HRA Employee Eligibility Form

Employer Name:				Division:
Employee Name:				☐ Male ☐ Female
Date of Birth:		Social Security #:		
Street:		City:	State:	Zip:
Date of Hire:	HRA Eligibility Date:	Termination/Benefit End Date:		

Benefit Information

HRA Benefit Amount		☐ **I decline HRA benefit coverage.**
Type of Coverage:	☐ Employee Only	☐ Employee + Child(ren)
	☐ Family	☐ Employee + Spouse

Dependents Covered by HRA

First Name	Last Name	Social Security #	Date of Birth	Relationship to Employee

Medicare Eligibility

Is the employee or any dependent enrolled in Medicare? ☐ Yes ☐ No

Medicare Participant Name	Medicare Health Insurance Claim Number (HICN)	Effective Date Eligibility/Entitlement Part A	Effective Date Eligibility/Entitlement Part B	Effective Date Eligibility/Entitlement Part D

Employee Signature ______________________ **Date** ______________________

Revised December 2016

www.flexbank.net ***Phone: 937.299.5515*** *~ Free Phone: 888.677.8373 ~ Fax: 937.299.7992*
1250 W. Dorothy Lane, Suite 107, Dayton OH 45409

SAVE A TRIP TO THE BANK!

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION

New Enrollment ☐ Change ☐ Revoke Authorization ☐

Employer Name: ______________________________

Employee Name: ______________________________

Last 4 Digits of Employee SS#: ______________________________

Internet E-Mail Address*: ______________________________
E-mail address required to elect direct deposit (print clearly).

Daytime Phone Number: ______________________________

Once your claim has been processed, you should receive a confirmation email. This email will state the amount of your reimbursement and when the funds should be in your account. **It generally takes two business days from the day your reimbursement is processed for the funds to appear in your account.** If the bank rejects a direct deposit due to the account being closed (or incorrect information given to FlexBank), a FlexBank representative will contact you to obtain the new account information.

PLEASE ATTACH VOIDED CHECK HERE
If you do not have a voided check available, please clearly PRINT the following information:

Bank Name: ______________________________

9 Digit Routing Number: ______________________________
Please obtain the routing number from your check stock or from your bank. Do not use the routing number listed on your deposit slips.

Account Number: ______________________________

Please check type of account: Checking ☐ Savings ☐

I understand it is my responsibility to notify FlexBank, Inc. if I close the account or choose to no longer receive reimbursements via direct deposit. I further understand that I must submit a new authorization form in a timely manner should I change bank accounts. Bank fees incurred due to participant error will be the responsibility of the participant. FlexBank, Inc. reserves the right to remove funds from the employee's designated account in the event of a processing error.

I hereby authorize FlexBank, Inc. to credit/debit my personal bank account electronically with reimbursements from my account.

Employee Signature: ______________________________ Date ________________

How to submit this form:

via Mail: FlexBank Administrators, 1250 W. Dorothy Lane, Suite 107, Dayton OH 45409
via Fax: 937.299.7992 or 888.677.9373
via Email: Claims@FlexBank.net

Kettering City Schools
Tax-Free Health Reimbursement Account

HRA Plan Design Effective January 1, 2018
Coverage Period Calendar Year

If you are covered by your employer's group health insurance plan, and are ineligible to contribute to an HSA you will receive a benefit known as a Health Reimbursement Arrangement (HRA).

HRA Benefit

Single: If you have single coverage, your HRA will reimburse you for the first $750 (classified employee) or $1,000 (certified employee) of expenses applied toward your in- and/or out-of-network medical deductible.

Family: If you have family coverage, your HRA will reimburse you for the first $1,500 (classified employee) or $2,000 (certified employee) of expenses applied toward your in- and/or out-of-network medical deductible.

One person in the family or a combination of family members may use the $1,500 (classified employee) or $2,000 (certified employee) HRA benefit.

