Finance Process Explanation/Forms

Prepared for New Clients

This guide assumes the client controls the bank account(s) to fund claim payments and pay administrative fees. The following contains all the information that Promise Health Plan needs to collect to set up the financial interaction between Promise Health Plan and the client. Some of the set up described below is optional. Promise Health Plan may use a third-party to fulfill some or all of the services described below.

This document contains three (3) components and the explanation for each:

- **Claims Funding**
- **Refund/Adjustments/Other Recovered Funds**
- **Monthly Client Invoice**

Claim Funding (Except FSA/HRA)

Client will receive a check register weekly. This register will contain a list of all of the claims paid for the previous week, which now require funding for payments to be released. As an example, the check register could be sent on FRIDAY, with an ACH Debit from the client's account on TUESDAY. It would clear the client's account on WEDNESDAY. Promise Health Plan or its agent does not normally wait for authorization before making the debit. It is Promise Health Plan's expectation that funding will be available based on the check register. Check registers can be received on any day of the week of the client's choosing and will be the same day of each week going forward. The client can also choose the release (ACH Debit) day, but it is our recommendation to release on Tuesday or Wednesday to coincide with ECHO's payment production.

When the check register is available, an email with a link will be sent which will take you to the portal, where the register can be retrieved. Standardly, the register does not disclose PHI. If PHI is needed (such as employee names, SSNs, etc.), we will need it to identify the contact information of the person(s) who have access to PHI. Promise Health Plan or its agent will also need the client's banking information (Account number, routing number, etc.).

There will be a tab on the check register titled "**voids**". It is important to note that the voids are not netted from the draw from the client's account. The full amount shown on the check tab will be debited, and the voids will come as a separate credit.

ECHO Health is Promise Health Plan's payment solution partner. An ECHO Authorization form will need to be completed for each account from which the client is authorizing funds to be pulled.

Our e-payment partner, ECHO Health, utilizes Huntington Bank (HNB) to debit requests for claims funding. Please have the below IDs added to the debit filter at your bank:

Online ID #: 9170230001 (Manual)
Direct Transmission: #1341858404 (Automated)

Refunds/Adjustments/Other Recovered Funds

In the case of provider refunds, adjustments, or other recovered monies, Promise Health Plan or its agent will collect the funds from the provider/vendor, and they will be placed into a Promise Health Plan account. Promise Health Plan or its agent will then ACH the funds back into the client's account and a separate refund register will be provided. The Promise Health Plan Authorization Agreement for Debits and Credits form will need to be completed and returned.

Monthly Client Invoice

Each month, the client will receive a Client Invoice from Promise Health Plan or its agent for administrative fees. This includes our administrative fees, reinsurance fees, network access fees, and other amounts that are payable. The invoice will come via secure email. The invoice will **not** contain SSN's but **WILL** contain member ID numbers.

The invoice is a snapshot of the enrollment on the 15th of the month and is sent between the 20th -25th of the month. Any changes that occur after the snapshot will appear on the next month's invoice. Promise Health Plan or its agent allows retro adjustments for additions, terminations, and plan changes, going back 3 months.

We have partnered with **Invoice Cloud** to bring a fully electronic payment portal for payment of the monthly client invoice. The Invoice Cloud is accessed through the My Payment Portal link in the Promise Health Plan Portal.

Monthly administrative fees can be paid three ways through the Payment Portal:

1. **Auto Pay** (Preferred Payment Option) - Invoices can be scheduled to pay automatically by signing up for Auto Pay. Auto Pay will initiate recurring payments on the 1st of each the month.
2. **Scheduled Recurring** - Invoices can be scheduled to automatically pay each month on the same calendar day. Just select Scheduled Recurring Payments under My Profile and follow the onscreen instructions.
3. **On-demand** - Invoices can be scheduled to pay by selecting the on-demand option. Click on the Pay My Invoices button right on the home screen and follow the instructions. This is nonrecurring and will require action each month to initiate the payment.

Our payment portal partner, Invoice Cloud, utilizes Chase Bank to debit requests for payment for the monthly administrative premium list bill. Please have the below originator ID added to the debit filters at your bank:

Originator ID #: 0000063576
Originator: Promise Health Plan
Alternate Company Name: Invoice Cloud

Steps for access to the Promise Health Plan payment portal:

1. Client users must register for the Promise Health Plan portal and provide the selected username to the Promise Health Plan account manager.
2. The Promise Health Plan account manager will assign access to the payment portal for the client's designated primary user only.
3. The monthly client invoice will be sent via secure email to the requested recipients.
4. After the initial monthly client invoice is available, the primary user will log in to the Promise Health Plan Portal and select My Payment Portal under the Quick Links drop down menu.
5. After clicking the My Payment Portal Link, the designated primary user is attached as the owner of the account.
6. The Payment Portal is now active. The client notifies Promise Health Plan that their Payment Portal registration is now complete for the primary user
7. The Promise Health Plan account manager can now provide access to additional users as requested by the client.

