Occidental Petroleum Corporation

HIPAA Privacy Policies and Procedures

September 2014

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INTRODUCTION

Optional

Occidental Petroleum Corporation, on behalf of its Health Plans, is committed to protecting health information and complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, which became law on August 21, 1996. HIPAA is a federal statute that was designed to ensure the protection of an individual's personal health information. This statute has three components: HIPAA Privacy (effective April 14, 2003), Electronic Data Interchange (effective Oct. 16, 2003), and HIPAA Electronic Data Security (effective April 20, 2005). Individuals, in turn, are afforded significant new rights to enable them to understand and control how their health information is used and disclosed.

The Administrative Simplification provisions of HIPAA authorized the Secretary of the U.S. Department of Health and Human Services to, among other things, promulgate standards for the privacy of individually identifiable health information.

One of the major goals of HIPAA was to create a floor of national protections for the privacy of sensitive health information. Under HIPAA, Health Plans, Health Care Clearinghouses, and certain Health Care Providers must guard against misuse of a participant's individually identifiable health information, and must limit the use or disclosure of such information.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 ("ARRA") was adopted on February 17, 2009. Among other things, ARRA included the Health Information Technology and Economic and Clinical Health Act ("HITECH"). HITECH generally became effective on February 17, 2010, however, some provisions may be effective earlier and other provisions will become effective after regulations and guidance are provided by the Secretary of the U.S. Department of Health and Human Services ("HHS").

Following the issuance of guidance by HHS, Occidental Petroleum Corporation will continue to update policies and procedures, modify HIPAA-related training materials, and revise its physical, technical, and administrative safeguards as necessary to continue compliance with HIPAA requirements.

HIPAA – STATEMENT OF PRIVACY POLICY

The confidentiality of employees' Health Information is important to Occidental Petroleum Corporation ("Oxy" or "Plan Sponsor"). Oxy is committed to ensuring that employees' privacy is protected and all legal requirements under HIPAA are satisfied. Accordingly, the Health Plans sponsored by Oxy will not Use or disclose Protected Health Information ("PHI") other than as permitted or required by HIPAA, the HIPAA Regulations, and as set forth in these policies and procedures ("Policies and Procedures"). Oxy's policies and procedures apply to any current or former Participant in our Health Plan for whom we maintain Protected Health Information.

Oxy's Privacy Official is the individual primarily responsible for enforcing and implementing these policies and procedures. The Privacy Official is Darin Moss, the Vice President, Compensation and Benefits, who can be reached at (713) 215-7911.

Oxy is committed to have all members of its Workforce who have access to Protected Health Information comply with these Policies and Procedures. For purposes of these requirements, the Workforce includes individuals who would be considered part of our Workforce under HIPAA such as employees, volunteers, trainees, and other persons whose work performance is under the direct control of Oxy, whether or not they are paid by the Employer. The term "employee" includes all of these types of workers.

A Covered Entity must document all policies and procedures and update its documentation whenever it makes changes to its privacy practices. The objective of these policies and procedures is to provide guidance regarding the Health Plan's compliance with the Uses, Disclosures, safeguards and rights of Participants under the HIPAA Regulations.

Oxy, reserves the right to amend or change these Policies and Procedures at any time (and even retroactively) without notice. The Policies and Procedures do not address requirements under other federal laws or under state laws.

DEFINITIONS UNDER HIPAA

Affiliated Covered Entity. "Affiliated Covered Entity" means legally separated Covered Entities that may designate themselves as a single Covered Entity for purposes of the HIPAA Regulations.

Business Associates. *"Business Associate"* means a person who, on behalf of a Covered Entity (Health Plan, Health Care Provider or Health Care Clearinghouse), creates, receives, maintains or transmits Protected Health Information for a function or activity regulated by HIPAA, including claims processing or claims administration, data analysis, data processing or data administration, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management, and repricing, or provides (other than in the capacity as a member of the Workforce of such Covered Entity), legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such Covered Entity where the provision of the services involves the Disclosure of Protected Health Information from such Covered Entity, or from another Business Associate of such Covered Entity to the person. A "Business Associate" includes (1) a health information organization, E-prescribing gateway or other person that provides data transmission services with respect to Protected Health Information to a Covered Entity and that requires access on a routine basis to such Protected Health Information; (2) a person that offers a personal health record to one or more individuals on behalf of the Covered Entity; and (3) a Subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the Business Associate.

Business Associate Agreement. *"Business Associate Agreement"* means a written contract entered into by a Business Associate and a Covered Entity in accordance with the provisions of 45 CFR § 164.504(e)(2).

Covered Entity. *"Covered Entity"* means (1) a Health Plan, (2) a Health Care Clearinghouse, or (3) a Health Care Provider who transmits any Health Information in electronic form in connection with a transaction covered by HIPAA.

Designated Record Set. *"Designated Record Set"* means (1) a group of records maintained by or for a Covered Entity that is: (i) the medical records and billing records about individuals maintained by or for a covered Health Care Provider; (ii) the enrollment, Payment, claims adjudication, and case or medical management record systems maintained by or for a Health Plan; or (iii) used, in whole or in part, by or for the Covered Entity to make decisions about individuals, and (2) for purposes of this paragraph, the term "record" means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for a Covered Entity.

Disclosure. *"Disclosure"* means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Electronic Media. *"Electronic Media"* means electronic storage media on which data is or may be recorded electronically, including 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 transmission media used to exchange information already in electronic storage media. Transmission media will include, for example, the internet, extranet, intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. *See* 45 CFR § 160.103.

Electronic Protected Health Information (or "e-PHI"). *"Electronic Protected Health Information" or "e-PHI"* means Protected Health Information that is stored or transmitted by Electronic Media (e.g., the internet, extranet, e-mail, company intranet, dial-up lines, etc.) or other electronic storage media such as floppy disks, hard drives, magnetic tape or digital memory cards. Traditional (non-computer-based) fax, paper and telephone voice transmissions of PHI are not considered "electronic" under the HIPAA data security regulations. *See* 45 CFR § 160.103.

Electronic Transactions. *"Electronic Transactions"* contemplated by the HIPAA Regulations are as follows: (1) Health Care claims or equivalent encounter information, (2) Health Care Payment and remittance advice, (3) coordination of benefits, (4) Health Care claim status, (5) enrollment and disenrollment in a Health Plan, (6) eligibility for a Health Plan, (7) Health Plan premium Payments, (8) referral certification and authorization, (9) first report of injury, (10) health claims attachments, and (11) other transactions that the Secretary of Health and Human Services may prescribe.

Employer. *"Employer,"* when used in this these Policies and Procedures, means Occidental Petroleum Corporation.

Financial Remuneration. *"Financial Remuneration"* means direct or indirect payment for or on behalf of a third party whose product or service is begin described. For purposes of this definition, direct or indirect payment does not include any payment for Treatment of Participants.

Genetic Information. "*Genetic Information*" means, with respect to a Participant, information about (1) the Participant's genetic tests; (2) the genetic tests of the family members of the Participant; (3) the manifestation of a disease or disorder in family members of the Participant; or (4) any request for, or receipt of, Genetic Services, or participation in clinical research which includes Genetic Services, by the Participant or any family member of the Participant. The "Genetic Information" of a Participant or a Participant's family member shall include the genetic information of (1) a fetus carried by the Participant or a family member of the Participant who is a pregnant woman; and (2) any embryo legally held by a Participant or a family member of the Participant utilizing an assisted reproductive technology. "Genetic Information" does not include information about the sex or age of any Participant.

Genetic Services. "*Genetic Services*" means (1) a Genetic Test; (2) genetic counseling (including obtaining, interpreting, or assessing Genetic Information); or (3) genetic education.

Genetic Test. "*Genetic Test*" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. The term "Genetic Test" does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

Group Health Plan. *"Group Health Plan"* means an employee welfare benefit plan within the meaning of ERISA § 3(1), including insured and self-insured plans, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees and their dependents directly or through insurance, reimbursement or otherwise, that (1) has 50 or more Participants; or (2) is administered by an entity other than the Employer that established the plan.

Health Care. "*Health Care"* means care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of a Participant or that affects the

structure or function of the body; and (2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health Care Clearinghouse. *"Health Care Clearinghouse"* means a public or private entity, including a billing service, repricing company, community health management information system or community Health Information system, and "value-added" networks and switches, that does either of the following functions: (1) processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or (2) receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or a nonstandard data content for the receiving entity.

Health Care Component. *"Health Care Component"* means a component or combination of components of a Hybrid Entity designated by the Hybrid Entity in accordance with 45 CFR § 164.103.

Health Care Operations. *"Health Care Operations"* means any of the following activities of the Covered Entity to the extent that the activities are related to covered functions: (1) conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, contacting of Health Care Providers and patients with information about Treatment alternatives; and related functions that do not include Treatment; (2) Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner and provider performance, Health Plan performance, conducting training programs in which students, trainees, or practitioners in areas of Health Care learn under supervision to practice or improve their skills as Health Care Providers, training of non-Health Care professionals, accreditation, certification, licensing, or credentialing activities; (3) 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 claims for Health Care (including stop-loss insurance and excess of loss insurance), provided that the requirements of 45 CFR § 164.514(g) are met, if applicable; (4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; (5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of Payment or coverage policies; and (6) Business management and general administrative activities of the entity, including, but not limited to: (i) Management activities relating to implementation of and compliance with the requirements of the HIPAA Regulations; (ii) Customer service, including the provision of data analyses for policy holders, Plan Sponsors, or other customers, provided that Protected Health Information is not disclosed to such policy holder, Plan Sponsor, or customer; (iii) Resolution of internal grievances; (iv) Sale, transfer, merger, or consolidation of all or part of the Covered Entity with another Covered Entity, or an entity that following such activity will become a Covered Entity and due diligence related to such activity; and (v) Consistent with the applicable requirements of 45 CFR § 164.514, creating de-identified Health Information, or a Limited Data Set, and fundraising for the benefit of the Covered Entity.

Health Care Provider. *"Health Care Provider"* means a provider of services (as defined at 42 U.S.C. § 1395x(u)), a provider of medical or health services (as defined at 42 U.S.C. § 1395x(s)), and any other person or organization who furnishes, bills, or is paid for Health Care in the normal course of business.

Health Information. *"Health Information"* means any information, including Genetic Information, whether oral or recorded in any form or medium, that is created or received by a Health Care Provider, Health Plan, Public Health Authority, Employer, life insurer, school or university or Health Care Clearinghouse and related 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.

Health Oversight Agency. *"Health Oversight Agency"* means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the Health Care system (whether public or private) or government programs in which Health Information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which Health Information is relevant.

Health Plan. *"Health Plan"* means an individual or group plan that provides, or pays the cost of, medical care and includes the following, singly or in combination: (1) a Group Health Plan, (2) a health insurance issuer, (3) an HMO, (4) Part A or Part B of the Medicare program, (5) the Medicaid program, (6) the Voluntary Prescription Drug Benefit program, (7) an issuer of a Medicare supplemental policy, (8) an issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy, (9) an employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more Employers, (10) the health care program for uniformed services, (11) the veterans health care program, (12) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), (13) the Indian Health Service program, (14) the Federal Employees Health Benefits Program, (15) the Medicare Advantage program, (16) an approved State child health plan providing benefits for child health assistance, (17) the Medicare+Choice program, (18) a high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals, and (19) any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care. For purposes of these Policies and Procedures, "Health Plan" will include the Health Plans identified in these Policies and Procedures.

HIPAA. *"HIPAA"* means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time.

HIPAA Regulations. *"HIPAA Regulations"* means the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), any temporary, proposed or permanent regulations issued by the U.S. Department of Health and Human Services ("HHS"), and any technical pronouncements or guidance issued by HHS, the Federal Office for Civil Rights, the Centers for Medicare and Medicaid Services, or any other Federal agency having responsibility for issuing regulations or guidance under HIPAA. When a specific section of the HIPAA Regulations are referred to (e.g., Section 160.103) such reference is to title 45 of the Code of Federal Regulations.

HITECH Act. *"HITECH Act"* means the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, enacted on February 17, 2009.

Hybrid Entity. *"Hybrid Entity"* means a single legal entity that (1) is a Covered Entity; (2) whose business activities include both covered and non-covered functions; and (3) designates Health Care Components in accordance with 45 CFR § 164.103.

Individually Identifiable Health Information. *"Individually Identifiable Health Information"* is information that is a subset of Health Information, including demographic information collected from an Participant and is created or received by a Health Care Provider, Health Plan, Employer or Health Care Clearinghouse, and 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 that (1) identifies the individual; or (2) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Marketing *"Marketing"* means a communication about a product or service that encourages recipients of the communication to purchase the product or service except a communication made: (i) to provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for an individual, provided that any Financial Remuneration received by the Health Plan in exchange for making the communication is reasonably related to the Health Plan's cost of making the communication; or (ii) for the following Treatment or Health Care Operation purposes, except when the Health Plan receives Financial Remuneration in exchange for making the communication: (A) for Treatment of an individual by a Health Care Provider, case management or care coordination for the individual, or to direct or recommend alternative Treatments, therapies, Health Care Providers, or settings of care to the individual; (B) to describe a health-related product or service (or Payment for such product or service) that is provided by, or included in the Health Plan, including communications about the entities participating in a Health Care Provider network, replacement or, or enhancement to, a Health Plan, and health-related products or services available only to a Health Plan enrollee that adds value, but is not part of the benefits provided by the Health Plan; and (C) for case management or care coordination, contacting of individuals with information about Treatment alternatives, and related functions to the extent these activities do not fall within the definition of Treatment. .

Organized Health Care Arrangement. *"Organized Health Care Arrangement"* means, among other things: a Group Health Plan and a health insurance issuer or HMO with respect to such Group Health Plan, but only with respect to Protected Health Information created or received by such health insurance issuer or HMO that relates to individuals who are or who have been Participants or beneficiaries in such Group Health Plan; a Group Health Plan and one or more other Group Health Plans each of which are maintained by the same Plan Sponsor; or the Group Health Plans described above and health insurance issuers or HMOs with respect to such Group Health Plans, but only with respect to Protected Health Information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been Participants or beneficiaries in any of such Group Health Plans.

Participant. *"Participant"* means the person who is the subject of Protected Health Information.

Payment. *"Payment"* means (1) the activities undertaken by (i) a Health Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Health Plan, subject to the prohibition on the use and disclosure of PHI for underwriting purposes set forth in 45 CFR **§** 164.502(a)(5)(i); or (ii) a covered Health Care Provider or Health Plan to obtain or provide reimbursement for the provision of Health Care; and (2) the activities in paragraph (1) of this definition that relate to the individual to whom health care is provided and include, but are not limited to activities set forth in Section 164.501.

Plan Sponsor. *"Plan Sponsor"* is defined at Section 3(16)(B) of ERISA, 29 U.S.C. **§** 1002(16)(B), and includes the Plan Sponsor of the Health Plans identified in these Policies and Procedures, to the extent reference is made to the respective Health Plans as Covered Entities under HIPAA.

Privacy Official. *"Privacy Official"* means a person who is responsible for the development and implementation of the policies and procedures of the entity.

Protected Health Information. *"Protected Health Information"* or *"PHI"* means Individually Identifiable Health Information (except as provided in the second sentence of this definition), that is: (1) transmitted by electronic media; (2) maintained in electronic media; or (3) transmitted or maintained in any other form or medium. Protected Health Information includes Genetic Information in accordance with the Genetic Information Nondiscrimination Act of 2008, as amended ("GINA"). Protected Health Information excludes Individually Identifiable Health Information (i) in education records covered by the Family Education Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) in records described at 20 U.S.C. 1232g(a)(4)(B)(iv); (iii) in employment records held by a Covered Entity in its role as employer; and (iv) regarding an individual who has been deceased for more than fifty (50) years.

Psychotherapy Notes. *"Psychotherapy Notes"* means notes recorded (in any medium) by a Health Care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the Treatment plan, symptoms, prognosis, and progress to date.

Public Health Authority. *"Public Health Authority"* means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Required by Law. *"Required by Law"* means a mandate contained in law that compels an entity to make the Health Plan or Disclosure of Protected Health Information 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.

Secured Protected Health Information. "*Secured Protected Health Information*" means Protected Health Information that is rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.

Subcontractor. "*Subcontractor*" means a person to whom a Business Associate delegates a function, activity or service, other than in the capacity of a member of the Workforce of such Business Associate.

Summary Health Information *"Summary Health Information"* means information that may be Individually Identifiable Health Information, and: (1) 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 (2) from which the information described in the HIPAA Regulations has been deleted, except that the geographic information described in the HIPAA Regulations need only be aggregated to the level of a five digit zip code.

Treatment. *"Treatment"* means the provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination of management of Health Care by a Health Care Provider with a third-party; consultation between the Health Care Providers relating to a patient; or the referral of a patient for Health Care from one Health Care Provider to another.

Unsecured Protected Health Information. *"Unsecured Protected Health Information"* means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services, and therefore is not Secured Protected Health Information.

Use. *"Use"* means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

Workforce. *"Workforce"* means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity, is under the direct control of such entity, whether or not they are paid by the Covered Entity.

Privacy Official and HIPAA Contact Person

Policies:

Designate a Privacy Official. The Health Plan must designate a Privacy Official who is responsible for the development and implementation of the Health Plan's Policies and Procedures regarding the privacy of Protected Health Information.

Designate a Contact Person or Contact Office. The Health Plan must designate a contact person (or office) who is responsible for receiving complaints regarding privacy practices with respect to Protected Health Information and who is able to provide further information about matters covered by the Health Plan's Notice of Privacy Practices.

Compliance Procedure. The Health Plan must provide a process for Participants to make complaints concerning the HIPAA privacy Policies and Procedures or the Health Plan's compliance with either the Policies and Procedures or the HIPAA Regulations.

No Retaliation. The Health Plan shall not retaliate against a Participant who files a complaint either with the Health Plan's Privacy Official or the U.S. Department of Health and Human Services.

Procedures:

Privacy Official. The Privacy Official **Darin Moss,** the **Vice President, Compensation and Benefits,** who can be reached at (**713**) **215-7911**. The Privacy Official is responsible for the development and implementation of the Health Plan's privacy Policies and Procedures.

Contact Person. The Privacy Official is the point of contact for receiving privacy complaints and shall be able to provide further information about matters covered by the Health Plan's Notice of Privacy Practices. All complaints must be submitted in writing to this Contact Person.

Record Retention. The Health Plan will maintain a written or electronic record of the designations of the Privacy Official and the point of contact for receiving privacy complaints. The Health Plan will also document all complaints received, and their disposition, if any. The Health Plan will retain such documentation for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.530(a)(1)(i), (ii), (2)

Covered Entities – Organization of Health Plans

CONTENTS OF THIS SECTION

Identification Of Health Plans

HIPAA applies to certain Health Plans that are sponsored by the Employer. The HIPAA Regulations require that each Health Plan establish Policies and Procedures to comply with the privacy rules under HIPAA. This section is intended to identify those Health Plans that will be subject to these Policies and Procedures.

Policies.

The Plan Sponsor shall identify the Health Plans that will be subject to the HIPAA Policies and Procedures.

Procedures.

Identification of Health Plans and Plan Sponsors. The following Health Plan is subject to these Policies and Procedures:

Health Plan Name	Plan Sponsor
• Occidental Petroleum Corporation Welfare Plan (Medical, Dental and FSA components)	Occidental Petroleum Corporation
• Occidental Petroleum Corporation Retiree Medical Plan	Occidental Petroleum Corporation
• Occidental Petroleum Corporation Retiree Dental Plan	Occidental Petroleum Corporation
• Occidental Petroleum Corporation Health Promotion Plan	Occidental Petroleum Corporation
• Occidental Chemical Corporation Medical Plan	Occidental Chemical Corporation
• Occidental Chemical Corporation Retiree Medical Plan	Occidental Chemical Corporation
• Occidental Chemical Corporation Dental Assistance Plan	Occidental Chemical Corporation
• Occidental Chemical Corporation Retiree Dental Assistance Plan	Occidental Chemical Corporation
• Occidental Chemical Corporation Pretax Premium Plan	Occidental Chemical Corporation
• Occidental Chemical Corporation Special Welfare Plan for North Tonawanda Hourly Employees	Occidental Chemical Corporation
• Occidental Chemical Corporation Special Welfare Plan for North Tonawanda Salaried Employees	Occidental Chemical Corporation
• Blue Cross-Blue Shield Plan for Hourly Employees of Occidental Chemical Corporation at Niagara Falls	Occidental Chemical Corporation
• Blue Cross-Blue Shield Plan for Hourly Employees of Occidental Chemical and Plastics Corporation – North Tonawanda	Occidental Chemical Corporation
• Group Insurance Plan for Petrolia Hourly Employees	INDSPEC Chemical Corporation
• Group Insurance Plan for Petrolia Hourly Retirees	INDSPEC Chemical Corporation

Changes to Health Plans Subject to Policies and Procedures. The Privacy Official shall, with the approval of the Plan Sponsor, amend, modify, add to or delete the list of Health Plans that are subject to these Policies and Procedures, from time to time as appropriate.

