BlueCross BlueShield of Delaware

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

ACCOUNT RENEWAL FORM
FOR CONSUMER DRIVEN HEALTH PLAN

A. Full Legal Name: ________________________________ BCBSDE Account # __________
Street Address : ____
Name and Title of Contact Person: ________________________________
Email Address: ____ _
Name and Title of Billing Contact: ________________ Phone# __________ Fax: __________
Email Address: ____

B. Has your Business Entity Type changed?: ☐ YES ☐ NO ☐ No change since implementation

If so, please check one applicable box and indicate the effective date of the change ___/___/____:

____ C Corporation
____ S Corporation
____ Limited Liability Company (LLC)
____ Limited Liability Partnership (LLP)
____ Professional Association or Corporation (P.A. or P.C.)
_____ General Partnership
_____ Limited Partnership
_____ Sole Proprietor (Sch. C)
_____ Government

C. Have any of your employees become members of an LLC, partners in a partnership, a sole proprietor, & or shareholder of an 'S' corporation who owns at least 2% of the corporate stock (and family member employees)? ☐ YES ☐ NO

☐ **I understand these employees may not participate in an HRA or a Health FSA or a Dependent Care FSA. Please provide a separate list of employees if applicable**

D. Has your business become affiliated with any subsidiaries or other business entities?

☐ YES ☐ NO ☐ No change since implementation

If **YES**, please answer all questions in this section (Employer Information) using a separate sheet for each subsidiary or business entity.

E. Have you set up or will you be setting up a Health FSA Plan? ☐ YES ☐ NO ☐ No change since implementation

See *BCBSD FSA fee schedule and FSA set-up sheet for more information regarding BCBSD Health FSA Plans*. If you have a Health FSA Plan that is administered by a non- BCBSD administrator, please provide the administrator's name:

____

If yes, state the order of priority of plan payments:

HRA First ☐ Second ☐ ___Health FSA First ☐ Second ☐

F. List Deductible in underlying high deductible health plan (HDHP) for your new plan year:

Individual: ________ Family: ________

Do copays apply? ☐ YES ☐ NO

G. Are you making changes to the benefits to be covered under HRA? ☐ YES ☐ NO

If yes, please complete section below:

☐ All medical expenses covered under the HDHP that would be paid and subject to the deductible: ☐; coinsurance: ☐

☐ All Medical, including dental, vision, prescription drug, and **eligible over- the- counter items** – (Same as provided under a Health FSA)

If the HRA plan includes vision and dental benefits are the premiums for the respective underlying vision and dental plans?

________ 100% employer paid

________ 100% employee paid

________ Paid by employer and employees ____________________________.

List both vision and dental carrier if not BCBSD ____

(Please attach copy of benefit schedule (s)

H. Dollar Amount Provided by Employer Available to each Employee per Plan Year for Claims Reimbursement by Employer:

$________ Individual High Deductible Health Plan Coverage

$________Family High Deductible Health Plan Coverage

I. Is there a change to when the HRA funding amount is available to each employee at the beginning of the plan year?

☐ No change

☐ Full Amount Available on First Day of Plan Year – ***Note this option must be selected if you will provide a debit card.***

☐ Quarterly on 1st day of Calendar Quarter (**For non-debit card clients only)**

☐ Monthly on 1st day of Month **(For non-debit card clients only**)

J. Is there a change to the funding for new employees hired during the plan year?:

☐ No change

a. Full annual funding ☐

b._______%

c. _______Pro-rated schedule according to effective date of HDHP coverage (i.e. 1/12 of annual funding for each month participating in HRA plan)

K. COBRA

Note for Employers who are Subject to COBRA:

The HRA must be offered as a combined election in conjunction with the underlying HDHP. If employee elects the HDHP and HRA, then both the HDHP and HRA are required to be elected by COBRA qualified beneficiaries who elect medical coverage under COBRA. COBRA participants will pay the HDHP premium plus an additional HRA premium based on the HRA COBRA factor provided. Under COBRA, an employer is required to provide the same HRA funding to COBRA participants as provided to similarly situated active employees.

Is employer subject to COBRA? ☐YES ☐NO

- If yes and employer has debit card option – is debit card available to COBRA participants? ☐YES ☐ NO
(please note – unless requested DEBIT cards will be cancelled for COBRA participants)

* Unless BSBSD is notified COBRA participants with an HRA will receive full funding. Employer is responsible for notifying BCBSD if funding schedule changes.

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L. Is there a change to the Rollover of Balances at End of Plan Year to the Next Plan Year?: ☐ No change

( ) Entire Unused Balance
( ) Maximum of _____ %
( ) Maximum of _____ % up to $ __________
( ) No Rollover of Balances – **There will be a 90-day claims run out period for arrangements with no balance rollover.**

M. Is there a change to the Claims Processing Options/Funding Method? ☐YES ☐ NO (if yes please complete items below)

1. ( ) **Debit Card and Paper Claims Submission** – Complete *Employer Deposit Agreement with Bancorp* and check Funding Method below.

   ( ) ACH Debit is required- Complete BCBSD *Authorization Agreement for ACH / EFT Transactions* for **Paper Claims** ***and*** the *Authorization for ACH Debits and Credits* (Bancorp) for **Debit Card transactions**.

   Please note a separate pre-fund is required in order to issue debit cards.

2. ( ) **Paper Claims Submission Only** – Select **Funding Method** below.

   ( ) **ACH Debit** - Complete enclosed BCBSD *Authorization Agreement for ACH / EFT Transactions* for **Paper Claims.** Fees will apply to all returned ACH debits. (A separate fee schedule is attached).

3. ( ) **Automated Claims Rollover** – Select **Funding Method** below.

   ( ) **ACH Debit** - Complete enclosed BCBSD *Authorization Agreement for ACH / EFT Transactions* for **Paper Claims.** Fees will apply to all returned ACH debits. (A separate fee schedule is attached).

NOTE: When the debit card option is selected employers can expect to receive 2 weekly invoices. One invoice will be sent from Bancorp to replenish the debit card collateral account and another invoice will be sent from BCBSD to cover any paper claims activity.

____
Signature | Title | Date

____
Print Name | Print Title

____

Submitted by: ☐Marketing Representative______________________
☐Broker____