HIPAA Rules
and
Policy and Procedures Manual

NSM Insurance Group Health and Welfare Plan

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TABLE OF CONTENTS

PART 1 - INTRODUCTION AND BASIC POLICY AND PROCEDURES DATA 1
PART 2 - STATEMENT OF PRIVACY POLICY 2
PART 3 - COVERED PLANS 3
PART 4 - USES AND DISCLOSURES 4
4.1 General Uses and Disclosures 4
4.2 Disclosures with Authorization 4
4.3 Disclosure of Minimum Necessary Information 4
4.4 Routine Disclosures for Treatment, Payment, and Health Care Operations 5
4.5 Disclosures Required by Law, Government Functions, and Other Situations 5
4.6 Mandatory Disclosures 6
4.7 Business Associate Contracts 6
4.8 Other Disclosure Rules 6
4.9 Use and Disclosure of De-Identified Information 7
4.10 Use of Email or Internet for Transmission of Data – Rules and Restrictions 7
PART 5 - COVERED PERSON'S RIGHTS REGARDING PHI 9
5.1 Overview 9
5.2 Access, Inspection, and Copying of PHI 9
5.3 Amendment of PHI 9
5.4 Accounting of Disclosures 10
5.5 Requests for Additional Privacy Protections and Confidentiality 11
5.6 Notice of Privacy Practices 11
5.7 Actions by Covered Persons and Others Acting on Their Behalf 11
5.8 Matters Involving Any Breach 13
PART 6 - ADMINISTRATION OF THIS HIPAA POLICY 14
6.1 Overview 14
6.2 Authorized Persons and Lead Privacy Officer 14
6.3 Training 14
6.4 Complaints and Appeal and Review Request Procedure 14
6.5 Mitigation 15
6.6 Verification Requirements 16
6.7 Document Retention 16
6.8 Amendments to the Policies and Procedures 16
PART 7 - DEFINITIONS 17

APPENDIX A - BENEFIT PLAN RULES - HIPAA 22
A-1 Introduction and Definitions 22
A-2 Employer Use and Disclosure of Protected Health Information 22
A-3 Certification from the Employer 22
A-4 Safeguarding Electronic Protected Health Information 23
A-5 Exceptions to Protected Health Information Restrictions 23
A-6 Permitted Use and Disclosure 23

Part 1 – Introduction and Basic Policy and Procedures Data

HIPAA requires Covered Entities, such as the "Plan" as defined below, to: 1) safeguard and protect the privacy of individuals' health information; 2) limit how individuals' health information may be Used and Disclosed; 3) grant certain rights to individuals with respect to their health information; and 4) maintain certain administrative processes. HITECH augmented the requirements of HIPAA and imposed new requirements to protect Plan health information and expand individual rights.

This Manual includes both Policy materials and the Rules, or Plan terms that apply to the Benefit Plan listed below. For this purpose, the Rules stated in Appendix A to this Rules, Policy and Procedure Manual are incorporated into the Benefit Plan terms. Overall, this Rule, Policy and Procedure Manual is designed to be the Privacy Policies that apply to the Plan, as adopted and approved by the Employer. This Manual may be supplemented and/or amended by separate policies, procedures, and practices. No third party rights, including but not limited to rights of Covered Persons (a "Covered Person" is defined below for purposes of this Policy and includes the Participant, the Participant's spouse and dependents) or Business Associates, are intended to be created by this Manual. This Manual addresses HIPAA and HITECH and no other federal or state law.

The following basic information applies to this Policy and the Plan:

Description	**Policy Information**
1. Employer and Plan Sponsor:	NSM Insurance Group
2. Address:	555 E. North Lane, Suite 6060, Conshohocken, PA 19428 610-941-9877
3. Benefit Plan or Plans:	NSM Insurance Group Health and Welfare Plan
4. Covered Entity:	Same as Item 3 Above
5. PHI Authorized Persons By Title or Position With the Employer:	Human Resources Director
6. EIN of Plan Sponsor:	20-1804371
7. HIPAA Policy Information Contact:	The Employer Listed Above, at the Address Stated Above
8. Effective Date:	January 1, 2024

Part 2 - Statement of Privacy Policy

The following are the basic statements of Privacy that apply to this Policy:

Reasonable and Practical Steps. The Plan will take reasonable and practical steps, consistent with applicable law, this Policy and the terms of the Plan, to protect the privacy of Covered Persons and the privacy of PHI, in accordance with HIPAA, HITECH, and other applicable law. Please note that certain terms are stated and defined herein, and in Part 7 - Definitions.

Respect of Rights and Privacy. The Plan will respect the individual rights and privacy of Covered Persons relating to PHI about them, as required by HIPAA, HITECH, and other applicable law. Covered Persons may exercise their rights free from intimidating or retaliatory acts.

Permitted Uses and Disclosures. The Plan will permit the Use and Disclosure of PHI only as required or permitted by HIPAA, HITECH, and other applicable law. When PHI is Disclosed, it will be the minimum necessary under the circumstances.

Sharing with Business Associates. PHI may be shared with Business Associates that provide services to the Plan and that are subject to a Business Associate contract with the Employer and/or the Plan.

Part 3 – Covered Plans

Plans Subject to the Policy. The employee welfare benefit plan (the "Plan") that is a Group Health Plan that is subject to this Policy is listed in Part 1 above. (If more than one Plan is involved, they are each listed.) The Group Health Plan that comprises the Plan or is part of the Plan may include certain vision or dental services, flexible spending accounts, employee assistance plans, or other executive compensation plans or programs, and it may include health savings accounts or health reimbursement accounts that are integrated as part of the Group Health Plan. All component parts of the Group Health Plan under the Plan are covered by and subject to this Policy.

Plans or Programs of Benefits Excluded from this Policy. Any plan or program that does not involve PHI as defined by the statute, such as life insurance, short- and long-term disability, accidental death and dismemberment, business travel accident, and/or other similar type of programs, even if such a plan or program is included as part of the Wrap Plan document, are not impacted by or subject to HIPAA or HITECH and as a result are excluded from this Policy.

Part 4 – Uses and Disclosures

4.1 General Uses and Disclosures

The Plan may Use or Disclose PHI about a Covered Person without obtaining Authorization in the circumstances described below.

- Enrollment. Disclosure is permitted to the Employer for enrollment activities.
- Premium bids. For purposes of bidding insurance or other plan-related services.
- Plan Administration. For routine and day-to-day required operational activities, including claims and claim processing, appeals and appeal processing and invoicing and billing and collection matters.
- Plan Amendment and/or Termination Activities. For matters related to the amendment and/or termination of the Plan or any particular part or component of the Plan.
- Audits and Risk Assessment. For audit and risk assessment matters that relate to the Plan.
- As Required by Law.