* As long as you complete WellVibe prior to 12/31 of the prior year, you will receive an extra benefit of $950 single or $1,900 family (classified employee) or $500 single or $1,000 family (certified employee) in February. If you are hired after 9/30 of the prior year, you will have an extra 3 months to complete WellVibe. Funds will be given to you in May.

FlexBank Administrators
1250 W. Dorothy Lane, Suite 107
Dayton, Ohio 45409
Phone: 937.299.5515 ~ 888.677.8373
Claims@FlexBank.net
www.flexbank.net

HRA FAQs

How do I get reimbursed?
Prescription Drug Expenses: Use your Rx debit card at the pharmacy counter. If the debit card does not work or you don't have it with you, simply submit to FlexBank the itemized Rx tag given to you at the point of service along with a claim form for reimbursement.

All Other Types of Expenses (doctor office visit, outpatient surgery): When you incur a deductible expense, you will give your insurance card to the provider and they will bill the insurance company. Typically, you will not need to pay at the time of service. Ideally, you should wait to pay the expense until you receive your Explanation of Benefits (EOB) from your insurance company and your bill from the provider. The EOB will tell you how much you owe.

It's easy to get reimbursed from FlexBank. FlexBank reimburses *DAILY!* You should submit a claim form + the EOB to FlexBank by mail, fax, scan/email or take a picture of the forms with your smart phone. You should use the HRA reimbursement money to pay your medical provider.

Do I have to submit all requests for reimbursement before the end of the plan year?
No. You have up to 90 days after the end of the plan year to make requests for reimbursement. Any unused HRA benefit is forfeited after the 90 day run-out period.

Who is eligible for HRA reimbursement?
You may request reimbursement for eligible expenses for your spouse and eligible dependents covered by your employer's group health plan. Your children covered by your group health plan are eligible for reimbursement from the HRA through age 26 even if they are not considered your tax dependent.

What happens if I terminate employment?
Your HRA coverage is considered to be integrated with your group health plan. If you terminate coverage under the group health plan or otherwise fail to meet the eligibility conditions set forth under the Plan; your participation in the HRA will cease and any unused amounts are forfeited. You have ninety (90) days after the end of the plan year to submit claims to FlexBank for the dates service incurred while you were eligible under the HRA.

What happens if I am laid-off or take an unpaid leave of absence?
Participation in the Plan continues until you officially terminate employment or you are no longer covered under the group medical plan. Generally, HRAs are subject to COBRA continuation. See your benefits administrator for more information.

Please refer to the HRA Summary Plan Description (SPD) for complete plan design details.
You have the option of waiving your HRA benefit each Plan Year. See your Benefits Administrator if you would like to decline coverage.

☐ I will pick up my check - **BRING ID**

HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIM FORM

EMPLOYEE NAME	LAST 4 DIGITS OF EMPLOYEE SOCIAL SECURITY #	EMPLOYER NAME
PLEASE CHECK IF NEW ADDRESS ☐	DAYTIME PHONE #	YOUR EMAIL

HOME ADDRESS	CITY	STATE	ZIP

PLEASE SIGN BELOW

To the best of my knowledge and belief, my statements in this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants covered by my employer's group health plan. I certify that these expenses have not been previously reimbursed under this plan, an HSA, or any other benefit plan and will not be claimed as an income tax deduction, nor will I seek reimbursement from any other source.

Furthermore, the following person has authorization to speak with FlexBank on my behalf regarding the information contained in this claim:

Name______________________

Employee's Signature __________________________________ Date ____________________

Instructions for Submission of Claim Requests

1) Complete the information requested above.

2) Sign and date this form.

3) Attach a copy of the Explanation of Benefits (EOB) report from your medical insurance company.

4) For prescriptions, attach the receipt that includes patient name, medication name, date and amount owed.

5) Mail, fax or scan/email this form and your receipts.

Total Pages Sent ____________

Total Reimbursement Expected ____________

How to submit claims

- ✓ **via Mail: FlexBank Administrators, 1250 W. Dorothy Lane, Suite 107, Dayton OH 45409**
- ✓ **via Fax: 937.299.7992 or 888.677.9373**
- ✓ **via Email: Claims@FlexBank.net**
- ✓ **via Mobile: http://www.flexbank.net/m/**

Questions? Call us 888.677.8373 or visit our website www.flexbank.net.

