Dear _____:

Pursuant to Chapter 1215 of the Texas Insurance Code, _____ ("Plan Sponsor") is requesting certain claim information as described in Texas Insurance Code § 1215.003 ("Claim Information") from UnitedHealthcare, Inc. ("UHC") be provided to it through its agent ("Agent").

The Agent that the Plan Sponsor wishes to designate to receive the Claim Information on its behalf is:

_____

_____

_____

Plan Sponsor hereby requests that UHC provide the information described in Texas Insurance Code § 1215.003 to Agent.

UHC will be unable to provide the claim information requested without a HIPAA Certification by the Plan Sponsor. To that end, the Plan Sponsor makes the certification as required by Texas Insurance Code § 1215.003(e) by initialing and signing the Protected Health Information Certification attached as Exhibit A. The Plan Sponsor also hereby warrants and represents that the Agent is authorized by the Plan Sponsor to receive Claim Information and that the Agent has all necessary protections in place to safeguard and limit the use and disclosure of protected health information ("PHI") that the Agent may receive from UHC.

Furthermore, Agent agrees that it will only use Claim Information for the purposes specified in Texas Insurance Code Chapter 1215.

Plan Sponsor acknowledges that UHC is providing the Claim Information, including PHI, in accordance with Texas Insurance Code Chapter 1215. Plan Sponsor is requesting that UHC provide the Claim Information to Agent and, therefore, will not hold UHC liable for any damages resulting from the release of Claim Information, whether to Agent or to Plan Sponsor.

Plan Sponsor agrees to indemnify and hold UHC harmless against any loss, damage, or expense, including reasonable attorneys' fees that UHC may incur or be required to pay as a result of any claim, demand, cause of action, lawsuit or proceeding arising out of or in any way connected with the release of Claim Information by UHC under the terms of this letter. Furthermore, the Plan Sponsor agrees to indemnify and hold UHC harmless against any penalty which is or may be imposed upon UHC by any law or regulation in connection with providing Claim Information under the terms of this letter, unless it is determined that the liability therefore was the direct consequence of the dishonest, fraudulent or criminal acts of UHC.

Plan Sponsor

Name:

Title:

Signature:_____

Date:_____

Agent

Name:

Title:

Signature:_____

Date:_____

UnitedHealthcare
A UnitedHealth Group Company

PROTECTED HEALTH INFORMATION CERTIFICATION

I hereby certify that I am an appropriately authorized representative of the plan sponsor and have the authority to execute this certification. I further certify that the plan sponsor is acting in the capacity of a Covered Entity under HIPAA and has in place appropriate plan documents necessary to demonstrate compliance with applicable privacy requirements. I certify that the plan documents meet the requirements described below:

(initial each box below)

A. ☐ Plan documents describe employees or classes of employees or other persons under the control of the plan sponsor to be given access to the protected health information to be disclosed, provided that any employee or person who receives protected health information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description;

B. ☐ Restrict the access to and use by such employees and other persons described in the paragraph A above to the plan administration functions that the plan sponsor performs for the group health plan;

C. ☐ Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph A above with the plan document provisions required by law; and

D. ☐ The plan documents comply with the requirements of Section 164.504(f)(2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from UnitedHealthcare (hereafter referred to as the Company) to perform the plan administration functions.

Specifically, the plan sponsor will:

1. Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;
2. Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Company, or to whom it provides written direction to the Company to share protected health information, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;
4. Report to the Company any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available protected health information in accordance with 45 CFR §164.524;
6. Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526;
7. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
8. Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Company available in response to an inquiry from the Company or an appropriate regulatory entity for purposes of determining compliance with federal privacy requirements;
9. If feasible, return or destroy all protected health information received from the Company that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

On Behalf of _____
(Plan Sponsor)

Authorized Representative:

Name: _____

Signature: _____

Title: _____

Date: _____