

# SelectAccount<sup>®</sup>

## HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN DESIGN GUIDE

**For Office Use Only:**

SelectAccount Group Number \_\_\_\_\_

Enrollment Specialist \_\_\_\_\_

**Please complete this form and return to SelectAccount 45 days before your effective date so we can properly administer your plan.**

If you have any questions, please call our Group Leader Line at 1-888-460-4013 or our Agent Service Line at 1-888-460-4015. If your group has 51 or more employees, please contact your account manager. When complete, either fax this form to 651-662-1180 or toll-free at 1-866-231-0214, or mail it to SelectAccount, PO Box 64193, Saint Paul, MN 55164. **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) \_\_\_\_\_ Nature of Business \_\_\_\_\_

Type of Corporation  S Corporation\*  Political Subdivision/Church  C Corporation  LLC\*  Partnership\*  Other \_\_\_\_\_  Sole Proprietor\*

\*2% or more shareholders of an S Corporation, along with partners in a partnership, sole proprietors and participants of an LLC or PLLP do not have access to an HRA.

Number of Employees Eligible for Plan: \_\_\_\_\_

Person Responsible For Authorization of Plan Design:

Name \_\_\_\_\_ Title \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

Email Address \_\_\_\_\_

Main Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

Email Address \_\_\_\_\_

Additional Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

Email Address \_\_\_\_\_ To add more contacts, complete the Group Contact Change form.

**II. AGENT INFORMATION**

Agent Name (if applicable) \_\_\_\_\_ Email \_\_\_\_\_

Agent Code \_\_\_\_\_ Agent Phone ( ) \_\_\_\_\_

Agency Name (if applicable) \_\_\_\_\_ Email \_\_\_\_\_

Agency Code \_\_\_\_\_ Agency Phone ( ) \_\_\_\_\_

**III. TRANSFER OF ADMINISTRATION**

Is SelectAccount taking over administrative services from another HRA administrator?

- Yes  No (If yes, continue below. If no, continue to section III.)

Please indicate the current plan year start date \_\_\_\_\_ end date \_\_\_\_\_

Please select one:

- Takeover at renewal date:

Will the prior administrator handle the runout period for the prior plan year?

- Yes (recommended if group has rollover)  No (If the SelectAccount plan design is different than the previous administrator's plan design, attach the plan document.)

- Takeover mid plan year:

Will the prior administrator continue processing claims?  Yes  No (recommend if group has rollover)

If SelectAccount is taking over administrative services, please provide us with enrollment data. This information should include the effective date, current available balance and any pending claim amount for each participant.

If the prior administrator is continuing to process claims, please provide us with the prior administrator's name, address and phone number below so we can forward any appropriate information to them.

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

**IV. HEALTH PLAN ADMINISTRATIVE INFORMATION**

**Health Plan Administrator**

Health plan carrier (Required) \_\_\_\_\_

Is this an Options Blue HRA Plan?  Yes  No - Initial and ongoing enrollment must be provided to SelectAccount.

HRA Enrollment Forms are needed **only** if:

- your health plan is **not** an Options Blue HRA with Blue Cross and Blue Shield of Minnesota, or
- your health plan **is** with Blue Cross and Blue Shield of Minnesota and your small group is **not** plan number 161, 165,167, or 169.

(Electronic enrollment file format requirements will be provided via email following the approval of the plan design guide.

Health plan group/subgroup #(s)(or attach the group account structure to the PDG) \_\_\_\_\_

Are health plan accumulations calendar year or plan year?  Calendar Year  Plan Year

Plan year not available for Blue Cross and Blue Shield of Minnesota (BCBSMN) small groups.

**V. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS**

**Plan Year**

Is 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: \_\_\_\_\_ (plan year not available for BCBSMN small groups)

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 = \$ \_\_\_\_\_ (this option not available for BCBSMN small groups)
- 3 - Participant + Spouse = \$ \_\_\_\_\_ (this option not available for BCBSMN small groups)
- 4 - Participant + Children = \$ \_\_\_\_\_ (this option not available for BCBSMN small groups)
- 5 - Family = \$ \_\_\_\_\_ (required)

**V. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)**

**Eligible Expenses**

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

- Health Plan eligible medical expenses
- Health Plan eligible drug expenses
- All IRC section 213(d) eligible expenses
- COBRA premiums and insurance premiums

