

Health Reimbursement Arrangement (HRA) with Health Incentive Account (HIA) Group Setup Document – Standard

Directions: Complete only if UPMC Health Plan is administering the HRA/HIA plan.

1. Corporate Group Name <i>Legal name of entity</i>	
2. Corp ID <i>Assigned by UPMC Health Plan (4-character alpha numeric code)</i>	
3. Group ID <i>Group number as assigned in MC400 (6-digit code)</i>	
4. Subgroup Number <i>Subgroup number as assigned in MC400 (3-digit code). When applicable, a second subgroup is necessary for owners (see # 10).</i>	
5. UPMC Health Plan Sales Representative and/or Account Manager	
6. Federal Tax ID Number <i>Tax ID that is used to file federal taxes</i>	<i>(xx-xxxxxxx format)</i>
7. Plan Effective Date <i>Contract start date</i>	
8. Business Entity <i>C Corp, S Corp, Partnership, or Limited Partnership (LP), Limited Liability Company (LLC), Non-Profit, Sole Proprietorship, Government Entity, or Church. Reminder: Owners of an S Corp, Partnership, LP, or LLC may not participate in an HRA.</i>	
9. Number of Employees – HRA Plan <i>Number of employees eligible to participate in HRA. (See #10 to determine whether owners should be included in “number of employees.”)</i>	
10. Owners – Non-funded HRA Plan <i>List the name of the owners who will be on the non-funded HRA plan, when only one plan option is offered. (Note: The plan design will mirror the HRA minus the HRA funding.) Owners of an S Corp, Partnership, LP, or LLC may not participate in an HRA.</i>	
11. HRA Plan Information <i>Indicates the HealthyU deductible for the plan and the plan code.</i>	<p>Check one option only</p> <p><input type="checkbox"/> HRA PPO \$750 Individual / \$1,500 Family (20D)</p> <p><input type="checkbox"/> HRA PPO \$1,250 Individual / \$2,500 Family (20A)</p> <p><input type="checkbox"/> HRA PPO \$2,500 Individual / \$5,000 Family (20B)</p> <p><input type="checkbox"/> HRA PPO \$3,750 Individual / \$7,500 Family (20C)</p> <p><input type="checkbox"/> HRA EPO \$750 Individual / \$1,500 Family (30D)</p> <p><input type="checkbox"/> HRA EPO \$1,250 Individual / \$2,500 Family (30A)</p> <p><input type="checkbox"/> HRA EPO \$2,500 Individual / \$5,000 Family (30B)</p> <p><input type="checkbox"/> HRA EPO \$3,750 Individual / \$7,500 Family (30C)</p>

<p>12. HRA Contributions <i>Indicates the amount the employer will be funding annually per coverage tier. "Family" includes any tier other than individual, i.e. employee and spouse, employee and child, employee and children, and family.</i></p>	<table border="1"> <thead> <tr> <th>Deductible</th> <th>HRA Allocation</th> </tr> </thead> <tbody> <tr> <td>\$750/\$1500</td> <td>\$125/\$250</td> </tr> <tr> <td>\$1250/\$2500</td> <td>\$125/\$250</td> </tr> <tr> <td>\$2500/\$5000</td> <td>\$750/\$1500</td> </tr> <tr> <td>\$3750/\$7500</td> <td>\$1375/\$2750</td> </tr> </tbody> </table>	Deductible	HRA Allocation	\$750/\$1500	\$125/\$250	\$1250/\$2500	\$125/\$250	\$2500/\$5000	\$750/\$1500	\$3750/\$7500	\$1375/\$2750
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<p>13. HIA Limits <i>Indicates the maximum amount of health incentive funds that can be earned in the account each year. "Family" includes any tier other than individual i.e. employee and spouse, employee and child, employee and children, and family.</i></p>	<p>Individual Coverage: \$500 Family Coverage: \$1,000</p>										
<p>14. HIA/HRA Funding Structure <i>HRA dollars are available on the first day the plan is effective.</i></p> <p><i>Example: Deductible \$1,250</i> First: Plan/Employer exposure \$625 (if full \$500 is earned in HIA) Second: Employee exposure \$625</p>	<p>HIA/HRA pays first (Plan/Employer exposure first)</p>										
<p>15. Reimbursement Order <i>Describes which account pays first (HRA or HIA) when funds are used.</i></p>	<p>HIA pays first, if funds are available, then the HRA</p>										
<p>16. Covered Services <i>Defines whether HRA & HIA funding can be used for medical plan expenses in addition to deductible and coinsurance.</i></p> <p><i>Please note: options in this section do not imply integrated pharmacy.</i></p>	<p>Certain non-covered services</p> <p>Out-of-Network Claims</p> <p>Amounts above R&C (reasonable & customary) (R&C charges are for out-of-network claims only)</p>										
<p>17. Midyear Enrollment Proration <i>Indicates how deductible and funds are allocated to employees who join midyear.</i></p> <p>Quarterly – Annual deductible and funds are divided by 4 and then multiplied by the number of quarters (full/partial) remaining in the plan year.</p>	<p>Quarterly proration</p> <p>The following will be prorated:</p> <ul style="list-style-type: none"> • HRA Allocation • HIA Maximum Limit • Deductible • Out of Pocket Limit 										
<p>18. Roll-In Max <i>Describes the maximum amount of HRA & HIA funds that can rollover.</i></p>	<p>2 times the deductible in the HIA+HRA combined</p>										

Employer approval of HRA/HIA setup provisions:

Print name of authorized representative

Title

Signature of authorized representative

Date

AUTHORIZATION AGREEMENT FOR ACH DEBITS

Finance Department Contact Information

Group contact responsible for funding the HRA.

If an e-mail address is not provided, the HRA Claims Utilization Invoice will be faxed.

Name: _____

Title: _____

Phone: _____ Fax: _____

Street: _____

City: _____ State _____ Zip _____

E-mail: _____

Corporate Group Name _____ Federal Tax ID Number _____
(XX-XXXXXXX)

I (we) hereby authorize UPMC Health Plan, herein called COMPANY, to initiate debit entries to my (our) _____ Checking Account or _____ 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: _____
Routing number has nine digits

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): _____ *Please print* Group ID: _____ *Group ID has six digits*

Date: _____ Signature: _____