Capital

An Independent Licensee of the Blue Cross Blue Shield Association

HEALTH SAVINGS ACCOUNT (HSA) PLAN DESIGN GUIDE

Please complete this form and return to Capital Blue Cross 45 days before your effective date so we can properly administer your plan. If you have any questions, please call our Sales Line at 855.363.2583. When complete, email this form to capitalbluecross.sales@HelloFurther.com or fax it to 866.231.0214.

All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Legal Name _____

Employer's Street Address _____

City _____ State _____ ZIP Code _____

Employer's Tax I.D. Number (required) _____

Type of Corporation ☐ S Corporation ☐ C Corporation ☐ Partnership ☐ Sole Proprietor
☐ Political Subdivision/Church ☐ LLC ☐ Non-Profit ☐ Other_____

Number of Employees Eligible for Plan: _____

Main Contact Person:

Health Spending Employer Portal Access Type: (check one) ☐ Edit Access ☐ View-only access

Main Contact Person _____ Title _____

Phone Number ( ) _____

Email Address _____

Additional Contact Person:

Health Spending Employer Portal Access Type: (check one) ☐ Edit Access ☐ View-only access

Additional Contact Person _____ Title _____

Phone Number ( ) _____

Email Address_____

Please check if additional contact should receive email notifications for Fee Billing: ☐ Yes ☐ No

II. HEALTH PLAN GROUP STRUCTURE

Groups with under 100 enrolled: *Please provide your group structure information below. Please list only the subgroup ID(s) and Class ID(s) which will hold enrollment for employees to be offered HSAs.*

Group ID _____ Subgroup ID(s) _____ _____ _____ _____

Plan ID(s) _____ _____ _____ _____ _____ _____

Class ID(s) _____ _____ _____ _____ _____ _____

Groups with 100+ enrolled: Please attach your group structure document and indicate any that should be excluded from HSA set up.

III. AGENCY/BROKERAGE INFORMATION

Agency Name: _____ Agency Code: _____

Agent Name: _____ Agent Code: _____

Agency Contact Name *(if different than agent)*: _____

Email: _____ Phone: _____

Address: _____

IV. TRANSFER OF ADMINISTRATION

Is Capital Blue Cross taking over administrative services from another administrator? ☐ Yes ☐ No

If yes, participants who wish to transfer dollars are required to complete a Transfer Request Form after the account is established.

V. ACCOUNT ADMINISTRATIVE INFORMATION

HSA Administration Start Date _____ QHDHP Renewal Date _____

Capital Blue Cross offers three different options for HSA Accounts. (*The fees for each option are listed on the pricing sheet.)*

Please select one HSA Administration Option: ☐ Value HSA ☐ Select HSA ☐ Premium HSA

(Members can choose a different administration option and will have the difference in administration costs automatically deducted out of their HSA.)

Employer Contributions:

Will the employer contribute to the accounts? ☐ Yes ☐ No

Plan Information

Select one of the following:

☐ Pre-tax contributions are allowed.

☐ Pre-tax contributions are not allowed.

Eligibility:

Employees must work at least _____ hours per week to be eligible. Benefits will begin on: (select **only** one):

- ☐ First of the month following date of hire
- ☐ Date of hire
- ☐ First *day* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other_____
- ☐ First of the *month* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other_____

VI. ADMINISTRATIVE FEES

Fees will be billed on a monthly basis. If participant paid, the monthly fee will be deducted from the participant's account balance

Participant Fees

☐ Employer Paid ☐ Participant Paid

You will receive an email when your detailed billing information is available and another e-mail notification two business days in advance of the scheduled ACH transaction confirming the amount of funds to be transferred. Sign into the Employer Portal to view and print your invoice detail under Reports and Invoices.

Automated Clearinghouse Information

I hereby authorize Further, on behalf of Capital Blue Cross, to charge our bank account through Automated Clearinghouse for Administrative Fees. The following bank information is provided for initiation of this procedure.

Bank Name _____ Type of Account: ☐ Checking ☐ Saving

Bank ABA Number _____
(The ABA number is the nine-digit number located in the lower left corner of your check.)

Bank Account Number _____
(Funds will be drawn from your bank account on or after the 20th of each month.)

VII. DEDUCTION/CONTRIBUTION INFORMATION

Select one of the following contribution methods:

1. ☐ **Employer Portal:** You may add deduction information, upload a file or create a recurring payroll frequency. Upload your deduction information here.
2. ☐ **Direct Deposit/ACH Push:** An ACH push is a customer or member initiated transaction of an electronic transfer of funds. An account number report will be available in the online group service center once the enrollment is completed.
3. ☐ **Secure File Transfer with ACH pull:** This option allows employers or their vendors to create a file using Capital Blue Cross format requirements via automated secure upload.

Account funding must be initiated by you with an ACH bank set up prior to submitting contribution files. Complete below:

If you selected option 1 or 3, complete the banking information below:

I hereby authorize Further, on behalf of Capital Blue Cross, to charge our bank account through Automated Clearinghouse for **HSA contributions**. The following bank account information is provided for initiation of this procedure.

☐ **Use same billing information as Administrative Fees above**

Bank Name _____ Type of Account: ☐ Checking ☐ Savings

Bank ABA Number _____

(The ABA number is the nine-digit number located in the lower left corner of your check.)

Bank Account Number _____

VIII. ADMINISTRATIVE TIPS

ONLINE ACCESS: Capital Blue Cross Employer Portal

Your employees have access to a powerful tool for managing their HSA. By registering at capbluecross.com/funds, your employees can:

- Make withdrawals from their account
- Enroll in direct deposit
- Make online contributions
- View recent claims or reimbursement request
- Create and view a customized statement
- Manage their personal profile
- Request a debit card for any dependent(s)

You and your employees can also access forms and enrollment materials at **learn-capitalbluecross.hellofurther.com**

LOCATIONS: Multiple locations are available for 51+ groups only. If you want multiple locations, as indicated by Subgroup IDs, please complete and attach the Location Addendum (F11208). Locations must be the same across all products administered by Capital Blue Cross. If you wish to have different ACH accounts by location, please complete the ACH Addendum (F11207).

COORDINATING WITH AN FSA: For participants that have a FSA and a HSA, the FSA provides reimbursement for permitted benefits such as vision and dental care benefits until the health plan deductible is met. Once the health plan deductible is met, all Section 213(d) expenses, excluding those expenses applied to the In-Network deductible for the QHDHP, are eligible for reimbursement. This affects only those participants who are eligible to contribute to their HSA. Participants who are not eligible to contribute to an HSA will have a general purpose (Full) FSA.

PLAN/ACCOUNT SUMMARIES: Capital Blue Cross will prepare and provide a Benefit Summary to the group contact.

IX. SIGNATURES

It is agreed that necessary information concerning current and future employees and/or their dependents who participate in this Plan, and employees whose participation is to be changed or discontinued, shall be provided to Capital Blue Cross on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signature _____ Date _____

Printed Name _____ Title _____