

Health Reimbursement Account (HRA) Enrollment Kit



Significant Savings

24/7 Web access

Fast, Efficient, Convenient

The benefit that benefits everyone



EBS-RMSCO, Inc.
Employee Benefit Solutions

HRA Plans

The HRA Plan

A Health Reimbursement Account is an employee benefit plan established under IRC Section 105, and it allows you to pay for certain health care expenses that are not covered by your insurance.



Your HRA account is funded periodically by your employer, and the amount funded is not included in your taxable income. You can use your HRA account to reimburse qualified expenses for yourself, your spouse and any dependents claimed on your federal tax return.

If you have unused money in your HRA account at the end of the Plan year, some Plans allow you to “roll” the balance to the next year. Since the funds in your account were from your employer, you typically forfeit any unused balance if you terminate employment.

Types of HRA Plans

“Stand-Alone” HRA: A “stand-alone” HRA is the most common form of an HRA. It covers all standard IRC Section 213(d) expenses for you and your spouse/dependents. Examples of expenses include out-of-pocket medical expenses such as copays, prescription drugs, diabetic supplies, vision expenses, hearing aides, dental services, orthodontics and more.

“Deductible Only” HRA: In this design, only medical expenses applicable to the deductible of the health Plan qualify for reimbursement. An Explanation of Benefits (EOB) is typically required with each reimbursement request.

Other HRAs: Other types of HRA Plan designs include Limited HRAs, Retiree HRAs, Copayment HRAs, Restricted Expense HRAs and others. All HRAs operate under the premise that your employer allocates money to you to pay for medical related purposes, and the contribution amount is not included in your taxable income.

HRA with an FSA: Some employers offer both an HRA and an FSA (Flexible Spending Account). Your employer decides which benefit will “pay first.”

Know the Details

Understanding the specifics of your employer’s HRA Plan is critical. Carefully read your Plan’s Summary Plan Description (SPD) to better understand the terms of your Plan.

Remember, each HRA Plan may be the same in concept, but can be unique in detail. Be informed of the specific provisions offered by your employer.



An HRA Plan is like a gift of tax-free money from your employer!

Read your Summary Plan Description (SPD) carefully to understand the specific terms of your Plan. The Plan Document governs your rights and benefits under each Plan and is available through your Employer.

Web Access. Claim Processing. Dedicated Customer Service.

Web Access

View your account online 24/7 via www.ebsrmsco.com. While online, you can:

- Submit claims for reimbursement
- View claims history
- Check your available balance and run reports
- Access forms such as Direct Deposit, Certification of Medical Necessity, Release of Information and various Reimbursement Request Forms
- Enter your email address to receive important Plan related materials
- Use our online services, such as our online eligible expense listing
- For even more convenience, download our mobile application to your smart phone!



Customer Service

Most of your questions can be answered by visiting the website. But if you need to speak with a Customer Service Representative, simply call 800-327-7130; Monday, Tuesday, Thursday and Friday from 8am EST to 5pm EST and Wednesday from 9am EST to 5pm EST. You can also email our

Customer Service Department at ebs.customerservice@ebsrmsco.com.

Filing a Claim

To receive the fastest reimbursement for an eligible out-of-pocket expense, submit your claims online. Supporting receipts and documentation can be scanned and attached to your online claim, or you can email, fax or U.S. mail the required paperwork. Another option is to download a paper Reimbursement Request form. Complete the form by itemizing your expenses and following the important and detailed instructions found directly on the form. Reimbursement Request forms and

required documentation can either be mailed or faxed for processing.

Know the Details

Claim deadlines apply. For example, active participants have a set number of “run-out” days following the Plan year in which they can continue to submit paperwork for out-of-pocket expenses incurred during the Plan year. Be sure to carefully read your Plan’s SPD to understand the terms and deadlines associated with your Plan. There is typically a \$30 minimum check amount, except for the final check for the Plan year. There is no \$30 check minimum with direct deposit.

Direct Deposit

Avoid the \$30 check minimum and a trip to the bank by completing either a Direct Deposit paper or online form found on the website.



Email Address

Provide or update your email address online and help us “go-green”. You’ll receive only plan related information such as account statements, claim related information, and RFI (Request for Information) Letters (for Card participants).

