Capital

An Independent Licensee of the BlueCross BlueShield Association

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) 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 1-866-231-0214.

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 indicate if additional contact should receive email notifications for: ☐ Fee billing ☐ Claim billing

II. AGENCY/BROKERAGE INFORMATION

Agency Name: _____ Agency Code: _____

Agent Name: _____ Agent Code: _____

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

Email: _____ Phone: _____

Address: _____

III. 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 HRAs.*

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

Plan ID(s) _____ _____ _____ _____ _____ _____

Class ID(s) _____ _____ _____ _____ _____ _____

Groups with 100+ enrolled: *Please attach your group structure document and indicate any Plan ID's or Class ID's that should be excluded from HRA set up.*

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS

Plan Year
Plan Year - Start Date: _____ End Date: _____

Choose one of the rfpcc funding options:

☐ **OPTION #1 - EMPLOYER PAYS FIRST HRA**

With this option, you (the employer), fund the HRA as expenses are reimbursed up to a predetermined amount. The HRA pays until the funds are exhausted. After that, the employee is responsible for out-of-pocket health care expenses.

Indicate the annual funding amounts for the Employer Pays First Option:

1 - Participant/Single = $_____ *(required)*
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children =$_____
5 - Family = $_____ *(required)*

Eligible expenses and reimbursement options -- choose only ONE of the following options:
(Please note if you do offer an FSA along with your HRA, the default reimbursement method for your FSA will be set to match your HRA plan.)

☐ **1a. All Health Plan Eligible Medical** (includes deductible, copay & coinsurance)
Reimbursement method - select one:
- ☐ Medical Autopay
- ☐ Medical Autopay with Pay-the-Provider

☐ **1b. All Health Plan Eligible Medical and Prescription Drug** (includes deductible, copay, coinsurance & prescription drug)
Reimbursement method - select one:
- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay with Pay-the-Provider
- ☐ Medical Autopay + Rx Debit Card
- ☐ Medical Autopay with Pay-the-Provider + Rx Debit Card

☐ **1c. Medical Deductible only** (no coinsurance or copays are eligible for reimbursement)
Reimbursement method - select one:
- ☐ Medical Autopay
- ☐ Medical Autopay with Pay-the-Provider

☐ **1d. All IRS Eligible Medical** (All IRS allowed medical*, including deductible, copay, and coinsurance)
Reimbursement method - select one:
- ☐ Debit Card
- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider

**All IRS allowed medical includes all 213(d) eligible expenses with exception to prescription drugs, over-the-counter drugs, vision and dental*

☐ **1e. All IRS Eligible Medical and Prescription Drug** (All IRS allowed medical and prescription drug*, including deductible, copay, and coinsurance)
Reimbursement method - select one:
- ☐ Debit Card
- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider

**All IRS allowed medical and/or prescription drug includes all 213(d) eligible expenses with exception to over-the-counter drugs, vision and dental*

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

OPTION #1 - EMPLOYER PAYS FIRST HRA (continued)

☐ **1f. All 213(d) Eligible** (Includes all IRS eligible medical, prescription drug, over-the-counter drugs, vision and dental)
Reimbursement method - select one:
- ☐ Debit Card
- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider

☐ **1g. Prescription Drug Only**
Reimbursement method - select one:
- ☐ Debit Card
- ☐ Rx Autopay

If you elected an option above from 1d to 1g and chose autopay, would you like for your employees to have an option to opt out of Automated Claim Payment and choose a debit card instead?

☐ Yes ☐ No

☐ **OPTION #2 - SHARED PAYMENT HRA**

With this option, you (the employer), and your employee share in the medical costs. As expenses are incurred, the HRA reimburses according to the cost-share level (e.g. 50/50, 80/20) until the HRA is exhausted.

Indicate the annual funding amounts for the Shared Payment HRA Option:

1 - Participant/Single = $_____ *(required)*
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children =$_____
5 - Family = $_____ *(required)*

Reimbursement Level

Indicate the reimbursement level percentage that will be provided for claims paid by the HRA: *(select **only** one)*

☐ 80% of eligible expenses ☐ 50% of eligible expenses ☐ Other _____

Eligible expenses and reimbursement options -- choose only ONE of the following options:
(Please note if you do offer an FSA along with your HRA, the default reimbursement method for your FSA will be set to match your HRA plan.)

