Employer Portal Access Form

HealthPlans
A HARVARD PILGRIM COMPANY

Group Health Plan Name: _____ **Group Number:** _____

INTRODUCTION

Health Plans, Inc. is pleased to offer you our Employer Portal, a website providing you with self-service access to a set of tools designed to assist you in managing your Group Health Plan. Before using this tool, please consider which staff in your organization and which individuals supporting your Plan from outside your company have a legitimate business need to access this data. Only approved classes of employees or other workforce members as listed in the HIPAA Privacy Provisions section of your Group Health Plan's Summary Plan Description (SPD), or authorized Business Associates, may be given access to an individual's Protected Health Information (PHI). This form provides you with the necessary steps to authorize such individuals for access to either: (1) standard plan information excluding Protected Health Information or (2) data which includes PHI. This procedure is required in accordance with the Health Insurance Portability and Accountability Act (HIPAA), which was enacted to protect the privacy of individuals' health information.

SECTION A - TERMS OF ACCESS

Completion of this form is the first step required for the individuals designated below to receive a temporary password and instructions for logging in, changing their password and accessing reports, enrollment and/or claims. By completing and signing this form, you are verifying that:

1. You are the Plan's Privacy Officer and you have authorized the designated employees and/or Business Associates listed below to have access to online Plan information in order to perform necessary administrative functions for the management and operation of your Plan. If the job titles of the listed employees are not currently identified in your SPD, you are approving the addition of such titles to your SPD;
2. You have provided the designated employees with the HIPAA training necessary, and/or that you have entered into a validly existing Business Associate Agreement with any designated Business Associate, to ensure that they will use or disclose an individual's Protected Health Information ONLY for the purposes set forth in the HIPAA Privacy Provisions section of your Plan's SPD, including but not limited to the following:
    - The designated employees and Business Associates will only use or disclose an individual's Protected Health Information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations;
    - The designated employees and Business Associates will NOT use or disclose an individual's Protected Health Information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA;
    - The designated employees and Business Associates will take appropriate and reasonable safeguards to protect the confidentiality, integrity and availability of the Protected Health Information they create, receive, maintain, or transmit, and they will promptly report to the Plan Sponsor any "security incident" (as such term is defined under HIPAA or any applicable state data security laws) about which they become aware; and
    - The designated employees and Business Associates will promptly report to the Plan Sponsor any use or disclosure of an individual's Protected Health Information that is made in violation of or is inconsistent with the rules set forth in the Plan's SPD.
3. a) You will limit the designated employees' and Business Associates' access to PHI to the amount reasonably necessary to accomplish the intended use or purpose for which the access is needed and limit such access to the amount reasonably necessary in order for the employees and Business Associates to perform the responsibilities and functions of their job in accordance with HIPAA's "minimum necessary" standards, b) Health Plans is not responsible to determine whether any PHI requested to be accessed is the minimum necessary and such determination is solely made by the Plan Sponsor, and c) Health Plans may rely on the request for access to Plan information containing PHI as being the minimum necessary amount needed for the intended use or purpose in accordance with the HIPAA regulations; and
4. You will report any and all changes to the below listing of employees and/or Business Associates to Health Plans in a timely manner.

Please return all pages of this form to verify your agreement with the statements in Items 1-4 under Section A.

SECTION B - EMPLOYEES

I would like the following employees to have access to the Employer Portal (check all that apply):

1. Employee Name: _____ Title: _____
   Email Address: _____ Department: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only
   - ☐ Your Plan Benefits (no PHI)

2. Employee Name: _____ Title: _____
   Email Address: _____ Department: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only
   - ☐ Your Plan Benefits (no PHI)

3. Employee Name: _____ Title: _____
   Email Address: _____ Department: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only
   - ☐ Your Plan Benefits (no PHI)

4. Employee Name: _____ Title: _____
   Email Address: _____ Department: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only
   - ☐ Your Plan Benefits (no PHI)

5. Employee Name: _____ Title: _____
   Email Address: _____ Department: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only
   - ☐ Your Plan Benefits (no PHI)

Continued on Page 3

Please return all pages of this form to verify your agreement with the statements in Items 1-4 under Section A.

SECTION C - BUSINESS ASSOCIATES

I would like the following Business Associates to have access to Online Reporting (check all that apply):

1. Name: _____ Title: _____
   Email Address: _____ *Organization: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only

2. Name: _____ Title: _____
   Email Address: _____ *Organization: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only

3. Name: _____ Title: _____
   Email Address: _____ *Organization: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only

4. Name: _____ Title: _____
   Email Address: _____ *Organization: _____
   - ☐ Reports (no PHI)
   - ☐ Reports (with PHI)
   - ☐ Enrollment (with PHI), view only
   - ☐ Enrollment (with PHI), edit authority
   - ☐ Claims (with PHI), view only

*Please indicate the organization this individual represents, e.g., your broker. Please note Health Plans will require any designated Business Associate to also sign a **Confidentiality & Non Disclosure Agreement** and **Privacy & Data Security Agreement** with Health Plans, Inc.

To set up access to the Employer Portal, Health Plans will send a temporary password via secure email, to each individual listed above. The subject line of this email will be PGP Universal Secured Message. Only ONE user per password is allowed. Once the individual has received a temporary password, he or she can contact your Health Plans Account Manager if further assistance in accessing the portal is needed.

Health Plans will also amend your Plan Document, if necessary, to add any classes of employees requiring access to PHI as listed above if such employees are not already identified in your SPD.

AUTHORIZATION

Group Health Plan's Privacy Officer Signature: _____

Print Name: _____

Title: _____ Date: _____

Please return all pages of this form to verify your agreement with the statements in Items 1-4 under Section A.
Completed form should be returned to your Health Plans Account Manager.