BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

VEHI - HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN DESIGN GUIDE

Please complete this form and return to BCBSVT 45 days before your effective date so we can properly administer your plan.
If you have any questions, please call our Sales Line at 855-363-2583. When complete, email this form to mymoneybcbsvt.sales@hellofurther.com or fax it to 1-866-231-0214; or mail it to BCBSVT MyMoney, (PO Box 982814 El Paso, TX 79998-2814).

All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Legal 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_____

**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 FSA.*

Number of Employees Eligible for Plan: _____

Main Contact Person:
(Has access to all plan information and can add, edit, or remove portal access for additional contacts.)

Main Contact Person _____ Title _____

Phone Number ( ) _____

Email Address_____

Additional Contact Person:
(Has access to all plan information and edit access for group portal.)

Additional Contact Person _____ Title _____

Phone Number ( ) _____

Email Address_____

Additional Contact Email Notifications

☐ Fee billing information ☐ Claim billing information

II. HEALTH PLAN GROUP STRUCTURE

Group Structure can also be submitted on an Excel spreadsheet

Parent Code A316

Group Number(s) _____ _____ _____ _____ _____ _____ _____

Division Codes(s) _____ _____ _____ _____ _____ _____ _____

III. CLAIM REIMBURSEMENT PROCESSING

You will receive an automated email notification with the claim reimbursement totals. Sign into the Online Group Service Center to view and print your complete invoice detail under Claim Reimbursement Invoices.

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

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

IV. ADMINISTRATIVE FEES

You will receive an automated email notification when your detailed billing information is available and another email notification two business days in advance of the scheduled ACH transaction confirming the amount of funds to be transferred. Sign into the Online Group Service Center to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information (completion of this section is mandatory)

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **Administrative Fees.** The following bank account information is provided to Further for initiation of this procedure.

Please select **one:**
☐ **Use same bank account as indicated for claim reimbursements; OR**
☐ **Use bank account information indicated below:**

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 _____

(Funds will be drawn from your bank account on or after the 20th of each month.)

V. TRANSFER OF ADMINISTRATION

(This information will only be used to provide information to your employees.)

Is BCBSVT taking over administrative services from another administrator? ☐ Yes ☐ No

If yes, fill out the fields below.

If no, skip to the signatures section.

With your previous plan, was rollover allowed to carry over from year to year?

☐ Yes ☐ No

PRIOR ADMINISTRATOR INFORMATION:

Prior Administrator's Name: _____

PLAN YEAR INFORMATION:

Please select one of the following and fill out the corresponding section.

☐ **TAKEOVER AT NEW PLAN YEAR:**

Please select the administrator that will be processing the runout claims for the previous plan year.

☐ The prior administrator

☐ BCBSVT (If BCBSVT is handling the runout, indicate runout and rollover for that plan year)

☐ Runout Period Months: _____

☐ **TAKEOVER AT MIDYEAR:**

What is the last date the prior administrator will process claims? _____

What is the date that the enrollment data and balances will be submitted to BCBSVT? _____

Please note: There will be a blackout period between when the data is received and when BCBSVT will begin to process claims. The plan will be set up according to the plan design guide submitted to BCBSVT.

VI. ADMINISTRATIVE TIPS AND DEFINITIONS

ONLINE ACCESS: mymoneybcbsvt-group.hellofurther.com

With BCBSVT, your employees have access to a powerful tool for managing their HRA. By registering, 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 **learn-mymoneybcbsvt.hellofurther.com**

COORDINATING WITH AN HSA: For participants that have an HRA and an 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 Further or the health plan is not with Blue Cross and Blue Shield of Vermont, the group is required to manually notify Further which employees are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (X22527) to Further 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.

VII. 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 BCBSVT 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: A health savings account (HSA) health plan paired with a health reimbursement arrangement (HRA) poses possible tax code concerns. An employee who enrolls in the 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 _____