☐ **2a. All Health Plan Eligible Medical** (includes deductible, copay & coinsurance)
Reimbursement method - select one:
- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

☐ **2b. All Health Plan Eligible Medical and Prescription Drug** (includes deductible, copay, coinsurance & prescription drug)
Reimbursement method - select one:
- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

OPTION #2 - SHARED PAYMENT HRA (continued)

☐ **2c. Medical Deductible Only** (no coinsurance or copays are eligible for reimbursement)
Reimbursement method - select one:

- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

☐ **2d. All IRS Eligible Medical** (All IRS allowed medical*, including deductible, copay, and coinsurance)
Reimbursement method - select one:

- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

***** *All IRS allowed medical and/or prescription includes all 213(d) eligible expenses with exception to over-the-counter drugs, vision and dental.*

☐ **2e. All IRS Eligible Medical & Prescription Drug** (All IRS allowed medical and prescription drug*, including deductible, copay, and coinsurance)
Reimbursement method - select one:

- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider

***** *All IRS allowed medical and/or prescription includes all 213(d) eligible expenses with exception to over-the-counter drugs, vision and dental.*

☐ **2f. All 213(d) Eligible** (Includes all IRS eligible medical, prescription drug, over the counter, vision and dental)
Reimbursement method - select one:

- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider

☐ **2g. Prescription Drug Only**
Reimbursement method:

- ✓ Reimbursement Method will be Rx Autopay

☐ **OPTION #3 - EMPLOYEE PAYS FIRST HRA**

With this option, the employee is responsible for out-of-pocket health care expenses up to a preset amount of expenses you choose. After that, you (the employer) fund the HRA as the employee submits expenses for reimbursement.

Indicate the **Employee Responsibility Amount***: (This is the amount that the employee will pay out of pocket prior to reimbursement from the Employer Funding Amount.)

1 - Participant/Single = $_____ *(required)*
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children =$_____
5 - Family = $_____ *(required)*

Indicate the **Employer Funding Amount*:** (This is the amount that the employer will pay for each coverage tier after the employee has satisfied their Employee Responsibility Amount.)

1 - Participant/Single = $_____ *(required)*
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children =$_____
5 - Family = $_____ *(required)*

**** The combination of both the employee responsibility amount and the employer funding amount must be less than or equal to the out-of-pocket amount for that coverage tier.***

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

OPTION #3 - EMPLOYEE PAYS FIRST HRA (continued)

Eligible expenses and reimbursement options -- choose only ONE of the following options:

(Please note if you do offer an FSA along with your HRA, the default reimbursement method for your FSA will be set to match your HRA plan.)

☐ **3a. All Health Plan Eligible Medical** (Includes deductible, copay, coinsurance)
Reimbursement method - select one:

- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

☐ **3b. All Health Plan Eligible Medical and Prescription Drug** (Includes deductible, copay, coinsurance and prescription drug)
Reimbursement method - select one:

- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider

☐ **3c. Medical Deductible Only** (no coinsurance or copays are eligible for reimbursement)
Reimbursement method - select one:

- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

V. HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATION REQUIREMENTS

Mid -Year Enrollees/Contract Changes

Indicate how mid-year enrollees and contract changes will be administered: (select only one)

☐ HRA funding is 100% regardless of date of enrollment/contract change.
☐ HRA funding is prorated in monthly increments back to the first of the month of the date of enrollment/contract change.

Rollover

Indicate what happens to unused balances at the end of the plan year. If funding option Employee Pays First is selected, rollover dollars can only be used AFTER the annual employee pays first pre-set threshold amount has been paid. (Select ***only*** one)

- ☐ Entire balance rolls over to subsequent plan year
- ☐ No balance rolls over
- ☐ A percentage of the balance rolls over to subsequent plan year _____%

Cap on Health Reimbursement Arrangement Balance

Is there a cap on the overall balance (including Rollover) that can accumulate in the account? ☐ Yes ☐ No

If yes, the recommended cap is the annual deductible amount or total annual out-of-pocket amount.
Please indicate amounts below:

1 - Participant/Single = $_____ *(required)*
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children =$_____
5 - Family = $_____ *(required)*

VI. HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATIVE REQUIREMENTS (continued)

Runout Period

Participants have _____ months after the end of the plan year to submit claims incurred during that plan year. (The standard runout period is 6 months.)

The runout period noted above begins at termination date for terminated employees.

Terminations

Indicate what happens to the HRA balance when a participant terminates. NOTE: Account balance stays with terminated participant if COBRA has been elected ***(mandatory.)*** *Please check one of the following options:*

- ☐ Account balance returns to employer after runout period if terminated participant or eligible dependent does not elect COBRA. (default)
- ☐ Account balance remains with terminated participant or eligible dependent to spend-down until funds are depleted. If spend-down is selected, eligible expenses for terminated participants remain the same as for active participants. Spend-down is subject to any applicable rollover and runout period provisions and fees. (Only available for funding options #1 & #2 - not available for funding option #3.)