4.2 Disclosures with Authorization

With respect to any Disclosure of PHI that is not expressly permitted hereunder, any such Disclosure may only be made if there is Authorization as provided under this Policy. The Plan as Covered Entity and/or a Business Associate, on behalf of the Plan, may request or require an Authorization from a Covered Person. Such Authorization will be made on a form provided by the Plan or the Employer consistent with this Policy.

In the event that the Authorized Persons need to Use or Disclose PHI to Insurers, health plans, and/or service providers with whom the Plan of the Employer contracts for the provision of coverage and/or services, a request may be made to Covered Persons to provide Authorization and such Authorization may be required with respect to a certain Plan operation or need in order for the Covered Person to obtain coverage or benefits under the Plan.

4.3 Disclosure of Minimum Necessary Information

Any time that PHI will be Disclosed under this Policy, the Authorized Persons will in their discretion determine what constitutes the minimum necessary information that will be used and Disclosed and will Disclose only such minimally needed information. This may include de-identified information, if such information will be satisfactory to accomplish the intended purpose.

The minimum necessary requirement does not apply to Uses or Disclosures for: a) Treatment purposes; b) Disclosures to a Covered Person of his or her own PHI; c) Uses or Disclosures made with Authorization; or d) Uses or Disclosures Required by Law.

Legal References:
45 C.F.R. § 164.502(b)
45 C.F.R. § 164.504(a)
45 C.F.R. § 164.504(f)
45 C.F.R. § 164.514(d)
42 U.S.C § 17935(b)

4.4 Routine Disclosures for Treatment, Payment, and Health Care Operations

PHI may be Used and Disclosed with respect to the following:

- Treatment. PHI may be Used and Disclosed to a health care provider for purposes of Treatment.
- Payment Activities. PHI may be Used and Disclosed for the Plan's Payment Activity purposes.
- Health Care Operations. PHI may be Used and Disclosed for the purposes of the Plan's own Health Care Operations, which include Use by and Disclosure to a Plan Business Associate for the Plan's Health Care Operations purposes.
- Limited Health Care Operations. PHI may be Disclosed to another Covered Entity for purposes of that Covered Entity's Limited Health Care Operations if the Covered Entity has (or had) a relationship with the Covered Person and the Plan PHI requested pertains to that relationship.
- Routine Uses and Disclosures. PHI may be Disclosed if such Disclosure relates to Treatment, Payment, and Health Care Operations made on a routine and recurring basis.
- Claim Appeals. Any time a Covered Person (by or through the Participant or otherwise) under the Plan requests any type of claim appeal, PHI may be Disclosed to permit such Covered Person the opportunity to pursue such claim appeal, or for the Plan to defend its position with respect to such claim appeal.
- Customer Services. PHI may be Disclosed to assist Covered Persons with various eligibility and claims questions, when initiated by the Covered Person with respect to any aspect of Plan operation.
- Data Analysis. Authorized Persons and/or Business Associates may perform Plan auditing, rate setting, and benefits planning and analysis using claims and appeals information obtained from Insurers.

Legal References:
45 C.F.R. § 164.502(a)
45 C.F.R. § 164.506

4.5 Disclosures Required by Law, Government Functions, and Other Situations

The Plan, its Insurers, and its Business Associates, without obtaining a Covered Person's Authorization, may Use and Disclose PHI if Required by Law, for certain specialized government functions, including national security, and in other similar situations, including the following items:

- Required by Law. Anytime Disclosure is Required by Law.
- Armed Forces. Any time Disclosure is required by military command authority to assure the proper execution of the military mission.
- Disease Control. Any time Disclosure of PHI to public health authorities is required to prevent or control disease.
- Child Abuse or Neglect. Any time Disclosure of PHI is required to report or address child abuse or neglect.
- FDA. Any time Disclosure is required to address adverse events or product defects.
- Disease. Any time Disclosure of PHI is authorized by law to address the risk of contracting or spreading a disease or condition.
- Litigation. Any time the Plan and/or the Employer is (or are) a party to or threatened with litigation, Disclosure may be made in such matter and/or pursuant to any Court or administrative order, subpoena or discovery request.

- Law Enforcement – PHI may be Disclosed to law enforcement officials as Required by Law, including in criminal proceedings.
- Health Care Agencies – PHI may be Disclosed to health care agencies for activities authorized by law (including audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, compliance with regulatory programs, or civil rights law.
- Workers' Compensation or Non-Covered Benefits – PHI may be Disclosed for purposes of workers' compensation or employee benefits not subject to the PHI rules, related to work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws, and life insurance, disability and related programs and benefits.
- Threats – PHI may be Disclosed if in good faith there is a belief that Disclosure may prevent or lessen a serious and imminent threat to the health or safety of any person.

4.6 Mandatory Disclosures

The following are mandatory Uses and Disclosures of PHI under HIPAA, and the Plan will Use and Disclose PHI as described below.

- Department of Health and Human Services. PHI may be Disclosed to the Secretary of the Department of Health and Human Services, or his or her designee, to investigate or determine the Plan's compliance with HIPAA.
- Participant (including Covered Persons) Disclosures. PHI may be Disclosed to a Participant and the Participant's spouse and dependents, pursuant to a request to access such Participant's PHI.

Legal References:
45 C.F.R. § 164.501
45 C.F.R. § 164.502(a)(1)
45 C.F.R. § 164.502(a)(2)
45 C.F.R. § 164.508(a)(3)
45 C.F.R. § 164.512

4.7 Business Associate Contracts

The Plan may Disclose Plan PHI to a Business Associate of the Plan and may permit a Business Associate to receive, create, access, or Disclose PHI on behalf of the Plan as long as the Business Associate provides certain written assurances (through a Business Associate Contract) to the Plan. The form of such contract may be that employed by the Plan, or any other form reasonably acceptable to the Plan.

For a Business Associate to be permitted to receive any PHI, the Business Associate must be under Contract.

Legal References:
45 C.F.R. § 164.502(e)
45 C.F.R. § 164.504(e)
42 U.S.C. § 17934
42 U.S.C. § 17938

4.8 Other Disclosure Rules

The Plan will not directly or indirectly receive remuneration or payment in exchange for any Plan PHI Disclosures. The Plan will not Disclose PHI for purposes of any marketing or other related communications unless such Disclosure is reviewed and approved by legal counsel to the Plan.

Legal References:
45 C.F.R. § 164.501
45 C.F.R. § 164.508(a)(3)
45 U.S.C. § 17935-6

4.9 Use and Disclosure of De-Identified Information

The Plan may De-Identify health information and may Use or Disclose such De-Identified Information without Authorization or limitation, as long as there is no reasonable basis to believe that such De-Identified information can be used, alone or in conjunction with other available information, to identify a Covered Person.

a. De-Identified Information.