Fully Insured Health Plans

The HIPAA Regulations recognize that fully insured health insurance issuers and HMOs are subject to HIPAA in their own right as Covered Entities. To the extent the Health Plan and Employer do not receive Individually Identifiable Health Information in connection with fully insured health insurance coverages or HMO coverages, their obligations under HIPAA will be minimal.

Policies.

The Health Plan, to the extent it is a Group Health Plan or Health Care Component under the HIPAA Regulations, is not subject to the HIPAA Regulations' provisions regarding personnel designations, training, safeguards, complaints, sanctions, mitigation, and policies and procedures (*See* 45 CFR § 164.530(a)-(f), and (i)) to the extent that:

1) Solely Through Health Insurance or HMO. The Health Plan provides health benefits solely through an insurance contract with a health insurance issuer or an HMO;

2) Limitations on Protected Health Information Disclosed to Plan Sponsor. The Health Plan or Health Care Component does not disclose Protected Health Information to the Plan Sponsor, except for:

   a) Summary Health Information; or

   b) Information on whether the Participant is participating in the Health Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Health Plan.

3) Remaining HIPAA Requirements. If the above conditions apply, the Health Plan's fully insured components and coverage under an HMO must only comply with the non-retaliation and non-waiver provisions of the HIPAA Regulations (45 CFR § 164.530(g), (h)); and

4) Documentation. The Health Plan must maintain written or electronic documentation of any related documents. Such documents must be retained for a minimum of six (6) years from the date of their creation or the date when they last were in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.530(k)

Hybrid Entities

In recognition that some employers may establish wrap-around benefit plans consisting of both health (e.g., medical) and non-health (e.g., disability) components, the use of the "Hybrid Entity" concept permits the HIPAA Regulations to be applied solely to the Health Care Components of the wrap-around plan.

Policies.

If it is determined that the Health Plan should operate as a Hybrid Entity, the HIPAA Regulations shall be applied only to the Health Care Component(s) of the Health Plan.

Procedures.

Health Care Component. To the extent that the Plan Sponsor designates a Health Plan's Health Care Components as part of a Hybrid Entity, any reference in the HIPAA Regulations to a "Health Plan," shall refer to the Health Care Component of the Health Plan if such Health Care Component performs the functions of a Health Plan.

Protected Health Information. To the extent that the Plan Sponsor designates a Health Plan's Health Care Components as part of a Hybrid Entity, reference in the HIPAA Regulations to "Protected Health Information" refers to Protected Health Information that is created or received by or on behalf of the Health Care Component of the Health Plan.

Safeguard Requirements. To the extent that the Plan Sponsor designates a Health Plan's Health Care Components as part of a Hybrid Entity, the Health Plan will ensure that any Health Care Component(s) of the Health Plan comply with the applicable requirements of the HIPAA Regulations. In particular, and without limiting this requirement, the Health Plan shall ensure that:

1) The Health Plan's Health Care Component(s) does not disclose Protected Health Information to another component of the Health Plan under circumstances in which the HIPAA Regulations would prohibit such Disclosure if the Health Care Component and the other component were separate and distinct legal entities;

2) A component that would be a Business Associate of a component that performs covered functions if the two components were separate legal entities does not Use or disclose Protected Health Information that it creates or receives from or on behalf of the Health Care Component in a way prohibited by the HIPAA Regulations; and

3) If a person performs duties for both the Health Care Component in the capacity of a member of the Workforce of such component and for another component of the Hybrid Entity in the same capacity with respect to that component, such Workforce member must not Use or disclose Protected Health Information created or received in the case of or incident to the Workforce member's work for the Health Care Component in a prohibited way.

Health Plan's Responsibilities. As a Hybrid Entity, the Health Plan will have the following responsibilities:

1) HIPAA Regulations. Comply with the HIPAA Regulations as they pertain to Hybrid Entities.

2) Hybrid Entity Documentation. Implement Policies and Procedures to ensure compliance with the HIPAA Regulations.

    a) Designate the Health Care Components of the Health Plan and appropriately document in written or electronic form the designation, provided that, if the Health Plan designates a Health Care Component or Components, the Health Plan will include any component that would meet the definition of a Covered Entity if it were a separate legal entity. Health Care Component(s) also may include a component only to the extent that it performs:

        i) Covered functions; or

        ii) Activities that would make such component a Business Associate of a component that performs covered functions if the two components were separate legal entities.

    b) Retain the written or electronic designations of Health Care Components for a minimum of six (6) years from the date of creation or the date when the designation was last in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR §§ 164.103, 164.105

Affiliated Covered Entities

To the extent the Employer or its subsidiaries or affiliates sponsors a number of different Health Plans, the different Health Plans may designate themselves as a single Covered Entity for various HIPAA requirements including the provision of a single Notice of Privacy Practices.

Policies.

Legally separate Covered Entities that are affiliated may designate themselves as a single Covered Entity for purposes of the HIPAA Regulations.

Procedures.

Requirements for Designation As An Affiliated Covered Entity:

1) Affiliated Covered Entity Designation. Legally separate Covered Entities may designate themselves (including any Health Care Components of such Covered Entity) as a single Affiliated Covered Entity for purposes of the HIPAA Regulations, provided that all of the Covered Entities designated are under common ownership or control (within the meaning of 45 CFR § 164.103).

2) Documentation. The designation of an Affiliated Covered Entity must be maintained in a written or electronic record and retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

Safeguard Requirements. An Affiliated Covered Entity must ensure that:

1) Uses and Disclosures. Use and Disclosure of Protected Health Information by the Affiliated Covered Entity complies with the HIPAA Regulations;

2) Covered Functions. If the Affiliated Covered Entity combines the functions of a Health Plan, Health Care Provider, or Health Care Clearinghouse, the Affiliated Covered Entity will comply with the HIPAA Regulations (see e.g., 45 CFR §§ 164.308(a)(4)(ii)(A) and 164.504(g)) as applicable to the Health Plan, Health Care Provider, or Health Care Clearinghouse covered functions performed; and

3) Related Purposes. If the Affiliated Covered Entity combines the functions of a Health Plan, Health Care Provider or Health Care Clearinghouse, the Affiliated Covered Entity may Use or disclose the Protected Health Information of individuals only for purposes related to the appropriate function being performed.

HIPAA Regulations/Citations
45 CFR § 164.105(b)

Organized Health Care Arrangements

To the extent the Health Plan includes certain fully insured health insurance coverages or HMO coverages, use of an Organized Health Care Arrangement will permit certain Health Information to be provided between the Health Plan and the health insurance issuer or HMO.

Policies.

Organized Health Care Arrangement. To the extent the Health Plan operates as an Organized Health Care Arrangement:

1) Sharing Information. The Health Plan may share Protected Health Information with separate Covered Entities comprising the Organized Health Care Arrangement for any Health Care Operations activity of the Organized Health Care Arrangement.

2) Joint Activities. The Health Plan may, to the extent applicable, perform one or more activities jointly with the other Covered Entities comprising the Organized Health Care Arrangement.

HIPAA Regulations/Citations
45 CFR §§ 160.103, 164.506(c), 164.508, 164.520(d)

Multiple Covered Functions

Covered Entities perform a number of covered functions that cause them to be a Health Plan, Health Care Provider or Health Care Clearinghouse under HIPAA. To the extent that a Covered Entity performs multiple covered functions (involving any combination of Health Plans or Health Care Providers), it must comply with the provisions applicable to multiple covered functions.

Policies.

Compliance With Applicable HIPAA Regulations. If the Health Plan performs multiple covered functions that would make the Health Plan operate as any combination of a Health Plan, a covered Health Care Provider, and a Health Care Clearinghouse, the Health Plan will comply with the HIPAA Regulations that are applicable to the Health Plan, Health Care Provider, or Health Care Clearinghouse covered functions performed.

Related Purposes. If the Health Plan performs multiple covered functions, the Health Plan may Use or disclose the Protected Health Information of Participants who receive services, but only for purposes related to the appropriate function being performed.

HIPAA Regulations/Citations
45 CFR §§ 164.501, 164.504(g)

PARTICIPANTS' RIGHTS

CONTENTS OF THIS SECTION

Right To Inspect And To Obtain Copies

One of the major objectives of the HIPAA Regulations is to permit Participants to have access to their Protected Health Information. Consequently, Health Plans must develop appropriate policies and procedures to facilitate such access by Participants.

Policies.

Right of Access. Participants have the right to inspect and to obtain a copy of their Protected Health Information that the Health Plan maintains in a Designated Record Set, for as long as the Protected Health Information is maintained in the Designated Record Set, except for Psychotherapy Notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

1) Access Granted. To the extent a Participant is granted access to Protected Health Information, such Protected Health Information shall be provided in accordance with the terms and conditions of the HIPAA Regulations.

2) Access Denied. To the extent a Participant is denied access to Protected Health Information, the Participant shall follow the procedures applicable to the review of a denial of access set forth below.

3) Information in Electronic Format. If the Health Plan (or its Business Associate) maintains a Designated Record Set that includes the Protected Health Information of a Participant, the Participant shall have a right to (i) obtain from the Health Plan a copy of such information in the electronic form and format requested by the Participant, if readily producible in such form and format, or if not, in a readable electronic form and format as agreed to by the Health Plan and the Participant; and (ii) request that the Health Plan transmit such copy directly to an entity or person designated by the Participant, provided that such designation is in writing, signed by the Participant, and clearly identifies the designated person and where to send the copy of the Protected Health Information.

Procedures.

Requests for Access to Protected Health Information. The Health Plan may allow Participants to request access to inspect or to obtain a copy of their Protected Health Information that the Health Plan maintains in a Designated Record Set. The Health Plan may require such requests for access to be made in writing.

Health Plan's Response.

1) PHI Maintained On-Site or Off-Site. If the Participant requests access to Protected Health Information that is maintained by the Health Plan or is accessible to the Health Plan on-site, the Health Plan will act on such a request no later than 30 days after receiving the request as follows:

a) If the Health Plan grants the request for access, in whole or in part, the Health Plan will inform the Participant of the Health Plan's acceptance of the request and provide the access requested in accordance with the Provision of Access requirements listed below.

b) If the Health Plan denies the request, in whole or in part, the Health Plan will provide the Participant with a written denial in accordance with the Denial of Access requirements listed below.

c) If the Health Plan is unable to meet these requirements within the 30-day time period, the Health Plan may take up to an additional 30 days (a total of 60 days) for such actions by providing the Participant, within the first 30-day period, a written statement of the reasons for the Health Plan's delay and the date by when the Health Plan will complete the Health Plan's action on the request for access.

2) Information Not Accessible**.** If the Health Plan does not maintain the Protected Health Information that is the subject of a Participant's request for access, and the Health Plan knows where the requested information is maintained, the Health Plan will inform the Participant where to direct his or her request for access.

Provision of Access. If the Health Plan provides a Participant with access, in whole or in part, to his or her Protected Health Information, the Health Plan will do so by adhering to the following procedures:

1) Providing the Access Requested. The Health Plan will provide the access requested by the Participant, including inspection or obtaining a copy, or both, of the Protected Health Information the Health Plan maintains about the Participant in Designated Record Sets. If the same Protected Health Information that is the subject of a request for access is maintained in more than one (1) Designated Record Set or at more than one (1) location, the Health Plan need only produce the Protected Health Information once in response to a request for access.

2) Form of Access Requested.

a) The Health Plan will provide the Participant with access to the Protected Health Information in the form or format requested by the Participant, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed to by the Participant and by the Health Plan.

b) If the Health Plan (or its Business Associate) maintains a Designated Record Set that includes the Protected Health Information of a Participant, the Health Plan shall, upon the request of the Participant, provide a copy of such information in the electronic format and format requested by the Participant if it is readily producible in that form or format, or if not, in a readable electronic form and format as agreed to by the Health Plan and the Participant. The Health Plan shall transmit such copy directly to an entity or person designated by the Participant, provided that such designation is in writing, signed by the Participant, and clearly identifies the designated person and where to send the copy of the Protected Health Information.

c) The Health Plan may provide a summary of the Protected Health Information requested, in lieu of providing access to Protected Health Information, or the Health Plan may provide an explanation of the Protected Health Information to which access has been provided, if the

Participant agrees in advance to such a summary or explanation and the Participant agrees in advance to the fees imposed, if any, by the Health Plan for such summary or explanation.

3) Manner of Access. The Health Plan will arrange with the Participant for a convenient time and place for the Participant to inspect or to obtain a copy of his or her Protected Health Information, or the Health Plan will mail a copy of the Protected Health Information at the Participant's request. The Health Plan may discuss the scope, format, and other aspects of the request for access with the Participant as necessary to facilitate the timely provision of access.

4) Fees. If the Participant requests a copy of his or her Protected Health Information or agrees to a summary or explanation of such information, the Health Plan may impose a reasonable, cost-based fee. This fee will include only the cost of:

   a) Labor for copying the Protected Health Information that the Participant has requested, whether in paper or electronic form;

   b) Supplies for creating the paper or electronic media if the Participant requests that the electronic copy be provided on portable media;

   c) Postage, when the Participant has requested that the copy, summary or explanation be mailed; and

   d) Preparing an explanation or summary of the Protected Health Information, if the Participant agrees in advance to the fees imposed, if any, by the Health Plan for such summary or explanation.

   When a copy of a Participant's Protected Health Information is to be provided in electronic format, the Health Plan may impose a reasonable, cost-based fee that does not exceed the Health Plan's labor costs for responding to the request for an electronic copy (or summary or explanation).

Denial of Access. If the Health Plan denies access, in whole or in part, to Protected Health Information, the Health Plan will do so only by adhering to the following requirements:

1) Partial Access. To the extent possible, the Health Plan will give the Participant access to any other portion of his or her Protected Health Information requested, after excluding the Protected Health Information as to which the Health Plan has a ground to deny access.

2) Form of Denial. Provide the Participant a timely, written denial. The denial will be written in plain language and will contain:

   a) The basis for the denial;

   b) If applicable, a statement of the Participant's review rights, including a description of how the Participant may exercise such review rights;

   c) A description of how the Participant may complain to the Health Plan. This description will identify the person/office who is responsible for receiving complaints about the Health Plan's compliance with the HIPAA Regulations and who is able to provide further information about the matters covered by the Notice of Privacy Practices; and

d) A description of how the Participant may complain to the Secretary of the U.S. Department of Health and Human Services. To complain about the Health Plan to the Secretary of the U.S. Department of Health and Human Services, the Participant must adhere to the following:

i) The complaint must be filed in writing, either on paper or electronically.

ii) The complaint must name the Health Plan as the entity that is the subject of the complaint and describe the Health Plan's acts or the Health Plan's omissions that the Participant thinks are in violation of the applicable parts of the HIPAA Regulations.

iii) The complaint must be filed within 180 days of when the Participant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary of the U.S. Department of Health and Human Services for good cause shown.

Non-Reviewable Grounds for Denial of Access. The Health Plan may deny a Participant access to his or her Protected Health Information without providing an opportunity for review, in the following circumstances:

1) Psychotherapy Notes. The Protected Health Information sought is not of a type or nature to which the Participant has a right of access because it is Psychotherapy Notes or it is information compiled in reasonable anticipation of, or for the Health Plan in, a civil, criminal, or administrative action or proceeding.

2) Federal Privacy Act. The Protected Health Information is contained in records that are subject to the federal Privacy Act (5 U.S.C. § 552a) and access to it may be denied, if the denial of access under the Privacy Act would meet the requirements of that law.

3) Confidentiality Agreement. The Protected Health Information was obtained from someone other than a Health Care Provider under a promise of confidentiality and the access requested by the Participant would be reasonably likely to reveal the source of the information.

Reviewable Grounds for Denial of Access. To the extent that the Health Plan denies a Participant access to his or her Protected Health Information (other than as described above), the Health Plan shall provide the Participant the right to have such denial reviewed in the following circumstances:

1) Physical Safety. A licensed Health Care professional shall determine, in the exercise of professional judgment, that the access requested by the Participant is reasonably likely to endanger the life or physical safety of the Participant or another person;

2) Safety of Others. The Protected Health Information makes reference to another person (unless such other person is a Health Care Provider) and a licensed Health Care professional has determined, in the exercise of professional judgment, that the access requested by the Participant is reasonably likely to cause substantial harm to such other person; or

3) Personal Representatives. The request for access is made by the personal representative of a Participant and a licensed Health Care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the Participant or to another person.

If the Health Plan denies a Participant access to his or her Protected Health Information on a ground that qualifies as a Reviewable Ground for Denial of Access, the Participant has the right to have the denial reviewed by a licensed Health Care professional who is designated by the Health Plan to act as a reviewing official and who did not participate in the original decision to deny access. Any request by a Participant for review of a denial of access shall be made in writing and submitted to the Health Plan within a reasonable period of time after the Participant's receipt of the denial of access from the Health Plan. The Health Plan will provide or deny access in accordance with the determination of the reviewing official as follows:

1) Designation of Health Plan. If the Participant requests a Review of a Denial of Access, the Health Plan will designate a licensed Health Care professional, who was not directly involved in the denial, to review the decision to deny access.

    a) The Health Plan will promptly refer the request for review to such designated reviewing official.

    b) The designated reviewing official will determine, within a reasonable time period, whether or not to deny the access requested by the Participant based on the following standards:

        i) In the exercise of professional judgment by the designated reviewing official, that the access requested is reasonably likely to endanger the life or physical safety of the Participant or another person;

        ii) The Protected Health Information makes reference to another person (unless such other person is a Health Care Provider) and the designated reviewing official determines, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person;

        iii) The request for access is made by the personal representative of a Participant and the designated reviewing official, in the exercise of professional judgment, determines that the provision of access to such personal representative is reasonably likely to cause substantial harm to the Participant or to another person; or

    c) The Health Plan will promptly provide written notice to Participants or their personal representatives (as applicable) of the determination of the designated reviewing official and the Health Plan will carry out the designated reviewing official's determination.

Documentation. The Health Plan will maintain a written or electronic record of the Designated Record Sets to which Participant may access for a minimum of six (6) years from the date of their creation. The Health Plan will maintain a written or electronic record of the titles of the persons or offices responsible for receiving and processing requests for access by individuals for a minimum of six (6) years from the date of their creation or the date when it or they were last in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.524

Right To Request An Amendment

The HIPAA Regulations are designed to permit Participants to have access to their Protected Health Information. Once Participants have accessed their Protected Health Information, they may believe that a basis exists to amend or clarify Protected Health Information. The HIPAA Regulations provide specific procedures to facilitate the amendment of Protected Health Information.

Policies:

Right to Amend. The Participant has the right to have the Health Plan amend Protected Health Information or a record about him or her maintained in a Designated Record Set for as long as the Health Plan maintains the Protected Health Information in the Designated Record Set.

Denial of Amendment. The Health Plan may deny a Participant's request for amendment of Protected Health Information or a record about the Participant maintained in a Designated Record Set, if the Health Plan determines that:

1) Source of PHI. The Protected Health Information or record that is the subject of the request was not created by the Health Plan, unless the Participant provides the Health Plan with a reasonable basis to believe that the originator of Protected Health Information is no longer available to act on the requested amendment;

2) Not Part of a Data Record Set. The Protected Health Information or record that is the subject of the request was is not part of the Designated Record Set;

3) Not Available for Inspection. The Protected Health Information or record that is the subject of the request would not be available for inspection under the rights that the HIPAA Regulations gives to Participants to access Protected Health Information; or

4) No Changes Needed. The Protected Health Information or record that is the subject of the request is accurate and complete.

Procedures.

Participant Requests for Amendment To Protected Health Information.

1) Requests to Amend. A Participant may request that the Health Plan amend the Participant's Protected Health Information which the Health Plan maintains in a Designated Record Set. A Participant must make such a request for an amendment in writing and provide the Health Plan with reasons to support the requested amendment.

2) Response to Request. The Health Plan will act on a Participant's request for an amendment no later than 60 days after receiving the request as follows:

   a) If the Health Plan grants a Participant's requested amendment, in whole or in part, the Health Plan will do so by following the procedures set forth below.

b) If the Health Plan denies a Participant's requested amendment, in whole or in part, the Health Plan will provide the Participant with a timely written denial by following the procedures set forth below.

c) If the Health Plan is unable to act on a Participant's request to amend his or her Protected Health Information that the Health Plan maintains in a Designated Record Set within 60 days after receiving the request, the Health Plan may take up to an additional 30 days to act on the request, provided that, within 60 days after receiving the request for an amendment, the Health Plan provides the Participant with a written statement of the reasons for the Health Plan's delay in acting on the request and the date by when the Health Plan will complete its action on the request.

Accepting the Amendment. If the Health Plan accepts (in whole or in part) a Participant's request for an amendment to his or her Protected Health Information that the Health Plan maintains in a Designated Record Set, the Health Plan will do the following:

1) Amending PHI. The Health Plan will make the appropriate amendment to the Protected Health Information or record that is the subject of the Participant's request for amendment by, at a minimum, identifying the records in a Designated Record Set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.

