HEALTH REIMBURSEMENT ARRANGEMENT (HRA) DIRECT PLAN DESIGN GUIDE

Horizon | MyWay℠

Please complete this form and return to Horizon 45 days before your effective date so we can properly administer your plan. All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Employer's 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: _____

HR Contact:
(Responsible for signing the Plan Design Guide and approving the plan design)

Name _____ Title _____

Phone Number ( ) _____

Email Address _____

Finance Contact
(Has access to all plan information when calling Horizon and will automatically be granted full access to the Spending Account Employer Portal)

Main Contact Person _____ Title _____

Phone Number ( ) _____

Email Address _____

Additional Contact Person:
(Has access to the plan information indicated below when calling Horizon. Access to the Spending Account Employer Portal may be granted by the Main Contact who will decide what online access is assigned by logging in to the Spending Account Employer Portal)

Additional Contact Person _____ Title _____

Phone Number ( ) _____

Email Address _____

Additional Contact Person has access to when contacting Horizon:

☐ All plan information OR ☐ Claim billing information

* Log in to the Spending Account Employer Portal to grant access to additional users or to add more contacts.

II. AGENCY/BROKERAGE INFORMATION

Agent/Broker Name *(if applicable)* _____ Email Address _____

Agent/Broker Code _____ Agent/Broker Phone _____

Agency/Brokerage Name *(if applicable)* _____ Email Address _____

Agency/Brokerage Code _____ Agency/Brokerage Phone _____

Agency/Brokerage Tax ID _____-_____

Agency/Brokerage Address _____

III. TRANSFER OF ADMINISTRATION

Is Horizon taking over administrative services from another HRA administrator?

☐ Yes ☐ No *(If yes, Horizon will contact you)*

IV. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Administrator

Health Plan Group Number _____ Health Plan Account Manager _____

Group size: (check one)

☐ SHBP ☐ Public

☐ Small (2-50) ☐ Labor

☐ Mid (51-99) ☐ Large / National / Jumbo (100+)

Is your plan fully insured or self insured? ☐ Fully insured ☐ Self insured

V. ENROLLMENT DATA

Participant eligibility will automatically be set up based on health plan enrollment.

VI. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS

Plan Year

Is the HRA funded calendar year or plan year?

☐ Calendar Year - start date: _____ *(calendar year end date is always the last day of the calendar year)*

☐ Plan Year - start date: _____ end date: _____

Choose one of the funding options below:

☐ **Option #1 – HRA Pays First**

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 pays for medical services out of pocket until the health plan deductible is met. Once the deductible is met, the health plan starts to pay subject to any coinsurance amounts.

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

1 - Participant/Single = $_____ *(required)*

2 - Participant + Child = $_____

3 - Participant + Spouse = $_____

4 - Participant + Children = $_____

5 - Family = $_____ *(required)*

VI. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

Eligible Expenses

HRA dollars may be used to reimburse: *(Please check **all** that apply)*

- ☐ Health Plan Deductible only
- ☐ Health Plan Deductible + Coinsurance – By selecting this option, funding allocations will be combined for both deductible and coinsurance. Claims will pay in the order that the deductible and coinsurance expenses are finalized.
- ☐ Health Plan eligible drug expenses
- ☐ Vision
- ☐ All IRS section 213(d) eligible expenses

Reimbursement Level – 100% of eligible expenses

Reimbursement Options

Check one:

- ☐ Medical Autopay
- ☐ Medical Autopay + Pay the Provider
- ☐ Medical Autopay + Rx Debit Card
- ☐ Medical Pay the Provider + Rx Debit Card
- ☐ Rx Debit Card
- ☐ Debit Card – only if the HRA covers all IRS 213d

Medical Autopay = Eligible health plan expenses (i.e. deductible and/or coinsurance) as indicated on the health plan Explanation of Benefits will automatically be reimbursed according to the participants available balance directly to the participant.

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 in to their bank account.

☐ **Option #2 – Employee Pays First HRA**

With this option, the employee pays out of pocket until a preset amount has been paid. When this "threshold" has been reached, the HRA pays until exhausted. You, the employer, fund the HRA as expenses are reimbursed up to a predetermined amount. After that the employee pays out of pocket until the health plan deductible is reached. Once the deductible is met, the health plan starts to pay subject to any coinsurance amounts.

Indicate your **health plan deductible amounts** by coverage tier:

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

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 = $_____
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children =$_____
5 - Family = $_____

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 = $_____
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children = $_____
5 - Family = $_____

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

VI. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

Eligible Expenses

HRA dollars may be used to reimburse: *(Please check **all** that apply)*

- ☐ Health Plan Deductible only
- ☐ Health Plan Deductible + Coinsurance – By selecting this option, funding allocations will be combined for both deductible and coinsurance. Claims will pay in the order that the deductible and coinsurance expenses are finalized.
- ☐ Health Plan eligible drug expenses
- ☐ All IRS section 213(d) eligible expenses

Reimbursement Level – 100% of eligible expenses

Reimbursement Options

Check one:

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

Medical Autopay = Eligible health plan expenses (i.e. deductible and/or coinsurance) as indicated on the health plan Explanation of Benefits will automatically be reimbursed according to the participants available balance directly to the participant.

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 in to their bank account. Please note: debit card is not available with the Employee Pays First HRA option.

VII. HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATIVE 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.
- ☐ HRA funding is a specified amount if the enrollment/contract change occurs in the last 6 months of the plan year.

If this option is selected, please enter the amounts below: *(not recommended if your plan year is less than 6 months)*

1 - Participant/Single = $_____ *(required)*

2 - Participant + Child = $_____

3 - Participant + Spouse = $_____

4 - Participant + Children = $_____

5 - Family = $_____ *(required)*

Rollover

Indicate what happens to unused balances at the end of the plan year. If funding option #2 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 _____%
- ☐ A dollar limit on the amount that can roll over to the subsequent plan year. Rollover amount cannot be the same as funding amount. Indicate limits below:

1 - Participant/Single = $_____

2 - Participant + Child = $_____

3 - Participant + Spouse = $_____

4 - Participant + Children = $_____

5 - Family = $_____

VII. HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATIVE REQUIREMENTS (continued)

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)*

Run-out Period

Indicate how long participants have after the end of the plan year to submit claims incurring during that plan year.

☐ 60 ☐ 90 ☐ 180 Other (specify) _____

The run-out period noted above begins at termination date for terminated employees.

Terminations

Account balance stays with terminated participant if COBRA has been elected (**mandatory**). Account balance returns to employer if terminated participant or eligible dependent does not elect COBRA.)

VIII. CLAIM REIMBURSEMENT PROCESSING

You will receive an automated e-mail notification with the claim reimbursement totals. Sign in to the Spending Account 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 Horizon to charge our bank account through Automated Clearinghouse for **claim reimbursements** made to our employees. The following bank account information is provided to Horizon 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: _____

IX. ADMINISTRATIVE TIPS AND DEFINITIONS

ONLINE ACCESS: horizonblue.com/employers

With Horizon, your employees have access to a powerful tool for managing their HRA. By registering with horizonblue.com/employers your employees can:

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

You can also access forms and enrollment materials at **horizonblue.com/employers**

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 are forfeited if not used for the applicable plan year.

XI. 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 Horizon 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 _____