To De-Identify Plan information, the following information will be deleted from a data set:

- Any name information.
- Geographic identifiers including, street address, city, county, precinct, state and zip code.
- Dates of birth and/or death, admission and/or discharge dates.
- Telephone numbers.
- Fax numbers.
- E-mail addresses.
- Social Security numbers.
- Medical record numbers.
- Plan beneficiary numbers.
- Account numbers.
- Certificate/license numbers.
- Biometric identifiers (e.g., finger, iris, or voice prints).
- Full-face photographic and any comparable images.

Limited Data Sets that are De-Identified may be used as long as the Authorized Person determines reasonably that such Use or transmission is appropriate under the circumstances.

Legal References:
45 C.F.R. § 164.502(d)
45 C.F.R. § 164.514
42 U.S.C. § 17935(b)

4.10 Use of Email or Internet for Transmission of Data – Rules and Restrictions

In order to simplify the Use and Disclosure of any PHI, but protect such PHI from inadvertent theft or Disclosure of PHI, the Plan, its Authorized Persons, and the Employer may not Use unprotected or unauthorized electronic transmission as a means of transmitting or conveying PHI.

a) Electronic Transmission. The transmission, Use or Disclosure by electronic means is unprotected or unauthorized, unless the Information Technology ("IT") department of the Employer, after inspection and analysis, has determined that the electronic transmission of information is subject to protections that are reasonably adequate to protect and secure the information from theft or improper Disclosure, including Forced TLS (Transport Layer Security), or the system used for conveying PHI is a secure send system with respect to all transmission and receipts of PHI by such electronic means to or from a Covered Entity, to or from the Business Associate, or pursuant to any Authorization, or otherwise.

If the IT Department of the Employer has so certified, the Authorized Persons may convey PHI through such authorized means. Any such secure electronic transmission must include reasonable verification that all access is secure to authorized workstations, pursuant to a reasonably secure control access policy of the IT Department of the Employer, password protected, with technical security measures designed to guard against unauthorized access.

b) No Electronic Transmission. If there is no IT Department available, or there is no reasonable determination as stated in 4.10(a) above, and/or there are questions regarding whether PHI can be transmitted securely over electronic means, then there shall be no transmission, conveyance, Use or Disclosure by electronic means and the alternative means below must be employed.

Such alternative means of transmitting PHI include the following permitted methods:

- Facsimile Transmission
- UPS or FedEx Tracked Overnight Transmission
- Courier With Signature Verification in a Sealed Labeled Envelope.

Legal References:
45 C.F.R. §164.312

Part 5 – Covered Person's Rights Regarding PHI

5.1 Overview

The Plan respects the rights of Covered Persons regarding PHI and will permit the access, inspection and copying of PHI, to the extent that the Plan or any Authorized Person has such access. The Plan will reasonably assist all Covered Persons in connection with their requests or need to access, inspect, correct, and/or copy PHI.

Insurers and health plans, and in some cases service providers to the Plan, may be Covered Entities and have independent compliance obligations under HIPAA and HITECH in connection with the services and coverage they provide under or to the Plan. To facilitate Covered Persons' rights under HIPAA and HITECH, Insurers, health plans, and service providers may require that a Covered Person use particular forms and processes.

Overall, it may be that the Plan and its Authorized Persons do not have direct access to any PHI, or access only to limited PHI, but they can assist Covered Persons with their access to such information. In other cases, the Plan or Authorized Persons may obtain certain PHI directly from the Covered Person in order to assist that Person with a claim, or processing of a claim or any other benefit right or feature under the Plan. These rules apply in all cases, but only to the extent that the Plan or Authorized Persons have actual access to PHI.

5.2 Access, Inspection, and Copying of PHI

All Covered Persons have the right to access, inspect, and copy his or her PHI for as long as the PHI is maintained, subject only to certain very limited exceptions. The Plan will assist the Covered Person in obtaining PHI or using PHI in connection with the Plan or processing of claims. However, all Covered Persons must note that the Plan can only provide access for inspection if the Plan has actual access to the PHI under the terms of the Plan and/or any insurance contract.

Any requests for access, inspection, and copying of PHI must be submitted in writing. Such writing may be in any format acceptable to the Plan or the Employer. For purposes of this Policy, no specific form is required for such a request.

In general, if the Plan has or had access to the requested information and it receives a written request for PHI, the Plan will respond within a reasonable period of time. The Plan will endeavor to respond within thirty (30) days, but reasonable cause may delay such a response and the time frame for a response may be reasonably extended.

The Plan will not normally deny any request for inspection or copying of PHI, but may do so in certain limited instances. If your request for inspection is denied, the Denial Procedures stated in Part 6, Section 6.4 will apply.

Legal References:
45 C.F.R. § 164.524
42 U.S.C. § 17935(e)

5.3 Amendment of PHI

A Covered Person has the right to request that the Plan amend his or her inaccurate or incomplete PHI. In respect of PHI for Covered Persons, often times, the Plan has no access to the PHI that is the subject of the request to amend. If the Plan does not have access to the PHI, it will inform the Covered Person of such fact by reasonable means. If the Plan knows the identity of the person or entity that controls the PHI at issue with the request, the Plan will include this information in any response. If the Plan does have access to the information subject to the request to amend, and can effect such an amendment, this section applies with respect to such request.

Request for Amendment. Any requests to amend PHI must be submitted in writing and must specify a reason to support the requested amendment. If the PHI is in the control of the Plan, the Plan may:

1. Accept the request; or

2. Deny the request based on one or more of the recognized grounds. The Plan will determine whether to approve or deny the request for amendment in a manner consistent with this Manual, HIPAA, HITECH, and other applicable law.

The Plan will respond within a reasonable period of time, generally within sixty (60) days after receipt of a request for amendment. If the Plan is unable to respond within this timeframe, then the Plan will advise the Covered Person, in writing, that it requires additional time, which will generally be no more than an additional thirty (30) days.

Acceptance of Request. If the Plan accepts a request for amendment, in whole or in part, the Plan will notify the Covered Person in writing and will reasonably inform recipients of the amendment.

Denial of a Request for an Amendment. The Plan may deny a request to amend a Covered Person's PHI if the PHI was not created by the Plan, the PHI is not part of the Designated Record Set, the PHI is not available for access and inspection under HIPAA, or the PHI is accurate and complete.

Any request for an amendment that is denied may be appealed under Part 6, Section 6.4.

Legal References:
45 C.F.R. § 164.526

5.4 Accounting of Disclosures

A Covered Person has the right to request an accounting of Disclosures of his or her PHI by or on behalf of the Plan. The request directed to the Plan must be with respect to PHI under the possession and control of the Plan. In many cases the Plan does not have access, control or use of PHI or information for such an accounting.

Any such requests for an accounting must be submitted in writing. The Covered Person must indicate the time period for the requested accounting, which must be for Disclosures made within the past six (6) years or some shorter time period.

