

Coventry Consumer Choice (C3) Implementation Kit

This packet includes the following documents:

1. Product Selection Worksheet
2. Group Banking Setup Form
3. Sample HealthAmerica EOB
4. Sample C3 EOB

Product Selection Worksheet

This is a data gathering form to capture the HRA and/or FSA plan design and options for the employer. This form should be completed by the broker or HealthAmerica account manager. Below is detail for each section.

- **Section 1 – The HRA.** Employers may choose a Shared Deductible (employee pays first), Delayed Deductible (HRA pays first), or a Percent (%) Reimbursement package for their HRA. The deductibles listed on the grids represent the Single coverage deductible level for the health plan. To the right of the deductible amount is the available HRA plan design. Place a check mark next to the plan selected by the Employer.
- **Section 2 – HRA Family Amounts.** After the plan design is chosen in section 1, the employer can choose to fund 1x or 2x the HRA funding amount. For example, let's say the employer chose the \$1000 deductible plan where the employee pays the first \$250 and the HRA pays the next \$750. If they chose the 1x funding option, each enrolled employee would have access to \$750 of HRA funding regardless of their enrolled coverage tier. If the employer chose the 2x funding option, employees enrolled in the family coverage tiers would have access to \$1500 of HRA funding. The default is 2x Individual Amounts.
- **Section 3 – Individual Cap.** The Individual Cap option offers a choice for how the HRA funding is applied. Circle Yes or No for your choice.
- **Section 4 – Pro-ration of HRA.** If selected, employees enrolling mid-year will receive a pro-rated HRA funding amount. The default (and norm) is no.
- **Section 5 – Select Run-Out.** The run-out period is the period of time after the close of the regular plan year where any outstanding claim information must be submitted to close out the HRA and/or FSA.
- **Section 6 – Optional HRA Services.** Employers may choose one or more HRA options from this list all for one single fee of \$2.95 PEPM for fully-insured groups or \$4.95 PEPM for self-funded groups.

- **Section 7 – C3 FSA Basic Services.** Basic information to set up the FSA. Please list the payroll frequencies (i.e. weekly, semi-monthly, etc.) and first payroll date after the plan's effective date. If multiple payroll frequencies are listed, please list the first payroll date after the plan's effective date for each frequency.
- **Section 8 – FSA – Optional Services.** The term "FSA Standalone" refers to employees not covered by a HealthAmerica health plan but elect to participate in the FSA. This members are subject to a \$7.95 PEPM fee but also have access to all of our online services (My Online Services, Health Risk Assessment, wellness tools, etc.). Employers may also choose the FSA Grace Period and/or an Additional Run-Out Period of 90 days – one or both for \$2.95 PEPM for fully-insured groups or \$4.95 PEPM for self-funded groups. The debit card option can also be chosen here. Please note that the debit card only applies to FSAs and Global HRAs.
- **Section 9 – HRA/FSA Debit Card Issuance Fee.** Please add your initials for employer acceptance of this fee.
- **Section 10 – Coventry Combination.** For "stacked" C3 HRAs and FSAs, please select which account pays first in the benefit order.

Group Banking Setup Form

This form is required to establish the funding mechanism for HRA and/or FSA reimbursements.

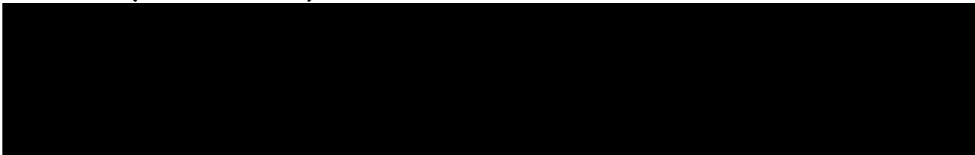
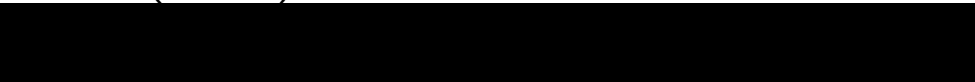
- Check the box for New Client Setup at the top of the form, complete the employer information, and check the box if the account applies to an HRA product, FSA product or both.
- Starting check number: If the employer is using a bank account that may also be used for other items (i.e. payroll, supplies, etc.) the starting check number to be used for HRA/FSA reimbursements should be high enough so that we do not cut duplicate checks on their account. For example, if the employer's current check number is 4950, you may choose to start the HRA/FSA reimbursements at 65000. This will also make bank reconciliation easier for the employer.
- Please attach a voided check from the employer's bank account that will be used for HRA/FSA reimbursements. Deposit slips are not acceptable as they sometimes contain different numbers than checks.
- Client Specific Signature Information: The person or persons authorized to write checks on the attached check's bank account should provide sample signatures in the boxes provided. If one person is able to authorize checks on this account, they should sign their name once in each of the three boxes. If two people are required to authorize checks on this account, both people should sign their names together in each of the three boxes.
- **IMPORTANT:** The sample signatures should NOT go outside the lines of the box as this can cause the form to be rejected. The best sample signature of the three will be digitized and printed on reimbursement checks for authorization.
- The employer should add their information at the bottom (date, group number, etc.) and sign the Authorization to Disburse area.
- Send the completed form and voided check to the London, KY address listed at the bottom of the form. The items should NOT be folded and send in a flat envelope so that scanning will be easier.