VII. CLAIM REIMBURSEMENT PROCESSING

You will receive an automated email notification with the claim reimbursement totals. Sign into the Employer Portal to view and print your complete invoice detail under Claim Reimbursement Invoices.

Automated Clearinghouse Information ***(completion of this section is mandatory)***

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

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 or savings deposit slip)

Bank Account Number:_____

VII. DEBIT CARD COPAY SUBSTANTIATION

Copay Amounts - The copay amounts provided below will allow these amounts to auto-substantiate when the debit card is used. If you have more copays than what is listed below, please complete the Group Copay Form F11264. Documentation will not be required for reimbursements.

Medical: _____ _____ _____ Vision: _____ _____ _____

Drug: _____ _____ _____ Dental: _____ _____ _____

VIII. TRANSFER OF ADMINISTRATION

(This information will only be used to provide information to your employees.)

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

If no, skip to the signatures section.

If yes, fill out the fields below:

With your previous plan, was rollover allowed to carry over from year to year? ☐ Yes ☐ No

PRIOR ADMINISTRATOR INFORMATION:

Prior Administrator's Name: _____

VIII. TRANSFER OF ADMINISTRATION (continued)

PLAN YEAR INFORMATION:

Please select one of the following and fill out the corresponding section.

☐ **TAKEOVER AT NEW PLAN YEAR:**

Please select the administrator that will be processing the runout claims for the previous plan year.

- ☐ The prior administrator
- ☐ Capital Blue Cross (If Capital Blue Cross is handling the runout, indicate runout and rollover for that plan year)
- ☐ Runout Period Months: _____
- ☐ Rollover (If Rollover was applicable, please ensure the ending balances transferred to Capital Blue Cross includes the final rollover balances)

☐ **TAKEOVER AT MIDYEAR:**

What is the last date the prior administrator will process claims? _____

What is the date that the enrollment data and balances will be submitted to Capital Blue Cross ? _____
Please note: There will be a blackout period between when the data is received and when Capital Blue Cross will begin to process claims. The plan will be set up according to the plan design guide submitted to Capital Blue Cross.

IX. ADMINISTRATIVE TIPS AND DEFINITIONS

Your employees have access to a powerful tool for managing their HRA. By registering, your employees can:

- Enroll in direct deposit
- View recent claims or reimbursement requests
- Create and view a customized statement
- Manage their personal profile

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, 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).

Groups with QHDHP: If your health plan is a QHDHP, you may only offer Option #3 - Employee Pays First HRA. If you want Capital Blue Cross to set up both the HSA and Employee Pays First HRA, please complete form M06369. The Employee Responsibility amount must be equal to or greater than the minimum annual deductible required for a QHDHP.

COORDINATING WITH AN FSA:
If the HRA allows reimbursement for health plan eligible expenses only, the HRA is primary and the FSA is secondary.
If the HRA allows all 213(d) expenses to be reimbursed, the FSA is primary and the HRA is secondary because unused FSA funds generally are forfeited if not used for the applicable plan year (unless and to the extend that a carryover applies).

MEDICAL AUTOPAY: Eligible health expenses (i.e. deductible and/or coinsurance) as indicated on the health plan Explanation of Benefits will be automatically be submitted against the employee's account and reimbursed directly to the participant. Claims will be processed and reimbursed according to the participant's available balance.

PAY-THE-PROVIDER: This feature allows a participant to have their medical claim reimbursements sent directly to their provider rather than to their home address or directly deposited into their bank account. This is only available for participants who have elected autopay.

Please note: Autopay is not appropriate for participants who have secondary health coverage. Contact Capital Blue Cross for a list of partners where autopay is available.

X. SIGNATURES

It is agreed that necessary information concerning current and future participants and/or their dependents who participate in this Plan and participants 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.

Please Note: A health savings account (HSA) compatible health plan paired with a health reimbursement arrangement (HRA) must be structured carefully to avoid possible tax code concerns. An employee who enrolls in the HSA compatible health plan and participates in the HRA may not be eligible to contribute to their own HSA, unless the HRA is structured to be HSA compatible. See "Groups with QHDHP" under Section IX (Administrative Tips and Definitions). Employees should be advised and encouraged to consult with their tax advisors.

Signature _____ Date _____

Printed Name _____ Title _____