2) Informing The Participant. The Health Plan will inform the Participant within 60 days after receiving the Participant's request to amend his or her Protected Health Information that the Health Plan has accepted the request. If the Health Plan is unable to act on the request for an amendment within the 60-day period after receipt of the request and the Health Plan provided the Participant with a written statement of the reasons for the Health Plan's delay and the date by when the Health Plan will complete the Health Plan's action on the request for an amendment, the Health Plan will inform the Participant that the request has been accepted as soon as the decision to accept is made, but in no event more than 90 days after the request for amendment was received by the Health Plan.

3) Informing Others. Before informing others of the amendment to a Participant's Protected Health Information, the Health Plan will obtain the Participant's identification of and the Participant's agreement to have the Health Plan notify the relevant persons with whom the amendment needs to be shared as follows:

a) The Health Plan will make reasonable efforts to inform and provide the amendment of the Protected Health Information to:

i) Persons identified by the Participant as having received Protected Health Information about the Participant and who need the amendment; and

ii) Persons, including the Health Plan's Business Associates, that the Health Plan knows have the Protected Health Information that is the subject of the amendment and that may have relied on, or could foreseeably rely on such information to the Participant's detriment.

Denial of Request to Amend. A denial of request to amend Protected Health Information shall state the basis for the denial of an amendment. Such basis for denial of amendment shall be one or more of the following:

1) Not Created By Health Plan. The Protected Health Information or record that is the subject of a Participant's request for amendment was not created by the Health Plan unless the Participant provides the Health Plan with a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on the requested amendment;

2) Not Part of a Data Record Set. The Protected Health Information or record that is the subject of a Participant's request for amendment is not part of the Designated Record Set;

3) Not Available for Inspection. The Protected Health Information or record that is the subject of a Participant's request for amendment would not be available for inspection under the rights that the HIPAA Regulations give to Participants to access Protected Health Information;

4) Accurate and Complete. The Protected Health Information or record that is the subject of the request for amendment is accurate and complete; or

5) Form of Health Plan Denial. The Health Plan's timely, written denial of a Participant's request for an amendment will also contain:

    a) A plain language statement describing the Participant's right to submit a written statement to the Health Plan disagreeing with the Health Plan's denial of the amendment, and how the Participant may file such a statement with the Health Plan;

    b) A statement that, if the Participant does not submit to the Health Plan a Statement of Disagreement with the Health Plan's denial of the amendment, the Participant has the right to request that the Health Plan include the Participant's request for amendment and the Health Plan's denial thereof with any future Disclosures the Health Plan may make of the Participant's Protected Health Information that is the subject of the amendment;

    c) A description of how the Participant may complain to the Health Plan under the Health Plan's established Policies and Procedures for such complaints by contacting the Contact Person or Contact Office for the Health Plan. This is the person/office who is responsible for receiving complaints about the Health Plan's compliance with the HIPAA Regulations and who is able to provide further information about the matters covered by the Notice of Privacy Practices; and

    d) A description of how the Participant may complain to the Secretary of the U.S. Department of Health and Human Services regarding the Health Plan's compliance with the HIPAA Regulations. To complain about the Health Plan to the Secretary of the U.S. Department of Health and Human Services, the Participant must adhere to the following:

        i) The complaint must be filed with the Secretary in writing, either on paper or electronically.

        ii) The complaint must name the Health Plan as the entity that is the subject of the complaint and describe the Health Plan's acts or the Health Plan's omissions that the Participant thinks are in violation of the applicable parts of the HIPAA Regulations.

iii) The complaint must be filed within 180 days of when the Participant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary for good cause shown. (The Secretary of the U.S. Department of Health and Human Services may prescribe additional procedures for the filing of complaints, as well as the place and manner of filing, by notice in the Federal Register.)

6) Statement of Disagreement. If the Health Plan denies the request for an amendment to a Participant's Protected Health Information, the Participant has the right to submit to the Health Plan a written statement ("Statement of Disagreement") disagreeing with the Health Plan's denial of all or part of the Participant's requested amendment that includes an explanation of the basis of the Participant's disagreement;

7) Rebuttal Statement**.** If a Participant submits a Statement of Disagreement to the Health Plan, the Health Plan may prepare a written rebuttal to the Participant's Statement of Disagreement. Whenever the Health Plan prepares such a rebuttal, the Health Plan will provide a copy to the person who submitted the Statement of Disagreement;

8) Recordkeeping. The Health Plan will, as appropriate, identify the record or Protected Health Information in the Designated Record Set that is the subject of the disputed amendment and append or otherwise link the Participant's request for an amendment, the Health Plan's denial of the request, the Participant's Statement of Disagreement, if any, and the Health Plan's rebuttal, if any, to the Designated Record Set; and

9) Future Disclosures.

a) If a Participant has submitted a Statement of Disagreement to the Health Plan, the Health Plan will be required to either:

i) Append or otherwise link to the Designated Record Set: (1) the Participant's request for an amendment; (2) the Health Plan's denial of the Participant's request; (3) the Participant's Statement of Disagreement; and (4) the Health Plan's rebuttal, if any; or

ii) Disclose an accurate summary of the items described in subparagraph 9(a)(i)(1)-(4) above.

b) If a Participant has not submitted a Statement of Disagreement to the Health Plan, the Health Plan will include the Participant's request for amendment and the Health Plan's denial, or an accurate summary of such information, with any subsequent Disclosure the Health Plan makes of the Participant's Protected Health Information. This requirement applies only if the Participant has specifically requested that the Health Plan provide the Participant's request for amendment and the Health Plan's denial thereof with any future Disclosures the Health Plan makes of the Participant's Protected Health Information that is the subject of the Participant's requested amendment.

c) When the Health Plan makes a subsequent Disclosure of a Participant's Protected Health Information electronically using a standard transaction under the HIPAA Regulations standard transactions and code sets requirements that does not permit the additional material to be included with the Disclosure, the Health Plan may separately transmit the required material to the recipient of the standard transaction.

Receipt of Notices of Amendment by Others. When the Health Plan is informed by a Health Care Provider, a Health Care Clearinghouse or another Health Plan of an amendment to a Participant's Protected Health Information, the Health Plan will amend the Participant's Protected Health Information that the Health Plan maintains in a Designated Record Set by, at a minimum, identifying the records in the Designated Record Set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.

Documentation. The Health Plan will maintain a written or electronic record of the titles of the persons or offices responsible for receiving and processing requests for amendments by Participants. The Health Plan will retain this information for a minimum of six (6) years from the date of its creation or the date when it was last in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.526

Right To Request Confidential Handling

On occasion, Participants may need to have Protected Health Information handled in a special manner or delivered to a different location. The HIPAA Regulations permit Health Plans to accommodate reasonable requests for such special handling.

Policies.

Alternate Communications. The Health Plan will allow Participants to request to receive communications of Protected Health Information from the Health Plan by alternative means or at alternative locations, if a Participant clearly informs the Health Plan that the Disclosure of all or part of that information could endanger the individual.

Procedures.

1) Participant Requests. A Participant must make a request for a confidential communication in writing and must specify how or where he or she wants to be contacted.

2) Health Plan Response. The Health Plan will attempt to accommodate reasonable requests for confidential communications. The Health Plan may condition the provision of a reasonable accommodation on receipt of appropriate information as to how Payment, if any, will be handled, and upon specification of an alternative address or other method of contact.

3) Basis For Participant Request. The Health Plan will not require an explanation from a Participant an explanation as to the basis for his or her request as a condition of providing communications on a confidential basis. The Health Plan may, however, require that the request contain a statement that disclosure of all or part of the information could endanger the individual.

HIPAA Regulations/Citations
45 CFR § 164.522 (b)

Right To Request Restrictions

To the extent desired, Participants may request a Health Plan to restrict access to their Protected Health Information in order to limit the Uses or Disclosures made of such Health Information and the individuals likely to have access to such information.

Policies.

Restrictions on Disclosures. The Health Plan's Participants may request that the Health Plan restrict the Uses or Disclosures of their Protected Health Information to carry out Payment, Health Care Operations or Treatment (as applicable).

Disclosures to Family or Others. The Health Plan's Participants may request that the Health Plan restrict Disclosures of their Protected Health Information to a family Participant, other relative, a close personal friend, or any other person identified by the Participant for involvement in the Participant's care and for notification purposes, as applicable, regarding the Participant's location, general condition or death.

Decisions By Health Plans. The Health Plan is not required to agree to a restriction.

Compliance With Restrictions. Generally, if the Health Plan has agreed to a restriction, the Health Plan will not Use or disclose the Protected Health Information in a manner other than as provided by the restriction.

Procedures.

Requests for Restrictions. The Health Plan shall review all requests for restrictions on the Uses or Disclosures of Protected Health Information.

1) Designated Participant to Review Requests. The Privacy Official, or his or her designee, shall review all requests for restrictions.

2) If Request Is Approved. If a request to restrict Uses or Disclosures of Protected Health Information is approved, in whole or in part, the Privacy Official, or his or her designee, shall advise the Participant and each Business Associate having access to the Protected Health Information of such restriction.

3) If Request Is Denied. If a request to restrict uses or Disclosures of Protected Health Information is denied, in whole or in part, the Privacy Official or his or her designee shall provide notice to the Participant of the action taken and the reasons for the denial of restrictions.

4) PHI Subject to Restrictions. If the Health Plan agrees to a Participant's request for a restriction on the Uses or Disclosures of his or her Protected Health Information to carry out Treatment, Payment, or Health Care Operations, then the Health Plan may not Use or disclose Protected Health Information in violation of such restriction, except as follows:

a) Emergencies. If the Participant is in need of emergency Treatment and the restricted Protected Health Information is needed to provide the emergency Treatment, the Health Plan may use the restricted Protected Health Information, or the Health Plan may disclose such information to a Health Care Provider to provide such emergency Treatment to the Participant. If restricted Protected Health Information is disclosed to a Health Care Provider for emergency Treatment, the Health Plan will request that such Health Care Provider not further Use or disclose the information.

b) Required by Law. If the Health Plan agrees to a restriction, such restriction would not prevent Uses or Disclosures to the extent that they are: required by the U.S. Department of Health and Human Services to investigate or determine the Health Plan's compliance with the HIPAA Regulations; Required by Law; for public health activities; about victims of abuse, neglect, or domestic violence; for health oversight activities; for judicial and administrative proceedings; for law enforcement purposes; about decedents; for cadaveric organ, eye or tissue donation purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions; or for workers' compensation.

5) Termination of Restrictions. If the Health Plan agrees to a restriction, the Health Plan may terminate that agreement if:

a) The Participant agrees to or requests the termination in writing;

b) The Participant orally agrees to the termination and the oral agreement is documented by the Health Plan; or

c) The Health Plan informs the Participant that the Health Plan is unilaterally terminating the Health Plan's agreement to the restriction,

provided, however, that such termination is only effective with respect to Protected Health Information created or received after the Health Plan has so informed the Participant.

6) Documentation. When the Health Plan agrees to a restriction on the Uses and/or Disclosures of Protected Health Information, the Health Plan will maintain a written or electronic record of such agreement for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.522(a)

Right To Receive An Accounting Of Disclosures

In order for Participants to gain a greater degree of understanding and control of their Protected Health Information, the HIPAA Regulations provide that the Health Plan will account for certain Uses and Disclosures of Protected Health Information, and that Participants can have access to that record of accounting.

Policies:

Right to an Accounting. Participants have the right to receive an accounting of Disclosures of Protected Health Information made by the Health Plan (or its Business Associates) during the six (6) year period before the date of their request for the accounting, provided, however, that Participants shall not be entitled to an accounting of Disclosures that occurred prior to April 14, 2003.

Disclosures Not Included in the Accounting. The following are Disclosures to which Participants do not have a right to an accounting, and the Health Plan will not include a listing of such Disclosures to Participants.

1) Payment. Disclosures made to carry out the Health Plan's Payment activities.

2) Health Care Operations. Disclosures made to carry out the Health Plan's Health Care Operations.

3) Treatment. Disclosures made by the Health Plan for the Treatment activities of a Health Care Provider.

4) Disclosures to Other Covered Entities.

    a) Payment Activities. Disclosures made by the Health Plan to a Health Care Provider, a Health Care Clearinghouse, or another Health Plan for the Payment activities of the entity that receives the information.

    b) Multiple Relationships. Disclosures made by the Health Plan to a Health Care Provider, a Health Care Clearinghouse, or another Health Plan for certain Health Care Operations activities of the Covered Entity that receives the information, if the Health Plan and the Covered Entity receiving the information either has or had a relationship with the Participant, the Protected Health Information pertains to such relationship, and the Disclosure is for one of the following purposes:

        i) Health care fraud and abuse detection or compliance;

        ii) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities;

        iii) Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, contacting of Health

Care Providers and patients with information about Treatment alternatives; and related functions that do not include Treatment; or

iv) Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner and provider performance, Health Plan performance, conducting training programs in which students, trainees, or practitioners in areas of Health Care learn under supervision to practice or improve their skills as Health Care Providers, training of non-Health Care professionals, accreditation, certification, licensing, or credentialing activities.

5) Prior Disclosure to Participant. Disclosures of a Participant's Protected Health Information made to the Participant.

6) Incidental Disclosures. Disclosures made incident to a Use or Disclosure otherwise permitted or required by the HIPAA Regulations.

7) Pursuant to Authorization. Disclosures made pursuant to an authorization.

8) Those Involved in Care of Participant. Disclosures made pursuant to the HIPAA Regulations to persons involved in the Participant's care or for other notification purposes.

9) National Security of Intelligence. Disclosures made for national security or intelligence purposes to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401, *et seq.*) and implementing authority (e.g., Executive Order 12333).

10) Law Enforcement. Disclosures made to correctional institutions or law enforcement officials having lawful custody of the Participant or other Protected Health Information about the Participant, if the correctional institution or such law enforcement official represents that such Protected Health Information is necessary for: (a) the provision of Health Care to the Participant; (b) the health and safety of the Participant or other inmates; (c) the health and safety of the officers or employees of or others at the correctional institution; (d) the health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another; (e) law enforcement on the premises of the correctional institution; and (f) the administration and maintenance of the safety, security, and good order of the correctional institution.

11) Limited Data Sets. Disclosures that are part of a Limited Data Set under the HIPAA Regulations' standards and implementation specifications regarding Limited Data Sets and Data Use Agreements.

12) Pre-HIPAA Disclosures. Disclosures that occurred before April 14, 2003.

Temporary Suspension of a Participant's Right to an Accounting of Disclosures. The Health Plan will temporarily suspend a Participant's right to receive an accounting of the Health Plan Disclosures made to a Health Oversight Agency or law enforcement official, respectively, for the time period specified by such agency or official, if such agency or official provides the Health Plan with a written statement that such an accounting to the Participant would be reasonably likely to impede the agency's activities and specifying the time period for which such a suspension of an accounting of Disclosures is required.

Partial Accounting Period. Participants will have the right to request an accounting of Disclosures from the Health Plan for a period of time less than six (6) years from the date of their request.

Procedures*:*

Content of the Accounting of Disclosures. A Participant will receive from the Health Plan a written accounting of the Disclosures that the Health Plan has made of his or her Protected Health Information that meets the following requirements:

1) Accounting Period. Unless the Disclosure is one that the Health Plan is not required to list in the accounting, or the Participant has requested a time period of less than six (6) years, the accounting of Disclosures will include Disclosures of the Participant's Protected Health Information that occurred during the six (6) years prior to the date of the request for an accounting, including Disclosures to or by the Health Plan's Business Associates.

2) Content of Accounting. Except as listed below, the accounting of Disclosures that a Participant will receive from the Health Plan will include, for each Disclosure:

    a) The date the Health Plan made the Disclosure;

    b) The name of the entity or person who received the Protected Health Information and, if known, the address of such entity or person;

    c) A brief description of the Protected Health Information disclosed; and

    d) A brief statement of the purpose of the Disclosure that reasonably informs the Participant of the basis for the Disclosure; or in lieu of such statement, a copy of the prior written request for Disclosure to the extent provided by one of the individuals or for any of the following purposes ("Special Disclosures") to the extent requested by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Health Plan's compliance with the HIPAA Regulations; Required by Law; for public health activities; about victims of abuse, neglect, or domestic violence; for health oversight activities; for judicial and administrative proceedings; for law enforcement purposes; about decedents; for cadaveric organ, eye, or tissue donation purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions; or for workers' compensation.

Multiple Disclosures During Accounting Period. If, during the period covered by the accounting, the Health Plan has made multiple Disclosures of a Participant's Protected Health Information for a single purpose in connection with one of the Special Disclosures (as identified above), the accounting with respect to such multiple Disclosures, may include:

1) Frequency. The frequency, periodicity, or number of Disclosures made during the accounting period;

2) Most Recent Disclosure. The date of the last such Disclosure during the accounting period; and

3) First Disclosure. For the first Disclosure during the accounting period:

    a) The date of the Disclosure;

b) The name of the entity or person who received the Protected Health Information and, if known, the address of such entity or person;

c) A brief description of the Protected Health Information disclosed; and

d) A brief statement of the purpose of the Disclosure that reasonably informs the Participant of the basis for the Disclosure or, *in lieu of such statement*, a copy of the written request for a Disclosure submitted in connection with one of the Special Disclosures (as identified above).

Accounting For Research Disclosures. If, during the period covered by the accounting, the Health Plan has made permitted Disclosures of Protected Health Information for a particular research purpose for 50 or more individuals, the accounting may, with respect to such Disclosures for which the Protected Health Information about the Participant may have been included, provide:

1) Identify Research Conducted. The name of the protocol or other research activity;

2) Research Activity. A description, in plain language, of the research protocol or other research activity, including the purpose of the research and the criteria for selecting particular records;

3) Description PHI Disclosed. A brief description of the type of Protected Health Information that was disclosed;

4) Period of Disclosures. The date or period of time during which such Disclosures occurred, or may have occurred, including the date of the last such Disclosure during the accounting period;

5) Sponsor of Research. The name, address, and telephone number of the entity that sponsored the research and of the researcher to whom the information was disclosed; and

6) Limitation Statement. A statement that the Protected Health Information of the Participant may or may not have been disclosed for a particular protocol or other research activity.

If the Health Plan provides an accounting for research Disclosures in accordance with the above-listed procedures and, if it is reasonably likely that the Protected Health Information of the Participant was disclosed for such research protocol or activity, the Health Plan will, at the request of the Participant, assist the Participant in contacting the entity that sponsored the research and the researcher.

Response to Request for Accounting.

1) Time to Respond. The Health Plan will provide the Participant with an accounting of Protected Health Information within 60 days after receiving a Participant's request for an accounting of Disclosures.

2) Request for Extension. If the Health Plan is unable to provide an accounting of Disclosures within the 60-day period, the Health Plan may take an additional 30 days on which to provide the accounting by providing the Participant, within 60 days after receiving the request for an accounting, with a written statement of the reasons for the Health Plan's delay and the date by which the Health Plan will provide to the Participant an Accounting of Disclosures of the Protected Health Information.

Fees for an Accounting. The first accounting of disclosures that a Participant requests within any 12-month period will be provided to the Participant by the Health Plan at no charge. For any additional accountings of Disclosures that a Participant makes within a 12-month period, the Health Plan will charge the Participant a reasonable cost-based fee. The Health Plan will notify the Participant in advance of this fee, and the Participant will have the opportunity to withdraw or modify his or her request for a subsequent accounting of Disclosures of Protected Health Information in order to avoid or reduce the fee.

Temporary Suspension of Right to an Accounting. The Health Plan will temporarily suspend a Participant's right to receive an accounting of the Health Plan Disclosures made to a Health Oversight Agency or law enforcement official, respectively, for the time period specified by such agency or official, if such agency or official provides the Health Plan with a written statement that such an accounting to the Participant would be reasonably likely to impede the agency's activities and specifying the time period for which such a suspension of an accounting of Disclosures is required.

1) Oral Request For Suspension of Accounting. If the agency or official statement discussed above is made orally, the Health Plan will:

   a) Document the statement, including the identity of the agency or official making the statement;

   b) Temporarily suspend a Participant's right to an accounting of Disclosures subject to the agency or official statement; and

   c) Limit the temporary suspension to no longer than 30 days from the date of the oral statement, unless a written statement is submitted to the Health Plan by the Health Oversight Agency or law enforcement official during that 30-day time period.

Documentation.

1) Data for Accounting. The Health Plan will maintain a written or electronic record of the information that the Health Plan is required to include in an accounting of disclosures for those Disclosures of Protected Health Information that are subject to an accounting. The Health Plan will maintain this record for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

2) Record of Accounting Disclosures. The Health Plan will maintain a written or electronic record of the written accounting that is provided to the Participant. The Health Plan will maintain this record for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

3) Record of Providers of Accounting. The Health Plan will maintain a written or electronic record of the titles of the persons or offices responsible for receiving and processing Participants' requests for an accounting. The Health Plan will maintain this record for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.528

Waiver Of Rights

In order for the HIPAA Regulations to serve the purpose for which they were intended, namely, to protect the privacy of Individually Identifiable Health Information, Employers and Plan Sponsors cannot force individuals to waive the protections afforded under the HIPAA Regulations.