Guidelines for Eligible/Ineligible Items and Services

Eligible Items/Services

Abortion	Crutches	Medical information plan charges	Speech therapy
Acupuncture	Dental sealants	Medical monitoring devices	Sterilization procedures
Adoption, pre-adoption medical expenses	Dental services and procedures	Medical records charges	Stop-smoking program
Alcoholism treatment	Dentures and adhesives	Norplant insertion or removal	Supplies to treat medical condition
Ambulance	Diabetic supplies	Obstetrical expenses	Support braces
Arthritis gloves	Diagnostic items/services	Occlusal guards	Surgery
Artificial limbs	Drug addiction treatment	Operations	Taxes on medical services and products
Artificial teeth	Drug overdose, treatment of	Optometrist	Telephone for hearing-impaired persons
Bandages, elastic bandages	Eye examinations, eyeglasses, equipment, and materials	Organ donors	TV for hearing-impaired
Blood-pressure monitoring devices	First aid kits	Orthodontia	Therapy
Blood-sugar test kits and test strips	Flu shots	Orthopedic shoe inserts	Thermometers
Body scans	Fluoridation services	Osteopath fees	Transplants
Braille books and magazines	Gauze pads	Ovulation monitor	Transportation expenses for person to receive medical care
Breast reconstruction surgery following mastectomy	Glucose-monitoring equipment	Oxygen	Tuition evidencing separate breakdown for medical expenses
Carpal tunnel wrist supports	Guide dog	Physical exams	Vaccines
Chelation therapy	Hearing aids	Physical therapy	Vasectomy/Reversal
Chiropractors	Hospital services	Pregnancy test kits	Viagra
Circumcision	Immunizations	Preventive care screenings	Vision correction procedures
Co-insurance amounts	Incontinence supplies	Prosthesis	Walkers
Cold/hot packs	Insulin	Psychiatric care	Wheelchair
Condoms	Laboratory fees	Radial keratotomy	X-ray fees
Contact lenses, materials, and equipment	Laser eye surgery; Lasik	Reading glasses	
Co-payments	Liquid adhesive for small cuts	Rehydration solution	
	Lodging at a hospital or similar institution	Rubbing alcohol	
	Mastectomy-related bras	Screening tests	
	Medical alert bracelet or necklace	Shipping and handling fees	
		Sleep-deprivation treatment	
		Smoking-cessation programs	

Potentially Qualifying Items—Drugs and Medicine

Allergy medicine	Ear wax removal drops	Sinus medications
Antacids	Eczema treatments	Spermicidal foam
Antibiotic ointments	Expectorants	Sunscreen
Antihistamines	Eye drops	Sun protective clothing
Anti-itch creams	Fever-reducing medications	Throat lozenges
Aspirin	First aid cream	Toothache/teething pain relievers
Asthma medications/devices	Fluoride Rinses	Wart removers
Bactine	Headache medications	Yeast infection medications
Birth-control pills	Hemorrhoid treatments	
Calamine lotion	Insect-bite creams and ointments	SPECIAL RULES APPLY
Claritin	Hormone replacement therapy	<i>The IRS states that OTC items classified as drugs and medicine are only eligible if they are accompanied by a doctor's prescription.</i>
Cold medicine	Laxatives	
Cough suppressants	Menstrual pain relievers	<i>The IRS also states that to pay for</i>
Decongestants	Morning-after contraceptive pills	
Diaper rash ointments/creams	Motion-sickness pills	
Diarrhea medicine	Nasal strips or sprays	

eligible drugs and medicines with the EBS One Card, additional rules apply. Prior to the purchase, the participant must provide the pharmacist with a copy of the prescription, and the pharmacist must assign the item an Rx number. The pharmacist must keep a record of the Rx number, the name of the purchaser (or the person for whom the prescription applies), and the date and amount of the purchase. Also, the pharmacy must provide the records for review to the employer or another agent upon request.

Eligible Dependent Care Expenses

Care in your home, someone else's home, or in a daycare center for child care and/or eldercare. Licensing requirements may apply.	Registration fees to a daycare.	nursery school expenses.	Day camp (not overnight) expenses if the camp qualifies as a day care center.
	Before and after school care for children under age 13.	Expenses paid to a relative are eligible, however, the relative cannot be under age 19 or a tax dependent.	FICA and FUTA payroll taxes of the daycare provider.
	Education expenses for a child not yet in kindergarten, such as		

Guidelines for Eligible/Ineligible Items and Services

Potentially Qualifying Expenses A Certification of Medical Necessity form must be completed by your physician.

