

Consumer Advantage

HRA Group Setup Document

1. Corporate Group Name <i>Legal name of entity</i>	
2. Corporate Number for Existing Groups <i>New groups to be assigned by UPMC Health Plan</i>	
3. MC400 Group Number <i>Group number as assigned in MC400</i>	
4. Sales Representative <i>Person who sold Consumer Advantage</i>	
5. Account Service Manager <i>Person responsible for implementation of account</i>	
6. Plan Effective Date <i>Contract start date</i>	
7. Number of Employees <i>Number of eligible employees</i>	
8. Federal Tax ID <i>ID that account uses to file federal taxes Please enter in XX-XXXXXXX format</i>	
9. Payroll Group Contact Information <i>Group contact responsible for funding the HRA. When email address is provided, UPMC Health Plan will send the bill each Tuesday.</i>	Name: _____ Title: _____ Phone: _____ Fax: _____ E-mail: _____
10. Subgroup Contact Information <i>Group contact for each of the subgroups. If there is more than one subgroup, please attach a separate sheet outlining the organization of the subgroups and the associated contact.</i>	Name: _____ Title: _____ Phone: _____ Fax: _____ E-mail: _____
11. HRA Plan Information <i>Indicate which standard plan is being offered. If a benefit non-standard plan is being offered, please attach a copy of that grid.</i>	HRA Plan: _____ HRA Nonstandard plan: _____ (Attach benefit grid)
12. Covered Services <i>Defines whether HRA funding can be used for plan eligible expenses only or expanded to 213 D expenses such as dental and vision (similar to what FSA funds can be used for; 213 D refers to tax code in which these expenses were defined). Only ASO customers have the option to</i>	<input checked="" type="checkbox"/> Plan Eligible only (standard option) <input type="checkbox"/> All of 213 D (for ASO groups only)

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<p>use HRA funds for 213 D expenses.</p>													
<p>13. HRA Contributions</p> <p><i>Indicates the amount the employer will be funding on an individual basis. "Family" includes any tier other than individual.</i></p>	<p>Please indicate dollar amount:</p> <p>Individual Only: \$ _____</p> <p>Family: \$ _____ (Family includes employee/spouse, employee/child, employee/children, and family)</p>												
<p>14. Ordering</p> <p><i>Describes whether HRA dollars are available on day 1, also known as the bridge (example 1), or whether the employee must first meet a deductible, and then have access to HRA funds (example 2).</i></p> <p><u>Example 1</u> <u>Example 2</u></p> <table border="0"> <tr> <td>Deductible</td> <td>\$1000</td> <td>Deductible</td> <td>\$1000</td> </tr> <tr> <td>1st - Employer Exposure</td> <td>\$500</td> <td>1st - Employee Exposure</td> <td>\$500</td> </tr> <tr> <td>2nd - Employee Exposure</td> <td>\$500</td> <td>2nd - Employer Exposure</td> <td>\$500</td> </tr> </table>	Deductible	\$1000	Deductible	\$1000	1 st - Employer Exposure	\$500	1 st - Employee Exposure	\$500	2 nd - Employee Exposure	\$500	2 nd - Employer Exposure	\$500	<p>Check one option only:</p> <p>_____ HRA Bridge pays first (Employer exposure first)</p> <p>_____ Employee pays first (Employee exposure first)</p>
Deductible	\$1000	Deductible	\$1000										
1 st - Employer Exposure	\$500	1 st - Employee Exposure	\$500										
2 nd - Employee Exposure	\$500	2 nd - Employer Exposure	\$500										
<p>15. Midyear Enrollment Proration</p> <p><i>Indicates how funds are allocated to employees who join midyear. Options are:</i></p> <ol style="list-style-type: none"> Monthly (total HRA funding is divided by 12 and then multiplied by the number of months employee is working). Quarterly (HRA funding divided by 4 and then multiplied by number of quarters employee is working) No proration - employee receives the whole allocation. Vesting refers to an arrangement in which an employer wishes to tie HRA rollover provisions to salary or length of service. 	<p>_____ Monthly</p> <p>_____ Quarterly</p> <p>_____ No proration – employee receives 100%</p>												
<p>If Employee Roll-over options are not being offered, skip questions 16-19.</p>													
<p>16. Rollover Percentage</p> <p><i>Indicates the percentage of unused HRA funds that can be rolled over at the end of the plan year. Value can be anywhere from 0 – 100%</i></p>	<p>Please indicate a percentage amount from 0-100%:</p> <p>_____ %</p>												
<p>17. Rollover Cap Provision</p> <p><i>Describes the maximum amount that may be accumulated in the HRA.</i></p> <p>Example: Some groups may want to cap rollover at the level of the deductible. On a \$1,000 plan, the rollover cap would be \$1,000.</p>	<p>Please specify a dollar amount:</p> <p>\$ _____</p>												
<p>18. Rollover Minimum</p> <p><i>Defines the minimum of amount the remaining funds to be rolled over at the end of the plan year. Rollover minimum works in conjunction with the rollover percentage, and must be defined for both individual and family plans.</i></p> <p>Example: Using a \$25 rollover minimum means that the accounts with less than a \$25 balance will not be rolled over into the next plan year.</p>	<p>Please specify amount below:</p> <p>Employee Only: \$ _____</p> <p>Family: \$ _____ (Family includes employee/spouse, employee/child, employee/children, and family)</p>												

