

Health Reimbursement Account (HRA) Enrollment or change form Benefits Card and Autopay



29625198 (12/18)

____/____/____
* Effective date

PLEASE PRINT CLEARLY

* This information is mandatory. Enrollment may be delayed if fields with an asterisk are not filled out.

Section 1 Application reason

Please refer to your plan's summary plan documents for a complete list of qualifying status changes. Election changes cannot be retroactive and must be consistent with the event.

New enrollee -OR- Update election due to a qualifying life event. Please describe qualifying life event below:

Section 2 Account holder information

* First name	M.I.	* Last name	* Date of birth ____/____/____	* Social Security number	
* Mailing address			* City	* State	* ZIP
* Physical address			* City	* State	* ZIP
* Email address			* Contact phone number		
* Employer	Division		* Hire date ____/____/____	* Group identification number (if known)	

Section 3 Payroll (check one)

Weekly (52 pay periods/yr) Bi-weekly (24 pay periods/yr) Bi-weekly (26 pay periods/yr) Semi-monthly Monthly
 Other _____

Section 4 Benefit account

Employee only Employee plus one Family Waive participation This year Permanently * Effective date (MM/DD/YY) ____/____/____
If employer offers multiple HRA plans, please indicate the plan you are enrolling in here:

Section 5 Eligible dependents

If your HRA plan reimburses expenses for dependents please fill out the below information. Qualified tax dependents is defined under Internal Revenue Code Section 152.

1	* First name	* Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	* Social Security number	* Date of birth ____/____/____
2	* First name	* Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	* Social Security number	* Date of birth ____/____/____
3	* First name	* Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	* Social Security number	* Date of birth ____/____/____
4	* First name	* Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	* Social Security number	* Date of birth ____/____/____

Section 6 Reimbursement (for additional information, please review page 2)

Autopay	<input type="checkbox"/> Enroll me in autopay	Autopay is not available to you if you or one of your dependents are covered by more than one insurance plan. You may enroll in the autopay or the benefits card, but not both.			
Benefits card	<input type="checkbox"/> I would like a Benefits Card ¹	<input type="checkbox"/> I already have a Benefits Card			
Direct deposit ²	<input type="checkbox"/> Enroll me in direct deposit ³	<input type="checkbox"/> Checking <input type="checkbox"/> Savings	Bank name		
	Routing number		Account number		

¹ BHS will issue two benefit cards in your name.

² If you do not opt in for Direct Deposit manual claim submissions will be reimbursed by check. If you do request direct deposit, your bank account will be credited and debited (called a micro-deposit) in a random amount ranging between \$0.01 and \$0.99. You will receive an email notification with further instructions for activating direct deposit.

³ Please include a voided check with your enrollment form.

Section 7 Authorization

I have read and agree to the terms and conditions on pages 1 and 2.

* Employee signature	* Signature date
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Please return to your human resources or benefits department upon completion.

Direct deposit

By having your healthcare reimbursement arrangement (HRA) reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a direct deposit remittance advice. The remittance advice will indicate the date your claim was paid and the amount that will be deposited to your bank account. All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to 2-3 business days to appear in the designated account. Should you make any changes to your bank account, such as account closure or change in account number, please notify BenefitHelp Solutions immediately. If there is an interruption in the direct deposit service, you will receive checks for reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.

Benefits Card

The Benefits Card provides direct access to your flexible spending account (FSA), allowing you to pay for eligible health care expenses at qualified locations where Visa™ is accepted. When you use your Benefits Card, you no longer have to pay for eligible expenses out of your pocket and wait for reimbursement. The money is deducted directly from your FSA account at the time of purchase. You may need to submit supporting documentation for certain purchases.

When using your Benefits Card at pharmacies, simply swipe your card first and choose "Credit" if asked. The card is a smart card that will only pay for IRS-eligible FSA purchases. The store clerk will ask you for another form of payment to pay for your other purchases. You then pay for the non-FSA-eligible items with another card, cash or check. Your IRS-eligible purchases are automatically approved and paid directly from your FSA account. That's it — no claim forms to submit!

When paying for services provided by a medical, dental or vision provider, the Benefits Card can automatically approve services that match a set copay or a multiple of that copay (not a percentage coinsurance) from your group health plan(s). Supporting documentation for these services is not needed. If the provider's charge is not a copay, you can still use the Benefits Card and benefit from having the expense directly deducted from your account. For expenses that do not match the copay, you will need to submit supporting documentation. In some situations, your card will automatically be approved even if it is an ineligible expense. This most often happens when paying for services incurred in a prior plan year or for services where you coincidentally owe a multiple of the copayment. It is your responsibility to use your Benefits Card only for eligible expenses.

Autopay

Autopay is an option for you to be automatically reimbursed for your eligible out-of-pocket medical, dental and prescription expenses processed by Moda Health without having to submit claim forms or supporting documentation. When Moda Health receives a timely claim from your provider, we will process and pay the claim according to your plan benefits. Moda Health will send you an explanation of benefits (EOB), then send the information to BenefitHelp Solutions for automatic reimbursement of eligible out-of-pocket expenses. The amount shown on the EOB under Patient Responsibility is the amount you will automatically receive — up to your annual HRA amount. Orthodontia and IRS-ineligible expenses, such as cosmetic procedures, are excluded from autopay. Unfortunately, you will not be able to use autopay if you have more than one insurance plan with Moda Health.

Terms and Conditions

By signing this application:

1. **Acceptable plan terms.** You agree to abide by the terms, conditions and provisions of the plan contained in your employer's plan documents. These documents are available to you through your human resources or benefits department.
2. **Responsibility.** You acknowledge that the Internal Revenue Code (IRC) permits claim reimbursement only for eligible expenses incurred after the effective date and prior to the termination date of your HRA account. You assume full responsibility for all taxes, penalties, interest or other consequences that may be assessed to you by any state, federal or other governmental taxing authority as a result of receiving reimbursement for a disallowed expense. You will only use your account to pay for eligible expenses incurred by yourself and/or your tax dependents. You understand that BenefitHelp Solutions, its agents or employees, will not be held liable if you submit ineligible expenses for reimbursement. Expenses cannot be reimbursed by any other plan. If requested, you agree to provide appropriate supporting documentation within the requested time frame. You understand that you cannot change or revoke an election until open enrollment or during an applicable change in status.
3. **Plan modification.** You have been informed that the plan offered by your employer may be modified from time to time, and you agree that your employer may cancel or amend your plan according to the employer's independent judgment and discretion without your consent or prior notice.
4. **Forfeiture.** You understand that you must claim reimbursement for eligible expenses incurred during the plan year for which you were an active participant within the run-out period of the plan year (and grace period if applicable), as stated in your Summary Plan Document. If any unused amounts remain in your account(s) after any applicable carryover, these amounts will be forfeited.
5. **Benefits Card.** If it is determined that the Benefits Card paid for an ineligible expense, you will either refund your account the amount of the ineligible expense or offset the ineligible expense with an eligible expense. If you fail to do so, the ineligible amounts may be included as taxable income at the end of the year. You understand that if you do not provide supporting documentation as required, your Benefits Card may be deactivated until your account is settled.
6. **HSA contributions.** You understand that if you, your spouse or your children participate in an HSA plan, HSA contributions may be disallowed if any HSA participants also participate in the HRA account.
7. **Autopay.** Only you and your eligible dependents are covered under Moda Health for your health insurance, and you do not have a non-tax dependent domestic partner enrolled on your health insurance.