HIPAA PRIVACY NOTICE

1. Definitions:

HIPAA means the Health Insurance Portability and Accountability Act of 1996 and regulations thereunder, as amended from time to time.

Personal Health Information (PHI) means health information that:
(a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse;
(b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
(c) either identifies the individual or reasonably could be used to identify the individual.

Health Care Expense means, unless otherwise specifically noted in the Adoption Agreement, an expense incurred by a Covered Individual, for medical care to the maximum extent permitted by law, but only to the extent that the Covered Individual incurring the expense is not reimbursed for the expense through another source, including other insurance or other accident or health plan. A Health Care Expense shall include medical care as defined in Section 213(d) of the Code, modified as required by law.

A Health Care Expense is incurred at the time the medical care or service that gave rise to the expense is furnished.

2. Use and Disclosure of PHI:

The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Plan will also use and disclose PHI as permitted by authorization of the subject of PHI.

(a) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefits claims (including appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing employee contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health Plan; and

(13) Reimbursement to the Plan.

(b) **Health care operations** include, but are not limited to, the following activities:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reduction health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation , renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administration activities of the Plan, including, but not limited to:

a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
b. Customer service, including data analyses for policyholders;

(8) Resolution of internal grievances.

(9) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

3. Plan Sponsor's Obligations:

With respect to PHI, the Plan Sponsor agrees to certain conditions. The Plan Sponsor agrees to:
(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
(b) Ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
(c) Not use or disclose PHI for employment related actions and decision unless authorized by an individual;
(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
(e) Report to the Plan any PHI use or disclosure, that is inconsistent with the uses or disclosures provided for, of which it becomes aware;
(f) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
(g) Make available the information required to provide an accounting of disclosures;
(h) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and,
(i) If feasible, return or destroy all PHI received for the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

4. Adequate separation between the Plan and the Plan Sponsor must be maintained:
In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
(1) The benefit manager; and,
(2) Staff designated by the benefits manager.
The Plan Sponsor shall identify, by name, these persons in writing to the Claims Administrator.

5. Limitation of PHI Access and Disclosure. The persons described in paragraph (c) above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

6. Noncompliance Issues. If the person described in paragraph (c) above does not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including, but not limited to, disciplinary action against such person.