Policies.

The Health Plan may not require Participants to waive rights provided to them under the HIPAA Regulations, including the right to file a complaint against the Health Plan with the Secretary of the U.S. Department of Health and Human Services as a condition for the provision of Treatment, Payment, enrollment in the Health Plan, or eligibility for benefits.

Procedures.

The Health Plan will not require that Participants waive rights given to them by the HIPAA Regulations as a condition for the provision of Treatment, Payment, enrollment in the Health Plan, or eligibility for benefits.

HIPAA Regulations/Citations
45 CFR § 164.530(h)

Personal Representatives Of Participants

To the extent Health Information is to be Used or disclosed, there are a myriad of situations that may necessitate other individuals having access to a Participant's Health Information. The HIPAA Regulations contemplate the need to appoint others to access a Participant's Health Information.

Policies.

Subject to applicable law, the Health Plan will treat a personal representative as the Participant for purposes of the Participant's privacy rights and the Health Plan's legal duties with respect to the Participant's Protected Health Information.

Procedures.

1) Adults and Emancipated Minors. If, under applicable law, a person has authority to act on behalf of a Participant who is an adult or an emancipated minor in making decisions related to Health Care, the Health Plan will treat such person as a personal representative with respect to Protected Health Information relevant to such personal representation.

2) Unemancipated Minors.

   a) If, under applicable law, a parent, guardian, or other person acting *in loco parentis* has authority to act on behalf of a Participant who is an unemancipated minor in making decisions related to Health Care, the Health Plan will treat such person as a personal representative with respect to Protected Health Information relevant to such personal representation, except that such person may not be a personal representative of an unemancipated minor, and the minor has the authority to act as an independent individual, with respect to Protected Health Information pertaining to a Health Care service, if:

      i) The minor consents to such Health Care service; no other consent to such Health Care service is Required by Law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative;

      ii) The minor may lawfully obtain such Health Care service without the consent of a parent, guardian, or other person acting *in loco parentis*, and the minor, or another person authorized by law consents to such Health Care service; or

      iii) A parent, guardian, or other person acting *in loco parentis* assents to an agreement of confidentiality between a covered Health Care Provider and the minor with respect to such Health Care service.

Notwithstanding the provisions of paragraph 2(a) above, the following additional procedures will apply to Disclosures regarding unemancipated minors:

a) If, and to the extent permitted or required by an applicable provision of State or other law, including applicable case law, the Health Plan may disclose, Protected Health Information about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis*;

b) If, and to the extent prohibited by an applicable provision of State or other law, including applicable case law, a Covered Entity may not disclose, or provide access to Protected Health Information about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis*; and

c) Where the parent, guardian, or other person acting *in loco parentis* is not the personal representative because:

i) The minor consents to such Health Care service; no other consent to such Health Care service is Required by Law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative;

ii) The minor may lawfully obtain such Health Care service without the consent of a parent, guardian, or other person acting *in loco parentis*, and the minor, or another person authorized by law consents to such Health Care service; or

iii) A parent, guardian, or other person acting *in loco parentis* assents to an agreement of confidentiality between a covered Health Care Provider and the minor with respect to such Health Care service;

and where there is no applicable access provision under State or other law, including case law, the Health Plan may provide or deny access under the Health Plan's applicable Policies and Procedures to a parent, guardian, or other person acting *in loco parentis*, if such action is consistent with State or other applicable law, provided that such decision is made by a licensed Health Care professional, in the exercise of professional judgment.

3) Deceased Members**.** If, under applicable law, an executor, administrator, or other person has authority to act on behalf of a deceased Participant or on behalf of the Participant's estate, the Health Plan will treat such person as a personal representative with respect to Protected Health Information relevant to such personal representation.

4) Abuse, Neglect, Endangerment Situations of The Health Plan's Participants**.** Notwithstanding a State law or any requirement of this procedure to the contrary, the Health Plan may elect not to treat a person as the personal representative of a Participant if the Health Plan has a reasonable belief that:

a) The Participant has been or may be subjected to domestic violence, abuse, or neglect by such person; or

b) Treating such person as the personal representative could endanger the Participant; and

c) The Health Plan, in the exercise of professional judgment, decides that it is not in the best interest of the Participant to treat the person as the Participant's personal representative.

HIPAA Regulations/Citations
45 CFR § 164.502(g)(1)-(5)

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

CONTENTS OF THIS SECTION

General Rules

The Health Plans may continue to Use and Disclose Protected Health Information for a number of purposes under the HIPAA Regulations. Certain of these Uses or Disclosures are permitted while others may be mandated when, for example, they are Required by Law.

Policies.

The Health Plan will not Use or disclose Protected Health Information, except as permitted or Required by Law.

The Health Plan is generally permitted to Use or disclose Protected Health Information to the extent such information is Used or disclosed:

(1) To the Participant;
(2) For Treatment, Payment, or Health Care Operations;
(3) Incident to an allowable Use or Disclosure;
(4) Pursuant to and in compliance with a valid authorization document;
(5) Pursuant to an agreement, or as otherwise permitted to those involved in the Participant's care, and for notification purposes;
(6) To create a Limited Data Set;
(7) For underwriting and related purposes;
(8) As Required by Law;
(9) For Public Health Activities;
(10) For Health Oversight Activities;
(11) For Judicial and Administrative Proceedings;
(12) For Law Enforcement Purposes, including Disclosures about Victims of Abuse, Neglect, or Domestic Violence;
(13) For purposes related to Decedents;
(14) For Cadaveric Organ, Eye, or Tissue Donation Purposes;
(15) For Research Purposes;
(16) To Avert a Serious Threat to Health or Safety;
(17) For Specialized Government Functions; and
(18) For Workers' Compensation.

The Health Plan is required to disclose Protected Health Information:

1) To a Participant, upon request.

2) When required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Health Plan's compliance with the HIPAA Regulations.

HIPAA Regulations/Citations
45 CFR § 164.502

For Treatment, Payment Or Health Care Operations

HIPAA intends to protect the privacy of Health Information while at the same time not precluding Plan Sponsors from administering their Health Plans to the extent necessary to manage Health Care costs and related expenses. The HIPAA Regulations expressly permit Plan Sponsors to utilize Protected Health Information to the extent necessary for Payment, Treatment or Health Care Operations.

Policies.

Permitted Uses and Disclosures of Protected Health Information. Except with respect to Uses or Disclosures that require an authorization, the Health Plan may Use or disclose Protected Health Information for Treatment, Payment, or Health Care Operations as set forth in the procedures below, provided that such Use or Disclosure is consistent with the HIPAA Regulations and applicable law.

Consent for Uses and Disclosures of Protected Health Information Permitted. The Health Plan may, but is not required to, obtain consent of the Participant to Use or disclose Protected Health Information to carry out Treatment, Payment, or Health Care Operations. Such consent shall not be effective to permit a Use or Disclosure of Protected Health Information when an authorization is required or when another condition must be met for such Use or Disclosure to be permissible under applicable law.

Procedures.

Treatment, Payment, or Health Care Operations

1) Payment for Health Care Operations. The Health Plan may Use or disclose Protected Health Information for the Health Plan's own Payment and/or Health Care Operations purposes.

2) Treatment. The Health Plan may Use or disclose Protected Health Information for the Health Plan's or a Health Care Provider's own Treatment activities.

3) Treatment by Others. The Health Plan may disclose Protected Health Information for Treatment activities of another Health Care Provider.

4) Payment of Health Care Provider. The Health Plan may disclose Protected Health Information to a Health Care Provider, whether such provider is covered by the HIPAA Regulations, for the Payment activities of that Health Care Provider.

5) Health Care Clearinghouse or Other Health Plans. The Health Plan may disclose Protected Health Information to a Health Care Clearinghouse use or another Group Health Plan for the Payment activities of the entity that receives the information.

6) Disclosures to Other Covered Entities. The Health Plan may disclose Protected Health Information to a Health Care Provider, a Health Care Clearinghouse, or another Health Plan for Health Care Operation activities of the entity that receives the information, if each entity either has or had a relationship with the Participant who is the subject of the Protected Health Information being requested, the Protected Health Information pertains to such relationship, and the Disclosure is for the purpose of:

   a) Health Care fraud and abuse detection or compliance;

   b) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities;

   c) Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, contacting of Health Care Providers and patients with information about Treatment alternatives; and related functions that do not include Treatment; or

   d) Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner and provider performance, Health Plan performance or conducting training programs for non-Health Care professionals, accreditation, certification, licensing, or credentialing activities.

7) Organized Health Care Arrangement. If the Health Plan participates in an Organized Health Care Arrangement, the Health Plan may disclose Protected Health Information about a Participant to a Health Care Provider, Health Care Clearinghouse or another Health Plan that participates in the Organized Health Care Arrangement for any Health Care Operations activities of the Organized Health Care Arrangement.

HIPAA Regulations/Citations
45 CFR §§ 160.103, 164.501, 164.502(a)(1),164.506

For Which An Authorization Is Required

To the extent the Use or Disclosure of Protected Health Information is not for Payment, Treatment or Health Care Operations, a Health Plan will need to consider having the Participant sign an authorization to permit such Use or Disclosure (unless other HIPAA exemptions apply).

Policies.

Use of Authorizations. Generally, the Health Plan may not Use or disclose a Participant's Protected Health Information without a valid authorization. Typical Uses and Disclosures for which an authorization from the Participant is not required include for Payment and Treatment Purposes, Health Care Operations, as Required by Law, and to the Participant or his or her personal representative.

Authorization Requirements - Marketing or Sale of Protected Health Information. The Health Plan shall obtain an authorization for any Use or Disclosure of Protected Health Information for Marketing, except if the communication is in the form of (i) a face-to-face communication made by the Health Plan to an individual; or (ii) a promotional gift of nominal value provided by the Health Plan. The Health Plan shall obtain an authorization for any Disclosure of Protected Health Information which constitutes a "sale of Protected Health Information" as defined in 45 CFR § 164.502(a)(5)(ii).

Limitations of Authorizations. When the Health Plan obtains a valid authorization from a Participant for the Health Plan's Use or Disclosure of his or her Protected Health Information, such Use or Disclosure will be consistent with such authorization.

Minimum Necessary. The Minimum Necessary standard does not apply to the Uses and Disclosures of a Participant's Protected Health Information made by the Health Plan under a valid authorization.

Transition Period. Generally, for periods prior to April 14, 2003, the Health Plan may Use or disclose Protected Health Information for purposes other than for research pursuant to an authorization or other express legal permission obtained from a Participant permitting the Health Plan to Use or disclose his or her Protected Health Information.

Procedures.

Authorization Document- General Requirements.

1) Authorization – General Requirements. A valid authorization document will contain at least the following elements:

   a) A description of the information to be Used or disclosed that identifies the information in a specific and meaningful fashion;

   b) The name or other specific identification of the person(s), or class of persons, authorized to make the requested Use or Disclosure;

   c) The name or other specific identification of the person(s), or class of persons, to whom the Health Plan may make the requested Use or Disclosure;

d) A description of each purpose of the requested Use or Disclosure. The statement "at the request of the Participant" is a sufficient description of the purpose when a Participant initiates the authorization and does not, or elects not to, provide a statement of the purpose;

e) An expiration date or an expiration event that relates to the Participant or the purpose of the Use or Disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for Use or Disclosure of Protected Health Information for research, including for the creation and maintenance of a research database or research depository. Otherwise, a specific date is required.

f) If the authorization is signed by a personal representative of the Participant, a description of such representative's authority to act for the Participant will also be included in the authorization document;

g) Statement regarding the Participant's right to revoke the authorization in writing, and either:

   i) The exceptions to the right to revoke and a description of how the Participant may revoke the authorization; or

   ii) To the extent that this information regarding the exceptions to a Participant's right to revoke an authorization and a description of how the Participant may revoke an authorization is included in the Health Plan's Notice of Privacy Practices, in addition to a reference to the Health Plan's Notice of Privacy Practices.

h) Statement regarding the Health Plan's ability or inability to condition Treatment, Payment, enrollment or eligibility for benefits on the authorization, by stating either:

   i) That the Health Plan may not condition Treatment, Payment, enrollment or eligibility for benefits on whether the Participant signs the authorization when the prohibition on conditioning of authorizations above) applies; or

   ii) The consequences to the Participant of a refusal to sign the authorization when the Health Plan is allowed by law to condition Treatment, enrollment in the Health Plan, or eligibility for benefits on failure to obtain such authorization.

i) The potential for information disclosed pursuant to the authorization to be subject to re-Disclosure by the recipient and no longer be protected by the HIPAA Regulations; and

j) If the authorization is for the Health Plan's (or its Business Associate's) Marketing purposes and the Marketing involves Financial Remuneration to the Health Plan from a third party, the authorization will state that such Financial Remuneration is involved.

k) If a Health Plan's Disclosure is a sale of Protected Health Information, the authorization must state that the Disclosure will result in Financial Remuneration to the Health Plan.

2) Plain Language Requirement. The authorization will be written in plain language.

3) Copy of the Authorization Document to the Participant. If the Health Plan seeks an authorization from a Participant for a Use or Disclosure of Protected Health Information, the Health Plan will provide the Participant with a copy of the signed authorization.

4) Additional Elements. A valid authorization may contain elements or information in addition to the elements listed in this procedure, provided that such additional elements or information are not inconsistent with the elements Required by Law to be included in the authorization document.

5) Defective Authorizations. An authorization document will not be valid if it has any of the following defects:

   a) The expiration date has passed or the Health Plan knows that the expiration event has occurred;

   b) The authorization has not been filled out completely;

   c) The authorization is known by the Health Plan to have been revoked;

   d) The authorization is an inappropriate compound authorization;

   e) The authorization inappropriately conditions the provision to a Participant of Treatment, Payment, enrollment in the Health Plan, or eligibility for benefits on the provision of an authorization; or

   f) Any material information in the authorization is known by the Health Plan to be false.

6) Compound Authorizations. An authorization for the Use or Disclosure of Protected Health Information will not be combined with any other document to create a compound authorization, except as follows:

   a) An authorization for the Use or Disclosure of Protected Health Information for a research study may be combined with any other type of written permission for the same or another research study. This exception includes combining an authorization for Use or Disclosure of Protected Health Information for a research study with another authorization for the creation or maintenance of a research database or repository, or with a consent to participate in research. When a Health Care Provider has conditioned the provision of research-related Treatment on the provision of one of the authorizations, any compound authorization created must clearly differentiate between the conditioned and unconditioned components and provide the individual with an opportunity to opt in to the research activities described in the unconditioned authorization;

   b) An authorization for a Use or Disclosure of Psychotherapy Notes will only be combined with another authorization for a Use or Disclosure of Psychotherapy Notes;

   c) An authorization, other than an authorization for a Use or Disclosure of Psychotherapy Notes, may be combined with any other such authorization, except when the Health Plan has conditioned the provision of Treatment, Payment, enrollment in the Health Plan, or eligibility for benefits, as provided for by law and described herein, on the provision of one of the authorizations. The prohibition in this paragraph on combining authorizations where one authorization conditions the provision of Treatment, Payment, enrollment in a Health Plan, or eligibility for benefits in Paragraph 7 (below) does not apply to a compound authorization created in accordance with Paragraph 6(a).

7) Prohibition on the Conditioning of Authorizations. The Health Plan will not condition the Payment, enrollment in the Health Plan, Treatment, or eligibility for benefits on the provision of an authorization, provided, however, that:

   a) The Health Plan may condition enrollment in the Health Plan or eligibility for benefits on provision of an authorization requested by the Health Plan prior to an individual's enrollment in the Health Plan, if:

      i) The authorization sought is for the Health Plan's eligibility or enrollment determinations relating to the Participant or for the Health Plan's underwriting or risk rating determinations; and

      ii) The authorization is not for a Use or Disclosure of Psychotherapy Notes (when an authorization for such Notes is required); and

   b) The Health Plan may condition the provision of Health Care that is solely for the purpose of creating Protected Health Information for Disclosure to a third party on provision of an authorization for the Disclosure of the Protected Health Information to such third party (e.g., pre-employment physicals, drug screenings and other tests performed by third parties for an Employer);

   c) Revocation of Authorizations. A Participant may revoke an authorization at any time, provided that the revocation is in writing, except to the extent that:

      i) The Health Plan has taken action in reliance on the authorization; or

      ii) If the authorization was obtained as a condition of obtaining health insurance coverage, or another law provides the health insurer with the right to contest a claim under the policy, or the policy itself.

8) Documentation. The Health Plan will maintain a written or electronic record of all the Health Plan's signed authorization documents and shall retain such documents for a minimum of six (6) years from the date of their creation or the date when they last the were in effect, whichever is later.

9) Transition Procedure - Prior Authorization. The Health Plan may Use or disclose Protected Health Information that the Health Plan created or received before April 14, 2003 pursuant to an authorization or other express legal permission obtained from a Participant before April 14, 2003, provided that the authorization or other express legal permission specifically permits such Use or Disclosure and there is no agreed-to restriction on its Use or Disclosure.

HIPAA Regulations/Citations
45 CFR §§ 164.502(a)(5)(ii), 164.508, 164.512

Psychotherapy Notes

The HIPAA Regulations provide for special treatment in connection with the Use or Disclosure of Psychotherapy Notes. In view of the sensitive information normally included in such Notes, a higher standard for Use or Disclosure generally applies under HIPAA.

Policies.

Authorization Required: Generally, before the Health Plan may Use or disclose Psychotherapy Notes, the Health Plan must obtain a valid authorization from the Participant.

Limited Situations When Authorization Not Required. The Health Plan is not required to obtain an authorization for the following Uses or Disclosures of Psychotherapy Notes:

1) Payment, Treatment or Health Care Operations. To carry out the following Payment, Treatment, or Health Care Operations activities:

    a) Use by the originator of the Psychotherapy Notes for Treatment;

    b) Use or Disclosure in the Health Plan's defense of a legal action or other proceeding brought by the Participant.

2) HHS Investigation. When required by the Secretary of the U.S. Department of Health and Human Services in his investigation or determination of the Health Plan's compliance with the HIPAA Regulations.

3) Required by Law. When Required by Law.

4) Health Oversight Agency. For Disclosures of Psychotherapy Notes to a Health Oversight Agency for oversight activities authorized by law with respect to the oversight of the originator of the Psychotherapy Notes.

5) Coroner or Medical Examiner. For Disclosures of Psychotherapy Notes 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.

6) Threatening Conditions. Uses or Disclosures of Psychotherapy Notes if the Health Plan, in good faith and consistent with applicable law and standards of ethical conduct, believes the Use or Disclosure:

    a) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

    b) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

7) Authorization May Not Be Combined. An authorization for a Use or Disclosure of Psychotherapy Notes may only be combined with another authorization for a Use or Disclosure of Psychotherapy Notes.

Procedures.

Authorization Requirements - Psychotherapy Notes.

1) Authorization Document. A valid authorization document will contain at least the following elements:

   a) A description of the information to be Used or disclosed that identifies the information in a specific and meaningful fashion;

   b) The name or other specific identification of the person(s), or class of persons, authorized to make the requested Use or Disclosure;

   c) The name or other specific identification of the person(s), or class of persons, to whom the Health Plan may make the requested Use or Disclosure;

   d) A description of each purpose of the requested Use or Disclosure. The statement "at the request of the Participant" is a sufficient description of the purpose when a Participant initiates the authorization and does not, or elects not to, provide a statement of the purpose;

   e) An expiration date or an expiration event that relates to the Participant or the purpose of the Use or Disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a Use or Disclosure of Protected Health Information for research, including for the creation and maintenance of a research database or research depository. Otherwise a specific date is required.

   f) If the authorization is signed by a personal representative of the Participant, a description of such representative's authority to act for the Participant will also be included in the authorization document;

   g) The Participant's right to revoke the authorization in writing, and either:

      i) The exceptions to the right to revoke and a description of how the Participant may revoke the authorization; or

      ii) To the extent that this information regarding the exceptions to a Participant's right to revoke an authorization and a description of how the Participant may revoke an authorization is included in the Health Plan's Notice of Privacy Practices, a reference to the Health Plan's Notice of Privacy Practices.

   h) A statement regarding the Health Plan's ability or inability to condition Treatment, Payment, enrollment or eligibility for benefits on the authorization, by stating either:

i) That the Health Plan may not condition Treatment, Payment, enrollment or eligibility for benefits on whether the Participant signs the authorization when the prohibition on conditioning of authorizations (as discussed below) applies; or

ii) The consequences to the Participant of a refusal to sign the authorization when the Health Plan is allowed by law to condition Treatment, enrollment in the Health Plan, or eligibility for benefits on failure to obtain such authorization.

i) The potential for information disclosed pursuant to the authorization to be subject to re-Disclosure by the recipient and no longer be protected by the HIPAA Regulations; and

j) If the authorization is for the Health Plan's Marketing purposes and the Marketing involves Financial Remuneration to the Health Plan from a third party, the authorization will state that such remuneration is involved.

