



SelectAccountSM

For Office Use Only:
 SelectAccount Group Number _____
 Enrollment Specialist _____

HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN DESIGN GUIDE

Please fill out this form in its entirety and return to SelectAccount 45 days prior to your effective date in order for us to properly administer your plan. If you have any questions on how to complete the form, please call our Group Leader Line at 1-888-460-4013 or our Agent Service line at 1-888-460-4015. If you are a 51+ group, please contact your account manager. When complete, either fax form to (651) 662-1180 or toll-free at 1-866-231-0214, or mail to SelectAccount, PO Box 64193, Saint Paul, MN 55164. **Incomplete forms will be returned to you resulting in 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 _____ Nature of Business _____

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

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

Number of Participants 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 _____

II. TAKEOVER INFORMATION

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)* No

Takeover mid plan year:

Will the prior administrator continue processing claims? Yes No *(recommended)*

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 () _____

III. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Administrator

Health plan carrier Blue Cross and Blue Shield of Kansas

Health plan group #(s) _____

Are health plan accumulations calendar year or plan year? Calendar Year Plan Year
(plan year not available for small groups)

IV. HEALTH REIMBURSEMENT ACCOUNT ADMINISTRATIVE INFORMATION

Plan Year

Is HRA funding 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 small groups)

Health Reimbursement Account Funding

Indicate the annual funding amounts for the HRA:

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

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 = \$ _____
2 - Participant + Child = \$ _____ (This option not available for small groups)
3 - Participant + Spouse = \$ _____ (This option not available for small groups)
4 - Participant + Children = \$ _____ (This option not available for small groups)
5 - Family = \$ _____

Rollover

Indicate what happens to unused balances at the end of the plan year: (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. Indicate limits below:

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

IV. HEALTH REIMBURSEMENT ACCOUNT ADMINISTRATIVE INFORMATION (continued)

Cap on Health Reimbursement Account Balance

Is there a cap on the overall balance 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 = \$ _____
- 2 - Participant + Child = \$ _____ (This option not available for small groups)
- 3 - Participant + Spouse = \$ _____ (This option not available for small groups)
- 4 - Participant + Children = \$ _____ (This option not available for small groups)
- 5 - Family = \$ _____

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 15 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.

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 section 213(d) eligible expenses
- COBRA premiums

Reimbursement Level:

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

- 100% of eligible charges 80% of eligible charges 50% of eligible charges

V. HEALTH REIMBURSEMENT ARRANGEMENT OPTIONAL FEATURES

You may select any of the features listed below that best meet your needs and those of your participants. *Additional fees apply. Please refer to the fee schedule.*

Crossover

Offering crossover eliminates the need for participants to complete and file a claim form to be reimbursed for eligible health plan expenses. The crossover election applies across all spending accounts (i.e. medical FSA, HRA, or HSA).

Medical Crossover

Eligible health plan expenses (i.e. deductible and/or coinsurance) as indicated on the Explanation of Benefits plus out of pocket expenses for prescription drug copays, will be electronically transferred to SelectAccount. They will be processed and reimbursed according to the participant's available balance. Please note crossover is not appropriate for any participants who have secondary health coverage with Blue Cross or another carrier. *(This feature is only available if health plan is with Blue Cross and Blue Shield of Kansas.)*

- Select one: Automatically enroll all participants in medical crossover. *(Participants may opt out by completing the medical crossover form F7856.)*
- Offer medical crossover to participants. *(Participants may elect crossover by 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.

VI. HEALTH REIMBURSEMENT ARRANGEMENT OPTIONAL FEATURES FEE

Participant Fees

Indicate Employer billing frequency - must match billing frequency for all SelectAccount products offered:

- Monthly (recommended)
- Annually

VII. FLEXIBLE SPENDING ACCOUNT INFORMATION

Does this plan interact with a Flexible Spending Account (FSA) administered by SelectAccount? Yes No

If yes, please choose the order between the HRA and FSA:

- HRA pays first, FSA pays second
- FSA pays first, HRA pays second

Standard primacy recommendations:

If the HRA allows reimbursement for health plan eligible expenses only, it is suggested to have the HRA as primary and the FSA as secondary.

If the HRA allows all 213 (d) eligible expenses to be reimbursed from the HRA, it is suggested to have the FSA as primary and the HRA as secondary because unused FSA funds are forfeited if not used for the applicable plan year.

Note that the HRA and FSA pay only after all other insurance has paid.

If SelectAccount is administering the FSA please submit a completed Flexible Spending Account Plan Design Guide (Form F9051), if not previously completed.

VIII. CLAIM REIMBURSEMENT PROCESSING

Claim Reimbursement Report

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

Name _____ Title _____
Phone Number () _____

Please indicate how you wish to be notified regarding claim reimbursement amounts: *(select **only one**)*

Fax Fax Number () _____
 Email E-mail Address _____

(Claims reimbursement reports are generated weekly. You will receive notification two days in advance of the ACH withdrawal.)

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

Standard Report *(lists each participant, 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 participants. The following bank account information is provided to SelectAccount information of this procedure.

Bank Name _____ Type of Account Checking Savings
Bank Location/Branch _____
Bank ABA Number _____ Bank Account Number _____

Attach a void check - mandatory

IX. ADDITIONAL 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 Addendum (X9055).

X. REQUEST FORMS

Would you like to request HRA Enrollment Forms for future enrollments? Yes No

If yes, please select option below:

Email (PDF)
 Mail to Group Contact. Number of enrollment forms needed: _____

XI. ADDITIONAL REQUIRED INFORMATION

Agent Name (if applicable) _____

Agent Code _____ Agent Phone () _____

Agency Name (if applicable) _____

Agency Code _____ Agency Phone () _____

Internal:

Sales Representative _____ E-mail Address _____

Sales Representative Number _____ Phone () _____

Health Plan Account Coordinator _____ *(internal use only)*

SelectAccount Account Coordinator _____ *(internal use only)*

Special Instructions: _____

XII. SIGNATURES

It is agreed that necessary information concerning participants or participants and their dependents participating in or subsequent to the effective date of the Plan and participants whose participation is to be changed or discontinued shall be furnished 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.

Signature _____ Date _____

Printed Name _____ Title _____