AA meetings, transportation to	Ear plugs	fertility treatments	Rogaine
Acne treatment	Egg donor fees	Lodging not at a hospital or similar institution	Rubdowns
Adaptive equipment	Eggs and embryos, storage fees	Lodging of a companion	Schools and education, residential
Air conditioner	Elevator	Masks, disposable	Schools and education, special
Air purifier	Exercise equipment or programs	Massage therapy	Service animal, to assist individual with mental health disabilities
Alternative healers	Fertility treatments	Meals at a hospital or similar institution	Smoking-cessation medications
Automobile modifications	Fiber supplements	Medical conference admission, transportation, meals, etc.	Special foods
Behavioral modification programs	Fitness programs	Medicines and drugs	Sperm, storage fees
Birthing classes	Food thickeners	Mentally handicapped, special home for	St. John's Wort
Blood storage	Foods	Mineral supplements	Stem cell, harvesting; storage of
Books, health-related	Gambling problem, treatment for	Naturopathic healers	Student health fee
Breast pumps	Genetic testing	Nicotine gum or patches	Sunburn creams and ointments, medicated
Capital expenses	Glucosamine	Nonprescription drugs and medicines	Sunglasses
Car modifications	Hand sanitizer	Nursing services provided by a nurse or other attendant	Swimming lessons
Cayenne pepper	Health club fees	Nutritional supplements	Swimming pool maintenance
Childbirth classes	Health institute fees	Nutritionist's professional expenses	Transportation of someone other than the person receiving medical care
Chinese herbal practitioner	Herbs	Occupational therapy	Transportation to and from a medical conference
Chondroitin	Holistic or natural healers	Orthopedic shoes	Treadmill
Christian Science practitioners	Home care	Personal trainer fees	Tuition for special-needs program
Classes, health-related	Home improvements (such as exit ramps, widening doorways, etc.)	Petroleum jelly	Ultrasound, prenatal
Club dues and fees	Humidifier	Prenatal vitamins	Umbilical cord blood storage
Compression hose	Hypnosis	Prescription drugs	Varicose veins, treatment of
Contraceptives	Inclinor	Probiotics	Veterinary fees
Counseling	Infertility treatments	Propecia	Vitamins
Crowns, dental	IVF (in vitro fertilization)	Psychoanalysis	Weight-loss programs and/or drugs prescribed to induce weight loss
Dancing lessons	Lactation consultant	Psychologist	Wigs
Deductibles	Lactose intolerance tablets	Rental cars	
Diabetic socks	Lamaze classes	Retin-A	
Dietary supplements	Language training		
Disabled dependent care expenses	Lead-based paint removal		
DNA collection and storage	Learning disability, instructional fees		
Doula	Legal fees in connection with		
Drugs and medicines			
Dyslexia treatment			

Ineligible Items/Services

Appearance improvements	Face lifts	Meals of a companion	Safety glasses
Babysitting and child care	Feminine hygiene products	Meals while attending a medical conference	Shampoos
Car seats	Founder's fee	Missed appointment fees	Shaving cream or lotion
Cologne	Funeral expenses	Moisturizers	Skin moisturizers
Controlled substances in violation of federal law	Hair colorants	Mouthwash	Soaps
Cosmetic procedures	Hair removal and transplants	Nail polish	Surrogate or gestational carrier expenses
Cosmetics	Hand lotion	Nursing services for a baby	Tanning salons and equipment
Dental floss	Household help	One-a-day vitamins	Teeth whitening
Deodorant	Illegal operations and treatments	Perfume	Toiletries
Dependent care expenses	Lipsticks	Permanent waves	Toothbrushes
Diapers or diaper service	Lodging while attending a medical conference	Prepayments	Toothpaste
Diet foods	Makeup	Prescription drug discount programs	Transportation costs of disabled individual commuting to and from work
Drug testing kits for home use	Maternity clothes	Prescription drugs and medicines obtained from other countries	Veneers
Ear piercing	Mattresses	Recliner chairs	Vision discount programs
Electrolysis or hair removal	Meals not at a hospital or similar institution		
Face creams			

This is not a comprehensive list and is subject to change at any time and without notice.
A complete list is available on the www.ebsrmsco.com website. Plan restrictions may apply.

Health Reimbursement Account (HRA) Mandatory Second Payer (MSP) Form

Mandatory reporting requirements apply to all HRA participants and their spouse/dependents as a result of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. These Mandatory Second Payer (MSP) rules ensure that Medicare does not pay for medical claims that should be first paid by another source and are designed to identify which entity is the primary payer. You are required to complete this form. If you do not have any dependents, only complete the "Your Information" section. If you are not eligible for, or currently participating in, a Medicare related program, you must still report basic census information for yourself and each of your dependents. Dependents are the individuals claimed on your Federal Tax Return (examples: spouse, children, etc). Please complete a second form to report additional dependents. Call EBS-RMSCO Customer Service at 800-327-7130 with questions.

Return this completed form using the Sending Instructions below.