2) Plain Language Requirement. The authorization will be written in plain language.

3) Copy of the Authorization Document to the Participant. If the Health Plan seeks an authorization from a Participant for a Use or Disclosure of Protected Health Information, the Health Plan will provide the Participant with a copy of the signed authorization.

4) Additional Elements. A valid authorization may contain elements or information in addition to the elements listed in this procedure, provided that such additional elements or information are not inconsistent with the elements Required by Law to be included in the authorization document.

5) Defective Authorizations. An authorization document will not be valid if it has any of the following defects:

a) The expiration date has passed or the Health Plan knows that the expiration event has occurred;

b) The authorization has not been filled out completely;

c) The authorization is known by the Health Plan to have been revoked;

d) The authorization is an inappropriate compound authorization;

e) The authorization inappropriately conditions the provision to a Participant of Treatment, Payment, and enrollment in the Health Plan, or eligibility for benefits on the provision of an authorization;

f) Any material information in the authorization is known by the Health Plan to be false.

6) Compound Authorizations. An authorization for a Use or Disclosure of Psychotherapy Notes may only be combined with another authorization for a Use or Disclosure of Psychotherapy Notes.

7) Prohibition on the Conditioning of Authorizations. The Health Plan will not condition the provision to a Participant of Payment, enrollment in the Health Plan, Treatment, or eligibility for benefits on the provision of an authorization, except:

a) The Health Plan may condition enrollment in the Health Plan or eligibility for benefits on provision of an authorization requested by the Health Plan prior to a Participant's enrollment in the Health Plan if:

i) The authorization sought is for the Health Plan's eligibility or enrollment determinations relating to the Participant or for the Health Plan's underwriting or risk rating determinations; and

ii) The authorization is not for a Use or Disclosure of Psychotherapy Notes (when an authorization for such notes is required); and

iii) As applicable, the Health Plan may condition the provision of Health Care that is solely for the purpose of creating Protected Health Information for Disclosure to a third party on provision of an authorization for the Disclosure of the Protected Health Information to such third party.

8) Revocation of Authorizations. A Participant may revoke an authorization at any time, provided that the revocation is in writing, except to the extent that:

a) The Health Plan has taken action in reliance on the authorization; or

b) If the authorization was obtained as a condition of obtaining health insurance coverage, other laws provide the insurer with the right to contest a claim under the policy or the policy itself.

9) Documentation. The Health Plan will maintain a written or electronic record of all of the Health Plan's signed authorization documents and shall retain such documents for a minimum of six (6) years from the date of their creation or the date when they last were in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.508(a)(2),(b)

To Family, Friends Or Others Involved In The Participant's Care Or Payment

The HIPAA Regulations contemplate circumstances when family members or friends may be involved with Participant's Health Care or Treatment, or may have a need to be informed about a Participant's Health Care or condition. These types of Disclosures may be permitted under limited

Policies.

The Health Plan may Use or Disclosure Protected Health Information to those involved in a Participant's Health Care if the Participant is informed in advance of the Health Plan's Use or Disclosure and has the opportunity to agree to, prohibit or restrict such Use or Disclosure**.**

Procedures.

Permitted Disclosures. The Health Plan may disclose to a family member, other relative, a close personal friend of the Participant, or any other person identified by the Participant, the Protected Health Information directly relevant to such person's involvement with the Participant's Health Care or Payment related to the Participant's Health Care.

Disclosures When Participant Available. If the Participant is present for, or otherwise available prior to a Use or Disclosure to a family member, other relative, close personal friend of the Participant, or any other person identified by the Participant, of Protected Health Information directly relevant to such person's involvement with the Participant's Health Care or Payment related to the Participant's Health Care, and the Participant has the capacity to make Health Care decisions, the Health Plan may Use or Disclosure the Protected Health Information to such person by first:

1) Agreement. Obtaining the Participant's agreement;

2) Opportunity to Object. Providing the Participant with the opportunity to object to the Disclosure (provided that the Participant does not express an objection to such Disclosure); or

3) Inference. Reasonably inferring from the circumstances, based on the exercise of professional judgment, that the Participant does not object to the Disclosure.

Disclosures When Participant Not Available. If the Participant is not present, or the opportunity to agree or object to the Health Plan's Use or Disclosure cannot practicably be provided because of the Participant's incapacity or an emergency circumstance, the Health Plan may, in the exercise of professional judgment, determine whether the Disclosure is in the best interests of the Participant and if so, disclose only the Protected Health Information that is directly relevant to the person's involvement with the Participant's care or Payment related to the Participant's Health Care or needed for notification purposes.

HIPAA Regulations/Citations
45 CFR § 164.510(b)

For Notification Purposes

On occasion, Health Information may be needed to identify an individual or to assist in locating such individual. The HIPAA Regulations permit limited Uses or Disclosures to assist with these efforts.

Policies.

The Health Plan may Use or Disclosure Protected Health Information for notification purposes if generally the Participant is informed in advance of the Health Plan's Use or Disclosure and has the opportunity to agree to prohibit or restrict the Health Plan's Use or Disclosure.

Procedures.

Permitted Uses and Disclosures. The Health Plan may Use or disclose Protected Health Information to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of a Participant, or another person responsible for the care of the Participant, of the Participant's location, general condition, or death.

Uses and Disclosures When Participant Available. If the Participant is present for, or otherwise available prior to, the Health Plan's Use or Disclosure of Protected Health Information to an allowable person to notify, or assist in the notification of a family member, a personal representative of a Participant, or another person responsible for the care of the Participant (for purposes of determining the Participant's location, general condition, or death), and the Participant has the capacity to make Health Care decisions, the Health Plan may so Use or disclose the Protected Health Information by first:

1) Agreement. Obtaining the Participant's agreement;

2) Opportunity to Object. Providing the Participant with the opportunity to object to the Disclosure, and the Participant does not express an objection; or

3) Inference. Reasonably inferring from the circumstances, based the exercise of the Health Plan's professional judgment that the Participant does not object to the Disclosure.

Uses and Disclosures When Participant Not Available. If the Participant is not present, or the opportunity to agree or object to the Health Plan's Use or Disclosure cannot practicably be provided because of the Participant's incapacity or an emergency circumstance, the Health Plan may, in the exercise of professional judgment, determine whether the Disclosure is in the best interests of the Participant and, if so, disclose only the Protected Health Information that is necessary to notify (or assist in the notification of) a family member, a personal representative of a Participant, or another person responsible for the care of the Participant, of the Participant's location, general condition, or death.

HIPAA Regulations/Citations
45 CFR § 164.502(i)

For Workers' Compensation

The HIPAA Regulations recognize that certain Health Information is needed in order to respond to legal requirements involving various state workers' compensation laws. The HIPAA Regulations acknowledge the need to permit the Use or Disclosure of Health Information to comply with workers' compensation laws.

Policies.

The Health Plan may disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures to the extent necessary to comply with state workers' compensation laws.

Procedures.

1) Workers' Compensation Disclosures. The Health Plan may disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

2) Minimum Necessary. The Health Plan may assume that Protected Health Information requested in connection with compliance with a state workers' compensation law is the minimum necessary information required.

HIPAA Regulations/Citations
45 CFR § 164.512(l)

De-Identified Health Information

Health Plans must safeguard Protected Health Information from inappropriate Uses or Disclosures. To the extent the Use or Disclosure does not involve Individually Identifiable Health Information (i.e. the Health Information has been de-identified), such information may be Used or disclosed under the HIPAA Regulations without a Participant's prior authorization.

Policies.

Health information that does not identify a Participant and with respect to which there is no reasonable basis to believe that the information can be used to identify a Participant is not Individually Identifiable Health Information and is not subject to HIPAA or these Policies and Procedures.

Creating De-Identified Information. The Health Plan may use Protected Health Information to create information that is not Individually Identifiable Health Information or disclose Protected Health Information only to a Business Associate for such purpose, whether or not the de-identified information is to be used by the Health Plan.

Uses and Disclosures of De-Identified Information. Health Information that meets the standard and implementation specifications for de-identification under Section 164.514(a) and (b) of the HIPAA Regulations is considered not to be Individually Identifiable Health Information, i.e., it is de-identified. The requirements of the HIPAA Regulations do not apply to information that has been de-identified in accordance with the applicable requirements of Section 164.514 of the HIPAA Regulations, provided that:

1) No Ability to Re-Identify. Disclosure of a code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified constitutes Disclosure of Protected Health Information; and

2) If Health Information is Re-Identified. If de-identified information is re-identified, the Health Plan may Use or disclose such re-identified information only as permitted or required by the HIPAA Regulations.

Procedures.

De-Identification of Protected Health Information. The Health Plan may consider that Health Information is not Individually Identifiable Health Information only if:

1) Determination that Information Has Been De-Identified. A person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

    a) Determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify a Participant who is a subject of the information; and

b) Documents the methods and results of the analysis that justify such determination.

2) Removal of Identifier. The Health Plan does not have actual knowledge that the information could be used alone or in combination with other information to identify a Participant who is a subject of the information, and the following identifiers of the Participant or of relatives, Employers, or other Participants within the household of the Participant, are removed:

a) Names;

b) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

i) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

ii) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

c) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and 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;

d) Telephone numbers;

e) Fax numbers;

f) Electronic mail addresses;

g) Social security numbers;

h) Medical record numbers;

i) Health plan beneficiary numbers;

j) Account numbers;

k) Certificate/license numbers;

l) Vehicle identifiers and serial numbers, including license plate numbers;

m) Device identifiers and serial numbers;

n) Web Universal Resource Locators (URLs);

o) Internet Protocol (IP) address numbers;

p) Biometric identifiers, including finger and voice prints;

q) Full face photographic images and any comparable images; and

r) Any other unique identifying number, characteristic, or code, except as permitted by the re-identification procedures contained herein.

Re-Identification. The Health Plan may assign a code or other means of record identification to allow information de-identified under these procedures to be re-identified by the Health Plan, provided that:

1) Derivation. The code or other means of record identification will not be derived from or related to information about the Participant and will not be otherwise capable of being translated so as to identify the Participant; and

2) Security. The Health Plan will not Use or disclose the code or other means of record identification for any other purpose, and the Health Plan will not disclose the mechanism for re-identification.

HIPAA Regulations/Citations
45 CFR §§ 164.502(d), 164.514(a), (b), (c)

For Research Purposes

The Health Plan is permitted to Use or disclose Protected Health Information for research, provided that a number of processes and procedures are followed before such Protected Health Information is released for such research.

Policies.

The Health Plan may Use or disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures, for research purposes. The procedures address when the Health Plan must inform the Participant of, or when the Participant may agree to such a Use or Disclosure, the Health Plan information that may be used or disclosed, and the circumstances when the Participant's agreement may be given orally.

Generally, before April 14, 2003, the Health Plan may Use or disclose Protected Health Information for research purposes pursuant to an informed consent of the Participant to participate in research, or a waiver of informed consent by an Institutional Review Board ("IRB").

Procedures.

The Health Plan may Use or disclose Protected Health Information for research, regardless of the source of funding of the research, pursuant to the following procedures:

Institutional Review Board Approval of a Waiver of Participant's Authorization.

1) Nature of Authorizations. To Use or disclose Protected Health Information for research, regardless of the source of funding of the research, the Health Plan will obtain documentation that an alteration to or waiver, in whole or in part, of the Participant's authorization for the Use or Disclosure of Protected Health Information has been approved by either:

    a) An Institutional Review Board (IRB), established in accordance with 7 CFR § lc.107, 10 CFR § 745.107, 14 CFR § 1230.107, 15 CFR § 27.107, 16 CFR § 1028.107, 21 CFR § 56.107, 22 CFR § 225.107, 24 CFR § 60.107, 28 CFR § 46.107, 32 CFR § 219.107, 34 CFR § 97.107, 38 CFR § 16.107, 40 CFR § 26.107, 45 CFR § 46.107, 45 CFR § 690.107, or 49 CFR § 11.107; or

    b) A privacy board that:

        i) Has board members with varying backgrounds and appropriate professional competency as necessary to review the effect of the research protocol on the Health Plan's Participant's privacy rights and related interests;

        ii) Includes at least one board member who is not affiliated with the Health Plan, not affiliated with any entity conducting or sponsoring the research, and not related to any person who is affiliated with any of such entities; and

iii) Does not have any board member participating in a review of any project in which the board member has a conflict of interest.

2) Documentation of Waiver Approval**.** For a Use or Disclosure to be permitted based on documentation of approval of an alteration or waiver, the documentation will include all of the following:

a) Identification and Date of Action**.** A statement identifying the IRB or privacy board and the date on which the alteration or waiver of authorization was approved;

b) Waiver Criteria**.** A statement that the IRB or privacy board has determined that the alteration or waiver, in whole or in part, of the authorization satisfies the following criteria:

i) The Use or Disclosure of Protected Health Information involves no more than a minimal risk to the privacy of individuals based on, at least, the presence of the following elements:

(1) An adequate plan to protect the identifiers from improper Use and Disclosure;

(2) An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise Required by Law; and

(3) Adequate written assurances that the Protected Health Information will not be reused or disclosed to any other person or entity, except as Required by Law, for authorized oversight of the research study, or for other research for which the Use or Disclosure of Protected Health Information would be permitted by the HIPAA Regulations;

(a) The research could not practicably be conducted without the waiver or alteration; and

(b) The research could not practicably be conducted without access to and the Use of the Protected Health Information.

c) Protected Health Information Needed**.** A brief description of the Protected Health Information for which the Use or access has been determined to be necessary by the IRB or privacy board;

d) Review and Approval Procedures**.** A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures, as follows:

i) An IRB must follow the requirements of the Common Rule, including the normal review procedures (7 CFR § 1c.108(b), 10 CFR § 745.108(b), 14 CFR § 1230.108(b), 15 CFR § 27.108(b), 16 CFR § 1028.108(b), 21 CFR § 56.108(b), 22 CFR § 225.108(b), 24 CFR § 60.108(b), 28 CFR § 46.108(b), 32 CFR § 219.108(b), 34 CFR § 97.108(b), 38 CFR § 16.108(b), 40 CFR § 26.108(b), 45 CFR § 46.108(b), 45 CFR § 690.108(b), or 49 CFR § 11.108(b)) or the expedited review procedures (7 CFR § 1c.110, 10 CFR § 745.110, 14 CFR § 1230.110, 15 CFR § 27.110, 16 CFR § 1028.110, 21 CFR § 56.110, 22 CFR § 225.110, 24 CFR § 60.110, 28 CFR § 46.110, 32 CFR § 219.110, 34 CFR § 97.110, 38

CFR § 16.110, 40 CFR § 26.110, 45 CFR § 46.110, 45 CFR § 690.110, or 49 CFR § 11.110);

ii) A privacy board must review the proposed research at convened meetings at which a majority of the privacy board members are present, including at least one board member who satisfies the criterion stated above and the alteration or waiver of authorization must be approved by the majority of the privacy board members present at the meeting, unless the privacy board elects to use an allowable expedited review procedure; and

iii) A privacy board may use an expedited review procedure if the research involves no more than minimal risk to the privacy of the individuals who are the subject of the Protected Health Information for which the Use or Disclosure is being sought. If the privacy board elects to use an expedited review procedure, the review and approval of the alteration or waiver of authorization may be carried out by the chair of the privacy board, or by one or more board members of the privacy board as designated by the chair.

e) Required Signature**.** The documentation of the alteration or waiver of authorization must be signed by the chair or other board member, as designated by the chair, of the IRB or the privacy board, as applicable.

Reviews Preparatory to Research. To Use or disclose Protected Health Information for research, regardless of the source of funding of the research, the Health Plan will obtain from the researcher representations that:

1) The Use or Disclosure is sought solely to review Protected Health Information as necessary to prepare a research protocol or for similar purposes preparatory to research;

2) No Protected Health Information is to be removed from the Health Plan by the researcher in the course of the review; and

3) The Protected Health Information for which the Use or access is sought is necessary for the research purposes.

Research on Decedent's Information. To Use or disclose Protected Health Information for research, regardless of the source of funding of the research, the Health Plan will obtain from the researcher:

1) Representation that the Use or Disclosure is sought is solely for research on the Protected Health Information of decedents;

2) Documentation, at the Health Plan's request of the death of such deceased Participants; and

3) Representation that the Protected Health Information for which the Use or Disclosure is sought is necessary for the research purposes.

HIPAA Regulations/Citations
45 CFR § 164.512(i)

Minimum Necessary Standard

While the HIPAA Regulations permit certain Uses and Disclosure of Protected Health Information, such Uses or Disclosures are subject to a "minimum necessary" standard that permits only minimal information to be Used or Disclosed.

Policies.

Minimum Necessary Rule Applies. When Using or Disclosing Protected Health Information or when requesting Protected Health Information from another Covered Entity, the Health Plan must make reasonable efforts to limit Protected Health Information to the minimum necessary to accomplish the intended purpose of the Use, Disclosure, or request. Effective February 17, 2010, and continuing until the effective date of the guidance required by the HITECH Act to be issued by the Secretary of the U.S. Department of Health and Human Services regarding what constitutes the "minimum necessary" amount of Protected Health Information, the Health Plan shall limit its Use, Disclosure, or requests for Protected Health Information from another Covered Entity in those circumstances that are subject to the minimum necessary rule, to the extent practicable, to the Limited Data Set, or if needed by the Covered Entity, to the minimum necessary amount to accomplish the intended purpose of the Use, Disclosure, or request.

Minimum Necessary Rule Does Not Apply to:

1) Treatment. Disclosures to or requests by a Health Care Provider for Treatment;

2) To the Participant. Uses or Disclosures made to the Participant;

3) Pursuant to Authorizations. Uses or Disclosures made pursuant to an authorization;

4) HIPAA Compliance to HHS. Disclosures made to the Secretary of the U.S. Department of Health and Human Services ("HHS") to determine or investigate the Health Plan's compliance with the HIPAA Regulations;

5) HIPAA Compliance Required by Law. Uses or Disclosures that are Required by Law; and

6) HIPAA Regulations. Uses or Disclosures necessary for the Health Plan to comply with the HIPAA Regulations.

Procedures.

Workforce Access to Protected Health Information.

The Health Plan will identify either Workforce member or classes of Workforce members who need access to Protected Health Information to carry out their duties.

1) Limitations on Access . For each Workforce member or class of Workforce members, the Health Plan will define the categories or elements of Protected Health Information to which access is needed and any conditions or limitations appropriate to such access.

a) The Health Plan will make reasonable efforts to ensure that access to Protected Health Information by Workforce members or classes of Workforce members is limited to the categories or elements of the Protected Health Information that the Health Plan has determined are appropriate for those Workforce members.

2) Monitoring and Enforcement. The Health Plan will make reasonable efforts to ensure that any conditions or limitations the Health Plan determines as appropriate to Workforce members' access to the Protected Health Information are enforced.

Protected Health Information - Minimum Necessary Disclosures.

1) Routine Disclosures. For any type of Disclosure that the Health Plan makes on a routine and recurring basis, the Health Plan will implement policies and procedures (which may be standard protocols) that limit the Protected Health Information disclosed to the amount reasonably necessary to achieve the purpose of the Disclosure of the Protected Health Information.

2) Non-Routine Disclosures. For Disclosures that the Health Plan makes which are not on a routine and recurring basis, the Health Plan will develop the criteria designed to limit the Protected Health Information disclosed to the information reasonably necessary to accomplish the purpose of the Disclosure and the Health Plan will review requests for Disclosure on a Participant by Participant basis in accordance with such criteria.

3) Presumption of Minimum Necessary Disclosure. The Health Plan may rely, if such reliance is reasonable under the circumstances, on a requested Disclosure as being the minimum necessary for the stated purpose when:

a) The Health Plan discloses Protected Health Information to certain public officials if the public official represents that the information requested is the minimum necessary for the stated purpose(s);

b) The information is requested by a Health Care Provider, a Health Plan, or a Health Care Clearinghouse;

c) The information is requested by a professional who is a member of the Health Plan's own Workforce for the purpose of providing professional services to the Health Plan, if the professional represents that the information requested is the minimum necessary for the stated purpose(s);

d) The information is requested by a Business Associate if the Business Associate represents that the information requested is the minimum necessary for the stated purpose(s); or

e) Documentation or representations (as described in the Policies and Procedures for the Uses and Disclosures for research purposes) have been provided by a person requesting the information for research purposes.

Protected Health Information - Requests.

1) Requests to Covered Entities. The Health Plan may only request from Health Care Providers, Health Plans, or Health Care Clearinghouse, the amount of Protected Health Information that is reasonably necessary to accomplish the purpose of the Health Plan's request.

