount for the period from Employer's account (required if electing Benny™ Card)

☐ Employee Benefits Corporation receives a check for payroll deduction amount for the period from Employer

Employer holds the funds

☐ Employee Benefits Corporation auto-debits the amount equal to claims from Employer's account (not an option if electing Benny™ Card)

☐ Employee Benefits Corporation receives a check equal to claims from Employer (this option could delay reimbursement)

Administration Fees

Service Fees for EBC HRA

Administrative fees for the EBC HRA offered through Assurant Health are included as long as the employer remains insured by Assurant Health and is covered under a qualified plan. Employers no longer insured by Assurant Health or no longer covered under a qualified plan will be required to assume the fees (calculated using our standard fee structure). Employee Benefits Corporation will invoice the employer beginning the first of the month following termination from Assurant Health or the qualified health plan.

Client requests to reprocess participant claims for Employee Benefits Corporation-approved mid-year plan design changes will be billed at $100 per hour.; this fee may include data retrieval

Plan Design changes off Plan Year will be charged $50.00

Participants will pay applicable fees associated with stop payment requests on reimbursement checks

Administrative Services Provided by Employee Benefits Corporation:

- The EBC HRA Answer Book
- Plan Documents and updates
- Summary Plan Description (SPD)
- Set up of employee enrollment information on Employee Benefits Corporation system
- Monitoring of employee medical expense plan reimbursement limits
- Review of benefit claims for payment qualification
- Paying of qualifying claims (to the extent Employer has provided funds)
- Nondiscrimination Worksheet

Service Fees for BESTflex Plan

Administrative fees for the BESTflex Plan offered through Assurant Health are included as long as the employer remains insured by Assurant Health and is covered under a qualified plan. Employers no longer insured by Assurant Health or no longer covered under a qualified plan will be required to assume the fees (calculated using our standard fee structure). Employee Benefits Corporation will invoice the employer beginning the first of the month following termination from Assurant Health or the qualified health plan. **The BESTflex Plan may only be used when the employer elects the EBC HRA.**

Administrative Services Provided by Employee Benefits Corporation:

- The BESTflex Plan Answer Book
- Plan Document and updates
- Summary Plan Description (SPD)
- Employee educational and enrollment materials
- One annual IRS Form 5500 (not required for most Section 125 Plans)
- Completion of one nondiscrimination test per plan year
- Review of benefit claims for payment
- Pay qualified benefit claims (to the extent the Employer has provided funds)

Optional Legal Services (billed separately by Employee Benefits Corporation and subject to change)

- Legal research or plan document changes by Employee Benefits Corporation ($50.00/hour; one-hour minimum)
- Legal research or plan document changes by Employee Benefits Corporation-appointed attorney (per attorney)

Optional Enrollment Services (billed separately and subject to change)

- Employee meetings ($55.00 per hour; 3 hour minimum plus any related travel charges)
- Employee Benefits Corporation staff travel over 3 hour drive from Madison WI (travel and food, lodging per diem)
- Extraordinary one time services (billed as agreed upon by Employee Benefits Corporation and Employer)

Web Address:
www.ebcflex.com

U.S. Mail:
Employee Benefits Corporation
PO Box 44347
Madison WI 53744-4347

Phone:
Monday - Friday, 8:00 - 5:00 CST
608 831 8445
800 346 2126

Fax:
608 831 4790

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Employee Benefits Corporation

Assurant Health

We are pleased to offer you Auto-Debit Authorization. You can have your plan funding withdrawn automatically from your checking or savings account. The best part is you won't have to change your present banking relationship to use this service. To take advantage of the direct payment plan, complete this authorization form and return it to Employee Benefits Corporation.

Here's How Auto Debit Authorization Works:

Fill out this form completely and fax it to us at **608 831 4790. Be sure to keep a copy for your records**.

You authorize a regularly scheduled withdrawal to be made from your checking or savings account. The amount debited from your account will be equivalent to the dollar amount of claims for a designated time frame or for a regularly scheduled payment. Withdrawals will be made automatically on a specified day.

In the case of holidays or weekends falling on the day the money is to be withdrawn from your account, the amount will be debited the next business day.

The BESTflex℠ Plan

Section 125 Administration

Please check the appropriate boxes.

There are several auto-debit options available:

☐ **EBC HRA "On-Demand" Claims Payments for Benny™ Card clients only**

You will receive a Claims Payment Register for all claims processed on one business day. On that day a debit is initiated from your account for those claims and is scheduled to occur the next business day. Claims are paid the day we debit your account.

