Designation of Administrator

_____ [group policyholder]
(hereinafter "Client") is the policyholder of a group health plan insured by EmblemHealth Insurance Company, EmblemHealth Plan, Inc., Health Insurance Plan of Greater New York and ConnectiCare Inc. (hereinafter collectively referred to as "Emblem"). Client hereby designates the entity identified below as its Administrator to act on Client's behalf in connection with the functions identified herein and such other functions that Client may designate in writing to Emblem for Client's Emblem group health plan (the "Purpose").

Designated Administrator:

_____

_____

_____

Administrator Contact: [Name] _____

[Phone] _____

[E-mail] _____

2. For the transactions identified below, Client hereby authorizes Emblem to accept, rely upon and process transactions it receives from Administrator on Client's behalf or on behalf of the Plan and/or Plan members and further authorizes Emblem to initiate and perform the transactions (and all activities normally or reasonably associated with such transactions) with Administrator that Emblem would otherwise perform directly with the Client. In the event that Client notifies Emblem in writing to conduct any additional transactions with the Administrator on Client's behalf subsequent to the execution of this Designation, then the terms of this Designation shall apply to such additional services and such additional services shall be considered part of the Purpose even though not specifically listed herein. Client understands and agrees that all transactions are subject to the terms of its health plan group contract(s) with Emblem.

3. Client understands and agrees that Administrator, including its respective employees, agents and subcontractors shall not be deemed an employee(s) or agent(s) of Emblem. Client and its employees, agents or subcontractors shall not represent in any manner that Administrator or its employees, agents or subcontractors are employees or representatives of Emblem. Emblem shall have no financial liability for services performed by Administrator.

4. Client understands and agrees that Administrator must agree to the terms of Emblem's Trading Partner Agreement in order for Emblem to conduct any electronic transactions with Administrator.

5. Client agrees to indemnify, defend and hold Emblem, its subsidiaries, affiliates, officers, directors, employees agents, successors and assigns (collectively "Emblem Related Parties") harmless from any and all first or third party legal or administrative action, claim, liability, penalty, fine, assessment, lawsuit, litigation or other loss expense or damage, (including, without limitation, any reasonable attorney's fees and costs), (collectively, "Liability") that Emblem or its affiliates may incur directly arising out of or relating to any delay, error or omission made by Administrator in connection with the transactions and/or service(s) contemplated hereunder upon which Emblem relied, any breach by Administrator or its representatives and agents or contractors of any applicable law, regulation or other legal mandate related to the performance of administrative services for Client.

6. If "Claims transactions for purposes of Health Reimbursement Arrangement (HRA) and/or Health Savings Account (HSA) administration" is checked below, Client must also execute and supply to Emblem a HIPAA plan sponsor certification in a form determined by and/or acceptable to Emblem, and the Client must ensure that the terms of such certification must remain applicable and in force until such time that Client directs Emblem to discontinue sending such transactions to its designated administrator. Claims transactions for this purpose refer to any and all information about finalized Emblem claim determinations relating to Client's covered members as may be necessary and appropriate for the purpose of HRA and/or HSA administration.

Designated Functions: (check applicable box(es))

☐ Enrollment and Disenrollment transactions.

☐ Billing and Payment.

☐ Claims transactions for purposes of Health Reimbursement Arrangement (HRA) and/or Health Savings Account (HSA) administration.

Requested and Agreed to by Client:

By: _____

Name: _____

Title: _____

Date: _____

HEALTH REIMBURSEMENT ARRANGEMENT
HIPAA CERTIFICATION

On behalf of the _ _____ [LEGAL NAME OF PLAN] group health plan (the "Plan"), __ _____ [EMPLOYER NAME], as Plan Sponsor ("Employer") of the Plan, does hereby warrant, represent and certify the following:

1. **Information Requested.** Employer has requested ConnectiCare to supply Plan's Business Associate,_____ [THIRD PARTY ADMINISTRATOR NAME] (called "Recipient") with the demographic and claims data containing Protected Health Information (called "PHI") requested by Recipient and needed solely for the purposes of administering the Plan's Health Reimbursement Arrangement ("HRA").

   Please indicate if the data should include (check all that apply): ☐ **Pharmacy Claims Data** ☐ **Behavioral Health Claims Data**

2. **Plan Administration Purpose.** Such PHI is required for Recipient to perform the following plan administration function(s) on behalf of the Plan: Using the claims data requested by Employer in paragraph 1, Recipient will administer Employer's HRA.

3. **Minimum Necessary Determination.** Employer has conducted its own separate analysis to determine that each and every piece of information and data element requested hereunder that is PHI is the minimum necessary for Recipient to perform the above plan administration function(s).

4. **Notice to Employees.** Employer has distributed to all Plan Participants the privacy notice required under the Health Insurance Portability And Accountability Act of 1996 ("HIPAA"), and that notice states that Recipient will be receiving PHI about participants in the Plan.

5. **Plan Document Amendment & Agreement.** Employer has amended the Plan's Plan Document to provide, and also hereby agrees to the following. In addition, if Employer is not Recipient, then Employer agrees that it has also ensured that Recipient agrees to the following to the extent applicable to Recipient:

- Employer shall not use or further disclose the PHI other than as permitted or required under the Plan Documents or as required by law;
- Employer shall not request, and Recipient shall not disclose member-level claims data to the Employer.
- Employer shall ensure that its agents, subcontractors and/or Business Associates (as defined under HIPAA) to whom it provides the PHI, either directly or through ConnectiCare, agree in writing to the same restrictions and conditions that apply to Employer;
- Employer shall not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
- Employer shall report to the group health plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Employer shall provide access to the PHI to Plan Participants in accordance with Section 164.524 of the HIPAA regulations;
- Employer shall make available the PHI to Plan Participants for amendment and incorporate any amendments to the PHI in accordance with Section 164.526 of the HIPAA regulations;
- Employer shall provide an accounting to Plan Participants of disclosures in accordance with Section 164.528 of the HIPAA regulations;
- Employer shall make its internal practices, books, and records relating to the use and disclosure of the PHI available to the Secretary of the Health and Human Services for purposes of determining compliance by the group health plan;
- Employer shall, if feasible, return or destroy all PHI received hereunder and retain no copies when no longer needed for the above purpose, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
- Employer shall ensure that adequate separation is established between Employer and the group health plan, as required under Section 164.504(f)(2)(iii) of the HIPAA regulations.

6. **Indemnification.** In consideration of the provision by ConnectiCare of access to the PHI hereunder, Employer hereby agrees to defend, indemnify and hold harmless ConnectiCare from any and all damages and losses, including reasonable attorneys' fees and court costs, which may be incurred by ConnectiCare with respect to the disclosure to, or use of PHI by Employer and/or Recipient hereunder, or breach of the warranties, representations, certifications or agreements set forth above.

I hereby agree to the above and certify and warrant and represent that it is true:

By: _____ Date: _____
Authorized Officer of Employer
Printed Name: _____ Title: _____

I have reviewed the above and have determined that it is acceptable to comply with this request for PHI: ____ Yes ____ No
By: _____ Date: _____
ConnectiCare Privacy Officer