Optima Health

Optima Rewards H.I.P.

New Group Submission Form

Administered by

CHOICE STRATEGIES

Please complete the form with the requested information. To save a copy of the form to complete and submit later, select **File** > **Save as** > in the desired location. Then click **Submit** on the last page of this from when ready to submit to Optima Health for set-up of your group.

EMPLOYER'S INFORMATION

1. Employer's Legal Name Group #(s)

Address
Street or PO Box *City* *State* *Zip*

Mailing Address
If Different *Street or PO Box* *City* *State* *Zip*

Phone Fax Federal Tax ID Number

Primary Contact Title

Ext# Email

Secondary Contact Title

Ext # Email

2. What is the HIP Funding Period? **Start Date**: **End Date**:
(Must match deductible end date if applicable)

3. Number of employees eligible to participate in the Optima Rewards HIP?

AGENT INFORMATION

4. Broker Name Agency Name

Address
Street or PO Box *City* *State* *Zip*

Mailing Address
If Different *Street or PO Box* *City* *State* *Zip*

Phone Fax Federal Tax ID Number

Email

OPTIMA SALES REP INFORMATION

5. Name Phone Email Fax

6. The employer is *(check only one)*

Sole-proprietorship	LLC
Partnership	PC
S Corp	Non-Profit
C Corp	

7. What is the enrollee waiting period for The Optima Design HIP funds *(check only one)?*

One Month	30 Days
Two Months	60 Days
Three Months	90 Days

Other *(Please explain – no more than 255 characters)*

8. When will The Optima H.I.P. be effective for new enrollees?

Immediately after waiting period *(100 + eligibles only)*

First of month after waiting period

Other *(Please explain – no more than 255 characters)*

9. Upon an enrollee's termination when does the HIP coverage end?

On the date of termination *(100 + eligibles only)*

End of the month after termination

Other *(Please explain – no more than 255 characters)*

10. Eligible classes of employees covered *(check all that apply):*

Full-time Active minimum hours per week worked

Part-time Active minimum hours per week worked

Retired Employees *(100 + eligibles only)*

Other *(Please explain – no more than 255 characters)*

11. Does the employer have, or at any time had, an ERISA qualified plan that required an IRS 5500 form *(i.e. self-funded health care plan, retirement plan or flexible benefit plan)?*

Yes No

If YES, what is the last 500 series (501, 502, etc.) number that was used?

12. What is your company's fiscal year end date?

13. Who is your COBRA administrator?

Adress:

Street or PO Box *City* *State* *Zip*

NOTE: Cobra eligibility regulations apply to both the HRA benefit and to the health plan benefit coverage. Enrollees can elect Cobra HRA continuation and/or Optima Design health plan continuation. HRA Cobra enrollees pay a separate fee for HRA continuation.

14. Optima Medical Plan selected?

Optima Vantage

Association Plan? Yes No

Benefit Plan: Start Date *(mm-dd-yyyy)* End Date *(mm-dd-yyyy)*

- ☐ 10/10
- ☐ 10/20 Large
- ☐ 10/20 Small
- ☐ 10/25
- ☐ 15/35
- ☐ 15/35 No Rx
- ☐ 20/40
- ☐ 25/50
- ☐ 15/80%
- ☐ 20/80%
- ☐ 25/70%
- ☐ 500/15/80%
- ☐ 500/20/80%
- ☐ 1000/20/80%
- ☐ 1500/20/80%
- ☐ 1000/25/70%
- ☐ 2000/25/70%

Other (Large Group Only - ex: xxxx/xxxP)

Optima Plus

Association Plan? Yes No

Benefit Plan: Start Date *(mm-dd-yyyy)* End Date *(mm-dd-yyyy)*

- ☐ 15/90%
- ☐ 10/90%
- ☐ 15/80%
- ☐ 20/80%
- ☐ 500/25/80%
- ☐ 750/25/80%
- ☐ 1000/25/80%
- ☐ 1500/25/80%
- ☐ 1750/30/70%

Other (Large Group Only - ex: xxxx/xxxP)

Optima Mandated POS
(offered with Vantage plans only)

