Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Updated 8/8/2017

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:	**HRA Non Preferred Vendor:**	**HSA Preferred Vendor:**
☐ Benefit Strategies ☐ Group Dynamic ☐ Health Equity ☐ HR Concepts	_____ (Enter vendor name above)	☐ BenefitWallet ☐ Benefit Strategies ☐ Health Equity

Effective Dates:	Medical Plan:	HRA/HSA:	OR	☐ 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?	☐ Yes	☐ No		
Employer HRA/HSA Contributions by Contract Type:	Individual: $ Family: $ Other: $	OR OR OR	Individual: % Family: % Other: %	

Please complete for Health Reimbursement Arrangement (HRA) Only

Medical Plan Year Type: ☐ Plan Year ☐ Calendar Year

HRA Design Option Selection:

☐ **Option A**	☐ **Option B**	☐ **Option C**
HRA applies to: • Deductible Only* • 2nd Part of Deductible	*HRA applies to:* • Deductible Only* • 1st Part of Deductible	*HRA applies to:* **Medical**: ☐ Deductible ☐ Copay ☐ Coinsurance **Rx***: ☐ Deductible ☐ Copay ☐ Coinsurance **HRA Pays** *First/Last/Percent/Other*:
Select Auto-Pay Recipient ☐ Employee (recommended) ☐ Provider	*Select Auto-Pay Recipient* ☐ Employee (recommended) ☐ Provider	*Select Auto-Pay Recipient* ☐ Employee (recommended) ☐ Provider
*If offered with an HSA PPO or an HSA HMO, Rx Deductible also applies.	*If offered with an HSA PPO or an HSA HMO, Rx Deductible also applies.	*If an Rx only **debit card** is being used, **DO NOT** check the Rx boxes above

<u>Option C</u>: Please outline what expenses will be covered under this plan design, including reimbursement limits. (<u>Example</u>: Rx Coinsurance up to $500.)

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 <u>NOT</u> be offered** alongside this HRA or HSA design

HPHC Sales Contact	**Email Address:**
Employer Contact Signature:	**Phone Number:**

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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***	**Ineligible Dependents**
● Active employees	● Partners	● Former spouses
● COBRA participants	● LLC members	● Domestic partners
● C-corporations owners receiving W-2s	● 2% owners of Sub-S corporations	● Individuals who are not the subscriber's tax dependents

***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 do not meet Massachusetts Minimum Creditable Coverage (MCC) standards. However, if offered with an employer funded Health Reimbursement Arrangement (HRA) the combination of the plan plus the funded HRA may 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)			
	Eligible to…		
Employee type	***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 *second health plan, Employee or Spouse enrolled in a traditional Health FSA or HRA*)	✗ 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. Please choose the appropriate vendor option on the next page.

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Updated 8/8/2017

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Preferred Vendors: Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA)

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. Employer certifies that the data will be used by the vendor solely to administer a qualified HSA or HRA. 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 additional administrative fees may be billed by the HRA/HSA vendor Employer hereby agrees to notify Harvard Pilgrim, immediately, in writing, of any HRA and/or HSA design or vendor changes.

Massachusetts employers in the Small Group Market: Employer agrees to adhere to Harvard Pilgrim's HRA contribution policy by contributing no more than 50% to the value of the in-network deductible of the employer offered medical plan and no more than 50% of a member's out of pocket maximum for medical or prescription drug coinsurance.

Employer Contact Name:	**Date:**
Employer Contact Signature:	**Phone Number:**

Non-Preferred HRA Vendors Only

This section MUST be completed if you are using a Non-Preferred Vendor. 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 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. Employer certifies that the data will be used by the vendor solely to administer a qualified HSA or HRA. Such data will be provided electronically. Employer authorizes Harvard Pilgrim to obtain confirmation of implemented HRA design from Employer's designated third-party vendor.

Employer acknowledges that it has entered into an agreement with an HRA vendor who is not a preferred Harvard Pilgrim vendor, and therefore, 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 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 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 vendor. Employer hereby agrees to notify Harvard Pilgrim, immediately, in writing, of any HRA design or vendor changes.

Employer Contact Name:	**Date:**
Employer Contact Signature:	**Phone Number:**
External Vendor ID# *(To be assigned by vendor)*	

NOTE: *Please be sure that the employer returns a signed Identification of Third Party form along with this completed Design Worksheet to their Account or Sales Executive. The HRA Feed CANNOT be set up unless your Harvard Pilgrim Sales Contact has received both completed forms.*

GROUP HEALTH PLAN IDENTIFICATION OF REPRESENTATIVE FORM

Harvard Pilgrim cannot release **ANY** account information to a third-party unless this form is completed.

Account Name ______________________________ **Policy #(s)** ______________

Account hereby authorizes the following ***third-party company(ies)*** to represent the Account in order to carry out Group Health Plan functions that involve the use and disclosure of Protected Health Information (PHI) on behalf of the Account:

Third Party Company Information			**Authorizations**		
Third Party Company Name (e.g. Broker Agency, HRA/HSA/ COBRA Administrator)	**Phone**	**Role of Third Party** (check all that apply)	**Administrative Functions**	**HPHConnect Access**	**Special Request** (Please Specify)
		☐ Broker/Consultant ☐ Enrollment TPA ☐ COBRA admin ☐ HRA Vendor ☐ HSA Vendor ☐ Other (please specify):	Y☐ N ☐	Y☐ N ☐	
		☐ Broker/Consultant ☐ Enrollment TPA ☐ COBRA admin ☐ HRA Vendor ☐ HSA Vendor ☐ Other (please specify):	Y☐ N ☐	Y☐ N ☐	
		☐ Broker/Consultant ☐ Enrollment TPA ☐ COBRA admin ☐ HRA Vendor ☐ HSA Vendor ☐ Other (please specify):	Y☐ N ☐	Y☐ N ☐	

- "Administrative Functions" is defined as communication of PHI via verbal, written, electronic and/or system access for a specific purpose to manage eligibility and/or billing for the account. Additional authorizations may be required when assisting members.
- "HPHConnect Access" is all-inclusive access to enrollment, billing, and reporting functionality for this online application.
- "Special Requests" are generally for ASO customers that require more than enrollment/billing related PHI such as claims data.

Account hereby acknowledges that Harvard Pilgrim will only release to a third-party representative what could be released directly to the Account per Harvard Pilgrim's disclosure policy. The Account and its representatives will adhere to all applicable HIPAA regulations, including the execution of Business Associate Agreements where applicable. The Account hereby agrees to notify Harvard Pilgrim, immediately, in writing, if any of these designations change.

Authorized Account Signature ______________________________ **Date** ______________

Print Name and Title ____

Email ______________________________ **Phone** ______________

The account must complete, sign, and return this form to:

Fax: 617-509-3456, Attn: Sales, Central Contract Administrator ***OR*** Email: Sales_Contract_Administrator@hphc.org

* The General Laws of Massachusetts c.93H, 201 CMR 17:00, Standards for the Protection of Personal Information of Residents of the Commonwealth, requires all third party service providers to provide written certification that such service provider has a written, comprehensive information security program that is in compliance with the provisions of these regulations, the scope of which applies to all persons that own, license, store or maintain personal information about a resident of the Commonwealth.