

Health Reimbursement Arrangement (HRA)

Company Name:

Specific HRA Contact:

Title:

Same as primary contact- if the same no need to complete Access to Benefit Strategies employer portal

E-Mail:

Telephone: ()

Fax: ()

Will you require representation at enrollment meetings? Yes* No ***Date & Time:**

Eligibility Requirements:

Hours worked/week

Waiting Period

Coverage end date for a termination

Plan Type:

Single Employer Plan

Controlled Group (Please complete below)

Participating Employer Name

Federal Tax ID #

City / State/ Zip

Run out after plan year end: 90 Days (Benefit Strategies' default) Other:

Please Note: A \$250 fee will apply for a run out different from default. A terminated employee's plan year end date is their termination date.

Plan Documents

Plan Name:

Plan Number:

Who is responsible for plan documents? Other Benefit Strategies- Please indicate New Plan Restate Plan

Effective Date of your First HRA Plan:

Do you offer an HSA? Yes No **FSA?** Yes No

Is your plan subject to FMLA? Yes No *(In most cases companies with 50 employees or more are subject to FMLA)*

Plan Specifics

List the name of all medical insurance plan(s) subject to the HRA:

**Please attach a copy of your medical insurance benefit summary*

If an HRA is already in place, will Benefit Strategies be handling the run-out for the previous HRA provider?

Yes* No **If Yes, please provide the pertinent demographic and balance information*

HRA Submission

- Manual Claim Submission
- Debit Cards (Only allowed for code 213 expenses)
- Direct File Feed¹ Available with Blue Cross Blue Shield of Massachusetts(BCBSMA), Harvard Pilgrim Health Care (HPHC) and Tufts Health Plan (THP)

***The file feed will be used to reimburse:**

Participant (BCBSMA, HPHC & THP)

Provider (THP, HPHC groups)

HRA Pays (Choose one option)

- Full Amount of Deductible
- First Portion of Deductible
- Second Portion of Deductible
- On a Per Claim basis: _____ %
- Custom (Please Explain): See attachment

Employer HRA Contribution

HRA Pays

Employee Pays

\$ _____ Flat Dollar Amount

\$ _____ Single Person Plan

\$ _____ Two Person Plan

\$ _____ Family Plan*

\$ _____ *Per Member Maximum for HRA

When HRA funds will be made available to participants:

Whole Amount Up Front (*Beginning of Plan Year*)

Custom Please Explain: _____

Are Funds Pro-Rated? Yes No

