Plan Sponsor Certification of Group Health Plan HIPAA Compliance and Authorization for Third Party Access to PHI

BlueShield of Northeastern New York

Group Name	**Group Number(s)**
Group Health Plan Name *(Employee Welfare Benefit Plan as filed for ERISA)*	**Plan Sponsor Owner/Group Health Plan Decision Maker**

The entity ("Plan Sponsor"), named above provides benefits under a Group Health Plan for its employees in the form of insurance contracts or administrative services agreements (collectively "Benefit Contract") administered by BlueShield of Northeastern New York ("Company").

The Group Health Plan is a covered entity as defined by the Health Insurance Portability and Accountability Act (HIPAA Rules) but it is generally not a physical entity. The Plan Sponsor of the Group Health Plan acts on its behalf to perform certain plan administrative functions authorized by the Group Health Plan document which often require access to the Group Health Plan participants' protected health information ("PHI"). The Plan Sponsor hereby certifies compliance with certain requirements of the HIPAA Rules and other state and/or federal laws including, but not limited to, the following:

Plan Documents

The Group Health Plan documents comply with the requirements of § 164.504(f)(2) including, but not limited to the following:

- Establish the permitted or required uses and disclosures of PHI;
- Ensure the PHI is adequately protected;
- Identify the persons/classes of persons with access to PHI and restrict access to those persons;
- Limit uses/disclosures of PHI to those permitted by the Group Health Plan documents or required by law and prohibit uses/disclosures of PHI for employment or other benefit-related decisions;
- Require Plan Sponsor to report any use or disclosure of PHI inconsistent with the Group Health Plan documents;
- Require Plan Sponsor to make PHI available **a)** for access in accordance with § 164.524; **b)** for amendment and incorporate amendments to PHI in accordance with § 164.526; and **c)** to provide an accounting of disclosures in accordance with § 164.528;
- Require agents/subcontractors with access to PHI to comply with the same restrictions and conditions that apply to Plan Sponsor.

Authorized Representatives

In accordance with the HIPAA Rules and other applicable federal and state laws:

- Plan Sponsor has a HIPAA compliant Business Associate Agreement with the agency and/or representatives ("Authorized Representatives") named in Exhibit A and Exhibit B, as applicable, requiring compliance with the same restrictions/conditions that apply to Plan Sponsor;
- Authorized Representatives may not request and Company may not release PHI pertaining to sensitive health conditions such as HIV/AIDS, mental health, alcohol/substance abuse and, in some cases, sexually transmitted diseases or abortion. These conditions are subject to various state and federal privacy laws that require the individual's specific written authorization;
- Authorized Representatives must protect the PHI, as obligated, upon non-renewal/termination of the Benefit Contract;

Broker Agencies and Minimum Necessary

As the Plan Sponsor Owner/Group Health Plan Decision Maker, I am aware that the minimum necessary rule at 164.514(d)(2) requires Plan Sponsor to limit access to PHI to persons or classes of persons identified in the Group Health Plan document with a valid need for the information. I understand the potential risk involved in the event I authorize ALL representatives within a Broker Agency to access PHI and that violations of minimum necessary requirements may be deemed a breach of PHI and/or result in various fines/penalties.

Miscellaneous Provisions

I, the Plan Sponsor Owner/Group Health Plan Decision Maker named above, and the Authorized Representatives named in Exhibit A and Exhibit B understand and agree:

- That we are aware of, understand, and will comply with our obligations under the HIPAA Rules and that violation of such obligations could result in civil penalties up to $1.5 million in a calendar year and potential criminal penalties against the responsible individual(s);
- To notify Company in writing of any changes to the information contained in this form and Company shall not be responsible for releasing PHI in reliance on this form if Plan Sponsor and/or its Authorized Representatives fail to submit such notification;
- To indemnify, defend and hold harmless Company, its affiliates and employees, without limitation, from and against any and all claims, actions, damages, losses, liabilities, fines, penalties, costs or expenses as a result of Plan Sponsor's and/or its Authorized Representatives' breach of their obligations and inappropriate access, use, or disclosure of PHI by unauthorized representatives, which are defined to be individuals without proper approval to access, use, or disclose PHI.
- That Company may review requests to ensure compliance with minimum necessary criteria and Company policies;
- That Company may revoke this form in its sole discretion upon written notice to Plan Sponsor;
- That Company will terminate exchange of PHI pursuant to this form upon non-renewal/termination of Benefit Contract.

