



# MEDICAL MUTUAL®

## New Small Group (2-50) HRA Set-Up Form

(Return electronically to Medical Mutual Sales Team)

### Group Information

Group Name:

Group Address:

Group Tax ID #:

Broker Name Contact:

Phone:

Email:

Group Accounting Contact:

Phone:

Email:

Group HR Contact:

Phone:

Email:

Other Group Contact(s):

Phone:

Email:

### HRA Plan Information/Design:

#### Section 1: Previous HRA

Is there an HRA in place today?  Yes  No

If yes, are there HRA balances being transferred?  Yes  No

If yes, expected delivery date \_\_\_\_\_ (must be within 45 days of benefit start date)

#### Section 2: Funding (Choose one option)

Debit card option (below are the requirements)

- HRA will fund in and out of network claims
- HRA will process as an aggregate amount for family contracts
- HRA must be 1<sup>st</sup> to process
- Claims Settlement Daily:

How much should the HRA fund?

Sub/Single	Employee + 1	Family
\$ _____	\$ _____	\$ _____

Continue to Section 3

Claims Integration (claims automatically process against the HRA)

- HRA will fund claims:  In Network only  In and out of Network
- HRA must follow medical deductible for processing on EE+1 and Family contract types

Medical deductible: Embedded  Aggregate

- Claims Settlement Weekly:

Network Deductible

Sub/Single	Employee + 1	Family
\$ _____	\$ _____	\$ _____

Non-Network Deductible

Sub/Single	Employee + 1	Family
\$ _____	\$ _____	\$ _____

Claims integration funding options include HRA 1<sup>st</sup>, 2<sup>nd</sup>, or percentage based

Who pays first? (Level One)

HRA  Subscriber or  Split

Sub/Single	Employee + 1	Family	Split	
\$ _____	\$ _____	\$ _____	HRA %	Sub %

Who pays second? (Level Two)

HRA  Subscriber or  Split

Sub/Single	Employee + 1	Family	Split	
\$ _____	\$ _____	\$ _____	HRA %	Sub %

Who pays third? (Level Three) (If applicable)

HRA  Subscriber or  Split

Sub/Single	Employee + 1	Family	Split	
\$ _____	\$ _____	\$ _____	HRA %	Sub %

Totals should equal deductibles

Sub/Single	Employee + 1	Family		
\$ _____	\$ _____	\$ _____		

#### Section 3: Other Options

Do you want HRA prorated? (Monthly only)  Yes  No

Will there be wellness credits?  Yes  No

### Electronic Signature:

Group Official: \_\_\_\_\_ Date: \_\_\_\_\_

Broker Official: \_\_\_\_\_ Date: \_\_\_\_\_



**Medical Mutual Information (Internal use only)**

Prepared By: \_\_\_\_\_ Cost Center: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Group Account Executive Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Group Name: \_\_\_\_\_

Base Group Number: \_\_\_\_\_ Section Numbers: \_\_\_\_\_

Is this an existing Medical Mutual group?  yes  noIs this group part of a consortium or association? Or does the group have multiple group numbers or bill groups?  yes  no If yes to either, contact Product Management.

HRA Start Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ HRA Reset Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Benefit Period Start Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Benefit Period End Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Debit Card Stock:  Standard (Only option available for debit card type HRA's) If Wellness credits marked yes in Section 3 on front, insert comments below**Eligible Expenses (Select the eligible expense covered by the HRA Plan)****Claims Integration Eligible Expenses**

Select	Eligible Expenses	Network	In/Out Network
<input type="checkbox"/>	MEDICAL DEDUCTIBLE	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	MEDICAL DEDUCTIBLE, INCLUDING MMRx	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	MEDICAL COINSURANCE	<input type="checkbox"/>	<input type="checkbox"/>

**Debit Card HRA Eligible Expenses**

<input type="checkbox"/>	MEDICAL (DEDUCTIBLE, COINSURANCE, COPAYS)	N/A	<input type="checkbox"/>
<input type="checkbox"/>	PHARMACY	N/A	<input type="checkbox"/>

**FSA / HRA: (If applicable)** Order can be customized only if both HRA and FSA are debit card enabled, otherwise the HRA plan will be prioritized 1<sup>st</sup> and FSA 2<sup>nd</sup>.**Order of Benefit Payment (If both HRA and FSA are debit card enabled, select one.)** Eligible expenses paid under FSA before HRA Eligible expenses paid under FSA after HRA**Sales Notes and/or Comments:****Product Development Approval:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Operations Approval:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**CDHP Code and Effective Date (to be completed by Operations):**

Group #: \_\_\_\_\_ Section(s): \_\_\_\_\_

CDH Code: \_\_\_\_\_ Debit Card: \_\_\_\_\_ Custodian: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Group #: \_\_\_\_\_ Section(s): \_\_\_\_\_

CDH Code: \_\_\_\_\_ Debit Card: \_\_\_\_\_ Custodian: \_\_\_\_\_ Effective Date: \_\_\_\_\_