Revised April 2016

Kettering City School District:Health Reimbursement Arrangement **Effective Date: * January 1, 2018**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: *January 1st through December 31st**

Plan Type: HRA

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage contact your plan administrator, 937-499-1409 For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.dol.gov/ebsa/pdf/SBC-Uniform-Glossary-final.pdf or call 1-877-264-2323 x 61565 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/ Single; $0/family	*If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Is there an overall annual limit on what this plan pays?	Yes, this year the plan will reimburse medical expenses up to *$1,700/single (classified) or $1,500/single(certified) or $3,400/family (classified) or $3,000/family (certified). This plan will reimburse you for *In and/or Out of Network medical expenses.	This amount may vary each year. This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You will be responsible for all expenses outside of the limits. This plan will reimburse you expenses as described in the "answers" column to the left.
Are there services covered before you meet your deductible?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
Are there other deductibles for specific services?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
What is the out-of-pocket limit for this plan?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
What is not included in the out-of-pocket limit?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
Will you pay less if you use a network provider?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
Do you need a referral to see a specialist?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.

All copayment and coinsurance costs shown in this chart may be after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable.	Not Applicable.	Only expenses reimbursable under the conditions of the Health Reimbursement Arrangement (HRA) will be covered up to the available HRA benefit balance.
	Specialist visit	Not Applicable.	Not Applicable.	
	Preventive care/screening/ immunization	Not Applicable.	Not Applicable.	
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable.	Not Applicable.	
	Imaging (CT/PET scans, MRIs)	Not Applicable.	Not Applicable.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs (Tier 1)	Not Applicable.	Not Applicable.	
	Preferred brand drugs (Tier 2)	Not Applicable.	Not Applicable.	
	Non-preferred brand drugs (Tier 3)	Not Applicable.	Not Applicable.	
	Specialty drugs (Tier 4)	Not Applicable.	Not Applicable.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable.	Not Applicable.	
	Physician/surgeon fees	Not Applicable.	Not Applicable.	
If you need immediate medical attention	Emergency room care	Not Applicable.	Not Applicable.	
	Emergency medical transportation	Not Applicable.	Not Applicable.	
	Urgent care	Not Applicable.	Not Applicable.	
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	Not Applicable.	Not Applicable.	
If you need mental	Outpatient services	Not Applicable.	Not Applicable.	

health, behavioral health, or substance	Inpatient services	Not Applicable.	Not Applicable.	
If you are pregnant	Office visits	Not Applicable.	Not Applicable.	
	Childbirth/delivery professional services	Not Applicable.	Not Applicable.	
	Childbirth/delivery facility services	Not Applicable.	Not Applicable.	
If you need help recovering or have other special health needs	Home health care	Not Applicable.	Not Applicable.	
	Rehabilitation services	Not Applicable.	Not Applicable.	Only expenses reimbursable under the conditions of the Health Reimbursement Arrangement (HRA) will be covered up to the available HRA benefit balance.
	Habilitation services	Not Applicable.	Not Applicable.	
	Skilled nursing care	Not Applicable.	Not Applicable.	
	Durable medical equipment	Not Applicable.	Not Applicable.	
	Hospice services	Not Applicable.	Not Applicable.	
If your child needs dental or eye care	Children's eye exam	Not Applicable.	Not Applicable.	
	Children's glasses	Not Applicable.	Not Applicable.	
	Children's dental check-up	Not Applicable.	Not Applicable.	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
• Cosmetic Surgery

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
Refer to your Heath Reimbursement Arrangement (HRA) summary plan description (SPD).

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877 267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 937-499-1409.

Does this plan provide Minimum Essential Coverage? *The HRA alone does not provide Minimum Essential Coverage.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? *The HRA alone does not meet Minimum Value Standards.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 937-499-1409
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 937-499-1409
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 937-499-1409
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 937-499-1409