The Plan generally will respond to a request for an accounting within approximately sixty (60) days after receipt. If the Plan is unable to respond within this timeframe, then the Plan will send the Covered Person written notice that the time will be reasonably extended. When the Plan is able to account for Disclosures, the Plan will send to the Covered Person the accounting of PHI Disclosures that will include the date of Disclosure, the name and address of the person or entity who received the PHI, a description of the PHI Disclosed and the basis for the Disclosure. The Plan will provide a Covered Person with one accounting in any 12-month period free of charge. A reasonable fee will be charged for subsequent accountings within the same 12-month period.

The Plan shall provide such an accounting except for the Disclosures described below.

- PHI that is not in the possession or control of the Plan.
- To carry out Treatment, Payment, and Health Care Operations.
- For national security or intelligence purposes.
- To the Covered Person about such Covered Person's PHI.
- That constitute an incidental Disclosure, which is incident to a Use or Disclosure otherwise permitted or required by HIPAA (subject to 45 C.F.R. § 164.502).
- Pursuant to a Covered Person's Authorization.
- To persons involved in a Covered Person's care or payment for such care.
- To correctional institutions or law enforcement officials.

- As part of Limited Data Sets.

Any request for an accounting under this Section is subject to the Appeal rules stated in Section 6.4.

Legal References:
42 C.F.R. § 164.502
45 C.F.R. § 164.528
42 U.S.C. § 17935(c)

5.5 Requests for Additional Privacy Protections and Confidentiality

A Covered Person has the right to request that the Plan restrict the Use and Disclosure of his or her PHI for certain purposes, as long as the Plan actually has such PHI. Such request should be made in writing and should be specific regarding the requested protection and rationale for such protection. The Plan and its Authorized Persons are not required to agree to any restriction, but will evaluate such requests in good faith. In the event that such request is determined to be in good faith with reasonable basis and such request does not unduly burden the Plan or the Authorized Persons, the Plan may agree to comply. Such an agreement will be made in writing to confirm the agreed restriction. Such a restriction may be removed at any time with reasonable notice to the Covered Person.

Similarly, a Covered Person has the right to request that the Plan use alternative means or alternative locations to communicate PHI. The Plan may accommodate the request if the Covered Person clearly demonstrates that the Disclosure of all or part of the PHI by the usual means could endanger the Covered Person, or the Covered Person provides additional reasonable rationale.

Such requests must be submitted in writing. The Plan will determine whether to approve or deny the request.

If any such requests under this Section are denied, the Covered Person or such Person's representative may file an Appeal of such denial under Section 6.4.

Legal References:
45 C.F.R. § 164.522(a)
45 C.F.R. § 164.522(b)
42 U.S.C. §17935(a)

5.6 Notice of Privacy Practices

If the Plan is a Group Health Plan that provides health benefits solely through an insurance contract with a health insurance issuer and does not create or receive any PHI, other than Summary Health Information, or information on an individual's participation status in the Plan, or enrollment and disenrollment information; then, the Plan is not required to maintain or provide a notice under this section.

The Plan will reasonably confirm that the Health Insurer, or Health Maintenance Organization, as applicable, will provide the appropriate Notice.

If the Plan is a Group Health Plan where all or a portion of the Plan is self-insured and the Plan creates PHI, or receives PHI from any source, the Plan will undertake the Notice as required. Please contact the Plan Administrator if you have concerns about your privacy.

Legal References:
45 C.F.R. § 164.520

5.7 Actions by Covered Persons and Others Acting on Their Behalf

As defined herein, and for convenience under this Policy, a "Covered Person" includes the Participant, the Participant's spouse and the Participant's covered dependents under the Plan. The Plan recognizes that rights relating to the Use and Disclosure of PHI and other rights may be exercised by each Covered Person, their personal representatives and/or family members. Under this Policy, rights and access are granted to persons other than the specific Covered Person as described in this Section.

- Personal Representatives. The Plan will permit generally the role of a Personal Representative of any Covered Person, as long as there is no reasonable basis to decline to recognize such a Personal Representative, and such capacity as a Personal Representative has been demonstrated in writing, and as long as an exception does not apply. A Personal Representative may be any natural adult (as determined by state law), a provider or provider representative, or an attorney, accountant or financial advisor. The Plan will make reasonable efforts to limit Disclosures to a Personal Representative with respect to PHI to the information relevant to such Personal Representation.

- Minor Child Dependent. A parent, guardian, and other person acting as the parent under applicable law, has the authority to act on behalf of a dependent as the personal representative of the Minor Child Dependent. The following exceptions apply: 1) the minor lawfully obtained the services with the consent of someone who is authorized by law to give that consent other than the parent, guardian, or other person acting in the place of a parent (for example a court); 2) the minor lawfully consented to and obtained the services, and state law does not require the consent of anyone else (regardless of whether the consent of another person also has been obtained), and the minor has not requested that such person be treated as the personal representative; and 3) the parent consented to a confidentiality agreement between the health care provider and the minor with respect to the services.

- Adults and Emancipated Minors. If, under applicable state law, a person has the authority to act on behalf of a Covered Person who is an adult or emancipated minor in making decisions relating to health care, then the Plan will treat such person as a Personal Representative.

Summary of Covered Person Representatives:

Covered Person	Relationship to the Covered Person	Personal Representative Permitted?
Adult	Spouse or other Adult Covered	Yes, with the legal authority to act being verified, including a power of attorney for health care or other court order, or other written authorization.
Minor Child	Parent or Guardian	Yes, with verification of relationship, or other written authorization.
Adult Child	Guardian or Other Adult	Generally, the parent of an Adult Child does not automatically have rights to act as Personal Representative, unless there is legal authority otherwise, such as a power of attorney for health care, or other court order or other written authorization.
Deceased Person	Executor, Administrator or other person with legal authority to act on behalf of the deceased person or the deceased person's estate	Yes, with legal authority verified which may include a will or the court appointment of executor.

a) Decline of Disclosures and Representatives. The Plan may decline any Disclosures at any time, based upon its reasonable determination that it is not in the best interest of the Covered Person to make such Disclosure if the Plan has a reasonable belief that the Covered Person has been, or may become, subject to abuse, domestic violence, or neglect by the person, and/or treating the person requesting or authorized to receive the information as the Personal Representative could endanger the Covered Person.

b) Disclosures to Other Persons or Entities Involved. Under HIPAA, the Plan has the discretion to Disclose a Covered Person's PHI to any individual without Authorization, if such Disclosure is necessary for its Payment Activities or Health Care Operations. This may include Disclosures of a Covered Person's PHI to the Covered Person's family members. In making these Disclosures, the Plan will make reasonable efforts to limit Disclosures to the minimum necessary to accomplish the intended purpose.

c) Disclosures Without Authorizations. Additionally, PHI may be Disclosed without Authorization to a Covered Person's family members, friends, and others who are not Personal Representatives for any of the reasons described below.

