EVHC

AUTHORIZATION TO ACCESS PROTECTED HEALTH INFORMATION

Name of legal entity sponsoring health plan ("Plan Sponsor"): _____
The Plan Sponsor named above provides benefits under a health plan, as defined by the Health Insurance Portability and Accountability Act ("HIPAA"), for its employees ("Health Plan").

The Health Plan is (check one): ☐ Fully Insured ☐ Self-Insured.

HIPAA sets forth requirements for Plan Sponsors and Health Plans regarding the disclosure of PHI to the Plan Sponsor (see 45 C.F.R. §164.504(f)). The purpose of this form is for the Plan Sponsor to designate the individual(s) authorized to receive protected health information ("PHI") relating to the Health Plan as permitted by HIPAA and to confirm that the Plan Sponsor is compliant with the HIPAA requirements applicable to the level of access specified below.

☐ By checking this box, Plan Sponsor authorizes Luminare Health Benefits, Inc. to provide the individual(s) or classes of individuals under the control of the Plan Sponsor listed below ("Authorized Representative") with PHI relating to the Health Plan. The Plan Sponsor expressly acknowledges that the Authorized Representative(s) is or are authorized to receive PHI on behalf of the Health Plan in accordance with the level of access indicated below:

LMTD –Allowed access to Health Plan information that does not involve individual claim or other health information but exceeds summary health information or information on whether an individual has enrolled or disenrolled in the Health Plan. Summary health information is information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group Health Plan, and which has been de-identified in accordance with § 164.514(b)(2)(i) (geographic information only needs to be aggregated to the level of a five digit zip code). Examples:

- Access to Plan Identification Cards
- Verification of whether a COBRA election has been made
- Verification of receipt of premium / contribution payment
- Copies of 1095-C, or similar health plan forms required by law

CLM 1 –Allowed access to limited individual claim and health information, but not to a level that discloses an individual's health condition. Examples:

- Able to check the status of a claim of a particular date of service
- Able to verify whether the individual has met their deductible or out-of-pocket maximum.

CLM 2 –Allowed access to PHI that could include claim information containing details about an individual's health condition. Examples:

- Able to receive detailed information about specific individual claims
- Able to receive copies of explanation of benefit statements

FINANCE –Allowed access to information about the financial status of the plan, but not allowed access to any individual PHI. Examples:

- Able to receive reports about funding levels of the plan
- Able to receive copies of check registers related to plan funds

ATTESTATION AND ACKNOWLEDGEMENT

I attest that Plan Sponsor has granted me the authority to designate the individuals listed above to receive the level(s) of protected health information specified herein relating to the Health Plan.

I further attest that Plan Sponsor is and shall remain in compliance with the HPAA requirements applicable to the level of access requested above and acknowledge that Luminare will rely upon this representation in providing Plan Sponsor with the requested information. I further acknowledge that Luminare may refuse to disclose PHI pertaining to certain sensitive diagnoses or treatments such as mental health, substance abuse and other conditions subject to additional privacy considerations under federal and state privacy law in the absence of written authorization from the subject individual.

I understand that the designations made herein will remain in effect until I provide Luminare Health Benefits, Inc. with written notification of any changes to this authorization and Luminare provides written acknowledgment of receipt of such changes.

SIGNATURE: _____

PRINTED NAME: _____

TITLE: _____

DATE: _____

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Name of Authorized Representative	Title of Authorized Representative	Company/Entity Affiliation of Authorized Representative (Plan Sponsor, Vendor, etc.)	Role of Authorized Representative	Email Address	Phone Number	Level of Access Authorized	Type of Change	Effective Date of Change
			☐Plan Sponsor ☐Broker/ Consultant ☐ Network ☐PBM ☐Reinsurer ☐Enrollment Vendor ☐COBRA Vendor ☐FSA/HSA/ HRA Vendor ☐Telemed Vendor ☐Analytics Vendor ☐Other			☐LTD ☐CLM1 ☐CLM2 ☐FINANCE	☐New Auth Representative ☐Change in Level of Access for Existing Representative ☐Removal of Authorized Representative	
			☐Plan Sponsor ☐Broker/ Consultant ☐ Network ☐PBM ☐Reinsurer ☐Enrollment Vendor ☐COBRA Vendor ☐FSA/HSA/ HRA Vendor ☐Telemed Vendor ☐Analytics Vendor ☐Other			☐LTD ☐CLM1 ☐CLM2 ☐FINANCE	☐New Auth Representative ☐Change in Level of Access for Existing Representative ☐Removal of Authorized Representative	
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