**Reimbursement Level** – 100% of eligible expenses

**Option #2 – Shared Payments HRA**

*With this option, you, the employer, and your employee share in the medical costs until the account is exhausted. As expenses are incurred, the HRA reimburses the employee according to the cost-sharing level (e.g. 50/50, 80/20) until the HRA is 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 met. Once the deductible is met, the health plan starts to pay subject to any coinsurance amounts.*

Indicate the annual funding levels for the Shared Payments HRA Option:

- 1 - Participant/Single = \$ \_\_\_\_\_ *(required)*
- 2 - Participant + Child = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 3 - Participant + Spouse = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 4 - Participant + Children = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 5 - Family = \$ \_\_\_\_\_ *(required)*

**Eligible Expenses**

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

- Health Plan eligible medical expenses
- Health Plan eligible drug expenses
- All IRC section 213(d) eligible expenses
- COBRA premiums and insurance premiums

**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 \_\_\_\_\_

**Option #3 – Employee Pays First HRA** (only available for plans effective on or after 1/1/2010)

*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. Additional fee applies to all participants. Please refer to the fee schedule.*

**Requirements**

- Group must have Blue Cross and Blue Shield of Minnesota health plan (currently not available for CCStpa or BlueLink Tpa groups)
- HRA plan year must match the health plan deductible accumulation period (calendar vs. plan year)
- Automatic enrollment in medical crossover
- Only eligible expenses are Health Plan eligible Medical and/or Health Plan eligible Drug - all IRC Section 213(d) expenses are not allowed

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

- 1 - Participant/Single = \$ \_\_\_\_\_
- 2 - Participant + Child = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 3 - Participant + Spouse = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 4 - Participant + Children = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 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 = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 3 - Participant + Spouse = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 4 - Participant + Children = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 5 - Family = \$ \_\_\_\_\_

**V. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)**

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 = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 3 - Participant + Spouse = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 4 - Participant + Children = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 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.**

**Eligible Expenses**

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

- Health Plan eligible medical expenses
- Health Plan eligible drug expenses

**Reimbursement Level**

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

- 100% of eligible expenses
- 80% of eligible expenses
- 50% of eligible expenses
- Other \_\_\_\_\_

**VI. 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 = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 3 - Participant + Spouse = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 4 - Participant + Children = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 5 - Family = \$ \_\_\_\_\_ *(required)*

**Rollover**

Indicate what happens to unused balances at the end of the plan year. If funding option #3 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 = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 3 - Participant + Spouse = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 4 - Participant + Children = \$ \_\_\_\_\_ *(this option not available for BCBSMN small groups)*
- 5 - Family = \$ \_\_\_\_\_

## VI. 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 = \$ \_\_\_\_\_ (this option not available for BCBSMN small groups)  
3 - Participant + Spouse = \$ \_\_\_\_\_ (this option not available for BCBSMN small groups)  
4 - Participant + Children = \$ \_\_\_\_\_ (this option not available for BCBSMN small groups)  
5 - Family = \$ \_\_\_\_\_ (required)

### 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 12 months.)

### Terminations

Indicate what happens to the HRA balance when a participant terminates: (Please check **all** that apply.)

- 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.  
 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. HEALTH REIMBURSEMENT ARRANGEMENT OPTIONAL FEATURES

You may select any of the features listed below that best meet your needs and those of your participants.

### Crossover

Offering crossover eliminates the need for participants to complete and file a claim form to be reimbursed for eligible health plan expenses.

#### Medical Crossover

Eligible health plan expenses (i.e., deductible, coinsurance) as indicated on the health plan Explanation of Benefits will be electronically transferred to SelectAccount. Claims will be processed and reimbursed according to the participant's available balance.

Please note: crossover is not appropriate for any participants that have secondary insurance coverage with Blue Cross or another carrier. (This feature is only available if the health plan is Blue Cross and Blue Shield of Minnesota or CCStpa/BlueLink.)

Along with medical crossover, any available spending account balance(s) are accessed when purchasing a prescription drug at the pharmacy at point of service. This feature is only applicable when Prime Therapeutics is the pharmacy benefit manager and prescription drug benefits are allowed with the spending account plan.