- Information describing the Covered Person's location or general condition is provided to a family member or other person responsible for the Covered Person's care (including PHI to a public or private entity authorized by law or by its character to assist in disaster relief efforts), as long as the Covered Person has the opportunity to agree or object to the Disclosure.
- PHI is Disclosed to a family member, close friend, or other person identified, who is involved in the Covered Person's Treatment or payment for that Treatment, and the Covered Person has the opportunity to agree or object to the Disclosure.
- PHI is Disclosed to a family member, friend, or other person involved in the Covered Person's care for appropriate purposes, as determined by the Plan in its reasonable discretion, and it is impossible (due to incapacity or emergency) to obtain the Covered Person's agreement.

Legal References:
45 C.F.R. § 164.502(g)
45 C.F.R. § 164.510

5.8 Matters Involving Any Breach

When a Use or Disclosure of PHI is not authorized, such occurrence will be evaluated. Some Use or Disclosure that is not authorized or permitted is not considered a breach. This includes: a) the unintentional Use or Disclosure of PHI by a workforce member or person acting under the authority of a Covered Entity or a Business Associate, if such disclosure is in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted; b) any inadvertent disclosure by an Authorized Person of the Covered Entity or a Business Associate of PHI to another person authorized to access PHI at the same Covered Entity or Business Associate, and the PHI is not Used or Disclosed improperly; or c) a disclosure of PHI where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to or will not retain such information. In addition, a breach does not occur if after investigation, it is determined that there is a low probability that PHI has been compromised based on a risk assessment of the nature and extent that PHI is involved, the identity of the unauthorized person who Used or Disclosed PHI, whether PHI was acquired or viewed, and mitigation of risk on PHI disclosure.

After such an evaluation, if a breach occurred, a Notice is issued to the affected persons. The Notice must include a brief description of what happened, a description of the types of PHI involved, steps the individual should take to protect themselves from potential harm, a brief description of the actions taken in response to the breach by the Plan, and contact information for the individual to ask questions. Such notice is sent by first class mail, or other means reasonably determined to be effective. The Authorized Persons or Plan may seek legal counsel to assist in evaluating such circumstance, mitigating any further harm, to further investigate such matter, and or take action deemed necessary.

Legal References: § 164.400 to § 164.414

Part 6 – Administration of This HIPAA Policy

6.1 Overview

This Policy requires certain administrative parameters and functions as well as integration of this Policy with the operation of the Plan. The Plan Authorized Persons have complete discretionary authority with respect to the interpretation of this Policy and its operation and the administration of the Policy terms.

6.2 Authorized Persons and Lead Privacy Officer

Authorized Persons under the Policy or the Plan are designated to address HIPAA and Disclosure matters with respect to the Plan. The Authorized Persons or the Employer may designate a lead Privacy Officer or Officers and the Employer and/or the Plan may delegate to Authorized Persons or to any Business Associate the performance of certain required functions under this Policy.

6.3 Training

The Plan and the Employer will arrange for reasonable access to and reasonable training programs for Authorized Persons with respect to their obligations under this Policy and HIPAA and HITECH. Such training will occur periodically and may be in the form of in-person training, attendance at webinar sessions, telephonic training and/or other reasonable training processes. The Plan will maintain reasonable records of such training.

Legal References:
45 C.F.R. § 164.530(b)

6.4 Complaints and Appeal and Review Request Procedure

In the event that a Covered Person has a complaint regarding HIPAA or PHI, or wishes to Appeal a denial of any request under these Policies, the Covered Person, or such Person's authorized representative, must provide the Complaint or Appeal in writing. The Covered Person or representative must reasonably provide in the writing the following information regarding any Complaint or Appeal:

1. A detailed statement of facts regarding the complaint or denial upon which the Complaint or Appeal is filed, including whether the matter is a general Complaint or an Appeal of a denial under this Policy;
2. Any terms of the Plan or Policy, or any other rules or authority upon which the submitter wishes to rely;
3. A detailed position statement regarding the Complaint or Appeal; and
4. Any further information the Covered Person or representative wishes to include.

In the event that the matter submitted is a general Complaint, the Plan, acting through its Authorized Persons or its representatives, will provide a response that includes the following information:

1. A detailed statement of facts that the Plan has in regard to the Complaint filed;
2. The applicable terms of the Plan or this Policy and any other rules, guidelines and the Legal References which involve the subject matter of the Complaint;
3. A detailed response and analysis statement regarding the Complaint; and
4. The decision or action steps taken regarding such Complaint.

In the event the matter submitted is an Appeal of a denial of a request under these Policies and Procedures, the Plan will undertake the following Appeal and Review Request Procedure:

- The Plan will conduct a complete evaluation and analysis of the Appeal request including the facts presented on the Appeal;
- The Plan will evaluate the Plan terms, as applicable, this Policy and the legal references relevant to the Appeal;
- If the Appeal involves any medical-related determination, the Plan will retain a licensed health care professional to determine medical matters related to the Appeal, including without limitation with respect to PHI access, that the access is reasonably likely to endanger the life or physical safety of the Covered Person or another person; and
- If the Appeal involves any medical-related determination and/or dissemination of PHI to certain representatives or relatives of an individual, the Plan will have evaluated whether the PHI contains information about another person, and the licensed health care professional will be asked to determine whether the access is reasonably likely to cause substantial harm to the other person.

An Appeal response will include the following information:

1. A detailed statement of facts that the Plan has in regard to the Appeal;
2. The applicable terms of the Plan or this Policy and any other rules, guidelines and the Legal References that involve the subject matter of the Appeal;
3. A copy of any medical-related determination obtained from a licensed professional, if applicable;
4. A detailed response and analysis statement regarding the Appeal; and
5. The decision and/or action steps taken regarding such Appeal.

In regard to any Appeal regarding Disclosure of PHI, the Plan may deny a Covered Person's request to access, inspect, or copy PHI only if it was compiled in reasonable anticipation of, or for use in, civil, criminal, or administrative proceedings, or the Plan received the PHI from someone other than a health care provider under a promise of confidentiality and providing access to the PHI would be reasonably likely to reveal the source.

No person acting for or on behalf of the Plan, the Employer or any Authorized Person may intimidate, threaten, coerce, discriminate against, or take retaliatory action of any kind against a Covered Person for lodging a good faith complaint or otherwise exercising his or her privacy rights under HIPAA or HITECH.

In the event that the Appeal or Complaint involves inappropriate conduct on the part of any Authorized Person or Employee of the Employer, the Plan will refer the matter to the Employer for the appropriate employment-related sanction under the Employer's policies.

