

CDH File Feed Auth Form Aid

This is meant to serve as a guide for understanding and completing the following CDH File Feed Authorization Form. Below are descriptions for what should be included in the applicable boxes on the CDH form, in descending order. If you have any additional questions, please direct them to your Account Executive.

Employer name and Corporate Account Structure- The name of your organization and its corporate structure.

Effective dates- If the medical plan and the HRA/HSA have different effective dates, please indicate that in this box, or check off “Same as Medical Plan” if they have the same effective dates.

Medical Plan aligned with HRA/HSA (MD# Required)- Any plan that you want to go over on the file feed to the HRA/HSA vendor should be indicated here. Please use the corresponding plan number that begins with the letters “MD” as assigned by Harvard Pilgrim.

Number of Eligible Employees- Please list the number of employees that are eligible for the HRA/HSA

Employees not eligible for this HRA or HSA?- If there are employees who should not have an HRA/HSA, but still will be enrolled in a medical plan, please check off “YES” so that a non HRA or non HSA plan division can be set up for them, ensuring their info won’t go over on the file feed. Please provide this list of employees that are not eligible for the HRA or HSA to your account executive so that they may be put on the appropriate plan in Harvard Pilgrim’s system.

Employer HRA/HSA Contributions- Please use this section to list the dollar amounts that will be funded into the HRA/HSA per plan type for Individual, Family, and Other (Dual, Employee w/ child) plans.

The next section should only be filled out if you’re setting up an HRA

Medical Plan Year Type- Check off the applicable year type based on when your medical plan renews. Calendar year if plan runs 1/1/21-12/31/21, Plan year if it renews any other time of year.

HRA Design Option Selection- This section allows you to customize your group’s HRA design. Please check off the appropriate design option you’re looking for.

At the bottom of the CDH form you will need to list all plan division numbers (supplied by HPHC) that you want to go over on the file feed as well as the division numbers that should NOT be going over on the file feed (Non HRA and Non HSA divisions)

CDH File Feed Authorization Form

Complete one form per each financial account type (HRA or HSA)

Upon completion, please return to your Harvard Pilgrim Health Care Sales Contact

Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA)																		
Employer Name:		Corporate Structure (C-Corp/LLC/etc)																
HRA Preferred Vendor: <input type="checkbox"/> Voya Financial <input type="checkbox"/> Flores & Associates <input type="checkbox"/> HRC Total Solutions <input type="checkbox"/> Health Equity	HRA Non Preferred Vendor: _____ (Enter vendor name above)	HSA Preferred Vendor: <input type="checkbox"/> HealthEquity <input type="checkbox"/> HRC Total Solutions <input type="checkbox"/> Fidelity <input type="checkbox"/> Flores & Associates																
Effective Dates: Medical Plan: HRA/HSA: OR <input type="checkbox"/> Same as Medical Plan																		
Medical Plan aligned with HRA/HSA (MD# Required):																		
Number of Eligible Employees:																		
Are there members <u>not</u> eligible for this HRA or HSA? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Employer HRA/HSA Contributions by Contract Type:</td> <td style="width: 15%;">Individual: \$</td> <td style="width: 10%;">OR</td> <td style="width: 15%;">Individual: %</td> <td style="width: 30%;"></td> </tr> <tr> <td></td> <td>Family: \$</td> <td>OR</td> <td>Family: %</td> <td></td> </tr> <tr> <td></td> <td>Other: \$</td> <td>OR</td> <td>Other: %</td> <td></td> </tr> </table>				Employer HRA/HSA Contributions by Contract Type:	Individual: \$	OR	Individual: %			Family: \$	OR	Family: %			Other: \$	OR	Other: %	
Employer HRA/HSA Contributions by Contract Type:	Individual: \$	OR	Individual: %															
	Family: \$	OR	Family: %															
	Other: \$	OR	Other: %															
Please complete for Health Reimbursement Arrangement (HRA) Only																		
Medical Plan Year Type: <input type="checkbox"/> Plan Year <input type="checkbox"/> Calendar Year																		
HRA Design Option Selection:																		
<input type="checkbox"/> Option A <i>HRA applies to:</i> <ul style="list-style-type: none"> Deductible Only* 2nd Part of Deductible <i>Select Auto-Pay Recipient</i> <input type="checkbox"/> Employee (recommended) <input type="checkbox"/> Provider <small>*If offered with an HSA PPO or an HSA HMO, Rx Deductible also applies.</small>	<input type="checkbox"/> Option B <i>HRA applies to:</i> <ul style="list-style-type: none"> Deductible Only* 1st Part of Deductible <i>Select Auto-Pay Recipient</i> <input type="checkbox"/> Employee (recommended) <input type="checkbox"/> Provider <small>*If offered with an HSA PPO or an HSA HMO, Rx Deductible also applies.</small>	<input type="checkbox"/> Option C <i>HRA applies to:</i> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Medical</td> <td style="width: 50%;">Rx*</td> </tr> <tr> <td><input type="checkbox"/> Deductible</td> <td><input type="checkbox"/> Deductible</td> </tr> <tr> <td><input type="checkbox"/> Copay</td> <td><input type="checkbox"/> Copay</td> </tr> <tr> <td><input type="checkbox"/> Coinsurance</td> <td><input type="checkbox"/> Coinsurance</td> </tr> </table> HRA Pays First/Last/Percent/Other: <i>Select Auto-Pay Recipient</i> <input type="checkbox"/> Employee (recommended) <input type="checkbox"/> Provider <small>*If an Rx only debit card is being used, DO NOT check the Rx boxes above</small>		Medical	Rx*	<input type="checkbox"/> Deductible	<input type="checkbox"/> Deductible	<input type="checkbox"/> Copay	<input type="checkbox"/> Copay	<input type="checkbox"/> Coinsurance	<input type="checkbox"/> Coinsurance							
Medical	Rx*																	
<input type="checkbox"/> Deductible	<input type="checkbox"/> Deductible																	
<input type="checkbox"/> Copay	<input type="checkbox"/> Copay																	
<input type="checkbox"/> Coinsurance	<input type="checkbox"/> Coinsurance																	
<p style="color: red;">Option C: Please outline what expenses will be covered under this plan design, including reimbursement limits. (Example: Rx Coinsurance up to \$500.)</p>																		
To be completed by HPHC, Broker or Third-Party Vendor																		
Below please list the 10 digit Group & Division numbers that...																		
Will be offered alongside this HRA or HSA design		Will NOT be offered alongside this HRA or HSA design																