You must select this option when electing the Benny™ Card

☐ **EBC HRA Claims Payments**

Funds are drawn from your account in an amount equivalent to claims to be paid for a specified time period. You will receive a Claims Payment Register, which will include claims to be for that period and the scheduled debit date.

☐ **BESTflex Plan FSA Payroll Deductions**

The amount debited from your account will be equivalent to the anticipated payroll deductions in the BESTflex Plan. Your payments will be made automatically on a specified day. You will receive your billing statement indicating the amount that will be debited from your account. If your claims in the Health Care FSA exceed the amount on deposit we will draw the excess due to pay those claims as well. Once funds are in our account, reimbursement checks will be released.

You must select this option when electing the Benny™ Card

☐ **BESTflex Plan FSA Claims Payments**

Claim payments will be made automatically on a specified day. You will receive a Claims Activity Report, which will include all claims processed for the period. That amount will be debited from your account.

This is not an option with the Benny™ Card

☐ **I do not choose Auto-Debit**

Service Agreement

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Company name

Name of financial institution | Branch

City | State | Zip

Bank Account Number (from check; see illustration, right)

Routing Number (from check; see illustration, right)

Account Type:

☐ Checking

☐ Savings

☐ General Ledger

MEMO:

I' 056073356 I: 5435732348 II' 1438

Routing Number (Exactly 9 Digits) | **Bank Account Number**

AUTHORIZATION FOR DIRECT PAYMENT:

I authorize EMPLOYEE BENEFITS CORPORATION and the financial institution named above to initiate withdrawals from my checking/savings account. This authority will remain in effect until I notify you in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. In the event of an error, please notify Employee Benefits Corporation immediately.

X ______________________ / /

Signature | Date (mm/dd/yyyy)

Name – Please print

☐ **Please revoke Auto-Debit** / /

Effective revocation date (mm/dd/yyyy)

X ______________________ / /

Signature | Date (mm/dd/yyyy)

Name – Please print

Please keep a copy for your records.

Employee Benefits Corporation

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www.ebcflex.com

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Assurant Health

Section 105 Administration

Section 125 Administration

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Responsibilities of the Employer

Effect of Service Agreement

This Service Agreement, along with the BESTflex Plan Document, EBC HRA Document and any addenda attached to the Service Agreement, contains all the provisions of an Internal Revenue Code § 105 "health reimbursement arrangement", Internal Revenue Code § 125 "cafeteria plan" sponsored by the Employer. This Service Agreement is also a contract between the Employer and Employee Benefits Corporation. Assurant Health is not a party to this Service Agreement. Employer acknowledges that Employee Benefits Corporation and Assurant Health are neither partners nor legal representatives or agents for the other.

Plan Sponsor and Administrator

The Employer is both the sponsor and the administrator of the BESTflex Plan and/or the EBC HRA, with the ultimate responsibility for: (1) ensuring that the BESTflex Plan and/or the EBC HRA complies with all applicable federal, state, and local laws, including Internal Revenue Code § 105, 106 and 125; (2) establishing, amending, terminating, and interpreting the BESTflex Plan and/or the EBC HRA provisions; and (3) determining whether particular claims shall be paid; and (4) collecting refund payments from Participants in situations such as overpayments due to excess contribution amounts, and other situations requiring refund of overpayments. Although the Employer has engaged Employee Benefits Corporation to provide certain documents and administrative services (including review and payment of qualified claims under the BESTflex Plan and/or the EBC HRA, if applicable), Employee Benefits Corporation shall whenever possible, consistent with this Service Agreement, act as directed by the Employer.

Funding of Plan

Employer folds the funds: Employee Benefits Corporation will notify the Employer of the amount of all claims received for a specific period of time. After notification, Employee Benefits Corporation will initiate auto-debit of required funds.

Employee Benefits Corporation holds the funds: The Employer shall provide Employee Benefits Corporation with all funds that Employee Benefits Corporation needs to pay benefit claims under the BESTflex Plan and/or the EBC HRA if FSAs and/or HRAs are elected. If Employee Benefits Corporation receives qualified benefit claims for the Health Care FSA or the EBC HRA in excess of the corresponding funds from the Employer, the Employer shall provide the funds to Employee Benefits Corporation within two (2) days of notice of such request by Employee Benefits Corporation. Claims will be released upon receipt of payment.