Association Plan? Yes No

Benefit Plan: Start Date End Date

(mm-dd-yyyy) *(mm-dd-yyyy)*

- [ ] 10/10
- [ ] 10/20 Large
- [ ] 10/20 Small
- [ ] 10/25
- [ ] 15/35
- [ ] 15/35 No Rx
- [ ] 20/40
- [ ] 25/50
- [ ] 15/80%
- [ ] 20/80%
- [ ] 25/70%
- [ ] 500/15/80%
- [ ] 500/20/80%
- [ ] 1000/20/80%
- [ ] 1500/20/80%
- [ ] 1000/25/70%
- [ ] 2000/25/70%

Other (Large Group Only - ex: xxxx/xxxP)

NOTE: A standard 90 day run-out period applies after the plan end date for HIP continued funding for eligible expenses incurred while enrollees were active under plan.

REPORTS

15. Please indicate how often you would like us to generate and email the following reports:

Bank Transaction Reconciliation *(list of applicable card transactions)*

Weekly Monthly

Claim Reimbursement (*list of reimbursements from HRA funds)*

Weekly Monthly

Enrollee Account Balance *(account balances of all enrollees which indicates start balance, used YTD, and available balance)*

Weekly Monthly

Please provide the email address(es) that these reports should be sent to:

Email Address #1 Email Address #2

Note: The following reports are required to reconcile your bank statement for HRA disbursement transactions:

1. Bank Transaction Reconciliation
2. Claim Reimbursement
3. Refund Report (*this will be mailed as refunds are processed for employees)*

16. Eligible Expenses

1. ☐ Medical and Rx expenses covered by the Plan
2. ☐ 1 above, and all other IRS eligible expenses i.e., dental and vision expenses

17. Optima Rewards

Health Incentive Program (HIP) Structure and Funding: The following activities ***must*** be completed through the Healthy Roads web sit accessed through optimahealth.com for credit or by calling Healthy Roads at 1-877-330-2746.

Employer Funded Pay Out
All must be funded with a minimum on each item, $250 total.

	Complete funding amount
1. Completion of a Personal Health Assessment *(on-line)* (*minimum $100 required*)	$
2. Completion of a Exercise Tracker *(on-line)* (*minimum $50 required*)	$
3. Completion of a Nutrition Tracker *(on-line)* (*minimum $100 required*)	$
4. Completion of a "Kick Off" call with Health Coach *(phone)* Only employees categorized as moderate or high risk will be eligible. (*minimum $50 required*)	$
	Total: $

19. SUBSTANTIATION

The IRS stipulates that the plan sponsor (employer) ensure that HRA plans are properly substantiated. In other words, purchases made using HIP funds must be proven to be eligible under the plan. Choice Care substantiates purchases via claim feeds from Optima Health.

Optima Health will provide periodic claim feeds to Choice Care for all eligible transactions for HIP reimbursement. In most co-share plans, manual submission plans and direct provider pay plans this data feed will complete the substantiation process. The Optima Health data feed will also be used in the case of card based HRA transactions.

1. Employees are instructed to keep all receipts for qualified expenses that are reimbursed with HRA funds whether they are auto-paid to a provider or if the Choice Care Card is used.
2. If applicable, co-pay matching, data feed and recurring expense match will be activated in the system.
3. Receipt requests may be generated for all other purchases.

NOTE: If additional information is needed, receipt request notifications will be sent to enrollees via Email or Mail. Employees are requested to provide an email address on the enrollment application to receive plan information.

Employer ACH Authorization Release

(Employer Name) HEREBY authorizes

The Choice Care Card, or mbi (known as "MBI MBI-I-BANK"), to initiate ACH (automated clearing house) transfer entries for the following depository:

Financial Institution Name

Address
Street *City* *State* *Zip*

Routing and Transit Number Bank Account Number

Type of Account *(Please check one)* Checking Account Saving Account

Information Provided by

Title Today's Date

Please Note: This account must have overdraft protection. If it does not currently have overdraft protection, please add it prior to the effective date of the plan. If overdraft protection is not added to the bank account and a transaction is returned to The Choice Care Card, a $35 Non Sufficient Fund (NSF) fee will be assessed.

To confirm the account information provided, the Card processor will submit a non-refundable $1.00 pre-note debit to the above mentioned account. A minimum of $1.00 must be deposited immediately to avoid a NSF $35 fee from the card processor and will be the employer's responsibility.