Legal References:
45 C.F.R. § 164.530(d)
45 C.F.R. § 164.530(e)
45 C.F.R. § 164.530(g)
45 C.F.R. § 164.530(h)

6.5 Mitigation

The Plan will mitigate, to the extent feasible, any harmful effects that it knows have resulted from Uses or Disclosures of PHI in a manner inconsistent with this Manual, HIPAA and/or HITECH.

Legal References:
45 C.F.R. § 164.530(f)

6.6 Verification Requirements

The Plan will take and will require any applicable Business Associates to take reasonable actions to verify the identification and authority of any person or entity that requests PHI, that requests actions with respect to PHI, or that seeks to exercise any Covered Person's rights. Verification procedures may include, but are not limited to, verifying a Covered Person's user ID and password and verifying documents demonstrating authority to act.

Legal References:
45 C.F.R. § 164.514(h)
42 U.S.C. § 17935(b)(2)

6.7 Document Retention

The Plan shall retain copies of this Rules, Policy and Procedures Manual and other documents required by HIPAA and HITECH for at least six (6) years from the date of their creation or when they were last in effect (whichever is later).

With respect to PHI, the Plan and/or the Employer will not generally retain or maintain any PHI that it does not directly generate for a period of time beyond that necessary under the circumstances. In other words, after the PHI is used for the purposes intended, whether it is to aid a Covered Person with a claim for benefits or otherwise, when such conduct is completed, the PHI will not be maintained or stored. It will either be destroyed or returned to the Covered Person.

In the event that PHI derived from other sources is being maintained, for any period, PHI will be stored in a locked file or room and labeled with the following label:

Confidential and Protected HIPAA Materials.
No Unauthorized Access Under Penalty of Law

No person will have access to such PHI unless such person is an Authorized Person or the designee of an Authorized Person.

Legal References:
45 C.F.R. § 164.530(j)

6.8 Amendments to the Policies and Procedures

This Rules, Policy and Procedures Manual may be amended, modified and/or terminated at any time by the Employer, in writing.

This Rules, Policy and Procedures manual will be automatically updated for any changes in law, including HIPAA and/or HITECH.

Legal References:
45 C.F.R. § 164.530(i)

Part 7 – Definitions

The following defined terms apply to this Policy. To the extent there is any inconsistency between the Policy and applicable law, applicable law will apply. The Authorized Persons have complete discretionary authority to interpret the terms and provisions of this Policy, and to evaluate, determine and apply facts hereunder.

"Authorization." An "Authorization" is a written permission by or on behalf of a Covered Person to Use PHI. Generally, an Authorization is needed for Uses and Disclosures for purposes other than Treatment, Payment, or Health Care Operations, or as otherwise permitted or required by HIPAA and/or HITECH.

"Authorized Persons." The term "Authorized Persons" means those persons who are authorized to access, Use, and Disclose PHI to administer the Plan, as provided under the terms of this Policy or the Plan and/or with respect to Plan operations, administration and claims processing in conformity with the requirements of the Plan and HIPAA. Such Authorized Persons are listed in Part 1. Anyone acting on behalf of the Plan should verify whether a particular individual qualifies as an Authorized Person prior to permitting such individual to access, Use, or Disclose Plan PHI. The Plan or Employer may designate a Privacy Officer, that shall be an Authorized Person who is the lead Authorized Person for purposes of contact and communications, as provided under HIPAA.

"Business Associate." A "Business Associate" is a person or entity who performs or assists in the performance of, on behalf of the Plan, a function or activity involving the Use or Disclosure of PHI (including claims processing or administration, data analysis, processing, or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing), or any other function or activity regulated by the HIPAA Regulations. Such a Business Associate is also a person or entity who provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, insurance or financial services to or for the Plan and/or the Employer where the provision of the service involves PHI.

"Covered Entity." A "Covered Entity" includes the Plan, any other health plan (including a Group Health Plan, Insurer, health maintenance organization, sponsor of Medicare prescription drug cards, and government health benefit plan, such as Medicare and Medicaid), a health care provider (such as a physician, hospital, or pharmacy) that electronically transmits any health information in connection with an electronic transaction for which the Secretary of the Department of Health and Human Services has established a standard pursuant to HIPAA, and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).

"Covered Person." For purposes of this Policy, the term "Covered Person" is a term of convenience to refer to any person eligible under the Plan, including the Participant, the Participant's spouse, and the Participant's covered dependents.

"De-Identification" or *"De-Identify."* "De-Identification" or to "De-Identify" means the removal of personal identifying information (such as name, Social Security number, address) that could identify an individual, as more fully described in this Policy.

"De-Identified Information." "De-Identified Information" refers to PHI that has been De-Identified, as provided in this Policy.

"Designated Record Set." "Designated Record Set" shall mean a group of records maintained by or for the Plan that includes: (i) the medical records and billing records about individuals maintained by or for a covered health care provider; or (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, used, in whole or in part, by or for the Plan or its designee to make decisions about individuals' claims. As used in this definition, the term "Record" means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for the Plan.

"Disclosure" or *"Disclose."* The term "Disclosure" or "Disclose" means the release, transfer, provision of access to, or to divulge in any other manner outside of the Plan. Disclosures in this Policy generally apply to PHI.

"Electronic Health Record." The term "Electronic Health Record" refers to health-related information on an individual, including a Covered Person, that is created, gathered, managed, and consulted by authorized health care clinicians and staff and maintained in an electronic form on Electronic Media.

"Electronic Media." The term "Electronic Media" means any of the following:

a. Electronic storage media, including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

b. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dialup lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including those on paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via Electronic Media.

"Employer." The term "Employer" means the entity identified above that employs employees covered by the Plan and sponsors (also known as the Plan Sponsor) of the Plan.

"Group Health Plan." The term "Group Health Plan" refers to an Employer welfare benefit plan (as defined in Section 3(1) of ERISA), to the extent the plan provides medical care (as defined in 42 U.S.C. § 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, which either (i) has 50 or more participants (as defined in Section 3(7) of ERISA), or (ii) is administered by an entity other than the Employer that established and maintains the plan. In this case, the Group Health Plan is the Plan, as defined in Part 1, above.

"Health Care Operations." The term "Health Care Operations" refers to any of the following services or activities necessary to carry out the covered functions of the Plan, specifically:

a. conducting quality assessment and improvement activities, outcomes evaluation, and development of clinical guidelines (provided that obtaining generalizable knowledge is not the primary purpose of any studies resulting from these activities), population-based activities related to improving health or reducing health care costs, protocol development, care management, and care coordination, contacting of health care providers and Covered Persons about Treatment alternatives, and related functions that do not include Treatment;

b. reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance and health plan performance, conducting training programs, engaging in accreditation, certification, or licensing activities;

c. underwriting, premium rating, and other activities for purposes of creation, renewal, or replacement of a contract of health insurance or health benefits and ceding, securing, or placing a contract for reinsurance of risk relative to claims for health care (including stop-loss insurance and excess loss insurance);

d. conducting or arranging for medical review, legal services, and auditing functions (including fraud and abuse detection and compliance programs);

e. business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the Covered Entity, including formulary development and administration, development or improvement of methods of payment, or coverage policies; and

f. business management and general administrative activities including management activities related to HIPAA implementation and compliance, customer service, resolution of internal grievances, due diligence and other activities in connection with the sale, transfer, merger, or consolidation of all or part of a Covered Entity, and creating De-Identified Information or Limited Data Sets.