- Select one:  Automatically enroll all participants in medical crossover. (Participants may opt out by requesting online or completing the medical crossover form F7856.)  
 Offer medical crossover to participants. Not available with funding option #3. (Participants may elect crossover by requesting online or completing the medical crossover form F7856. Highest participant fee applies. Please refer to the fee schedule.)  
 Do not offer medical crossover to participants. Highest participant fee applies. Please refer to the fee schedule. Not available with funding option #3.

## VII. HEALTH REIMBURSEMENT ARRANGEMENT OPTIONAL FEATURES (continued)

**Dental Crossover** - only available for funding options #1 and #2 AND if eligible expenses chosen are all IRC section 213(d).

Do you offer dental coverage through Delta Dental of Minnesota?

Yes - complete the dental crossover section below     No - Default

Eligible dental plan expenses (i.e. deductible and/or coinsurance) as indicated on the dental Explanation of Benefits, plus other patient responsibility amounts will be electronically transferred from Delta Dental of Minnesota to SelectAccount. They will be processed and reimbursed according to the participant's available balance. Please note dental crossover is not appropriate for any participants who have secondary dental insurance coverage. Electing this feature does not impact the monthly participant fees.

Select one:  Automatically enroll all participants in dental crossover. (Participants may opt out of dental crossover by requesting online or completing the dental crossover form F7854.)  
 Offer dental crossover to participants.  
*(Participants may elect crossover by requesting online or completing the dental crossover form F7854.)*  
 Do not offer dental crossover to participants

**Pay-the-Provider** *(This feature is only available if health plan is with Blue Cross Blue Shield of Minnesota)*

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 crossover. **Additional fee applies to all participants regardless of their pay-the-provider election. Please refer to the fee schedule.**

Select one:  Automatically enroll all participants in pay-the-provider. Must also select auto-enroll in medical crossover. (Participants may opt out of pay-the-provider by requesting online or completing the Pay-the-provider Election form F9089.)  
 Offer pay-the-provider to participants. (Participants may elect pay-the-provider by requesting online or by completing the Pay-the-provider Election form F9089.)  
 Do not offer pay-the-provider to participants.

## VIII. CLAIM REIMBURSEMENT PROCESSING

Please indicate the contact person for reimbursement payments, if different from main contact person:

Name \_\_\_\_\_ Title \_\_\_\_\_  
Phone Number (        ) \_\_\_\_\_ Email Address \_\_\_\_\_

Please indicate your preferred claim reimbursement report format: *(select **only one**)*

Standard Report (lists each employee, by location)  
 Total Only Report (lists totals only, by location)

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

I hereby authorize SelectAccount to charge our bank account through Automated Clearinghouse for **claim reimbursements** made to our employees. The following bank account information is provided to SelectAccount 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**

**ONLINE ACCESS:** [www.selectaccount.com](http://www.selectaccount.com)

With SelectAccount, your employees have access to a powerful tool for managing their HRA. By registering with [selectaccount.com](http://selectaccount.com), your employees can:

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

You can also access forms and enrollment materials at **[www.selectaccount.com](http://www.selectaccount.com)**

**LOCATIONS:** Multiple SelectAccount locations are available for 51+ groups only. If you want multiple SelectAccount locations, please complete and attach the Location Addendum (F8928). Locations must be the same across all products administered by SelectAccount. If you wish to have different ACH accounts by location, please complete the Group ACH Authorization Agreement form (F9055).

**COORDINATING WITH AN HSA:** For participants that have a HRA and a HSA, the HRA 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 deductible expenses, 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 full HRA.

Please note: If the HSA is not administered by SelectAccount or the health plan is not with Blue Cross and Blue Shield of Minnesota, the group is required to manually notify SelectAccount which employees are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (F8978) to SelectAccount to indicate that the deductible has been satisfied prior to receiving reimbursement for 213(d) eligible expenses.

**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.

**ACCOUNT FEES:** For participants who have an HRA stacked with a SelectAccount FSA, only one monthly participant fee will apply. Participant fees are billed monthly via mail and are payable by check only. You will receive one bill for the entire group including the billed amount for each location (if applicable).

**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 SelectAccount 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: An Options Blue health savings account (HSA) health plan paired with a health reimbursement arrangement (HRA) poses possible tax code concerns. An employee who enrolls in the Options Blue HSA health plan and participates in the HRA may not be eligible to open or contribute to their own HSA. Employees must be advised.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