Sample EOBs

These documents should be used for employee education purposes. Please duplex each EOB when printing for the most accurate reproduction for the employee.

- **HealthAmerica EOB:** This is a sample copy of the HealthAmerica EOB they will receive in the mail after services have been applied to their deductible. The employee should retain this EOB for their records. It does not have to be sent anywhere.
- **C3 EOB:** This is a sample copy of the C3 EOB they will receive in the mail after their claim has been applied to their HRA and/or FSA account. It will also list any remaining member responsibility left after processing. The employee can match the C3 EOB to the HealthAmerica EOB by claim number, date of service and procedure codes. As a default, HRA and FSA reimbursements for deductible and coinsurance services will be automatically reimbursed directly to the provider; HRA and FSA reimbursements for office visit and Rx copays will be automatically reimbursed to the member.

Document Instructions

- **Production Selection Worksheet:** Return to your HealthAmerica account manager. Once received, a Confirmation Document will be mailed directly to the employer for final approval of their plan design details.
- **Group Banking Setup Form:** The employer should send this form directly to the London, KY address on the form. Also send an email to your HealthAmerica account manager confirming the date the form was sent for tracking purposes.
 - Mid-Market (10-150 lives)

 - Small Market (2-9 lives)

- **Plan Document and Administrative Services Agreement (ASA):** These documents will be sent directly to the employer and must be signed prior to the plan's effective date. The employer should review and sign the documents, make a copy for their records and return the original documents to their HealthAmerica account manager.
- **Summary Plan Description (SPD):** The SPD will be available for download from the employer's Online Account Management (OAM) portal after the plan's effective date. It is their responsibility to provide copies of the SPD to their employees within 60 days of the plan effective date.

Employer specific questions regarding their C3 administration details (i.e. contribution reports, check distribution, banking, set-up, etc.) may be directed to our C3 Employer Services Line at 800-722-1758. Questions about how the product works or the product that was purchased should be sent to your HealthAmerica account manager.



Product Selection Worksheet for HRAs and FSAs

Part 1 – The HRA - The Coventry Consumer Choice (C3) Health Reimbursement Arrangement (HRA) covers in and out of network deductible expenses (including pharmacy) and works in conjunction with your medical high deductible health plan. Each employer should select the type of HRA below, which determines if the employee or the employer pays first; then the employer should chose the deductible and funding amount that matches their plan design and mark an X next to their selection. Basic Shared and Delayed Deductible HRAs and selected % Reimbursement Packages listed here are available at no additional charge for Fully Insured Groups. ASO Groups have a charge of \$2.95 PEPM.

Shared Deductible HRA (the employee pays first)

In-Network Single Deductible	Single Upfront Deductible	Single ER Funding Amount	Employer Selection
1000	250	500	
1000	250	250	
1000	250	750	
1000	500	500	
1000	750	250	
1250	250	1000	
1250	500	750	
1250	750	500	
1500	500	1000	
1500	750	750	
1500	1000	500	
2000	500	1500	
2000	750	1250	
2000	1000	1000	
2000	1500	500	
2500	500	2000	
2500	1000	1500	
2500	1250	1250	
2500	1500	1000	
2500	2000	500	
3000	500	2500	
3000	1500	1500	
3000	1000	1000	
3000	1000	2000	
3000	2000	1000	
4000	500	3500	
4000	1000	3000	
4000	1500	2500	
4000	2000	2000	
4000	2500	1500	
5000	500	4500	
5000	1250	3750	
5000	1500	3500	
5000	2000	3000	
5000	2500	2500	
7500	500	7000	
7500	3750	3750	
7500	4000	3500	