"HIPAA." The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder.

"HITECH." The term "HITECH" refers to the Health Information Technology for Economic and Clinical Health ("HITECH") Act of 2009, Title XIII of division A and Title IV of division B of the American Recovery and Reinvestment Act ("ARRA").

"HIPAA Privacy Official." The "HIPAA Privacy Official" (or "Officer") is the individual or individuals who are determined by the Authorized Persons or the Plan to be responsible for the implementation of this Policy and related privacy policies, procedures, and practices.

"HIPAA Privacy Rule." The "HIPAA Privacy Rule" is the standards for Privacy of PHI, promulgated by the Department of Health and Human Services to implement HIPAA, as amended or as otherwise modified, including by HITECH.

"Insurer." The term "Insurer" means an underwriter, insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance. This term does not include a Group Health Plan.

"Limited Data Set." The term "Limited Data Set" means PHI that:

a. has had most identifiers removed, as described more fully in the Policy;

b. is Used and Disclosed only for research, public health, or Health Care Operations; and

c. is Disclosed only to a recipient who has signed a Data Use Agreement.

"Limited Health Care Operations." "Limited Health Care Operations" means the activities identified in sections (a) and (b) in the definition of Health Care Operations above and for purposes of health care fraud and abuse detection or compliance.

"Participant." The term "Participant" means persons who are or were eligible for benefits under the Plan as a Participant, as that term is defined under the Plan.

"Payment Activities." The term "Payment Activities" means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or a covered health care provider or other health plan to obtain or provide reimbursement for the provision of health care related to the Plan. Such activities include:

a. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims;

b. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

c. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

d. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

e. Utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services; and

f. Disclosure to consumer reporting agencies of any of the following Protected Health Information relating to the collection of premiums or reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of the health care provider and/or health plan.

"Plan." The "Plan" is the Group Health Plan identified as the "Plan" in Part 1.

"Plan Sponsor." The "Plan Sponsor" is the entity which is the Plan Sponsor identified in Part 1, and is the entity that established and maintains the Plan.

"Privacy Official." The "Privacy Official" or "Privacy Officer" as may be referenced in this Policy means the individual or individuals designated as such by the Authorized Persons or the Plan to manage access to PHI with regard to the Plan for purposes of complying with the HIPAA Privacy Standards and carrying out the functions related to the Plan. Each Authorized Person is a "Privacy Official" unless otherwise indicated.

"Protected Health Information" or "PHI." "Protected Health Information" or "PHI" means any information, whether oral or transmitted or maintained in any form or medium (including Electronic Media), that satisfies all of the following:

a. Created or received by a health care provider, health plan, Employer, 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. Identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

The term "Protected Health Information" or "PHI" does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g, and/or student treatment records described at 20 U.S.C. §1232g(a)(4)(B)(iv), and/or employment records held by an entity in its role as Employer.

"Required by Law." The term "Required by Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law. Required by Law includes, but is not limited to: court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

"Summary Health Information." "Summary Health Information" is information:

a. that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided health benefits under the Plan;

b. from which the following information has been deleted: (i) names, (ii) all geographic subdivisions smaller than a state (including street address, city, county, and precinct), except that such geographic information may be aggregated to the level of a five-digit zip code, (iii) all elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, and date of death, (iv) all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older, (v) telephone numbers, (vi) fax numbers, (vii) electronic mail addresses, (viii) social security numbers, (ix) medical record numbers, (x) health plan beneficiary numbers, (xi) account numbers, (xii) certificate/license numbers, (xiii) vehicle identifiers and serial numbers, including license plate numbers, (xiv) device identifiers and serial numbers, (xv) Web Universal Resource Locators (URLs), (xvi) Internet Protocol (IP) address numbers, (xvii) biometric identifiers, including finger and voice prints, (xviii) full face photographic images and any comparable images, and (xix) any other unique identifying number, characteristic, or code.

"Treatment." "Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers. It includes coordination or management of health care by a provider with a third party, as well as consultation between health care providers related to a patient, or the referral of a patient for health care from one health care provider to another

"Use." "Use" in this Policy means the sharing, employment, application, utilization, examination, or analysis of information within the Plan. Use generally will apply to Plan PHI.

Appendix A – Benefit Plan Rules – HIPAA

HIPAA Rules

A-1 Introduction and Definitions

These Rules are designed to be incorporated by reference into the Plan's document as part of the terms and conditions of the Plan. These terms are to provide the Rules under the Plan for purposes of implementing the HIPAA Privacy Standards, as found at Part 160, and subparts A and E or part 164, of Title 45 of the Code of Federal Regulations, as amended from time to time, and the HIPAA Regulations at Subchapter C of Subtitle A of Title 45 of the Code of Federal Regulations, as amended from time to time, with respect to this Group Health Plan.

The Definitions stated in the Policy at Part 7 are incorporated herein by reference.

A-2 Employer Use and Disclosure of Protected Health Information

Except as provided in this Appendix, the Employer's Use or Disclosure of Protected Health Information received from a Group Health Plan, from an Insurer or HMO in connection with such Group Health Plan, or from a Business Associate of such Group Health Plan is limited to the Uses and Disclosures set forth herein and the Policy. For purposes of a Group Health Plan's Payment Activities and Health Care Operations, no individuals in the Employer's workforce may access or Use Protected Health Information other than those individuals identified by the Employer as Authorized Persons under its Privacy Policy. In the event that the Employer becomes aware that anyone has failed to comply with the provisions of this Appendix, the Employer will address it, or report such noncompliance to the designated Privacy Official or other Authorized Person, as applicable.

