

Episcopal Diocese of Iowa 2011 Health Insurance and Health Reimbursement Account (HRA) Employer Responsibilities

2011 COST of the clergy/employee health insurance package:

- Single: \$9,822/year (\$8,844 Insurance; \$588 HRA contribution; \$390 Dental Insurance)
- Family: \$21,837/year (\$20,364 Insurance; \$1,083 HRA contribution; \$390 Dental Insurance)

2011 Health Insurance:

Coverage included in insurance through the Episcopal Church Medical Trust:

- Health coverage – *Empire BlueCross Blue Shield PPO 75/50 Plan*
- Prescription Drug coverage – *Medco Health*
- Employee Assistance Program (EAP) – *Cigna Behavioral Health*
- Mental Health coverage – *Cigna Behavioral Health*
- Assistance with Healthcare and Insurance-related problems – *Health Advocate*
- Vision coverage – *EyeMed*

Third Party Administrator:

- Health Reimbursement Account (HRA) - *Kabel Business Services*

Dental Coverage:

- Dental Insurance – *Delta Dental of Iowa*

What is an HRA?

It is an employer-funded account administered by a third-party administrator (Kabel Business Services) to help offset increased out-of-pocket medical costs to clergy and lay employees. In order to minimize the increasing cost of insurance benefits the Diocese of Iowa has selected a higher deductible insurance plan with a significantly lower premium. The employer savings in premium costs will be used to fund the HRA.

How It Works:

1. Employer pays employee(s) health insurance premium monthly to The Medical Trust.
2. Employer contributes a monthly HRA payment to the Diocese of Iowa of that will be held in a HRA Fund.
3. Kabel Business Services will reimburse employees up to \$1,800/single or \$3,600/family for HRA-qualified medical expenses.
4. The Diocese of Iowa pays Kabel Business Services for administration fees and employee reimbursements from the HRA Fund.
5. Money remaining in the HRA Fund at the end of the year may be rolled over to the next year.

2011 HEALTH INSURANCE, HRA, AND DENTAL COSTS

	Single	Family	
Empire BlueCross BlueShield PPO 75/50 Plan	\$ 737.00	\$ 1,697.00	monthly premium paid to The Medical Trust
Employer Contribution for Health Reimbursement Account (HRA)	49.00	90.25	monthly premium paid to Diocese of Iowa
Employer Contribution for Dental Insurance	32.50	32.50*	monthly premium paid to Diocese of Iowa
	\$ 818.50	\$ 1,819.75	

*single dental coverage is required for all eligible employees; family dental may be purchased (contact the diocesan office)

HOW THE HRA WORKS

For office visits and prescriptions: You pay a copay (HRA does not apply)

For other medical services that apply to deductible and have co-insurance, HRA reimburses up to \$1,800/\$3,600:

1. Provide your insurance card to medical provider
2. Medical provider submits claim to BCBS
3. BCBS sends you an Explanation of Benefits (EOB) telling you what you owe the provider
4. You pay first \$100 of deductible expenses
5. Send HRA reimbursement form with a copy of your EOB to Kabel Business Services
5. Kabel Business Services reimburses you per the agreed schedule
6. You pay your provider the balance due

EXAMPLE

Single or 1st family member with \$11,700 in medical expenses

Employee Deductible of \$900 – Employee will pay \$100; HRA reimburses \$800

Employee Coinsurance of 25% or \$2,700 – Employee will pay \$1,700; HRA will reimburse \$1,000

	<u>Deductible</u>	<u>Coinsurance</u>
Insurance	\$0	\$8,100
Employee	\$100	\$1,700
HRA	\$800	\$1,000

HRA

Reimbursement Claim Form

Kabel Business Services
 1454 30th Street, Suite 202, West Des Moines, IA 50266
 Fax 515-224-9256 Phone 1-800-300-9691
 For Account Inquiries Visit our web site at
 www.kabelbiz.com

Employer: Episcopal Diocese of Iowa	
Employee Name:	Social Security Number:
<input type="checkbox"/> New Address:	Phone:

HRA Deductible/Co-insurance Expense Claims

I have single coverage under the group health plan with a \$900.00 deductible and \$3,600.00 out-of-pocket maximum

I understand that I cannot submit claims to this account until I have paid the first \$100.00 of my deductible expenses. For the next \$8,000.00 of claims, I will need to pay my coinsurance at 10% rate and my employer will fund the difference between the amount owed to the provider and my portion of the co-insurance. For the next \$3,600.00 of claims, I will be responsible for my co-insurance at a rate of 25%. (My maximum out-of-pocket expense will not exceed \$1,800.00)

I have family coverage under the group health plan with a \$1,800.00 deductible and \$7,200.00 out-of-pocket maximum

I understand that I cannot submit claims to this account until I have paid the first \$100.00 of my deductible on one family member or \$200.00 for my family in total. For the next \$8,000 of claims for one person or \$16,000.00 for my family, I will need to pay my coinsurance at a 10% rate and my employer will fund the difference between the amount owed to the provider and my portion of the co-insurance. For the next \$3,600.00 worth of claims for one family member or \$7,200.00 for my family, I will be responsible for my co-insurance at a rate of 25%. (My maximum out-of-pocket expense will not exceed \$3,600.00.)

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount Incurred
<input type="checkbox"/> <i>Attach a statement of benefits from your insurance provider that shows the deductible/co-insurance expenses claimed.</i>				
			Total HRA Deductible/Co-insurance Expense Claim*	\$

I will attach an explanation of benefits showing the amount of the deductible fulfilled with my HRA Deductible Expense Claim. I will attach an explanation of benefits showing the amount of co-insurance fulfilled with my Co-Insurance Claim. I will only request payment of funds not previously requested.

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Health Reimbursement Arrangement Plan with respect to such expenses and that the medical expenses have not been reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee Signature

Date