Delayed Deductible HRA (the employer pays first)

In-Network Single Deductible	Single ER Funding Amount	Employer Selection
1000	750	
1000	500	
1000	250	
1250	750	
1250	500	
1500	1000	
1500	750	
1500	500	
2000	1000	
2000	1500	
2000	500	
2000	1250	
2500	1500	
2500	1250	
2500	500	
2500	2000	
2500	1000	
3000	1000	
3000	1500	
3000	2000	
3000	2500	
4000	1500	
4000	2000	
4000	2500	
4000	3000	
4000	3500	
5000	1500	
5000	2500	
5000	3500	
7500	3500	
7500	3750	
7500	7000	



Product Selection Worksheet for HRAs and FSAs

HRA % Reimbursement Packages: All are Basic HRAs and will apply a split of responsibility of each claim between the employer and the employee, up to the selected funding amount and subject to any upfront deductible provisions, if applicable. The percent reimbursement column states the percent the employer will pay of each claim up to the total claim amount stated (as both member and employer responsibility). The Single ER Funding column further clarifies the total amount the employer will pay out.

Medical Deductible	Single Upfront Deductible	Percent Reimbursement	Single ER Funding	Employer Selection
\$1000	\$500	80% of \$500	\$400	
\$1000	\$500	70% of \$500	\$350	
\$1500	\$500	80% of \$1000	\$800	
\$1500	\$1000	80% of \$500	\$400	
\$2000	\$1000	80% of \$1000	\$800	
\$2000	\$500	70% of \$1500	\$1050	
\$2000	\$1000	70% of \$1000	\$700	
\$2500	\$500	80% of \$2000	\$1600	
\$2500	\$500	70% of \$2000	\$1400	
\$2500	\$500	50% of \$2000	\$1000	
\$2500	\$1000	80% of \$1500	\$1200	
\$2500	\$1000	70% of \$1500	\$1050	
\$3000	\$500	80% of \$2500	\$2000	
\$3000	\$1000	80% of \$2000	\$1600	
\$3000	\$1000	70% of \$2000	\$1400	
\$3000	\$1000	50% of \$2000	\$1000	
\$5000	\$1000	80% of \$4000	\$3200	
\$5000	\$1000	70% of \$4000	\$2800	
\$5000	\$1000	50% of \$4000	\$2000	

Medical Deductible	No – Single Upfront Deductible	Percent Reimbursement	Single ER Funding	Employer Selection
\$1000	\$0	50% of \$1000	\$500	
\$1500	\$0	50% of \$1500	\$750	
\$2000	\$0	50% of \$2000	\$1000	
\$3000	\$0	50% of \$3000	\$1500	
\$5000	\$0	50% of \$5000	\$2500	

Part 2: HRA Family amounts- Circle the Family Funding and Upfront Deductible Amount requested:

- 1x Individual Amounts
- 2x Individual Amounts

Part 3: Individual Cap –

If Yes is selected, I would like to limit the funding and upfront deductible on each individual within a family to the single level. (Only applies if group has increased the HRA Family amounts above to 2x or 3x):

If No is selected, the HRA will function as a collective pool of upfront deductible for any, all, or a single family member to meet, and a collective pool of funding for any, all, or one member of the family to access. All members or any one member could satisfy the upfront deductible or utilize the entire funding.

I would like an Individual Cap on my HRA: Yes No

Part 4: Pro-ration of HRA – I would like **new employees** to receive a pro-rated HRA amount for the months that they are in the plan: Yes No

I would like the pro-ration on a monthly basis (1/12th) Yes No
 I would like the pro-ration on a quarterly basis (1/4th) Yes No

Part 5: Select Run-Out (time employees have to submit claims after plan year ends): 30 days 60 days



Product Selection Worksheet for HRAs and FSAs

Part 6: Optional HRA Services - Select any combination of the optional HRA features available for purchase for a charge of \$2.95 PEPM for Fully Insured Groups, \$4.95 PEPM for ASO Groups* (this includes the \$2.95 base HRA charge)