Your Information (Please print clearly)	
SSN #: _____ - _____ - _____ Name: _____ Address: _____ _____ _____ Date of Birth: ____/____/_____ Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Are you eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete the questions below. Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide Disabled Date: ____/____/_____ Are you in End-Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide End-Stage Date: ____/____/_____ Medicare Claim #: _____ - _____ - _____ - ____

I do not have a spouse or any dependents, and therefore do not have to complete the remainder of this form.

Your Spouse or Dependent #1 (Please print clearly)	
SSN #: _____ - _____ - _____ Name: _____ Address: <input type="checkbox"/> Check this box if address is same as above; else provide _____ _____ Date of Birth: ____/____/_____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female; Relationship to you: _____	Is this dependent eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete the questions below. Is this dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide Disabled Date: ____/____/_____ Is this dependent in End-Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide End-Stage Date: ____/____/_____ Medicare Claim #: _____ - _____ - _____ - ____

Your Dependent #2 (Please print clearly)	
SSN #: _____ - _____ - _____ Name: _____ Address: <input type="checkbox"/> Check this box if address is same as above; else provide _____ _____ Date of Birth: ____/____/_____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female; Relationship to you: _____	Is this dependent eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete the questions below. Is this dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide Disabled Date: ____/____/_____ Is this dependent in End-Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide End-Stage Date: ____/____/_____ Medicare Claim #: _____ - _____ - _____ - ____

By submitting this form, I certify that the information listed above is accurate to the best of my knowledge. I understand that this information is required to accurately coordinate benefits with Medicare and to meet mandatory reporting obligations. Date _____

Sending Instructions:

Mail to: EBS-RMSCO, Inc. HRA Dept., PO Box 2330, Blasdell, NY 14219; **Fax to:** 877-256-7228; **Email to:** ebs.customerservice@ebsrmsco.com

Health Reimbursement Account (HRA) Mandatory Second Payer (MSP) Form

Instructions: Please provide information for yourself and all your spouse/dependents. Dependents are the individuals claimed on your Federal Tax Return (examples: spouse, children, etc). Please complete a second form to report additional dependents. Call EBS-RMSCO Customer Service at 800-327-7130 with questions. **Return this completed form using the Sending Instructions below.**

Your Information	
SSN #: _____ - _____ - _____	Name: _____
Your Dependent #3 (Please print clearly)	
SSN #: _____ - _____ - _____ Name: _____ Address: <input type="checkbox"/> Check this box if address is same as above; else provide _____ _____ Date of Birth: ____/____/_____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female; Relationship to you: _____	Is this dependent eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete the questions below. Is this dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide Disabled Date: ____/____/_____ Is this dependent in End-Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide End-Stage Date: ____/____/_____ Medicare Claim #: _____ - _____ - _____
Your Dependent #4 (Please print clearly)	
SSN #: _____ - _____ - _____ Name: _____ Address: <input type="checkbox"/> Check this box if address is same as above; else provide _____ _____ Date of Birth: ____/____/_____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female; Relationship to you: _____	Is this dependent eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete the questions below. Is this dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide Disabled Date: ____/____/_____ Is this dependent in End-Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide End-Stage Date: ____/____/_____ Medicare Claim #: _____ - _____ - _____
Additional Information	
Impact of the Defense of Marriage Act <ul style="list-style-type: none"> Flexible Spending Accounts and Health Reimbursement Accounts are subject to Federal Law which generally supersedes state law. The Defense of Marriage Act is a Federal Law which defines marriage as being a union only between a man and a woman. The recent passage of the Marriage Equality Act in New York and similar laws in other states has no bearing on the determination of who is a spouse for purposes of Flexible Spending Accounts and Health Reimbursement Accounts. Only spouses (as defined under the Defense of Marriage Act) and dependents for Federal Tax purposes are eligible for tax-free Flexible Spending Accounts and Health Reimbursement Accounts benefits. 	
Carrier Information	
Check the boxes if you are enrolled in any of these benefits through your employer. <input type="checkbox"/> Medical; <input type="checkbox"/> Dental; <input type="checkbox"/> Vision; <input type="checkbox"/> Rx	

By submitting this form, I certify that the information listed above is accurate to the best of my knowledge. I understand that this information is required to accurately coordinate benefits with Medicare and to meet mandatory reporting obligations. Date _____

Sending Instructions:

Mail to: EBS-RMSCO, Inc. HRA Dept., PO Box 2330, Blasdell, NY 14219

Fax to: 877-256-7228; **Email to:** ebs.customerservice@ebsrmsco.com