Signatures(s)

Plan Sponsor Owner/Group Health Plan Decision Maker ***(required in all circumstances)*****.** By my signature below, I attest the certifications made herein are true and correct, and Plan Sponsor and its Authorized Representatives will comply with the terms and conditions set forth herein.

Signature: _____ Date: _____

Broker Agency Owner/Decision Maker ***(required only if Broker Agency is authorized in Exhibit A)*****.** By my signature below, I attest that I and the Broker Agency Representatives have read, understand, and will comply with the terms and conditions set forth herein.

Signature: _____ Date: _____

Exhibit A - Authorization for Third Party Access to PHI

(Authorized Representatives may use separate forms to protect the privacy of their information)

BlueShield of Northeastern New York

A. Authorized Employer or Non-Broker Representative *(e.g., Plan Sponsor employees, third party administrators, enrollment vendors, etc.)*

Company Name: _____ DOB: _____

Representative Name: _____ Phone: _____

Address: _____ Email: _____

Provide the information to the right only if authorized for Online Services access:

Security Question	Answer
Mother's Maiden Name	
Street You Grew Up On	
First Place of Employment	
Last 4 Digits of SSN	

By my signature below, I attest that I have read, understand, and agree to comply with the terms, conditions, and obligations as stated on Page 1 of this form as they apply to Authorized Representatives.

Signature: _____ Date: _____

B. Authorized Individual Broker Representative(s)

1. Representative Name: _____ Broker ID: _____
   DOB: _____ Phone: _____ Email: _____
2. Representative Name: _____ Broker ID: _____
   DOB: _____ Phone: _____ Email: _____
3. Representative Name: _____ Broker ID: _____
   DOB: _____ Phone: _____ Email: _____

By my signature below, I attest that I have read, understand, and agree to comply with the terms, conditions, and obligations as stated on Page 1 of this form as they apply to Authorized Representatives.

Broker Representative 1 Signature: _____ Date: _____

Broker Representative 2 Signature: _____ Date: _____

Broker Representative 3 Signature: _____ Date: _____

C. Authorized Broker Agency *(allows ALL of the Broker Agency's representatives to receive PHI on Plan Sponsor's behalf)*

Decision Maker Name: _____ Agency Name: _____

Address: _____

Broker ID: _____ Phone: _____ Email: _____

D. PHI Access[1]

LEVEL 1: Receive PHI by General Inquiry, Reports, etc. (no Online Services access)

- Obtain general reports/information (via paper/email) needed for plan functions
- Contact Customer Service to assist employees with benefits, claims, etc.[2]
- Administer Plan Sponsor's electronic enrollment, billing, FSA/HSA accounts, etc.

LEVEL 2: Includes ALL of Level 1 AND the below Online Services Inquiry Access

- Member Inquiries *(includes address, eligibility, student/handicap, primary care physician, other insurance/COB, benefits, referrals/pre-authorizations)*
- Billing Inquiries

LEVEL 3: Includes ALL of Levels 1 and 2 AND the below eEnroll Functions

- New, Pre, and/or Open Enrollment
- Terminate/Reinstate Subscriber
- Update Coverage
- Update Address (subscriber home)

OPTIONAL ACCESS: Only Permitted with Level 2 and/or Level 3 Access

- Arrow Reports *(available to groups with 100 or more subscribers)*
- BlueInsight *(available to groups with 500 or more subscribers)*

Circle ONE PHI Access level for each representative:

Authorized Representative(s)	Access Level(s)			Optional Access	
Employer or Non-Broker Representative	Level 1	Level 2	Level 3	Arrow Reports	BlueInsight
Individual Broker Representative 1	Level 1	Level 2	Level 3	Arrow Reports	BlueInsight
Individual Broker Representative 2	Level 1	Level 2	Level 3	Arrow Reports	BlueInsight
Individual Broker Representative 3	Level 1	Level 2	Level 3	Arrow Reports	BlueInsight
Broker Agency All	Level 1	Level 2	Level 3	Arrow Reports	BlueInsight

E. Plan Sponsor Owner/Decision Maker Signature *(required in all circumstances)*

I attest that I am the Plan Sponsor Owner/Group Health Plan Decision Maker with authority to authorize third party access to PHI and I am accountable to ensure such parties comply with the requirements of the Plan Sponsor Certification of Group Health Plan HIPAA Compliance form on page 1. I further attest that the Authorized Representatives named above are employees or agents of Plan Sponsor permitted to receive Group Health Plan participants' PHI.