Optional Service	Description of Service	Employer selection
Rollover HRA	Allows employees to rollover remaining HRA amounts from year to year, Rollover amount is 100% of balance Employer choice to cap rollover at \$_____	
Aligned HRA	Allow the HRA to cover coinsurance, copay and deductible	
Global Coverage HRA	Allow the HRA to cover all 213d expenses (vision, dental, etc.) in addition to copay, coinsurance and deductible	
Global Coverage HRA with Debit Card	Provides a debit card for both the employee and spouse, if applicable, to be used for eligible HRA expenses.	
Network Only HRA	Limit HRA reimbursement to In-Network services only	
Combined Basic HRA and HC-FSA	Combination and coordination of the basic HRA and HC-FSA services for Fully Insured Groups. *Note: ASO groups with Optional HRA Services and a basic FSA, must pay \$2.95 for the FSA and \$4.95 for the Optional HRA.	

Part 7: C3 FSA Basic Services - The Coventry Consumer Choice Flexible Spending Account (FSA) provides employers the option to offer both Health Care and Dependent Care FSAs (HC-FSA and DC-FSA). The Basic FSA services are available at no additional charge to Fully Insured Groups (unless paired with an HRA) and are \$2.95 PEPM for ASO groups regardless of combination with an HRA.

- a. Circle the accounts to be included: HC-FSA DC-FSA
- b. Select the HC-FSA Maximum Contribution Amount: \$1000/ \$2000/ \$3000/ \$4000/ \$5000
- c. Select Run-Out (time employees have to submit claims after plan year ends): 30 days 60 days
- d. Note Employer Payroll Frequency for FSA Contributions:
- e. Note Employer's First Payroll Date for FSA Contributions:

Part 8: FSA – Optional Services

Buy-Up Options	Description of Service	Employer Selection	Additional Charge
FSA Standalone	Offer the HC-FSA and/or DC-FSA to employees who do not have Coventry Medical Coverage		\$7.95 PEPM
FSA Grace Period	Ability to incur claims after the plan year end for 75 days		FI Groups - \$2.95 PEPM ASO Groups - \$4.95 PEPM
Additional Run-Out	Purchase 90-days of Run-out (allows employees 90 days from the end of the plan year to submit claims).		
Debit Card	Offer a debit card attached to the FSA (rate cap does not apply to FSA Standalone and the debit card - \$7.95+\$2.95 for FI and \$4.95 for ASO)		

Part 9: HRA/FSA Debit Card Issuance Fee: If the employer selects the debit card for the FSA or HRA there is an issuance fee of \$10 per employee. This fee is a one time fee and includes one card for the employee and one card for the spouse (if applicable).

The employer acknowledges the issuance fee of \$10 per employee that has a debit card: _____



Product Selection Worksheet for HRAs and FSAs

Part 10: C3 Coventry Combination –

If both the HRA and HC-FSA are chosen and the FSA is chosen to pay first the FSA will be allowed to pay the upfront deductible. Once the FSA funds are exhausted, the member will have access to the HRA funds.

If the HRA is chosen to pay first, all charges that are not eligible for HRA reimbursement will be eligible to pay out of the FSA, including the HRA upfront deductible. However, this option will not require the FSA funds to be exhausted before the member has access to the HRA funds.

Which account will pay first (HRA or HC-FSA)? _____

Group Name

Tax ID Number

Contact Name

Contact Name Email Address

Employer

Date

Broker

Date

Account Manager

Date

*Fees are capped at \$7.95 PEPM for HRA/FSA products.



COVENTRY CONSUMER CHOICESM



Banking Account Information Form

CHCH9584

New Client Setup Existing Bank Change Client Signature Change

Client Name: _____ Group Number: _____

Name of Bank: _____

Account #: _____ Starting Check #: _____

Please check the Coventry Consumer Choice product(s) that apply to this bank account: HRA FSA HRA/FSA

STAPLE VOIDED CHECK HERE

IMPORTANT:

1. Send completed form, voided check or MICR encoding specification sheet to Coventry Consumer Choice P.O. Box 7758, London, KY 40742.
2. If using an existing bank account that is not solely used for Coventry Consumer Choice products, the starting check # needs to allow enough gap in the check # range to avoid producing duplicate checks.
3. If there are multiple bank accounts for Coventry Consumer Choice products a completed form, voided check or MICR encoding specification sheet is required for each additional bank account.
4. If additional services are requested (i.e., positive pay, bank reconciliation, etc.), additional fees will apply. Please contact your Account Representative for more information.
5. Any banking changes will require the completion of a new form and a voided check or MICR encoding specification sheet.