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Participation & Contribution Guidelines: *For informational purposes only - Consult your legal counsel to determine your employees' & owners' eligibility*

Health Reimbursement Arrangement (HRA)	
Eligible Employees	Ineligible Employees*
● Active employees	● Partners
● COBRA participants	● LLC members
● C-corporations owners receiving W-2s	● 2% owners of Sub-S corporations

***PLEASE NOTE: HRA's cannot be funded directly or indirectly by employees.** In addition, any employee entitled to continuation of coverage under COBRA must be given the opportunity to continue the HRA as well. Be sure to review your plan with your legal counsel to ensure compliance with Federal Law.

****Note for Massachusetts Employers:** Plans that have deductibles that exceed \$2,000/\$4,000 may not meet Massachusetts Minimum Creditable Coverage (MCC) standards. However, if offered with an employer funded Health Reimbursement Arrangement (HRA) equal to the amount of the deductible beyond \$2,000/\$4,000, the plan will satisfy MA MCC standards. The Employer (as the Plan Sponsor) represents that all persons covered under the Plan Sponsor's insurance arrangement with HPHC will be covered under the HRA, regardless of the taxability of any HRA reimbursements to certain individuals, such as partners, LLP members or more than 2% S Corporation stockholders.

Health Savings Account (HSA)			
Employee type	Eligible to...		
	Open an HSA account?	Receive employer pre-tax contributions?	Make pre-tax payroll contributions?
Active employees	✓ YES	✓ YES	✓ YES
COBRA participants	✓ YES	✓ YES	✓ YES
C-corporations owners receiving W-2s	✓ YES	✓ YES	✓ YES
LLC members/ Partners in a Partnership	✓ YES	✗ NO	✗ NO
2% or Greater owners of Sub-S corporations	✓ YES	✗ NO	✗ NO
Employees enrolled in any part of Medicare	✗ NO	✗ NO	✗ NO
Employees who have other non-qualifying coverage (those with a <i>second health plan, Employee or Spouse enrolled in a traditional Health FSA or HRA</i>)	✗ NO	✗ NO	✗ NO

Harvard Pilgrim has its own eligibility guidelines for group health insurance plan enrollment based on contract state and market segment. Contact your Harvard Pilgrim Sales Contact for further information or clarification.

Signatures required below.

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Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA)

Please read and sign the acknowledgement below:

Employer hereby acknowledges that Harvard Pilgrim will release applicable eligibility and claims data to an Employer's HRA/HSA vendor that has been properly designated on the Identification of Third-Party Representatives form in accordance with the specifications requested by Employer and/or vendor. Such data will be provided electronically. Employer authorizes Harvard Pilgrim to obtain confirmation of implemented HRA/HSA design from Employer's designated third-party vendor.

Employer acknowledges that HSA claims data will not be released to the HSA vendor until individual member authorizations are received by Employer and/or the HSA vendor.

Employer acknowledges that it has entered into an agreement with an HRA/HSA vendor and Harvard Pilgrim is not responsible for issues that may arise in connection with the administrative services provided by such vendor. Employer hereby agrees that it is solely responsible for managing any matters related to the provision of HRA/HSA administrative services and shall work with the vendor directly on any issues related to such services. To the extent a member enrolled through Employer contacts Harvard Pilgrim concerning an HRA/HSA matter, Harvard Pilgrim will direct such member to contact Employer and/or vendor for assistance.

At Employer's direction, Harvard Pilgrim shall provide vendor with the applicable eligibility and claims data in accordance with the specifications requested by Employer and/or vendor. Employer acknowledges that additional administrative fees may be charged to Employer by the HRA/HSA vendor. Employer hereby agrees to notify Harvard Pilgrim, immediately, in writing, of any HRA/HSA design or vendor changes.

Employer Contact Name:	Date:
Employer Contact Signature:	Phone Number:
<u>External Vendor ID#</u> (To be assigned by vendor)	

NOTE: Please be sure that the employer returns signed Identification of Third Party-Representatives and Plan Sponsor Certification forms (if not already on file) along with this completed Design Worksheet to their Account or Sales Executive. ***The HRA/HSA Feed CANNOT be set up unless your Harvard Pilgrim Sales Contact has received these completed forms.***