2) Routine Requests. For requests of Protected Health Information that the Health Plan makes on a routine and recurring basis, the Health Plan will implement policies and procedures (which may be standard protocols) that limit the Protected Health Information requested to the amount reasonably necessary to accomplish the purpose for which the Health Plan's request is made.

3) Non-Routine Requests - Case by Case Review. For non-routine requests, the Health Plan will develop criteria designed to limit the request for Protected Health Information to that information reasonably necessary to accomplish the purpose for which the Health Plan's request is made and the Health Plan will review requests for Disclosure on a Participant by Participant basis in accordance with such criteria.

Protected Health Information – Limitation of Disclosure of Entire Medical Record. For all Uses, Disclosures, or requests subject to the minimum necessary rule, the Health Plan may not Use, disclose, or request an entire medical record, except when the entire medical record is specifically justified as the amount of information that is reasonably necessary to accomplish the purpose of the Use, Disclosure, or request.

Interim Procedures for Limiting Uses, Disclosures, and Requests to the Limited Data Set. Notwithstanding any of the procedures in this section to the contrary, effective February 17, 2010, and continuing until the effective date of the guidance required by the HITECH Act to be issued by the Secretary of the U.S. Department of Health and Human Services regarding what constitutes the "minimum necessary" amount of Protected Health Information, the Health Plan will implement procedures to limit its Use, Disclosure, or requests for Protected Health Information from another Covered Entity in those circumstances that are subject to the minimum necessary rule, to the extent practicable, to the Limited Data Set, or if needed by the Covered Entity, to the minimum necessary amount to accomplish the intended purpose of the Use, Disclosure, or request.

HIPAA Regulations/Citations
45 CFR § 164.502(b), 164.514(d)

Marketing

The Health Plan or the Employer may want to inform Participants of services or products that may be beneficial to them. It may be permissible to provide information to Participants about health-related services and products that may be available. In some cases, it may be necessary to obtain written authorization from Participants before his or her name and address, or other Protected Health Information may be used for Marketing.

Policy.

1) Authorization Required - Marketing. A Participant must generally provide written authorization in order for the Health Plan to Use or Disclosure his or her Protected Health Information for purposes of Marketing. For purposes of this policy, the HIPAA Regulations define "Marketing" to include, in general, any communication about a product or service that encourages the Participant to buy or use the product or service.

2) Remuneration. If the Marketing involves Financial Remuneration to the Health Plan or Employer from a third party, the authorization must state that such Financial Remuneration is involved.

3) Authorizations Not Required.

   a) Written authorization is not required to provide refill reminders or to otherwise communicate about a drug or biologic that is currently being prescribed for a Participant, provided that any Financial Remuneration received by the Health Plan in exchange for making the communication is reasonably related to the Health Plan's cost of making the communication.

   b) Written authorization is not required to Use a Participant's Protected Health Information for the following Treatment or Health Care Operations purposes except when the Covered Entity receives Financial Remuneration in exchange for making the communication:

      i) For Treatment of a Participant by a Health Care Provider, including case management or care coordination of the Participant, or to direct or recommend alternative treatments, therapies, Health Care Providers or settings of care to the Participant;

      ii) To describe a health-related product or service (or Payment for such product or service) that is provided by, or included in the Health Plan, including communications about the entities participating in a Health Care Provider network, replacement, or enhancement to, a Health Plan, and health-related products or services available only to a Health Plan enrollee that adds value, but is not part of the benefits provided by the Health Plan; and

      iii) For case management or care coordination, contacting of Participants with information about Treatment alternatives, and related functions to the extent these activities do not fall within the definition of Treatment.

   c) Written authorization is not required to communicate with Participants face-to-face about products or services.

d) Written authorization is not required to Use or disclose Participants Protected Health Information for the distribution of promotional gifts of nominal value.

Procedures.

Protected Health Information Marketing Purposes:

1) Application to Privacy Official. A Health Plan administrator who desires to use Protected Health Information to prepare or send the same communication to more than one Participant must first apply, in writing, to receive authorization from the Privacy Official. The application must demonstrate either that:

   a) The communication will meet the Policies above, or

   b) The Health Plan will have obtained authorization from the Participants whose Protected Health Information will be Used or disclosed for the communication, prior to sending the communication.

2) Authorization by Privacy Official. If the Privacy Official is satisfied that the communication will comply with the Policy, he or she will authorize the use of Protected Health Information for the communication. This authorization will be in writing, specifying which Protected Health Information may be used.

3) Documentation. The Privacy Official will retain all documentation under this policy for at least six (6) years from the date of its creation, or the date it was last sent or in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR §§ 164.501, 164.508(a)(3)

For Disaster Relief Purposes

The HIPAA Regulations recognize the importance of having access to Protected Health Information to aid in disaster relief efforts. This information can be used to assist in determining a Participant's location, general condition or death.

Policies.

The Health Plan may Use or Disclosure Protected Health Information for disaster relief purposes if the Participant is informed in advance of the Health Plan's Use or Disclosure and has the opportunity to agree to prohibit or restrict the Health Plan's Use or Disclosure.

Procedures.

The Health Plan may Use or Disclosure Protected Health Information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the Use or Disclosure of Protected Health Information, to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the Participant, or another person responsible for the care of the Participant, of the Participant's location, general condition, or death.

The following procedures apply to such Use or Disclosure of Protected Health Information for disaster relief purposes only if the Health Plan, in the exercise of professional judgment, determines that adhering to such requirements would not interfere with the ability to respond to the emergency circumstances.

1) Uses and Disclosures When Participant Available. If the Participant is present for, or otherwise available prior to the Health Plan's Use or Disclosure of Protected Health Information to an allowable person to notify, or assist in the notification of a family member, a personal representative of a Participant, or another person responsible for the care of the Participant, of the Participant's location, general condition, or death, and the Participant has the capacity to make Health Care decisions, the Health Plan may Use or disclose the Protected Health Information by first:

    a) Agreement. Obtaining the Participant's agreement;

    b) Opportunity to Object. Providing the Participant with the opportunity to object to the Disclosure, and the Participant does not express an objection; or

    c) Inference. Reasonably inferring from the circumstances based the exercise of the Health Plan's professional judgment that the Participant does not object to the Disclosure.

2) Uses and Disclosures When Participant Not Available. If the Participant is not present, or the opportunity to agree or object to the Health Plan's Use or Disclosure cannot practicably be provided because of the Participant's incapacity or an emergency circumstance, the Health Plan may, in the exercise of professional judgment, determine whether the Disclosure is in the best

interests of the Participant and, if so, disclose only the Protected Health Information that is directly relevant to the person's involvement with the Participant's Health Care. The Health Plan may, as applicable, exercise professional judgment and the Health Plan's experience with common practice to make reasonable inferences of the Participant's best interest in allowing a person to act on behalf of the Participant.

HIPAA Regulations/Citations
45 CFR § 164.510(b)(4)

Victims Of Abuse, Neglect Or Domestic Violence

Health Information can play a critical part in identifying victims of abuse, neglect or domestic violence. On occasion, Protected Health Information may need to be disclosed without regard to a Participant's authorization when necessary to address these issues and concerns.

Policies.

The Health Plan may disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures as Required by Law to address issues concerning victims of abuse, neglect or domestic violence. The procedures will address when the Health Plan must inform the Participant of, or when the Participant may agree to such a Disclosure, the information to be disclosed, and when the Participant's agreement may be given orally.

Procedures.

Permitted Disclosures of Protected Health Information. Except for reports of child abuse or neglect for which the Health Plan may disclose Protected Health Information for certain public health activities and purposes to a Public Health Authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect, the Health Plan may disclose Protected Health Information about a Participant whom the Health Plan reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence under the following circumstances:

1) Requested by Law. To the extent the Disclosure is Required by Law and the Disclosure complies with and is limited to the relevant requirements of such law;

2) Agreement By Participant. If the Participant agrees to the Disclosure; or

3) Statutory/Regulatory Authority. To the extent the Disclosure is expressly authorized by statute or regulation and:

   a) The Health Plan, in the exercise of professional judgment, believes the Disclosure is necessary to prevent serious harm to the Participant or other potential victim(s); or

   b) If the Participant is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the Protected Health Information for which Disclosure is sought is not intended to be the used against the Participant and that an immediate enforcement activity that depends upon the Disclosure would be materially and adversely affected by waiting until the Participant is able to agree to the Disclosure.

Informing the Participant. When the Health Plan makes such a Disclosure, the Health Plan will promptly inform the Participant that such a report has been or will be made, except if:

1) Risk of Harm. The Health Plan, in the exercise of professional judgment, thinks informing the Participant would place the Participant at risk of serious harm; or

2) Best Interest of Participant. The Health Plan would be informing a personal representative, and the Health Plan reasonably thinks the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the Participant as determined by the Health Plan in the exercise of professional judgment.

Personal Representative. Notwithstanding a state law or any provision of the Health Plan to the contrary, the Health Plan may elect not to treat a person as the personal representative of a Participant if:

1) Not in Best Interest. The Health Plan, in the exercise of professional judgment, decides that it is not in the best interest of the Participant to treat the person as the individual's personal representative.

2) Risk to Participant. The Health Plan has a reasonable belief that:

   a) The Participant has been or may be subjected to domestic violence, abuse or neglect by such person; or

   b) Treating such person as the personal representative could endanger the Participant.

HIPAA Regulations/Citations
45 CFR § 164.512(c)

For Judicial And Administrative Proceedings

HIPAA Regulations address Disclosure of Health Information in connection with any legal proceedings wherein Protected Health Information may be sought and provide specific protections to individuals on whose behalf information is being requested.

Policies.

The Health Plan may disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures as Required by Law for judicial and administrative proceedings. The procedures will address the circumstances when the Health Plan must, as a condition for Disclosure, receive satisfactory assurances from the party requesting the Protected Health Information that the Participant who is the subject of the Protected Health Information has been given notice of the request or that such party has made reasonable efforts to secure a qualified protective order.

These Policies and Procedures regarding disclosures for judicial and administrative proceedings do not supersede other provisions of the Policies and Procedures or rights that a Participant may have which otherwise permit or restrict the Uses or Disclosures of Protected Health Information.

Procedures.

Permitted Disclosures of Protected Health Information. The Health Plan may disclose Protected Health Information in the course of any judicial or administrative proceeding:

1) Orders of Court or Administrative Tribunal. In response to an order of a court or administrative tribunal, provided that the Health Plan discloses only the Protected Health Information expressly authorized by such order; or

2) In Absence of Orders of a Court or Administrative Tribunal. In response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal, if:

    a) The Health Plan receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to ensure that the Participant who is the subject of the Protected Health Information which has been requested has been given notice of the request.

        i) The Health Plan must receive from the requesting party a written statement and accompanying documentation demonstrating that:

            (1) The party requesting such information has made a good faith attempt to provide written notice to the Participant (or, if the Participant's location is unknown, to mail a notice to the Participant's last known address);

(2) The notice included sufficient information about the litigation or proceeding in which the Protected Health Information is requested to permit the Participant to raise an objection to the court or administrative tribunal; and

(3) The time for the Participant to raise objections to the court or administrative tribunal has elapsed, and:

(i) No objections were filed; or

(ii) All objections filed by the Participant have been resolved by the court or the administrative tribunal and the Disclosures being sought are consistent with such resolution.

- or -

b) The Health Plan receives "satisfactory assurance" from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order.

i) The Health Plan must receive from the requesting party a written statement and accompanying documentation demonstrating that:

(1) The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

(2) The party seeking the Protected Health Information has requested a qualified protective order from such court or administrative tribunal.

ii) A "qualified protective order" means an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

(1) Prohibits the parties from the Using or Disclosing the Protected Health Information for any purpose other than the litigation or proceeding for which such information was requested; and

(2) Requires the return to the Health Plan or the destruction of the Protected Health Information (including all copies made) at the end of the litigation or proceeding.

iii) The Health Plan may, however, disclose Protected Health Information in response to a subpoena, discovery request, or other lawful process without receiving either type of "satisfactory assurance" described herein if the Health Plan makes reasonable efforts to provide notice to the Participant sufficient to meet the notice requirements described above or to seek a qualified protective order sufficient to meet the requirements of a qualified protective order as described above.

HIPAA Regulations/Citations
45 CFR § 164.512(e)

For Law Enforcement Purposes

Special rules apply to the disclosure of Protected Health Information that is to be used to report certain injuries and health conditions to law enforcement officials.

Policies.

The Health Plan may disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures as Required by Law for law enforcement purposes. The procedures address when the Health Plan must inform the Participant of such Disclosure, when the Participant may agree to such a Disclosure, the Health Plan information that may be disclosed, and the circumstances when the Participant's agreement may be given orally.

Procedures.

Permitted Disclosures: Pursuant to legal process and as otherwise Required by Law, the Health Plan may disclose Protected Health Information as follows:

1) Reporting Laws. Protected Health Information shall be disclosed to the extent Required by Law, including laws that require the reporting of certain types of wounds or other physical injuries, provided, however, that special rules and restrictions will apply to Disclosures in connection with (a) certain public health activities and purposes and subsequent Disclosures to a Public Health Authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect; or (b) Protected Health Information about an Participant whom the Health Plan reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence to the extent the Disclosure is Required by Law and the Disclosure complies with and is limited to the relevant requirements of such law.

2) Legal Process. Protected Health Information shall be disclosed to the extent necessary to comply with:

    a) A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;

    b) A grand jury subpoena; or

    c) An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

        i) The information sought is relevant and material to a legitimate law enforcement inquiry;

        ii) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

iii) De-identified information could not reasonably be used.

Limited Disclosures: Identification and Location Purposes. Except for Disclosures Required by Law, the Health Plan may disclose Protected Health Information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that:

1) Type of Information to be Provided. The Health Plan may disclose only the following information:

   a) Name and address;

   b) Date and place of birth;

   c) Social security number;

   d) ABO blood type and Rh factor;

   e) Type of injury;

   f) Date and time of Treatment;

   g) Date and time of death, if applicable; and

   h) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

2) Excluded Information. Except as permitted above, the Health Plan will not disclose, in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, any Protected Health Information related to the Participant's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

Permitted Disclosure: Crime Victims. Except for Disclosures Required by Law and as described above, the Health Plan may disclose Protected Health Information in response to a law enforcement official's request for such information about a Participant who is or is suspected to be a victim of a crime, other than Disclosures that are subject to the Health Plan's Policies and Procedures concerning Uses and Disclosures for Public Health Activities or Disclosures about Victims of Abuse, Neglect or Domestic Violence if:

1) Participant Agreement. The Participant agrees to the Disclosure; or

2) Incapacity or Emergency. The Health Plan is unable to obtain the Participant's agreement because of incapacity or other emergency circumstance, provided that:

   a) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;

b) The law enforcement official represents that immediate law enforcement activity that depends upon the Disclosure would be materially and adversely affected by waiting until the Participant is able to agree to the Disclosure; and

c) The Disclosure is in the best interests of the Participant as determined by the Health Plan in the exercise of professional judgment.

Permitted Disclosure: Decedents. The Health Plan may disclose to a law enforcement official Protected Health Information about a Participant who has died for the purpose of alerting law enforcement of the death of the Participant if the Health Plan suspects that such death may have resulted from criminal conduct.

Permitted Disclosure: Crime on Premises. The Health Plan may disclose to a law enforcement official Protected Health Information that the Health Plan believes in good faith constitutes evidence of criminal conduct that occurred on the Health Plan's premises.

HIPAA Regulations/Citations
45 CFR § 164.512(f)

For Public Health Activities

Health Information may need to be disclosed to public health authorities to permit them to address situations involving disease control, child abuse or neglect, or FDA-related products.

Policies.

The Health Plan may disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures for public health activities. The procedures address when the Health Plan must inform the Participant of the Disclosure, or when the Participant may agree to such a Disclosure, the Health Plan information to be disclosed and the circumstances when the Participant's agreement may be given orally.

Procedures.

The Health Plan may disclose Protected Health Information for the public health activities described below:

1) Disease Control. A Public Health Authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a Public Health Authority, to an official of a foreign government agency that is acting in collaboration with a Public Health Authority;

2) Child Abuse or Neglect. A Public Health Authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

3) FDA Regulated Products. A Participant subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that Participant has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity. Such purposes include:

    a) To collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations;

    b) To track FDA-regulated products;

    c) To enable product recalls, repairs, or replacement, or a review or look back (including locating and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of the review or look back); or

    d) To conduct post-marketing surveillance.

4) Communicable Disease. A Participant who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the Health Plan or the Public Health Authority is authorized by law to notify such Participant as necessary in the conduct of a public health intervention or investigation.

HIPAA Regulations/Citations
45 CFR § 164.512(b)

For Health Oversight Activities

The Health Plan may disclose Protected Health Information to a Health Oversight Agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.

Policies.

Generally, the Health Plan may disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures for health oversight activities, including investigations and reviews conducted by the Secretary of the U.S. Department of Health and Human Services. The procedures address when the Health Plan must inform the Participant of a Disclosure and when the Participant may agree to such a Disclosure, the nature of the Health Plan information to be disclosed and the circumstances when a Participant's agreement may be given orally.

Procedures.

Permitted Disclosures of Protected Health Information for Health Oversight Activities. The Health Plan may disclose Protected Health Information to a Health Oversight Agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

1) The Health Care system;

2) Government benefit programs for which Health Information is relevant to beneficiary eligibility;

3) Entities subject to government regulatory programs for which Health Information is necessary for determining compliance with program standards; or

4) Entities subject to civil rights laws for which Health Information is necessary for determining compliance.

Exception to Health Oversight Activities. A health oversight activity does not include an investigation or other activity in which the Participant is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

1) The receipt of Health Care;

2) A claim for public benefits related to health; or

3) Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

Joint Activities or Investigations. Notwithstanding the procedure outlined above in Exception to Health Oversight Activities, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight.

Investigations and Reviews of the Health Plan's Operations Conducted by the U. S. Department of Health and Human Services.

1) The Health Plan will keep such records and submit such compliance reports, in such time and manner and containing such information, as the Secretary of the U.S. Department of Health and Human Services may determine to be necessary to enable the Secretary to ascertain whether the Health Plan has complied or is complying with the HIPAA Regulations.

2) The Health Plan will cooperate with the Secretary of the U.S. Department of Health and Human Services, if the Secretary undertakes an investigation or compliance review of the Health Plan's policies, procedures, or practices to determine whether the Health Plan is in compliance with the HIPAA Regulations.

3) The Health Plan will allow the Secretary of the U.S. Department of Health and Human Services access to information.

    a) The Health Plan will permit access by the Secretary during normal business hours to the Health Plan's facilities, books, records, accounts, and other sources of information, including Protected Health Information, that are pertinent to ascertaining the Health Plan's compliance with the HIPAA Regulations. If the Secretary determines that exigent circumstances exist, such as when documents may be hidden or destroyed, the Health Plan will permit access by the Secretary at any time and without notice.

    b) If any information required of the Health Plan by the Secretary is in the exclusive possession of any other agency, institution, or person and the other agency, institution, or person fails or refuses to furnish the information, the Health Plan will so certify and set forth what efforts the Health Plan has made to obtain the information.

HIPAA Regulations/Citations
45 CFR § 164.512(d)

Decedents

Health Information plays an important part in determining causes of death and related investigations. The HIPAA Regulations contemplate situations when such Use or Disclosure may be permitted.

Policies.

Generally, the Health Plan may Use or disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Use or Disclosures about decedents. The procedures address when the Health Plan must inform the Participant or his or her personal representative of such a Use or Disclosure and the Health Plan information that may be Used or disclosed.

The Health Plan will comply with the requirements of the HIPAA Regulations with respect to the Protected Health Information of a deceased Participant.

The Health Plan's obligations with respect to the Protected Health Information of a deceased Participant shall end after the Participant has been deceased for more than fifty (50) years.

Procedures.

Coroners and Medical Examiners. The Health Plan may disclose Protected Health Information 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.

Funeral Directors. The Health Plan may disclose Protected Health Information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, the Health Plan may disclose the Protected Health Information prior to, and in reasonable anticipation of, the Participant's death.

Research on Decedent's Information. The Health Plan may Use or Disclosure Protected Health Information for research, regardless of the source of funding of the research, provided that the Health Plan obtains from the researcher:

1) Representation that the Use or Disclosure sought is solely for research on the Protected Health Information of decedents;

2) Documentation, at the Health Plan's request of the death of such individuals; and

3) Representation that the Protected Health Information for which the Use or Disclosure is sought is necessary for the research purposes.

Permitted Disclosure for Law Enforcement: Decedents. The Health Plan may disclose Protected Health Information about a Participant who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the Participant if the Health Plan suspects that such death may have resulted from criminal conduct.

Personal Representatives of Deceased Participants. If, under applicable law, an executor, administrator, or other person has authority to act on behalf of a deceased Participant or of the Participant's estate, the Health Plan will treat such person as a personal representative of the Participant with respect to the Health Plan's Policies and Procedures with respect to Disclosure of a Participant's Protected Health Information to a personal representative.