Client Specific Signature Information

This section **MUST** be completed in order for the client specific signature to appear on the checks.

NOTE: Faxed signatures will not be accepted. The original signatures must be sent to P.O. Box 7758, London, KY 40742

Instructions:

- You **MUST** use a black, fine-point felt tip pen.
- Sign name as it should appear on checks. All three samples signatures must be signed.
- If 2 signatures are required, both signatures must fit within the signature boxes.
- **Stay within the box.** Anything outside the box will be truncated.
- Do not fold this document – mail to address below in a flat envelope.
- For your signature to appear properly, your signature must fill the ENTIRE box, from top to bottom and side to side.

Sample
Signature 1

Sample
Signature 2

Sample
Signature 3

Date: _____

Client Name: _____

Group Number: _____

Signer's Name & Title: _____

Signer's Name & Title: _____

(if 2 signatures required)

Authorization To Disburse

Client hereby authorizes Coventry Consumer Advantage, Inc. as a limited agent for the purpose of withdrawing funds from the account indicated above ("Account") at the financial institution named above ("Bank") for the payment of claims under the HRA and/or FSA established by Client for the benefit of its employees. Client agrees that the Account shall be fully funded by Client to assure that all necessary funding for the HRA and/or FSA, as applicable, is available to pay claims. Client understands and agrees that Coventry Consumer Advantage, Inc. shall have no obligation to pay claims under the HRA or FSA if Client does not sufficiently fund the Account.

Client Signature & Title: _____ **Date:** ____/____/____

Print Name: _____ **Client Contact Phone #:** (____) _____

Mail your completed form to: Coventry Consumer Choice, PO Box 7758, London, KY 40742

Doe, John
123 MAIN STREET
ERIE, PA 16509

THIS IS NOT A BILL

EXPLANATION OF BENEFITS

Our organization processes and pays the claim submitted from your health care provider(s). You have received this Explanation of Benefits (EOB) as our notification to you explaining how your medical claim(s), including payments or denials, are being processed.

Payments made on behalf of:

SAMPLE COMPANY

Insured: Doe, John
Patient: Doe, John
Group Name: SAMPLE COMPANY PPO HRA
ID Number: 99999999999
Date: 04/05/08

SAMPLE

** Payments made at the time services were rendered are not reflected on this statement. **

Claim Number: 2233445566	Provider: ASSOCIATED CLINICAL LABORATORIES LP
Plan Paid: \$0.00	Provider Billing Address: 1526 PEACH ST ERIE, PA 16501
Member Responsibility: \$36.84	** Provider billing address may differ from physical office location **

Service Date From - To Procedure Code / Description	Billed Contractual		Approved Amount	Member's Responsibility to Provider				Plan Paid	Cont. / Other	
	Amount	Adjustment		Copay	Coins.	Deduct.	Other		Rmk	Rmk
04/15/08 - 04/15/08 36415 /LAB/PATHOLOGY	\$9.70	\$5.45	\$4.25	\$0.00	\$0.00	\$4.25	\$0.00	\$0.00	1526	
04/15/08 - 04/15/08 80061 /LAB/PATHOLOGY	\$22.70	\$9.98	\$12.72	\$0.00	\$0.00	\$12.72	\$0.00	\$0.00	1526	
04/15/08 - 04/15/08 84439 /LAB/PATHOLOGY	\$19.40	\$10.22	\$9.18	\$0.00	\$0.00	\$9.18	\$0.00	\$0.00	1526	
04/15/08 - 04/15/08 80050 /LAB/PATHOLOGY	\$19.70	\$9.01	\$10.69	\$0.00	\$0.00	\$10.69	\$0.00	\$0.00	1526	
TOTALS:	\$71.50	\$34.66	\$36.84	\$0.00	\$0.00	\$36.84	\$0.00	\$0.00		

Contractual Remarks:
1526 - NETWORK PROVIDER CONTRACT APPLIED

To ensure that your health plan was properly billed, please review the services listed on your explanation of benefits. If you believe any of the services were incorrectly billed, contact a customer service representative using the toll free number listed on your insurance card.

Grievance Review Process

A covered individual has the right to dispute a denied claim through the Complaint and Grievance Review Process; you wish to appeal a denial decision, contact the Customer Service Organization number on the back of your Carc Review your Health Benefit Plan Document for further details regarding your right to dispute a denied claim.

