Highmark Delaware

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
ACCOUNT SET-UP FORM FOR CONSUMER-DIRECTED HEALTH PLAN

1. EMPLOYER INFORMATION

A. Full Legal Name: _____ EIN: _____

Street Address (no P.O. Boxes): _____

_____

Highmark Blue Cross Blue Shield Delaware (Highmark DE) Account # _____

Name and Title of Contact Person: _____

Phone #: _____ Fax #: _____ *Email Address: _____

Must provide email address for debit card service

Name and Title of Billing Contact: _____ Phone #: _____

Fax #: _____ Email Address: _____

B. Business Entity Type: (Please check one applicable box.)

- ☐ 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

Note: Members of an LLC, partners in a partnership, a sole proprietor, & any shareholder of an 'S' corporation who own at least 2% of the corporate stock (and family member employees), may not participate in an HRA or a Health Flexible Spending Account (FSA) or a Dependent Care FSA.

C. Is your business affiliated with any subsidiaries or other business entities? ☐ YES ☐ NO

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

_____

D. Do you have or will you be setting up a Health FSA Plan? See the Highmark DE FSA fee schedule and FSA set-up sheet for more information regarding Highmark DE Health FSA Plans. If you have a Health FSA Plan that is administered by a non-Highmark DE administrator, please provide the administrator's name and address.

If you offer an Health FSA Plan, state the order of priority of plan payments:

☐ HRA Pays First ☐ Health FSA Pays First

E. List Deductible in underlying high deductible health plan (HDHP): Individual _____ Family_____

Do copays apply? ☐ No ☐ Yes – If you answered YES, please attach copy of Benefit Summary detailing copays.

2. HEALTH REIMBURSEMENT ARRANGEMENT PARAMETERS *(Please identify HRA plan year start and end dates. Note: the HRA and the underlying HDHP must have the same start and end dates as the separate HRA and as a Health FSA plan.*

A. Please provide the plan year start and end dates as follows:

HDHP:

First Day of Plan Year: dd/mm/yyyy: _____

Last Day of Plan Year: dd/mm/yyyy: _____

HRA:

First Day of Plan Year: dd/mm/yyyy: _____

Last Day of Plan Year: dd/mm/yyyy: _____

Health FSA:

First Day of Plan Year: dd/mm/yyyy: _____

Last Day of Plan Year: dd/mm/yyyy: _____

B. Benefits to be covered under HRA – Check one only:

☐ 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, how 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 Highmark DE. _____

(Please attach copy of benefit schedule(s))

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

$_____ for Individual High Deductible Health Plan Coverage

$_____ for Family High Deductible Health Plan Coverage

D. When is the dollar amount provided in 2.C. available to each employee during the plan year for claims reimbursement (check one)?

☐ 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)**

☐ For new employees hired during the plan year, please note how you will handle funding.

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)

(Unless Highmark DE is notified otherwise, employees will receive full funding. Employer is responsible for notifying Highmark DE of funding schedule.)

E. Non-Debit Card Options (Complete Only if You Do Not Provide a Debit Card)

☐ Y ☐ N Are employees required to pay some or all of the deductible for the HDHP out-of-pocket from their own funds before the employer will provide HRA funds for claims reimbursement? If YES – please provide dollar amount $_____ (individual) $ _____ (family)

F. 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? ☐ Y ☐ N

- If YES and employer has debit card option, is debit card available to COBRA participants? ☐ Y ☐ N
  (Please note – unless requested debit cards will be cancelled for COBRA participants.)

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

G. Rollover of Balances at End of Plan Year to the Next Plan Year

Note: The HRA is not consumer-directed health care if rollover of balances is not permitted.

Rollover of balances at end of plan year to the next plan year **(check one):**

☐ 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.**

Note: There will be no claims run-out period with balance rollover arrangements. The rollover balance is based on the actual prior plan year balance 45 days following the end of the plan year.

H. The Debit Card will be deactivated the same date the HDHP is terminated.

I. **Claims Processing Options/Funding Method. Select your option below:**

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

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

☐ **Paper Claims Submission Only** – Select **Funding Method** below.

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

☐ **Automated Claims Rollover** – Select **Funding Method** below.

☐ **ACH Debit** - Complete enclosed Highmark DE *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 Highmark DE to cover any paper claims activity.

3. CERTIFICATION, AGREEMENT AND SIGNATURE

An individual with the legal authority to sign contracts on behalf of the business entity must sign this Set-Up Form. He or she may be a corporate officer of a corporation, a partner in a partnership a sole proprietor, etc.

The undersigned employer hereby certifies that:

a. All foregoing information is accurate and complete.

b. The Employer does not provide any other benefits under the cafeteria plan other than those listed or that will be implemented as shown on this Set-Up Form.

c. If offering a Health Reimbursement Arrangement(s) with a respective medical insurance plan(s) that is/are offered under a cafeteria plan, the Health Reimbursement Arrangement(s) may not be attributable, directly or indirectly, to employee pre-tax salary reductions made under the cafeteria plan. Consistent with these requirements:
   i. I understand that IRS published authority provides that an arrangement will not qualify as an HRA if employee salary reductions under the medical plan (including cashable flex credits) fund the HRA either directly or indirectly.
   ii. An employee will not be provided with a choice between payment of premiums for the medical insurance plan via salary reduction or HRA funds.
   iii. The salary reduction agreement indicates (or will indicate prior to the effective date of the HRA) that salary reductions (including cashable flex credits) are used solely for the non-HRA portion of the medical insurance plan and do not fund the HRA.
   iv. An employee may not elect to use HRA funds to pay for coverage under the **medical insurance** plan in lieu of paying for coverage under the medical insurance plan via salary reduction (including cashable flex credits).
   v. The Employer does not and will not allow Health Flexible Spending Account (Health FSA) forfeitures to fund the HRA.
   vi. The employee pre-tax contributions (including cashable flex credits) for the medical insurance plan are less than 100% of the applicable COBRA premium for such coverage (excluding the 2% administrative charge).

d. A Health Reimbursement Arrangement shall be established according to the information provided and any additional information that may be requested.

e. Highmark DE and its Flexible Benefits Department are not providing legal or tax advice and the Employer has and will obtain competent professional legal or tax advice as necessary for compliance with applicable laws and regulations; and agrees to:
   i. Provide updated backup information in a timely manner.
   ii. Abide by the requirements set forth in the plan document and summary plan description.
   iii. Provide any information required by Highmark Delaware's Flexible Benefits Department in the future in a timely manner as required for continued compliance with applicable laws and regulations.
   iv. Provide any updated information that may impact or change any of the certifications above in a timely manner.

Signature _____ Title _____ Date _____

Print Name _____ Print Title _____

Submitted by (Marketing Representative) _____ Date _____

Broker Representative (Print Name) *if applicable* _____

Broker Representative Signature *if applicable* _____ Date _____

Broker Agency *if applicable* _____