Nondiscrimination Testing

The Employer is to complete the nondiscrimination testing as required by Internal Revenue Code § 105 for the EBC HRA. A worksheet will be provided to assist in the process. Please keep your results from year to year. The employer provides census information for the BESTflex Plan and Employee Benefits Corporation will complete the required testing.

Cooperation with Employee Benefits Corporation

So that Employee Benefits Corporation can perform services regarding the Plan, the Employer shall timely provide Employee Benefits Corporation with all information that Employee Benefits Corporation
reasonably requests, including completed employee census for the BESTflex Plan, enrollment data, and otherwise cooperates with Employee Benefits Corporation.

Right To Recoup

If an administrative error occurs resulting in an EBC HRA overpayment to an employee, Employee Benefit Corporation retains the right to recoup the overpayment from the employee so that an Employer's Plan can be appropriately credited.

Optional Services

Optional services are billed separately and subject to change. Employee meetings are $55.00 per hour with a three hour minimum. See Fee Sheet for Employee Benefits Corporation staff travel of over three hours drive from Madison, WI excluding food and lodging per diem. Extraordinary one time services will be billed as agreed upon by Employee Benefits Corporation and Employer.

Optional Legal Services

Optional legal services are billed separately and subject to change. Legal research or EBC HRA document changes by Employee Benefits Corporation are $50.00 per hour with a one hour minimum. Legal research or EBC HRA document changes by Employee Benefits Corporation-appointed attorney are billed at the attorney's hourly rate.

Indemnity

The Employer shall indemnify Employee Benefits Corporation, its employees, directors, and agents (collectively, Indemnitees) and hold the Indemnitees harmless against all damages, losses, or other liabilities incurred by the Indemnitees arising from any act or failure to act by the Employer, its employees, directors, or agents in connection with the BESTflex Plan and/or the EBC HRA. Such indemnification shall include (and not be limited to) liabilities arising from a failure to timely provide Employee Benefits Corporation with information. Such indemnification shall also include liabilities arising from administration or interpretation of the BESTflex Plan and/or the EBC HRA by the Employer in a manner contrary to law.

Assurant Health

Section 105 Administration

The BESTflex Plan

Section 125 Administration

Terminations

Termination At End Of Term

After 30-Day Notice. Either party may, upon written notice to the other party at least thirty (30) days before the end of the initial Term or of any renewal Term, terminate this Agreement effective as of such end-of-term date.

Other Termination by Employee Benefits Corporation

Employee Benefits Corporation may terminate the Service Agreement effective (1) as of an end-of-Term date without the 30-day notice or (2) on a date other than an end-of-term date, but only if the Employer previously breached this Service Agreement, such as by failing to pay Employee Benefits Corporation for its services (if applicable), failing to provide funds for payment of claims, or failing to cooperate with Employee Benefits Corporation.

Wrap-Up Period

In the event of termination of (1) this Service Agreement, or (2) the agreement between Employer and Assurant Health, Employee Benefits Corporation shall continue to provide services through the end of the 90-day grace period for the plan year which the termination occurred and the employer shall pay Employee Benefits Corporation for such services in accordance with our standard pricing schedule.

Employer signature

By:

Signature

Title

/ /

Date (mm/dd/yyyy)

Employee Benefits Corporation signature

By:

Signature

Title

/ /

Date (mm/dd/yyyy)

Service Agreement

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Agent/broker information

☐ N/A

Failure to complete agent/broker information will result in the broker not being recognized as the agent on this account

Agency/Company Name

Tax identification number (TIN)

Business address | City | State | Zip

Street address | City | State | Zip

Agent/Broker Name | Telephone ( ) | Extension

Fax ( ) | E-mail address

Employee Benefits Corporation Representitive

Next Steps:

- Mail this Service Agreement and the HIPAA Business Associate Agreement to Employee Benefits Corporation
- A welcome letter with Answer Book(s) Summary Plan Description(s) andBESTflex Plan (if elected) Enrollment Forms are sent to the client
- An Employee Benefits Corporation Client Liaison contacts the client to review key Plan points, to answer questions and to schedule the employee meeting(s), if chosen
- If chosen, employee meetings begin
- The client returns BESTflex Plan (if elected) Enrollment Forms to Employee Benefits Corporation
- Employee Benefits Corporation enters the employee data into our system
- The Plan(s) begins

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