Participants Deceased For More Then Fifty Years. The Health Plan may Use or disclose Individually Identifiable Health Information about a Participant who has been deceased for more than fifty (50) years without application of the limitations on the Use or Disclosure of Protected Health Information under the HIPAA Regulations.

HIPAA Regulations/Citations
45 CFR § 164.512(g)

For Cadaveric Organ, Eye Or Tissue Donation Purposes

The Health Plan may disclose Protected Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Policies.

The Health Plan generally may disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures for cadaveric organ, eye or tissue donation purposes. The procedures describe the entities to which the Health Plan may disclose Protected Health Information for cadaveric, organ, eye, or tissue donation purposes.

Procedures.

The Health Plan may disclose Protected Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

HIPAA Regulations/Citations
45 CFR § 164.512(h)

To Avert A Serious Threat To Health Or Safety

The Health Plan is permitted under the HIPAA Regulations to Use or Disclose Protected Health Information to avert a serious threat to health or safety.

Policies.

The Health Plan generally may Use or disclose Protected Health Information, without the written authorization of the Participant or the opportunity for the Participant to agree or object to such Disclosures, to avert a serious threat to health or safety. The procedures address when the Health Plan may Use or Disclosure, Protected Health Information to avert a serious threat to health or safety.

Procedures.

Permitted Disclosures. The Health Plan may Use or disclose Protected Health Information, provided that the Health Plan, in good faith, believes the Use or Disclosure:

1) Serious Imminent Threat. Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

2) Able to be Prevented. Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

3) Needed to Identify. Is necessary for law enforcement authorities to identify or apprehend an individual:

   a) Because of a statement by an Participant admitting participation in a violent crime that the Health Plan reasonably believes may have caused serious physical harm to the victim;

      i) Such reasonable belief will be based upon the Health Plan's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority, or

      ii) Such Use or Disclosure may not be made if the statement by an Participant admitting participation in a violent crime is learned by the Health Plan:

         (1) In the course of Treatment to affect the propensity to commit the criminal conduct that is the basis for this Disclosure, or counseling or therapy; or

         (2) Through a request by the Participant to initiate or to be referred for the Treatment, counseling, or therapy to affect the propensity to commit the criminal conduct that is the basis for this Disclosure.

      iii) A Disclosure made because of a statement by an Participant admitting participation in a violent crime that the Health Plan reasonably believes may have caused serious physical harm to the victim shall contain only such statement and the following Protected Health Information:

(1) Name and address;

(2) Date and place of birth;

(3) Social security number;

(4) ABO blood type and Rh factor;

(5) Type of injury;

(6) Date and time of Treatment;

(7) Date and time of death, if applicable; and

(8) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

- or -

b) Where it appears from all the circumstances that the Participant has escaped from a correctional institution or from lawful custody For purposes of this procedure, "correctional institution" means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.

Presumption of Good Faith Belief. The Health Plan will be presumed to have acted in good faith with respect to a belief regarding the need to Use or disclose Protected Health Information to avert a serious threat to health or safety in the context described above if the belief is based upon the Health Plan's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

HIPAA Regulations/Citations
45 CFR § 164.512(j)

For Specialized Government Functions

The HIPAA Regulations permit certain Uses or Disclosures of Protected Health Information for military and veteran activities, national security and related purposes.

Policies.

The Health Plan may Use or disclose Protected Health Information without the written authorization of the Participant, or the opportunity for the Participant to agree or object to such Disclosures for specialized government functions. The procedures address when the Health Plan must inform the Participant of or when the Participant may agree to such a Use or Disclosure, the Health Plan's information that may be Used or disclosed, and the circumstances when the Participant's agreement may be given orally.

Procedures.

Military and Veterans Activities.

1) Armed Forces Personnel. The Health Plan may Use or disclose the Protected Health Information of Participants who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register the following information:

   a) Appropriate military command authorities; and

   b) The purposes for which the Protected Health Information may be used or disclosed.

2) Foreign Military Personnel. The Health Plan may Use or disclose the Protected Health Information of Participants who are foreign military personnel to their appropriate foreign military authority for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the *Federal Register* the following information:

   a) Appropriate military command authorities; and

   b) The purposes for which the Protected Health Information may be used or disclosed.

National Security and Intelligence Activities. The Health Plan may disclose Protected Health Information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401, et seq.) and implementing authority (e.g., Executive Order 12333).

Protective Services for the President and Others. The Health Plan may disclose Protected Health Information to authorized federal officials for the provision of protective services to the President or other persons authorized by 18 U.S.C. § 3056, or to foreign heads of state or other persons authorized by 22 U.S.C. § 2709(a)(3), or for the conduct of investigations authorized by 18 U.S.C. §§ 871 and 879.

Correctional Institutions and Other Law Enforcement Custodial Situations.

1) Permitted Disclosures. The Health Plan may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other Participant Protected Health Information about such inmate or individual if the correctional institution or such law enforcement official represents that such Protected Health Information is necessary for:

   a) The provision of Health Care to such individuals;

   b) The health and safety of such Participant or other inmates;

   c) The health and safety of the officers or employees or others at the correctional institution;

   d) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;

   e) Law enforcement on the premises of the correctional institution; and

   f) The administration and maintenance of the safety, security, and good order of the correctional institution.

2) For the purposes of this procedure, an Participant is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

HIPAA Regulations/Citations
45 CFR § 164.512(k)

Disclosures By Whistleblowers

HIPAA attempts to ensure that Disclosures necessary to permit the reporting of unlawful conduct may be reported without violating the privacy rules.

Policies.

The Health Plan will not be in violation of the HIPAA Regulations if a member of the Health Plan's Workforce or a Business Associate discloses Protected Health Information, provided that:

1) Suspicion of Unlawful Conduct. The Health Plan's Workforce member or Business Associate has a good faith belief that the Health Plan has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the Health Plan potentially endangers one or more patients (as applicable), workers, or the public; and

2) Disclosure to Responsible Party. The Disclosure is to:

   a) A Health Oversight Agency or Public Health Authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the Health Plan's sponsor or to an appropriate Health Care accreditation organization for the purpose of reporting the allegation of the Health Plan's failure to meet professional standards or the Health Plan's misconduct; or

   b) An attorney retained by or on behalf of the Health Plan's Workforce member or Business Associate for the purpose of determining the legal options of the Workforce member or Business Associate with regard to conduct that is unlawful or otherwise violates professional or clinical standards.

Procedures.

Permissible Whistleblowing Disclosures. If a member of the Health Plan's Workforce or a Business Associate has a good faith belief that the Health Plan has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the Health Plan potentially endangers one or more patients (as applicable), workers, or the public, such Workforce member or Business Associate may disclose Protected Health Information to either:

1) Governmental Agencies or Accrediting Organizations. A federal, state, or local Health Oversight Agency or Public Health Authority that is authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the Health Plan's sponsor or to an appropriate Health Care accreditation organization (e.g., the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)) for the purpose of reporting the allegation of the Health Plan's failure to meet professional standards or the Health Plan's misconduct; or

2) Legal Counsel. An attorney retained by or on behalf of the Health Plan's Workforce member or Business Associate for the purpose of determining the legal options of the Workforce member or Business Associate with regard to conduct that is unlawful or otherwise violates professional or clinical standards.

Minimum Necessary Disclosure. Any Disclosure of Protected Health Information made by a Workforce member or Business Associate pursuant to this procedure shall, to the extent feasible, be limited to the minimum necessary amount to allow appropriate investigation of the allegation of unlawful conduct or improper or inadequate care.

HIPAA Regulations/Citations
45 CFR § 164.502(j)

By Workforce Members Who Are Victims Of A Crime

HIPAA permits individuals who are victims of a crime to Disclose Protected Health Information to law enforcement officials.

Policies.

The Health Plan will not be in violation of the requirements of the HIPAA Regulations if a member of the Health Plan's Workforce who is the victim of a criminal act discloses Protected Health Information to a law enforcement official, provided that:

1) Disclosures Regarding Suspected Perpetrator. The Protected Health Information disclosed by the Workforce member is about the suspected perpetrator of the criminal act; and

2) Limited Disclosures. The Protected Health Information disclosed by the Workforce member is limited to the following information:

   a) Name and address;

   b) Date and place of birth;

   c) Social security number;

   d) ABO blood type and Rh factor;

   e) Type of injury;

   f) Date and time of Treatment;

   g) Date and time of death, if applicable; and

   h) A description of distinguishing physical characteristics, including height, the weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

HIPAA Regulations/Citations
45 CFR § 164.502(j)(2)

Underwriting And Related Purposes

The Health Plan may Use or disclose Protected Health Information for underwriting, premium rating and related purposes unless the Protected Health Information includes Genetic Information..

Policies.

Generally, the Health Plan may Use and disclose Protected Health Information (exclusive of any Protected Health Information that includes Genetic Information) for underwriting, premium rating and related purposes.

Procedures.

Specific Use or Disclosure. If the Health Plan receives Protected Health Information for the purpose of underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and if such health insurance or health benefits are not placed with the health insurer or with an administrative service organization, the Health Plan must ensure that the Health Plan, and the health insurance company or administrative service organization may not Use or disclose such Protected Health Information for any other purpose, except as may be Required by Law.

Enrollment Authorization. The Health Plan may condition enrollment for health benefits or eligibility for benefits on the provision of an authorization from an Participant in connection with his or her enrollment in the Health Plan, provided that:

1) The authorization sought is for the Health Plan's eligibility or enrollment determinations relating to the Participant or underwriting or risk rating determinations in connection with the Health Plan; and

2) The authorization sought is not for Use or Disclosure of Psychotherapy Notes.

Genetic Information. If the Health Plan receives Protected Health Information for the purpose of underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, the Health Plan must ensure that the Health Plan, and the health insurance company or administrative service organization, do not Use or disclose such Protected Health Information for any such purpose to the extent it includes Genetic Information.

HIPAA Regulations/Citations
45 CFR § 164.514(g)

Limited Data Set

The HIPAA Regulations recognize that there may be reasons to provide only limited amounts of Protected Health Information for research, public health or Health Care Operations and permit such Uses or Disclosures to occur without the authorization of Participants.

Policies.

The Health Plan may Use or disclose a Limited Data Set by entering into a Data Use Agreement with the Limited Data Set recipient.

The Health Plan may Use or disclose a Limited Data Set only for the purposes of research, public health or Health Care Operations.

Procedures.

Limited Data Set. A Limited Data Set is Protected Health Information that excludes the following direct identifiers of the Health Plan Participant or of relatives, Employers, or household members of the Plan Participant:

1) Names;
2) Postal address information, other than town or city, State, and zip code;
3) Telephone Numbers;
4) Fax numbers;
5) Electronic Mail addresses;
6) Social security numbers;
7) Medical record numbers;
8) Account numbers;
9) Certificate/license numbers;
10) Vehicle identifiers and serial numbers, including license plate numbers;
11) Device identifiers and serial numbers;
12) Web Universal Resource Locators (URLs);
13) Internet Protocol (IP) address numbers;

14) Biometric identifiers, including finger and voice prints; and

15) Full face photographic images and any comparable images.

Permitted Uses or Disclosures. The Health Plan may Use or disclose a Limited Data Set only for the purposes of research, public health, or Health Care Operations.

a) The Health Plan may Use Protected Health Information to create a Limited Data Set or disclose Protected Health Information only to a Business Associate for purposes of research, public health, or Health Care Operations, whether or not the Limited Data Set is to be Used by the Health Plan.

Data Use Agreement

1) Data Use Agreement Required. The Health Plan may Use or disclose a Limited Data Set only if the Health Plan obtains satisfactory assurance, in the form of a Data Use Agreement stipulating that the Limited Data Set recipient will only Use or disclose the Protected Health Information for limited purposes.

2) Contents of the Data Use Agreement. A Data Use Agreement between the Limited Data Set and the Health Plan must:

a) Establish the permitted Use and Disclosures of such information by the Limited Data Set recipient, such that the Limited Data Set may only be used or disclosed for the purposes of research, public health, or Health Care Operations. The Data Use Agreement will not authorize the Limited Data Set recipient to use or further disclose the information in a manner that would violate the HIPAA Regulations, if done by the Health Plan;

b) Establish who is permitted to Use or receive the Limited Data Set; and

c) Provide that the Limited Data Set recipient will:

i) Not use or further disclose the information other than as permitted by the Data Use Agreement or as otherwise Required by Law;

ii) Use appropriate safeguards to prevent Use or Disclosure of the information other than as provided for by the Data Use Agreement;

iii) Report to the Health Plan any Use or Disclosure of the information not provided for by its Data Use Agreement of which it becomes aware;

iv) Ensure that any agents, including a subcontractor, to whom it provides the Limited Data Set agrees to the same restrictions and conditions that apply to the Limited Data Set recipient with respect to such information; and

v) Not identify the information or contact the Participants whose information is contained in the Limited Data Set.

3) Monitoring HIPAA Compliance.

a) The Health Plan will not be in compliance with the HIPAA Regulations with respect to Limited Data Sets and Data Use Agreements if the Health Plan knows of a pattern of activity or practice of the Limited Data Set recipient that constituted a material breach or violation of the Data Use Agreement, unless the Health Plan takes reasonable steps to cure the breach or end the violation, as applicable and, if such steps are unsuccessful, the Health Plan shall:

i) Discontinue Disclosure of Protected Health Information to the recipient; and

ii) Report the problem to the Secretary of the U.S. Department of Health and Human Services.

b) If a Limited Data Set recipient and the Health Plan violate a Data Use Agreement, the Health Plan will not be in compliance with the HIPAA Regulations with respect to Limited Data Sets and Data Use Agreements.

HIPAA Regulations/Citations
45 CFR § 164.514(e)

Health Care Providers

The HIPAA Regulations require that Health Care Providers (that conduct Electronic Transactions) must separately comply with all of the HIPAA privacy, Electronic Transaction and data security requirements, including providing a Notice of Privacy Practices to individuals on whose behalf the Covered Entity may have Protected Health Information, developing HIPAA Policies and Procedures, entering into Business Associate Agreements, appointing a Privacy Official and conducting HIPAA training, among other things.

Policies.

Health Care Providers As Covered Entities. The Privacy Official shall identify any Health Care Provider who is a member of the Employer's Workforce (e.g., physicians, physician assistants, registered nurses or industrial nurses) and shall determine the extent to which he or she performs the following services or conducts the following transactions:

1) Health Care Services. The Privacy Official shall determine if the Health Care Provider provides services, health care services or furnishes bills or is paid for health care services in the normal course of business (within the meaning of Section 160.103 of the HIPAA Regulations); *and*

2) Electronic Transactions. The Privacy Official shall determine if the Health Care Provider transmits Health Information in electronic form in connection with a transaction covered by the HIPAA Regulations (45 CFR § 160.103). The Electronic Transactions contemplated by the HIPAA Regulations are as follows: (1) health care claims or equivalent encounter information, (2) health care payment and remittance advice, (3) coordination of benefits, (4) health care claim status, (5) enrollment and disenrollment in a Health Plan, (6) eligibility for a Health Plan, (7) Health Plan premium payments, (8) referral certification and authorization, (9) first report of injury, (10) health claims attachments, and (11) other transactions that the U.S. Secretary of Health and Human Services may prescribe.

Electronic Transactions. Effective April 14, 2003, Health Care Providers in the Employer's Workforce shall not directly or indirectly conduct any of the Electronic Transactions in connection with Health Information without the prior written approval of the Privacy Official.

Procedures.

Health Care Services. The Privacy Official shall identify all employees and members of the Workforce who provide Health Care services to other members of the Employer's Workforce.

1) Evaluate Purpose of In-House Service. The Privacy Official shall evaluate the rationale for having such Health Care services provided by members of the Employer's Workforce.

2) Determine Electronic Transactions Conducted. The Privacy Official shall determine what Electronic Transactions, if any, are conducted by or on behalf of the Workforce member who provides such Health Care services.

Health Care Provider Policy. The Privacy Official shall take such actions as may be necessary to preclude members of the Employer's Workforce from being treated as Covered Entities under HIPAA. Such actions may include, but not be limited to:

1) Outsource Health Care Services. The Privacy Official shall require that all Health Care services within the meaning of HIPAA be provided by a third-party organization that is not otherwise affiliated with the Employer.

2) Preclude Electronic Transactions. The Privacy Official shall establish such rules as may be necessary to preclude Health Care Providers who are members of the Employer's Workforce from conducting Electronic Transactions of a nature that would cause such Health Care Provider to be a Covered Entity under HIPAA.

3) Division of Responsibilities. The Privacy Official shall establish such rules as may be necessary to divide the responsibilities of any Health Care Provider who is a member of the Employer's Workforce such that the Health Care Provider's Health Care services do not relate to any Electronic Transactions that would be subject to HIPAA, and that such Electronic Transactions, if any, be conducted by third parties who are not otherwise affiliated with the Employer.

HIPAA Regulations/Citations
45 CFR §§ 160.102, 160.103

SAFEGUARDS

CONTENTS OF THIS SECTION

Identity Verification For Purposes Of Disclosures

Health Information is requested and provided by a number of sources and through a number of different mediums. In order to ensure that the Health Plan applies appropriate safeguards to the release of Health Information, it is important that it take steps to reasonably verify the individual(s) to whom Health Information is to be disclosed.

Policies.

Prior to making any Disclosure of Protected Health Information, the Health Plan must verify the identity of a person requesting Protected Health Information and the authority of any such person to have access to Protected Health Information, if the identity or any such authority of such person is not known to the Health Plan. This policy is not applicable to Disclosures made to those involved in the Participant's care and for notification purposes, including disaster relief purposes.

Prior to making any Disclosure of Protected Health Information, the Health Plan must obtain any documentation, statements, or representations, whether oral or written, from the person requesting the Protected Health Information when such documentation, statement, or representation is a condition of the Disclosure as discussed in the procedures that follow.

Procedures.

Process for Verification. Certain Disclosures may only occur if the Health Plan receives particular documentation, statements or representations from the person requesting the Protected Health Information. In making these Disclosures, the Health Plan may rely, if such reliance is reasonable under the circumstances, on documentation, statements, or representations that, on their face, meet the following applicable requirements. These verification procedures apply to the following Disclosures:

1) Telephonic Requests for Health Information. The Health Plan will establish identification procedures to be applied to those staff members who may be responsible for responding to telephone inquiries from Participants in connection with their Protected Health Information. These procedures may include:

   a) Developing questions and methods for verifying identity (e.g., Social Security number, mother's maiden name, personal identification number (PIN), amount of last paycheck or 401(k) withholding amount).

   b) Identifying the types of documents that should be requested from the caller (e.g., a written authorization, etc.).

   c) Identifying the types of statements and documentation that can be relied on in the verification process.

   d) Identifying situations when supervisors and/or Privacy Official approval of a Disclosure may be appropriate.

e) Identifying situations when Employer Legal Department review/consultation may be appropriate.

f) Determining the circumstances when Disclosures to a family member or friend who is involved in the individual's care may be permitted.

2) Requests for Law Enforcement Purposes. The Health Plan will disclose Protected Health Information if the administrative subpoena or similar process on its face demonstrates that the applicable requirements have been met.

3) Requests for Research Purposes. The documentation procedures that the Health Plan follows pursuant to the Health Plan's Policies and Procedures regarding Disclosures for research purposes may be satisfied by one or more written statements, if each statement is appropriately dated and signed in accordance with such Policies and Procedures.

4) Requests By Public Officials.

a) If the request is made in person, the individual making the request presents an agency identification badge, other official credentials, or other proof of government status;

b) If the request is in writing, the request is on the appropriate government letterhead;

c) If the Disclosure is to a person acting on behalf of a public official, a written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation of agency, such as a contract for services, memorandum of understanding, or purchase order, that establishes that the person is acting on behalf of the public official; or

d) The Health Plan may rely, if such reliance is reasonable under the circumstances, on any of the following to verify authority when the Disclosure of Protected Health Information is to a public official or a person acting on behalf of the public official:

i) A written statement of the legal authority under which the information is requested, or, if a written statement would be impracticable, an oral statement of such legal authority;

ii) The fact that a request is made pursuant to legal process, warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal.

Exercise of Professional Judgment. The above verification procedures will be met if the Health Plan relies on the Health Plan's exercise of professional judgment in making a Use or Disclosure in accordance with the HIPAA Regulations for purposes related to individuals involved in the Participant's care, and for notification purposes. The above verification procedures will also be met if the Health Plan acts on a good faith belief in making a Disclosure for purposes of averting a serious threat to health and safety.

HIPAA Regulations/Citations
45 CFR § 164.530(c)(l))

Privacy Training

Each Health Plan will identify those individuals within the Workforce who are in need of HIPAA training, prepare appropriate training materials, and deliver such training to the identified Workforce members prior to April 14, 2003, and periodically thereafter as required. Each Health Plan will also develop a procedure for identifying personnel who join the Health Plan Workforce from time to time, and provide HIPAA training to those individuals within a reasonable period of time after they join the Workforce. Records of all HIPAA training will need to be maintained under these Policies and Procedures.