THIS IS NOT A BILL

The amounts below include claims processed as of April 5, 2008
 The information does not reflect any claims received or adjusted after the above mentioned date.

Member Benefit Usage for Dates of Service **April 1, 2008 - March 31, 2009**

Type	Deductible Dollars			Out of Pocket Dollars		
	Year-To-Date Satisfied	Maximum \$	Remaining \$	Year-To-Date Satisfied	Maximum \$	Remaining \$
IN NETWORK-Individual	\$ 826.55	\$ 1,250.00	\$ 423.45	\$ 0.00	\$ 0.00	\$ 0.00
IN NETWORK-Family	\$ 826.55	\$ 2,500.00	\$ 1,673.45	\$ 0.00	\$ 0.00	\$ 0.00
OUT OF NETWORK-Individual	\$ 0.00	\$ 2,500.00	\$ 2,500.00	\$ 0.00	\$ 5,000.00	\$ 5,000.00
OUT OF NETWORK-Family	\$ 0.00	\$ 5,000.00	\$ 5,000.00	\$ 0.00	\$ 10,000.00	\$ 10,000.00

SAMPLE



COVENTRY CONSUMER CHOICESM
 Coventry Consumer Choice
 PO Box 7760
 London KY 40742

Forwarding Service Requested

>12345 6789012 345 678901
 John Doe
 123 Main Street
 Erie, PA 16509

Group Number: 1234567890

This is not a bill
Explanation of Benefits

This Explanation of Benefits (EOB) lists the services and other items that have been submitted to us for reimbursement from your health care account(s). Please review this EOB carefully and keep it with your records. Your health care account balance(s) and benefit information can be viewed at www.cvty.com.

Page 1 of 1
 Date: 4/25/2008

SAMPLE

SEE BACK FOR EXPLANATION OF COLUMNS CONSUMER-DIRECTED HEALTHCARE ACCOUNT SUMMARY

Service Date	Amount Submitted for Reimbursement	Amount Paid from Account	Type of Account	Message Code
Procedure Code/Description				
Member Name: JOHN DOE	Member ID#: 9999999999	Claim: 2233445566	Patient: JOHN DOE	
04/05/2008 80061 - MEDICAL	12.72	12.72	HRA	236
04/05/2008 36415 - MEDICAL	4.25	4.25	HRA	236
04/05/2008 84439 - MEDICAL	9.18	9.18	HRA	236
04/05/2008 80050 - MEDICAL	10.69	10.69	HRA	236

Remaining Member Responsibility: 0.00

Messages

236 Amount paid out of HRA account according to plan design.

Beginning HRA Balance: \$500.00 Year To Date Payments: \$36.84 Remaining HRA Balance: \$463.16

Our records reflect the above current dollar amounts as of 4/25/2008
 Please note that these amounts may not reflect claims recently submitted, still in processing
 If you have been previously set up with direct deposit, you will need to verify with your bank that the funds have been deposited into your account.

If there is an amount listed in the Remaining Member Responsibility box, you must pay this amount to the provider. If \$0.00 is listed, your provider was paid from your HRA and no other action is required. Keep this document for your records.

General Information

Explanation of your benefit activity

Service Date: The date the claim was incurred.

Procedure code/Description: The type of claim submitted for reimbursement.

Amount submitted for reimbursement: The amount submitted for reimbursement from your Coventry Consumer Choice (C3) account.

Amount paid from account: The amount paid from your C3 account. This may be less than the submitted amount depending on your account design and available funds.

Type of account: Refers to the account (FSA/DC-FSA/HRA).

Message Code: Code that refers to a description of how your reimbursement was calculated.

Remaining member responsibility: The dollar amount remaining, not paid by the account, that is member responsibility.

Beginning FSA/HRA balance: The dollar amount available at the beginning of the plan year.

Year to date payments: Amount paid out of your account since the beginning of your plan year.

Remaining balance: Amount remaining in your account for future reimbursements within the plan year.

You have the right to appeal the denial of reimbursement from your healthcare account in whole or part by verbal or written request within 180 days. To appeal this denial, contact Coventry Healthcare at the number on the back of your identification card. Enrollees, you can view eligibility, benefit information, and reimbursement status at your convenience. Please visit our website at www.cvty.com

Coventry Consumer Choice is administered by Coventry Consumer Advantage, Inc.

SAMPLE