A-3 Certification from the Employer

Except as provided in Parts A-5 and A-6, below, and the Policy, a Group Health Plan may Disclose Protected Health Information to the Employer only if the Employer agrees to comply with all of the following restrictions and obligations and such restrictions and obligations have been incorporated into the Group Health Plan document:

a. Not Use or Disclose the Protected Health Information other than as permitted by Part A-5 or A-6, the Policy, or as Required by Law;

b. Ensure that any agents, including a subcontractor, to whom the Employer provides Protected Health Information received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer, in accordance herewith, with respect to such information;

c. Not Use or Disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Insurance Plan of the Employer without consent;

d. Report to the Authorized Persons or Privacy Official, as applicable, any Use or Disclosure of the Protected Health Information of which the Employer becomes aware that is inconsistent with the Uses or Disclosures provided for in this Appendix;

e. Give individuals the right to access their Protected Health Information, in accordance with the HIPAA Privacy Standards;

f. Make available Protected Health Information for individuals to request amendments thereof, and incorporate any accepted amendments to their Protected Health Information, in accordance with the HIPAA Privacy Standards;

g. Make available the information required to provide individuals an accounting of the Employer's Disclosures of their Protected Health Information in accordance with the HIPAA Privacy Standards;

h. Make the Employer's internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from the Group Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Group Health Plan with the HIPAA Privacy Standards;

i. If feasible, return or destroy all Protected Health Information received from the Group Health Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which Disclosure was made or, 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; and

j. Ensure that the separation of the Employer's workforce that is set forth in this Section is established.

A-4 Safeguarding Electronic Protected Health Information

To the extent the Employer on behalf of a Group Health Plan maintains Protected Health Information in, or transmits Protected Health Information by Electronic Media, the Employer will:

a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of such information;

b. Ensure that the separation of the Employer's workforce that is set forth in Part A-3, above, is supported by reasonable and appropriate security measures in connection with such information; and

c. Report to the Privacy Officer or the Authorized Persons, as applicable, any attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system of which the Employer becomes aware.

In addition, the Employer will ensure that any agent, including a subcontractor, who will maintain Protected Health Information in, or transmit Protected Health Information by, Electronic Media on behalf of a Group Health Plan agrees to implement reasonable and appropriate security measures to protect such information and that any third parties are subject to an appropriate Business Associate Agreement.

A-5 Exceptions to Protected Health Information Restrictions

Notwithstanding anything to the contrary in this Appendix, the restrictions on Use of PHI as stated herein do not apply to Protected Health Information that either (a) is Disclosed to the Employer in compliance with a valid Authorization obtained from the individual who is the subject of such information; (b) is Summary Health Information that the Employer has requested for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Group Health Plan or (ii) modifying, amending, or terminating the Group Health Plan; or (c) consists solely of information on whether an individual is participating in the Group Health Plan or is enrolled in or has dis-enrolled from a benefit option under the Group Health Plan.

A-6 Permitted Use and Disclosure

The Employer is permitted to Use and Disclose Protected Health Information in connection with a Group Health Plan only for the purposes described below.

a. To the individual (or his valid Personal Representative) who is the subject of such information (see 45 C.F.R. § 164.502(a)(1)(i));

b. To carry out the Group Health Plan's Payment Activities or Health Care Operations (see 45 C.F.R. § 164.506);

c. To a health care provider for its Treatment activities (see 45 C.F.R. § 164.506);

d. To another Covered Entity or health care provider for its Payment Activities (see 45 C.F.R. § 164.506);

e. To another Covered Entity for its quality-related Health Care Operations if both the Group Health Plan and the Covered Entity have a relationship with the individual who is the subject of such information (see 45 C.F.R. § 164.506);

f. To an Insurer or HMO that provides health insurance or health coverage under the Plan for Plan-related Health Care Operations (see 45 C.F.R. § 164.506);

g. In compliance with a valid Authorization of the individual/owner of such information (see 45 C.F.R. § 164.508);

h. As Required by Law (see 45 C.F.R. § 164.512(a));

i. In the course of a judicial or administrative proceeding in response to a court order, administrative tribunal order, subpoena, discovery request, or other lawful process (see 45 C.F.R. § 164.512(e));

j. For public health activities (such as disclosure to a public health authority authorized by law to receive such information for the purpose of preventing or controlling disease) (see 45 C.F.R. § 164.512(b));

k. To a governmental agency regarding reasonable belief of abuse, neglect, or domestic violence (see 45 C.F.R. § 164.512(c));

l. To a family member, relative, or close personal friend of the individual who is the subject of such information, if relevant to such person's individual care or payment, or to a family member or Personal Representative of the individual who is the subject of such information, if relevant to such individual's location, general condition, or death; provided that the individual has the opportunity to agree or object or, if such opportunity cannot practicably be provided, the Employer in the exercise of professional judgment determines that a Disclosure is in the best interests of the individual (see 45 C.F.R. § 164.510(b));

m. To a health oversight agency for oversight activities authorized by law (including audits, investigations, licensure or disciplinary actions, and other activities necessary for appropriate oversight of the health care system or of programs for which health information is necessary for determining compliance with laws) (see 45 C.F.R. § 164.512(d));

n. To a law enforcement official for a law enforcement purpose (see 45 C.F.R. § 164.512(f));

o. To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law, or to funeral directors consistent with applicable law (see 45 C.F.R. § 164.512(g));

p. To organ procurement organizations or similar entities for the purpose of facilitating organ, eye, or tissue donation and transplantation (see 45 C.F.R. § 164.512(h));

q. For research purposes, if there is approval by an institutional review board or a privacy board and adequate documentation of such approval (see 45 C.F.R. § 164.512(i));

r. To avert a serious and imminent threat to the health or safety of a person or the public (see 45 C.F.R. § 164.512(j));

s. For specialized government functions, including (i) to Armed Forces personnel if deemed necessary by appropriate military command authorities to assure the proper execution of the military mission; (ii) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities; (iii) to authorized federal officials for the provision of protective services to the President or foreign heads of state; or (iv) to a correctional institution or a law enforcement official with lawful custody of an inmate if necessary for the health and safety of such individual, other inmates, officers or other employees at the correctional institution, or persons responsible for such inmate's transportation or otherwise for the administration and maintenance of the safety, security, and good order of the correctional institution (see 45 C.F.R. § 164.512(k));

t. To comply with laws relating to workers' compensation or other similar programs (see 45 C.F.R. § 164.512(l));

u. For marketing purposes if (i) occurring in a face-to-face encounter with the individual who is the subject of such information or (ii) involving a promotional gift of nominal value provided by the Plan (see 45 C.F.R. § 164.508(a)(3));

v. To a recipient who has agreed to a data use agreement, under which the recipient will use a Limited Data Set for research, public health activities, and/or Health Care Operations (see 45 C.F.R. § 164.514(e));

w. To the Secretary of Health and Human Services, if necessary to determine whether the Group Health Plan is in compliance with the HIPAA Privacy Standards (see 45 C.F.R. § 164.502(a)(2)(ii)); and

x. Incident to a Use or Disclosure permitted by one of the above Paragraphs provided that the Employer has reasonably safeguarded such information (see 45 C.F.R. § 164.502(a)(1)(iii)).

This HIPAA Rules, Policy and Procedures Manual is hereby adopted and approved by the Employer on this ____ day of _____, 20___,

The Employer

By: _____

Name: _____

Title: _____