



SuperMed HRA® COSE Health & Wellness Trust (COSE MEWA) Product Selection Form Checklist

Medical Mutual offers a seamless process to enroll in a health reimbursement account (HRA). To allow your client to take full advantage of their consumer-driven health plan, please complete the steps below.

Group Information:

Group Name:	Group Tax ID:	
Group Address:	Effective Date:	
Broker Name Contact:	Phone:	Email:
Group HR Contact:	Phone:	Email:
Group Accounting Contact:	Phone:	Email:

Select Your Product:

Step 1: Select your product and mandatory HRA design below

Please select the mandatory HRA funding amount. Non-network claims do not process through the HRA.

- | | |
|----------------------------|----------------------------|
| COSE MEWA HRA 30-1000 w/Rx | COSE MEWA HRA 3000 w/PD Rx |
| COSE MEWA HRA 30-2000 w/Rx | COSE MEWA HRA 5000 w/PD Rx |
| COSE MEWA HRA 30-3000 w/Rx | COSE MEWA HRA 6550 w/PD Rx |

Note: HRA funding amounts are mandatory at the dollar amounts indicated on the Product Selection Sheet.

Step 2: Complete the contract amendment, Product Selection Sheet and the HIPAA Privacy Certification form.

To access the required documents, go to MyBrokerLink.com > Producers Guide > Health Reimbursement Account > 1-50 sized groups.

Step 3: Complete your HRA deductible credits/balance transfers¹.

If your new group has an HRA with another carrier or Third Party Administrator (TPA), your group can transfer HRA deductible credits within 30 days of your effective date. Simply complete the HRA Balance and Deductible Credit Template on MyBrokerLink in the Producers Guide section. Find HRA Compatible Health Plans under Employer Funding Options and click on 1-50 sized groups. A link to the template is under Required Materials.

Step 4: Wait for bank set-up instructions

You will receive an email from the Treasury department at Medical Mutual (TreasuryDept@MedMutual.com) to confirm the banking arrangements.

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)

- 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
 - Claims Settlement Weekly:

Network Deductible		
Sub/Single	Employee + 1	Family
\$	\$	\$
Non-Network Deductible		
Sub/Single	Employee + 1	Family
\$	\$	\$

Claims integration funding options include HRA 1st, 2nd, or percentage based

Who pays first? (Level One)	Sub/Single	Employee + 1	Family	Split			
<input type="checkbox"/> HRA <input type="checkbox"/> Subscriber or <input type="checkbox"/> Split	\$	\$	\$	HRA	%	Sub	%
Who pays second? (Level Two)	Sub/Single	Employee + 1	Family	Split			
<input type="checkbox"/> HRA <input type="checkbox"/> Subscriber or <input type="checkbox"/> Split	\$	\$	\$	HRA	%	Sub	%
Who pays third? (Level Three) (If applicable)	Sub/Single	Employee + 1	Family	Split			
<input type="checkbox"/> HRA <input type="checkbox"/> Subscriber or <input type="checkbox"/> Split	\$	\$	\$	HRA	%	Sub	%
Totals should equal deductibles (Employees must have at least \$250.00 of deductible exposure)	Sub/Single	Employee + 1	Family				
	\$	\$	\$				

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:	
Base Group Number:		Section Numbers:	
Is this an existing Medical Mutual group? <input type="checkbox"/> yes <input type="checkbox"/> no			
HRA Start Date: ____ / ____ / ____		HRA Reset Date: <u>12</u> / <u>31</u> / ____	
Benefit Period Start Date: <u>01</u> / <u>01</u> / ____		Benefit Period End Date: <u>12</u> / <u>31</u> / ____	

Eligible Expenses (Select the eligible expense covered by the HRA Plan)

Claims Integration Eligible Expenses

Select	Eligible Expenses (Network Only)
<input type="checkbox"/>	MEDICAL DEDUCTIBLE
<input type="checkbox"/>	MEDICAL DEDUCTIBLE, INCLUDING MMRx

Sales Notes and/or Comments:

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Product Development Approval:

Name: _____	Date: _____
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Operations Approval:

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

Group #:	Section(s):		
CDH Code:	Debit Card:	Custodian:	Effective Date: