BlueCross BlueShield of Western New York

Plan Sponsor Certification of Group Health Plan HIPAA Compliance

Plan Sponsor Name *(Employer Group)* | **Group Number(s)**

Group Health Plan Name *(Employee Welfare Benefit Plan filed for ERISA)* | **Plan Sponsor Owner or Group Health Plan Decision Maker**

The Plan Sponsor named above provides benefits under a Group Health Plan for its employees in the form of certain benefit contracts administered by BlueCross BlueShield of Western New York ("Company"). The Plan Sponsor performs, directly or through third parties ("Authorized Representatives"), certain functions for administration of the Group Health Plan which requires access to Group Health Plan participants' protected health information ("PHI").

The Health Insurance Portability and Accountability Act (HIPAA) requires the Plan Sponsor to certify understanding of and compliance with certain HIPAA requirements before Company may disclose PHI to the Plan Sponsor or its Authorized Representatives.

As such, Plan Sponsor requests Company allow the Authorized Representatives named herein access to Company's Online Portal as a resource to perform such functions. Any such access granted is subject to the Plan Sponsor's certification and other provisions documented below.

1. Plan Sponsor certifies that:

a) The individual(s) or organization(s) identified herein are Authorized Representatives of the Plan Sponsor permitted to access the Group Health Plan participants' PHI.

b) The Group Health Plan documents ("Plan Documents") have been amended, *as applicable*, to comply with the requirements of 45 C.F.R. 164.504(f)(2), including but not limited to:

- Prohibiting uses/disclosures of PHI for employment or other benefit-related decisions;
- Describing the persons or classes of persons (i.e., Authorized Representatives) with access to PHI and restrict the access of those persons to perform plan administration functions related to the Group Health Plan;
- Requiring agents/subcontractors with access to PHI to comply with the same restrictions and conditions that apply to Plan Sponsor.

2. Plan Sponsor understands and agrees:

a) That, *when applicable*, it has obtained satisfactory assurance, by way of HIPAA compliant business associate agreements or equivalent written agreement, from the Authorized Representatives named herein 1) to comply with the same restrictions and conditions that apply to Plan Sponsor with respect to Group Health Plan participants' PHI; and 2) to require the same of any subcontractors working on behalf of the Authorized Representatives with access to Group Health Plan participants' PHI.

b) That violation of its obligations under HIPAA could result in civil and/or criminal penalties against the responsible individual(s);

c) That Company may not release PHI pertaining to sensitive health conditions such as HIV/AIDS, mental health, substance use disorders and certain other conditions without the individual's authorization as required by state or federal law;

d) 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 fails to submit such notification;

e) That the Authorized Representatives will protect the PHI, as obligated, upon non-renewal/termination of the benefit contract;

f) 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/or inappropriate access, use, or disclosure of PHI by unauthorized representatives;

g) That Company 1) may review requests to ensure compliance with minimum necessary criteria and Company policies; 2) may revoke this form in its sole discretion upon written notice to Plan Sponsor; and 3) will terminate exchange of PHI pursuant to this form upon non-renewal/termination of the benefit contract.

Plan Sponsor Owner or Group Health Plan Decision Maker Signature ***(required in all circumstances)***

By my signature below, I attest the certifications made are true and correct, and Plan Sponsor and its Authorized Representatives will comply with the terms, conditions, and obligations set forth herein.

⌦ **Signature:** _____ **Date:** _____

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Authorization for Third Party Access to PHI

Use this form to identify third parties (Authorized Representatives) authorized by the Plan Sponsor to access PHI via the Company's Online Portal in order to perform administration functions related to the Group Health Plan.

PLEASE PRINT CLEARLY

A: Plan Sponsor Representative(s) *(i.e., Plan Sponsor employees)*

1. Representative Name: _____ Title: _____

Last 4 of SSN: _____ DOB: _____ Phone: _____ Email: _____

2. Representative Name: _____ Title: _____

Last 4 of SSN: _____ DOB: _____ Phone: _____ Email: _____

3. Representative Name: _____ Title: _____

Last 4 of SSN: _____ DOB: _____ Phone: _____ Email: _____

4. Representative Name: _____ Title: _____

Last 4 of SSN: _____ DOB: _____ Phone: _____ Email: _____

By my signature below, I attest that I have read, understand, and agree to comply with the terms, conditions, and obligations on Page 1, which are incorporated herein by reference, as they apply to Authorized Representatives.

⌦ **Representative 1 Signature:** _____ **Date:** _____

⌦ **Representative 2 Signature:** _____ **Date:** _____

⌦ **Representative 3 Signature:** _____ **Date:** _____

⌦ **Representative 4 Signature:** _____ **Date:** _____

B: Individual Broker Agent

Agent Name: _____ Agency Name: _____

Broker ID: _____ DOB: _____ Phone: _____ Email: _____

By signing below, I attest that I understand and agree to comply with the terms, conditions, and obligations on page 1, which are incorporated herein by reference, as they apply to Authorized Representatives.

⌦ **Agent Signature:** _____ **Date:** _____

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

Owner/Decision Maker Name: _____ Broker ID: _____

Agency Name: _____ Phone: _____

Name of Primary Broker Agent representing this group *(optional)*: _____

By my signature below, I attest I am the Owner/Decision Maker named above and that I have read and understand the terms, conditions, and obligations on Page 1, which are incorporated herein by reference, as they apply to Authorized Representatives. I further attest that I am accountable to ensure all agents of the above broker agency with access to PHI understand and comply with the terms, conditions, and obligations on Page 1 as they apply to Authorized Representatives.

⌦ **Agency Owner/Decision Maker Signature:** _____ **Date:** _____

D: Plan Sponsor Owner or Group Health Plan Decision Maker Signature *(required in all circumstances)*

By my signature below, I attest I am the Plan Sponsor Owner or Group Health Plan Decision Maker with authority to authorize third party access to PHI and the Authorized Representatives named above are employees or agents of Plan Sponsor permitted to receive Group Health Plan participants' PHI. I further attest that I am accountable to ensure such parties understand and comply with the requirements of the Plan Sponsor Certification of Group Health Plan HIPAA Compliance on Page 1, which are incorporated herein by reference.

⌦ **Signature:** _____ **Date:** _____