Optima Rewards HIP
Group Change or Renewal Form

Administered By

Please fill out changes only. **Blank fields will assume continuation of the current terms.** Once the change is complete, a Summary of Material Modification (SMM) and an amendment document will be produced. The amendment must be signed by the employer and the SMM must be distributed to HIP participants within 60 days of the change.

Effective Date of Change _____ *(example: mm\dd\yyyy)*

1. EMPLOYER'S INFORMATION

Employer's Legal Name _____ Optima Health Current Group #(s) _____

Optima Health New Group #(s) if applicable _____

Optima Health Group #(s) to be termed (if applicable) _____

Contact _____ Email _____

(Person Choice Strategies should contact with questions regarding these changes.)

2. What is the HIP funding period? Start Date _____ *(mm/dd/yyyy)*
End Date _____ *(must match deductible end date)*

3. What is the enrollee waiting period for the Optima Rewards HIP *(check only one)*

- ○ One month
- ○ Two months
- ○ Three months
- ○ 30 Days
- ○ 60 Days
- ○ 90 Days

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

4. When will the Optima Rewards HIP 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)*

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

- ○ On the date of termination (100 + eligibles only)
- ○ End of the month after termination

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

Note: *A standard 90 day run-out period applies for continued HIP funding for eligible expenses incurred while enrollee was active under plan.*

6. 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)*

7. COBRA ADMINISTRATOR

Company Name _____ Company Contact _____

Address _____ _____ _____ _____
Street Address *City* *State* *Zip*

Phone _____ Ext _____ Fax _____ Email _____

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

8. Optima Health Medical Plan(s) selected?

Optima Vantage Association Plan? ◯ Yes ◯ No

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

Plan Name: _____

Optima Plus Association Plan? ◯ Yes ◯ No

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

Plan Name: _____

Optima POS/Mandated POS *(Mandated POS offered with Vantage plans only)*

Association Plan? ◯ Yes ◯ No

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

Plan Name: _____

***Note:** *A standard 90 day run-out period applies after the plan end date for continued HIP funding for eligible expenses incurred while enrollee was active under plan.*

9. Eligible Expenses
   - ◯ 1. Medical and Rx expenses covered by the plan
   - ◯ 2. Medical and RX expenses covered by the plan, and all other IRS expenses (i.e., dental and vision expenses)

10. **Health Incentive Program (HIP) Structure and Funding:** The following activities ***must*** be completed through the WebMD website accessed through optimahealth.com for credit.

Employer Funded Pay Out

All must be funded with a minimum on each item, $200 total.
This $200 will meet the minimum funding requirement for the HRA. Total HRA funding must not exceed plan deductible minus $200.

1.	Personal Health Assessment (PHA)	◯ $100	◯ $200	◯ $250
2.	Exercise Digital Health Assistant (DHA)	◯ $ 50	◯ $100	◯ $150
3.	Nutrition Digital Health Assistant (DHA)	◯ $ 50	◯ $100	◯ $150

11. Bank account changes (if applicable): Please complete the following ACH Form to provide changes.

11a. BROKER CHANGE

Broker Name _____ Agency Name _____

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

Phone _____ Ext _____ Fax _____ Email _____

11b. OPTIMA HEALTH CONTACT CHANGE

Optima Health Rep _____

Phone _____ Ext _____ Fax _____ Email _____

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:

P.O. Box 2205 / South Burlington, VT 05407 / 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 Authorization for changes:

Please print this signature page and fax or scan and submit to your Optima Health Sales Executive.

Print Name _____ Date _____

Signature _____ Group Name _____

Attach Scanned Signed Authorization

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

Print Form Submit Form