Health Reimbursement Arrangement (HRA) Legacy Group Setup Document

UPMC Health Plan

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

1. Corporate Group Name *Legal name of entity*	
2. Corporate ID *A four-character alphanumeric code assigned by UPMC Health Plan*	
3. Group ID A six-digit code assigned in MC400	
4. Subgroup Number *A three-digit code assigned in MC400. A second subgroup may be necessary for owners (see #10).*	
5. UPMC Health Plan Account Manager	
6. Federal Tax ID Number *(xx-xxxxxxx format)*	
7. Plan Effective Date	
8. Business Entity *C Corp, S Corp, Partnership, Limited Partnership (LP), Limited Liability Company (LLC), Nonprofit, Sole Proprietorship, Government Entity, or Church. Owners of an S Corp, Partnership, LP, or LLC may not participate in an HRA.*	
9. Number of Employees — HRA Plan *Number of employees participating in HRA. See #10 to determine whether owners should be included.*	
10. Owners — Non-Funded HRA Plan *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.*	
11. HRA Plan Information *Indicate which standard plan is being offered and the deductible for the plan. If a non-standard plan is being offered, please attach a copy of that grid.*	HRA Standard Plan Name: _____ Individual Deductible: $ _____ Family Deductible: $ _____ HRA Non-Standard Plan Name: _____ Individual Deductible: $ _____ Family Deductible: $ _____
12. HRA Contributions *Indicate the amount the employer will be funding on an individual basis. Family includes any tier other than individual. (Family includes employee and spouse, employee and child, employee and children, and family.)*	Individual Only: $_____ Family: $ _____

13. HRA Funding Structure

Describe whether the employee must first meet a portion of the deductible, then have access to HRA funds (example 1); whether HRA dollars are available on day one (example 2); or whether claims will be split 50/50 between the employer and employee (example 3).

Example 1: Employee pays first
Deductible: $1,000
First Employee exposure: $500
Second Employer (HRA) exposure: $500

Example 2: Employer pays first (Aggregate funding only)
Deductible: $1,000
First Employer (HRA) exposure: $500
Second Employee exposure: $500

Example 3: 50/50 cost sharing
Deductible: $1,000; HRA funding 50%
Employer (HRA) exposure: $500
Employee exposure: $500
Claim example: $200 deductible; $100 employee and $100 HRA funds

Check one option only:

☐ **Employee pays first (Employee exposure first)**
(Single) Employee $_____
HRA Funds $_____
(Family) Employee $_____
HRA Funds $_____

☐ **HRA pays first (Employer exposure first)**
(Single) HRA Funds $_____
Employee $_____
(Family) HRA Funds $_____
Employee $_____

☐ **HRA funds 50% of deductible expenses**

If your benefit plan has separate deductibles (participating and non-participating), do you wish to fund only the participating deductible?
☐ Yes — Recommended
☐ No — This indicates that you will fund both deductibles.
☐ N/A — Choose this option if your deductible is combined.

For UPMC Inside Advantage™ plans:
Please select the deductible levels that should be HRA-funded.
☐ Level 1
☐ Level 2
☐ Level 3 (Non-Participating)

14. HRA Funding Application

Define whether HRA funding for employees with family coverage is embedded or aggregate. Embedded HRA funding limits the amount of HRA funds or out-of-pocket liability for members in a family to the single coverage amount. Aggregate HRA funding applies HRA funds or out-of-pocket liability across the entire family regardless of how many individuals in the family incur claims. HRA funding or employee liability will be applied as indicated in the family coverage field in #13.

Please indicate how the HRA funds should be applied.

☐ Embedded HRA Funding (not permitted for HRA pays first)

☐ Aggregate HRA Funding

15. Covered Services

Define whether HRA funding can be used for plan deductible expenses only or expanded to 213(d) expenses such as dental, vision, and prescription drugs (similar to expenses an FSA covers).

☐ Plan deductible expenses only

☐ All of 213(d) expenses

16. Mid-Year Enrollment Proration *Indicate how funds are allocated to employees who join mid-year. Options are:* *1. No Proration – Employee receives entire annual amount.* *2. Monthly – Annual funds are divided by 12 and then multiplied by the number of months remaining in the plan year.*	☐ No proration — employee receives 100% ☐ Monthly proration
17. Roll-Over Maximum *Describe the maximum amount that may be accumulated in the HRA.* *Example: Some employers may want to cap the roll-over at a maximum level. On a $1,250 plan, the roll-over cap may be $2,500 for Employee only. If the employee rolls over HRA funds from year to year, it will eventually cap at $2,500 for an Employee only plan.*	Please specify a dollar amount. Individual Only: $_____ Family: $ _____

Employer approval of HRA 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 email address is not provided, the HRA Claims Utilization Invoice will be faxed.***	Name: _____ Title: _____ Phone: _____ Fax: _____ Street: _____ City: _____ State: ____ ZIP: _____ Email: _____

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) 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: _____ *Routing number has nine digits*

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

Date: _____ Signature: _____