All card transactions (POS), manual claim payments will be deducted via ACH directly from this account.

The banking process is as follows:

Debit Card Transactions (POS)

- Card swipes are settled within 1-3 business days after the card is used.
- Funds are withdrawn from the bank account listed above for all transactions settled on that date.
- "Zero balance email" is sent to administrative contact listed on the New Group Submission Form. This email informs the employer of the funds being withdrawn from the account above.
- These transactions appear on your statement as MBI MBI-I-BANK.

Manual Claims

- Manual claims are processed daily.
- Funds are withdrawn from employer's bank account within 2-3 business days.
- These transactions appear on your statement as The Choice Care Card.

Send to:

76 McNeil Rd. / 2nd Floor / Waterbury Center, VT 05677 / Phone: 1-888-278-2555 / Fax: 1-802-244-2020

ACH Filter Information for Your Group's Plan with The Choice Care Card

If your bank has filters or ACH blocks in place for your account please provide them with the below information authorizing The Choice Care Card and our MasterCard vendor, "MBI", to initiate ACH transactions to the account.

Choice Care Card Filter Information (for Fees and Manual Claims)

Submitting Bank (ODFI): People's United Bank

Company Name (Account Name): Choice Care Card and Choice Care Claim

Routing Number: 221172186

Origination ID: 022117218

Company ID: 0542075442 and C542075442

M&I Bank Filter Information for MBI (for Card Transactions)

Submitting Bank (ODFI): M & I Bank

Company Name (Account Name): MBI

Routing Number: 075000051

Origination ID: 07500005

Company ID: 1383261866 and W383261866

Acknowledgement Signature Page for HIP Benefit and ACH Authorization

- A dedicated bank account should be established for HIP funds administered by The Choice Care Card, LLC. ACH transfers will be made from this account to fund the HIP expenses and applicable Choice Care debit cards.

- This account must have overdraft protection. If it does not currently have overdraft protection, please add prior to the effective date of the HIP administered by The Choice Care Card, LLC. If overdraft protection is not added to the bank account and a transaction is returned to The Choice Care Card, LLC a $35.00 fee will be assessed.

- The installation process will not begin until the completed ACH Authorization page is returned to The Choice Care Card (Choice Care) installation department.

- The installation process will not be completed until the health insurance schedule of benefits is received by Choice Care.

- The HIP is subject to COBRA & HIPAA regulations. If the employer has 20 or more employees, the funds will be subject to COBRA regulations. If the employer has fewer than 20 employees COBRA will not apply. Any claims incurred after the employee termination date will not be eligible for reimbursement from HIP. (Individual statemandates may apply for groups with fewer than 20 employees.)

- It is understood that if the company terminates an employee it is the company's responsibility to notify Optima Health immediately. If the company fails to notify Optima Health of an employee termination it is the company's responsibility for any charges incurred after the termination date.

- The HIP funds can not be separated by line item. For example, if any physician services are made available for payment with the HIP funds, then all physician services must be made available for payment from the HIP.

- The employer may deduct invalid purchases from employee's paychecks.

- Employees who have terminated from the plan will have their transactions automatically resolved within 12 months.

- Federal regulation mandates that most transactions will require receipt verification. Employees must be instructed to save all receipts for services reimbursed with HRA funds. Choice Care may request receipts via mail or email from employees in order to further substantiate claims.

- Employees will be instructed to call the Choice Care member service department with any questions regarding HRA funds.

- I authorize Optima Health or TPA of this employer to release data on behalf of the employees in order to substantiate purchases made using HIP funds.

- I authorize Optima Health and the broker/consultant indicated above to be given read-only access to our company reports and administrative guide. I understand that the read-only password assigned to our company will be released to them by Choice Care.

Employer Acknowledgement

Please print this acknowledgment signature page to be faxed or scanned and submit to your Optima sales executive to complete the installation process.

I acknowledge having read and do understand the above details relative to The Choice Care Card, LLC administrative services and applicable operation of the Choice Care debit card. All my questions relating to Choice Care HRA administrative services have been answered completely and satisfactorily by my broker/consultant.

Date **I Agree** **I Do Not Agree**

Employer Signature

NOTE: Submitted forms and attachments are routed to your Optima Sales Executive