Signature: _____ Date: _____

[1] The Plan Sponsor Owner/Decision Maker may be required to verify user status upon Company's request or notification.
[2] Authorized Representative must prove involvement in employee's care as it relates to the issue in question.

Exhibit B: Authorization for Third Party Access to PHI

(Authorized Representatives may use separate forms to protect the privacy of their information)

BlueShield of Northeastern New York

A. Additional Authorized Employer or Non-Broker Representative(s)

1. Company Name: _____ DOB: _____
   Representative Name: _____ Phone: _____
   Address: _____ Email: _____

Provide the information to the right only if authorized for Online Services access:	Security Question	Answer
	Mother's Maiden Name	
	Street You Grew Up On	
	First Place of Employment	
	Last 4 Digits of SSN	

2. Company Name: _____ DOB: _____
   Representative Name: _____ Phone: _____
   Address: _____ Email: _____

Provide the information to the right only if authorized for Online Services access:	Security Question	Answer
	Mother's Maiden Name	
	Street You Grew Up On	
	First Place of Employment	
	Last 4 Digits of SSN	

3. Company Name: _____ DOB: _____
   Representative Name: _____ Phone: _____
   Address: _____ Email: _____

Provide the information to the right only if authorized for Online Services access:	Security Question	Answer
	Mother's Maiden Name	
	Street You Grew Up On	
	First Place of Employment	
	Last 4 Digits of SSN	

By my signature below, I attest that I have read, understand, and agree to comply with the terms, conditions, and obligations as stated on Page 1 of this form as they apply to Authorized Representatives.

Authorized Representative Signature 1: _____ Date: _____

Authorized Representative Signature 2: _____ Date: _____

Authorized Representative Signature 3: _____ Date: _____

B. PHI Access[1]

LEVEL 1: Receive PHI by General Inquiry, Reports, etc. (no Online Services access)
- Obtain general reports/information (via paper/email) needed for plan functions
- Contact Customer Service to assist employees with benefits, claims, etc.[2]
- Administer Plan Sponsor's electronic enrollment, billing, FSA/HSA accounts, etc.

LEVEL 2: Includes ALL of Level 1 AND the below Online Services Inquiry Access
- Member Inquiries *(includes address, eligibility, student/handicap, primary care physician, other insurance/COB, benefits, referrals/pre-authorizations)*
- Billing Inquiries

LEVEL 3: Includes ALL of Levels 1 and 2 AND the below eEnroll Functions
- New, Pre, and/or Open Enrollment
- Terminate/Reinstate Subscriber
- Update Coverage
- Update Address (subscriber home)

OPTIONAL ACCESS: Only Permitted with Level 2 and/or Level 3 Access
- Arrow Reports *(available to groups with 100 or more subscribers)*
- BlueInsight *(available to groups with 500 or more subscribers)*

Circle ONE PHI Access level for each representative:	Authorized Representative(s)	Access Level(s)		
	Employer or Non-Broker Representative 1	Level 1	Level 2	Level 3
	Employer or Non-Broker Representative 2	Level 1	Level 2	Level 3
	Employer or Non-Broker Representative 3	Level 1	Level 2	Level 3

Optional Access	
Arrow Reports	BlueInsight
Arrow Reports	BlueInsight
Arrow Reports	BlueInsight

C. Plan Sponsor Owner/Decision Maker Signature *(required in all circumstances)*

I attest that I am the Plan Sponsor Owner/Group Health Plan Decision Maker with authority to authorize third party access to PHI and I am accountable to ensure such parties comply with the requirements of the Plan Sponsor Certification of Group Health Plan HIPAA Compliance form on page 1. I further attest that the Authorized Representatives named above are employees or agents of Plan Sponsor permitted to receive Group Health Plan participants' PHI.

Signature: _____ Date: _____

[1] The Plan Sponsor Owner/Decision Maker may be required to verify user status upon Company's request or notification.
[2] Authorized Representative must prove involvement in employee's care as it relates to the issue in question.