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<p>19. Rollover Maximum</p> <p><i>Defines the maximum of amount the remaining funds to be rolled over at the end of the plan year. Rollover maximum works in conjunction with the rollover percentage, and must be defined for both individual and family plans.</i></p> <p>Example: Using a \$250 rollover maximum means that the accounts with more than a \$250 balance, only \$250 will be rolled over into the next plan year.</p>	<p>Please specify amount below:</p> <p>Employee Only: \$ _____</p> <p>Family: \$ _____</p> <p>(Family includes employee/spouse, employee/child, employee/children, and family)</p>
<p>20. Vesting Provisions</p> <p><i>To be filled out only if employer wishes to use vesting provisions by salary or length of service to allow access to HRA rollover balances. Subgroups must be used to set up vesting provisions. Vesting provisions must be described in a separate document</i></p>	<p><input checked="" type="checkbox"/> None</p> <p><input type="checkbox"/> Based upon years of service (please provide detail in separate document)</p> <p><input type="checkbox"/> Based upon salary ranges (please provide detail in separate document)</p>
<p>21. Reimbursement Period</p> <p><i>Describes number of days after the end of the plan year in which claims will be paid from the HRA. The standard option is 90 days.</i></p>	<p><input type="checkbox"/> 60 days</p> <p><input checked="" type="checkbox"/> 90 days (recommended)</p> <p><input type="checkbox"/> 120 days</p> <p><input type="checkbox"/> Other (please specify # of days) _____</p>
<p>22. COBRA HRA Balance Calculation Rule</p> <p><i>Describes how remaining HRA funds will be split in a COBRA situation in the case of a divorce. The preferred method is equal split as opposed to 100% of the balance going to the employee.</i></p>	<p><input type="checkbox"/> Balance split equally (recommended)</p> <p><input type="checkbox"/> 100% of balance to employee</p>
<p>23. Terminated Employees</p> <p><i>Indicates number of days after termination date in which claims will be paid from the HRA.</i></p>	<p><input type="checkbox"/> None <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days (recommended)</p> <p><input type="checkbox"/> 120 days <input type="checkbox"/> 1 year</p>

In addition to this document, you will need to have the group complete the ACH Direct Debit Agreement document on page 4 of this document.

Employer approval of HRA setup provisions:

Print name of authorized representative

Signature of authorized representative

Date

Please create an electronic copy of this completed form and submit to the ConsAdvImpl mail group in Microsoft Outlook.

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AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS (ACH DEBITS)

Company Name _____ Company ID Number _____

I (we) hereby authorize UPMC, herein called COMPANY, to initiate debit entries to my (our) _____ Checking Account / _____ Savings Account (select one) indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to debit the same to such account, I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of the U.S. law.

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s) _____ ID Number _____
(Please Print)

Date _____ Signature _____