Payment portal helpful hints:

- The My Payment Portal Link will not function until the initial invoice is sent.

- The designated primary user aka account owner is the only user that will have access to stored banking information.

- Additional users will be granted access to the Payment Portal only after the primary user/account owner has completed the entire registration process. Although all client users will see the My Payment Portal icon, the link will not function until access is granted by Client Management.

- Additional users cannot access stored banking information but are able to make a payment by reentering the banking details.

- Promise Health Plan or its plan is able to accept credit/debit card payments via the Payment Portal.

ECHO AUTHORIZATION AND GUARANTEE AGREEMENT

FOR
AUTOMATED CLEARING HOUSE ("ACH") AUTHORITY

EMPLOYER BENEFIT PLAN NAME:	
BENEFIT PLAN GROUP NUMBER:	
TPA NAME:	Luminare Health Benefits, Inc.

Employer Benefit Plan hereby authorizes ECHO Health, Inc., hereinafter called "ECHO", to initiate debit entries for approved benefit plan payments and to initiate, if necessary, credit entries and adjustments for any debit entries in error, and refunds received to Employer Benefit Plan's account indicated below at the depository named below, hereinafter called "Depository".

DEPOSITORY NAME:			
DEPOSITORY ADDRESS:			
CITY, STATE, ZIP:			
ROUTING ABA NUMBER: **(Must be 9 digits)**		**ACCOUNT NUMBER:**	

(Please include a copy of a Canceled Check)

Employer Benefit Plan does hereby agree and guarantee that the funds will be on deposit in the account specified above within twenty-four (24) hours of its approval of benefit payments from its Third-Party claim administrator. Further, funds, once available, will be withdrawn from this account and deposited in an account established by ECHO under the Employer Benefit Plan's name at ECHO's clearing bank. Failure to fund the above account in such timely manner may result in a delay of payments. Any fines or penalties assessed to the account established by ECHO will be the responsibility of Employer Benefit Plan. Continued failure to fund such account in this timely manner may result in a loss of service for the payment of claims.

ECHO will pay the costs related to the establishment, maintenance, and activity of accounts at its clearing bank or banks. Any credits or interest earned by reason of the maintenance and use of such accounts shall be the property of ECHO and may be used by it, including, but not limited to the payments of such costs.

This authority and guarantee are to remain in full force and effect until ECHO and Depository have received written notification from Employer Benefit Plan of its termination in such time and in such manner as to afford ECHO and Depository a reasonable opportunity to act on it.

EMPLOYER BENEFIT PLAN NAME:	
EXECUTED BY:	
TITLE:	
SIGNATURE:	
DATE:	

PROMISE HEALTH PLAN AUTHORIZATION AGREEMENT FOR DEBITS & CREDITS

COMPANY:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):	
ADDRESS:	
CITY, STATE, ZIP:	

Company authorizes Promise Health Plan or its agent to initiate the following Electronic Fund Transfers with the financial institution named below, hereinafter called FINANCIAL INSTITUTION.

Select all that apply:

X Provider Refund Credits

~~☐ COBRA Reimbursement Credit~~

X Other Recovered Funds *(examples: class action settlements, subrogation recoveries, RX rebates)*

Select one: ☐ Checking Account or ☐ Savings Account

FINANCIAL INSTITUTION NAME:			
BRANCH:			
CITY, STATE, ZIP:			
ROUTING ABA NUMBER: (Must be 9 digits)		**ACCOUNT NUMBER:**	

EFT Notifications

PRIMARY NOTIFICATION EMAIL ADDRESSES	
REMITTANCE ADVICE/PAYMENT BACKUP NOTIFICATIONS (up to three email addresses may be included):	1)
	2)
	3)

This authorization is to remain in full force and effect until Promise Health Plan or its agent has received written notification from any of the individuals listed above of its termination in such time and in such manner as to afford Promise Health Plan or its agent and FINANCIAL INSTITUTION a reasonable opportunity to act on it. I represent that I have authority on behalf of Company to sign this Authorization Agreement.

NAME:	
TITLE:	
EMAIL ADDRESS:	
SIGNATURE:	
DATE:	