Policies.

The Health Plan must train all individuals who are members of the Health Plan's Workforce on the Health Plan's HIPAA Policies and Procedures with respect to Protected Health Information, as necessary and appropriate for the members of the Workforce to carry out their functions on behalf of the Plan Sponsor for the Health Plan.

Procedures.

1) Workforce To Be Trained. The Health Plan will provide training on the Health Plan's HIPAA Policies and Procedures with respect to Protected Health Information, as necessary and appropriate for the individuals who are members of the Health Plan's Workforce to carry out their functions on behalf of the Health Plan as follows:

    a) To all individuals (employees, volunteers, trainees and other persons under the direct control of the Health Plan) who perform work for or on behalf of the Health Plan at the time or hire or transfer to a position for which the individual may have access to PHI;

    b) Thereafter, to each new member of the Health Plan's Workforce within a reasonable period of time after such individual joins the Health Plan's Workforce; and

    c) To those members of the Health Plan's Workforce whose functions are affected by a material change in the Health Plan's HIPAA policies or procedures, within a reasonable period of time after the material change becomes effective.

2) Departments/Individuals To Be Trained. The Health Plan shall provide training at levels and with emphasis on the Policies and Procedures that are applicable to various categories of Workforce members that are identified, based on the functions and responsibilities performed. Major functional categories for which different training programs might be offered include:

    a) Health Benefits Administration Staff

    b) Health Claim and Appeal Personnel

    c) Call Center Personnel

d) EAP Personnel

e) HR Advisors/Administrators

f) Privacy Officials

g) Contact Person(s)

h) Legal Department staff

i) Labor Relations Personnel

j) Others

3) Temporary Employee. The Privacy Official, in consultation with the Law Department, may choose to treat temporary employees and independent contractors as part of the Workforce, or as Business Associates.

a) Workforce Members. The Health Plan may choose to treat temporary employees and independent contractors (to the extent they handle or have access to Protected Health Information) as part of its Workforce. In the absence of a Business Associate Agreement, the temporary employees and independent contractors will be treated as part of the Health Plan's Workforce. (Note that if temporary employees and independent contractors are part of the Health Plan's Workforce, they may need to receive HIPAA training.)

b) Business Associates. Depending on whether the temporary employees and independent contractors will be handling or assisting in the handling of Protected Health Information (including claims processing or administration, data analysis, billing or utilization review), the use of a temporary agency or independent contractors to provide additional resources in the benefits administration area may create a Business Associate relationship under HIPAA. The HIPAA Regulations require Business Associate Agreements for non-employees to access Protected Health Information on behalf of a Health Plan (or the Plan Sponsor) unless they are treated as part of the Health Plan's Workforce.

4) Training Update. The Privacy Official will monitor developments under applicable law and the administration of the Health Plan, identify "material changes" in the underlying policies, and direct that appropriate training be prepared and delivered to all members of the Workforce that are impacted by the particular change.

5) Content of Training Records. The training records maintained for the Health Plan should, at a minimum, include the following information for each individual:

a) Name of trainee

b) Date entered Workforce

c) Date of initial HIPAA privacy training

d) Identity of trainees for initial training

e) Record of level of training session

f) Length of initial training period

g) Date of each training update session (e.g., due to changes in law or privacy policies, or periodic refresher courses)

h) Date of each training update

i) Identity of trainer for each update

j) Description of training materials, methodology, and location of updated training

6) Documentation. The Health Plan will maintain a written or electronic record that HIPAA training has been provided. The Health Plan shall retain this documentation for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR §§ 160.103, 164.502(e), 164.530(b); 65 Fed. Reg. 82480 (December 28, 2000)

Administrative, Technical And Physical Safeguards

The Health Plan must establish reasonable safeguards to protect Health Information from inappropriate Use or Disclosure. While incidental Uses or Disclosures may occur from time to time, policies and procedures must exist to generally preclude Uses or Disclosures other than as provided for under the HIPAA Regulations.

Policies.

The Health Plan must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information.

Procedures.

1) HIPPA Standard. The Health Plan must reasonably safeguard Protected Health Information from any intentional or unintentional Use or Disclosure that is in violation of the HIPAA Regulations.

2) Incidental Uses or Disclosures. The Health Plan must reasonably safeguard Protected Health Information so as to limit incidental Uses or Disclosures made pursuant to an otherwise permitted or required Use or Disclosure.

3) Specific Safeguards. Specific safeguarding procedures may include, but not be limited to:

   a) Locked File Cabinets. To the extent individuals are identified as having access to Protected Health Information, or are otherwise assigned to administering the Health Plan, development of dedicated file space only accessible to such individuals, or providing for locked file cabinets limited to only Protected Health Information may be appropriate.

   b) Off-Site Records Storage Facilities. Safeguards may be established to access Protected Health Information maintained in off-site storage facilities. Designation of Protected Health Information files as "Limited Access" and requiring written sign-in sheets (and approvals) may be considered.

   c) Microfiche/Electronic Storage Records. To the extent historical files are to be microfiched or otherwise stored on an electronic database, data security standards should be applied to ensure only limited access to such database.

   d) Central Depository. To the extent a centralized health records storage approach is utilized, it may be possible to develop a process whereby all Protected Health Information records are forwarded to and controlled by a single individual or department. Such an approach would permit a greater degree of control over any Use or Disclosure of Protected Health Information.

   e) Restricted Access to Call Center. Reconfiguring or relocating Health Information to an area where physical access can be limited. Limitations include dedicated space with lock or key-

pad access; partitioned space with limited path for access; or establishing an off-site location limited only to Health Plan employees.

f) Secure Computer Terminals. If access to the Health Information work area is not significantly restricted, the computer terminals serving the Health Information area should be "secured" by, among other things:

   i) Re-positioning computers so that they are in a "secure or dedicated area" that will deny access of the output to anyone other than authorized personnel.

   ii) Limiting viewing of computer screens to "users only" so that Protected Health Information is not inadvertently disclosed.

g) In-House Shredding. Maintain a secure storage bin wherein Protected Health Information may be stored for shredding at specific times each week or month. Have one person in a department assigned to shred Protected Health Information.

h) Third-Party Shredding Service. To the extent a third-party vendor performs shredding services, the storage bins should be maintained and accessible only by the third party. If shredding is to take place off-site, a Business Associate Agreement with the third-party vendor is required.

i) Scheduled Shredding. Identifying categories of documents for shredding and scheduling shredding after completion of project, lapse of time, etc. (Note: the document retention issue should be coordinated with any shredding decisions.)

j) Safeguarding Protected Health Information Transmitted By Electronic Mail. Whenever it is necessary to transmit Protected Health Information by electronic mail, the sender should adhere to the following guidelines:

   i) Do not identify the Participant in the "Re." line of the e-mail message (i.e., do not include name, HRID, or Social Security number, etc.).

   ii) Minimize the amount of Protected Health Information included in the body of an e-mail message.

   iii) Send "de-identified" data or records (when practical) and call the recipient to communicate the identity of the person to whom the Protected Health Information pertains.

   iv) Make any necessary Disclosure of Protected Health Information in a password-protected document that is attached to the e-mail (call the recipient to disclose the password).

   v) Develop a standard privacy caption for all e-mails that contain or transmit Protected Health Information (the caption may instruct the recipient to (i) inform the sender if the information has been received by error; (ii) instruct the recipient not to further disclose the Protected Health Information; and (iii) instruct the recipient regarding destruction of the electronic document (and printed paper document(s)) containing the Protected Health Information.

vi) Comply with Data Security rules in 45 CFR Parts 160, 162 and 164 of the HIPAA Regulations.

k) Facsimile Machines. Develop procedures to permit the sender to confirm the facsimile number to which the Health Information is to be sent is the correct one, and place the facsimile machine in a secure location to prevent unauthorized access to the information being transmitted from, or received through, the facsimile machine.

l) Specific Files. To the extent Health Information files (including health claim and appeal records) are developed, procedures should restrict copying of files and require the return of files to the Benefits Department (for secure storage or shredding). A record/log of the release and return of such files should be maintained.

HIPAA Regulations/Citations
45 CFR § 164.530(c)

Sanctions Against Workforce Members

Health Plans must establish appropriate sanctions in order to ensure that members of its Workforce will comply with the HIPAA Regulations and these Policies and Procedures.

Policies.

The Health Plan must have and apply appropriate sanctions against members of the Health Plan's Workforce who fail to comply with the Health Plan's privacy Policies and Procedures or the requirements of the HIPAA Regulations.

The Health Plan's sanction policy does not apply to a member of the Health Plan's Workforce who discloses Protected Health Information pursuant to the Health Plan's Policies and Procedures on (1) Disclosures by Whistleblowers; or (2) Disclosures by Workforce members who are victims of a crime.

Procedures.

Develop Appropriate Sanctions. In developing appropriate Workforce sanctions, it is necessary to recognize the nature of the noncompliance, develop any necessary modifications to the Policies and Procedures to avoid further noncompliance, and apply appropriate sanctions intended to mitigate the risk of noncompliance. While the Privacy Official, in consultation with the Plan Sponsor, will have discretion to determine the type of sanctions to be imposed in a particular situation, the range of sanctions may include:

1) Additional/remedial privacy training
2) Counseling by supervisor
3) Notation in personnel files
4) Letter of reprimand from supervisor
5) Removal from being within the Health Plan "firewall"
6) Removal from current position
7) Suspension from current position
8) Termination of employment
9) Other sanctions as determined by the Privacy Official

Documentation. The Health Plan will maintain a written or electronic record of the sanctions that are applied, if any. The Health Plan will retain such documentation for a minimum of six (6) years from the date of a sanction's creation or the date when it last was in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.530(e)(1),(2)

Mitigation

To the extent the Health Plan learns of any violation of its Policies and Procedures, it must take such steps as may be reasonable to mitigate the risk of further Uses or Disclosures of Health Information.

Policies.

The Health Plan must mitigate, to the extent practicable, any harmful effect that is known to the Health Plan due to a Use or Disclosure of Protected Health Information by the Health Plan's Workforce or a Business Associate in violation of the Health Plan's Policies and Procedures or the requirements of the HIPAA Regulations.

Procedures.

1) Workforce Violations. As soon as possible after the Health Plan becomes aware of a Use or Disclosure of Protected Health Information by a member of the Health Plan's Workforce that is contrary to the Health Plan's privacy Policies and Procedures or the HIPAA Regulations, the Health Plan will take reasonable steps to cure and/or cause the violation to cease and to mitigate any harmful effect of such improper Use or Disclosure that is known to the Health Plan.

2) Business Associate Violations. As soon as possible after the Health Plan becomes aware of a Use or Disclosure of Protected Health Information by a Business Associate that is contrary to the Health Plan's privacy Policies and Procedures or the HIPAA Regulations, the Health Plan will take reasonable steps to cure and/or cause the violation to cease and to mitigate any harmful effect of such improper Use or Disclosure that is known to the Health Plan.

HIPAA Regulations/Citations
45 CFR § 164.530(f)

Intimidating Or Retaliatory Acts Prohibited

In order to ensure that the HIPAA Regulations serve the purpose for which they were intended, Participants must feel comfortable in requesting access to their Protected Health Information and in exercising their rights with respect to Health Information. The HIPAA Regulations attempt to make certain that Participant will not fear any reprisals or retaliation for exercising their rights under HIPAA.

Policies.

The Health Plan will refrain from intimidating or retaliatory acts against anyone exercising a lawful right under the HIPAA Regulations.

Procedures.

1) Exercise of Rights Under HIPAA. The Health Plan will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any Participant for the exercise by the Participant of any right under, or for participation by the Participant in any process established by the HIPAA Regulations, including the filing of a complaint about the Health Plan either internally or with the U.S. Department of Health and Human Services.

2) Participation in HIPAA Processes/Investigations. The Health Plan will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any Participant for:

   a) Filing of a complaint about the Health Plan either internally or with the U.S. Department of Health and Human Services;

   b) Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under Part C of Title XI of the Social Security Act; or

   c) Opposing any act or practice made unlawful by the HIPAA Regulations, provided the Participant or other person has a good faith belief that the practice opposed is unlawful, and the manner of the opposition is reasonable and does not involve a Disclosure of Protected Health Information in violation of the HIPAA Regulations.

HIPAA Regulations/Citations
45 CFR § 164.530(g)

PLAN DOCUMENTS

CONTENTS OF THIS SECTION

Notice Of Privacy Practices

The Participants in the Health Plan have a right to adequate notice of the Uses and Disclosures of Protected Health Information that may be made by the Health Plan, and of the Participants' rights with respect to their Protected Health Information.

Policies:

Compliance With Notice. The Health Plan will not Use or disclose Protected Health Information in a manner inconsistent with its Notice of Privacy Practices.

Legal Requirements. The Health Plan's Notice of Privacy Practices will contain all of the requisite elements Required by Law.

Procedures.

Elements of the Notice of Privacy Practices: The Health Plan will provide a Notice of the Health Plan's privacy practices that is written in plain language and that contains the following required elements:

1) Description of Health Plan's Uses and Disclosures of Protected Health Information. The Health Plan's Notice of Privacy Practices will contain the following elements regarding the Health Plan's Use and Disclosures of Participants' Protected Health Information:

   a) A description, including at least one example, of the types of Uses and Disclosures that the Health Plan is permitted to make for Treatment, Payment, and Health Care Operations purposes. This description will include sufficient detail to place the Participant on notice of the Health Plan's Uses and Disclosures that are permitted or Required by Law.

   b) A description of each of the other purposes for which the Health Plan is permitted or required by the HIPAA Regulations to Use or disclose Protected Health Information without the Participant's written authorization. This description will include sufficient detail to place the Participant on notice of the Health Plan's Uses and Disclosures that are permitted or Required by Law.

   c) If the Health Plan's Use or Disclosure of Protected Health Information is prohibited or materially limited by other applicable law, the Health Plan's Notice of Privacy Practices will reflect the more stringent law.

   d) A description of the types of Uses and Disclosures that require an authorization, a statement that other Uses and Disclosures not described in the Notice of Privacy Practices will be made only with the Participant's written authorization, and a statement that the Participant may, under certain conditions, revoke such authorization.

   e) If the Health Plan intends to Use or disclose Protected Health Information for underwriting purposes, a statement that the Health Plan is prohibited from using or disclosing Protected Health Information that is Genetic Information of a Participant for such purposes.

2) Participant Rights. The Health Plan's Notice of Privacy Practices will contain a statement of the Participant's rights with respect to Protected Health Information and a brief description of how the Participant may exercise those rights.

3) Health Plan Duties. The Health Plan's Notice of Privacy Practices must provide information to Participants concerning the Health Plan's legal duties, including the duty to maintain the privacy of Protected Health Information, to provide notice of the Health Plan's legal duties and privacy practices with respect to Protected Health Information, and to notify affected Participants following a breach of Unsecured Protected Health Information.

4) Limitations in the Notice of Privacy Practices. In addition to the information the Health Plan is required to include in the Health Plan's Notice of Privacy Practices, if the Health Plan elects to limit the Health Plan's Uses or Disclosures of Protected Health Information that it is permitted to make, the Health Plan may describe the Health Plan's more limited Uses and Disclosures in the Health Plan's Notice of Privacy Practices. The Health Plan may not, however, include in the Health Plan's Notice of Privacy Practices a limitation affecting the Health Plan's right to make a Use and Disclosure that is Required by Law. Moreover, the Health Plan may not include in the Health Plan's Notice of Privacy Practices a limitation affecting the Health Plan's right to make a Use or Disclosure that the Health Plan in good faith, believes is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

5) Effective Date. The Notice will contain the date on which the Notice is first in effect, which may not be earlier than the date on which the Notice is printed or otherwise published. The effective date will be April 14, 2003, for the Health Plan's first Notice of Privacy Practices.

Providing the Notice of Privacy Practices: The Health Plan will make its Notice of Privacy Practices available as follows:

1) To Non-Participants. The Health Plan will provide the Health Plan's Notice of Privacy Practices upon request to any person. If the Health Plan has more than one Notice of Privacy Practices, the Health Plan will provide the Notice of Privacy Practices that is relevant to the person requesting the Notice. The Health Plan may provide the Health Plan's Notice of Privacy Practices electronically, however, persons have the right to receive the Notice of Privacy Practices in paper form.

2) To Participants. The Health Plan will provide its Notice of Privacy Practices to Participants as follows:

   a) Upon request;

   b) No later than April 14, 2003 to Participants then covered by the Health Plan;

   c) Thereafter, at the time of enrollment, to new Participants;

   d) In the manner described in the "Revisions to the Health Plan's Notice of Privacy Practices" procedure when a material revision is made to the Notice of Privacy Practices;

e) If the Health Plan has more than one Notice of Privacy Practices, the Health Plan will provide the Notice of Privacy Practices that is relevant to the Participant; and

f) A Notice of Privacy Practices will be provided to the named insured of a fully insured health policy by the health insurance issuer or health maintenance organization ("HMO").

3) Electronic Distributions. The Health Plan may provide the Notice of Privacy Practices to the Health Plan's Participants electronically (by means of the Health Plan's web-site or e-mail). If a Participant who receives the Health Plan's Notice of Privacy Practices through electronic distribution subsequently requests a paper copy of the Notice, the Health Plan will satisfy that request.

a) The Health Plan may provide the Notice of Privacy Practices to a Participant by e-mail, if the Participant agrees to electronic notice and such agreement has not been withdrawn. If the Health Plan knows that the e-mail transmission has failed, a paper copy of the Notice will be provided to the individual.

4) Three-Year Notice. No less frequently than once every three (3) years, the Health Plan will notify Participants of the availability of the Notice and how to obtain the Notice of Privacy Practices. Notification will be provided to the Participant who is covered under the Health Plan.

5) Posting on Web Site. If the Health Plan maintains a web site that provides information about the Health Plan's customer services or benefits, the Health Plan will prominently post the Health Plan's Notice(s) of Privacy Practices on the web site and make the Notice(s) available electronically through the web site.

6) Revisions to the Health Plan's Notice of Privacy Practices. The Health Plan will promptly revise and distribute the Health Plan's revised Notice of Privacy Practices whenever there is a material change to the Health Plan's Uses or Disclosures, the Participant's rights, the Health Plan's legal duties, or other privacy practices stated in the Health Plan's Notice of Privacy Practices. Except when Required by Law, the Health Plan will not implement a material change to any term of the Health Plan's Notice of Privacy Practices prior to the effective date of the Notice in which such material change is reflected. The Health Plan's Notice of Privacy Practices shall contain a statement that it reserves the right to change the terms of the Health Plan's Notice of Privacy Practices and to make the new Notice provisions effective for all Protected Health Information that the Health Plan maintains. The statement shall also describe how the Health Plan will provide Participants with a revised Notice. The distribution of the revised Notice of Privacy Practices shall be made as follows:

a) If the Health Plan posts its Notice of Privacy Practices on a web site, the Health Plan must (i) prominently post the revisions to the Notice of Privacy Practices or the revised Notice of Privacy Practices on the web site by the effective date of the material change to the Notice of Privacy Practices; and (ii) provide the revised Notice of Privacy Practices or information about the material change and how to obtain the revised Notice of Privacy Practices in the Health Plan's next annual mailing to Participants under the Health Plan.

b) If the Health Plan does not post its Notice of Privacy Practices on a web site, the Health Plan must provide the revised Notice of Privacy Practices or information about the material change and how to obtain the revised Notice of Privacy Practices to Participants under the Health Plan within 60 days of the material revision to the Notice of Privacy Practices.

Documentation. The Health Plan will document compliance with the HIPAA notice requirements by retaining copies of the Notices of Privacy Practices that the Health Plan issues for a minimum of six (6) years from the date of their creation or the date when such Notice(s) was last in effect, whichever is later.

HIPAA Regulations/Citations
45 CFR § 164.520, 164.530(i)(4),(j)

Business Associate Agreements

Health Plans need to rely on various third-party administrators and Health Care vendors to facilitate the payment of claims and to provide the necessary Health Information required for Health Plan administration. While the Health Plan may have access to this information under appropriate circumstances, the Health Plan frequently needs to rely on third parties for assistance. These third parties are known as "Business Associates" under the HIPAA Regulations and are required to enter into a Business Associate Agreement in order to receive Protected Health Information from or on behalf of the Health Plan.

Policies.

Disclosure to Business Associates. The Health Plan may only disclose Protected Health Information to a Business Associate and allow the Business Associate to create or receive Protected Health Information on the Health Plan's behalf if the Health Plan enters into a written contract under which the Business Associate agrees to appropriately safeguards the Protected Health Information and promises not to improperly Use or disclose the Protected Health Information.

Material Breach By Business Associate. If the Health Plan knows of a pattern of activity or practice of any Business Associate that constitutes a material breach or violation of the Business Associate's obligations under the contract or other written arrangement, the Health Plan will take reasonable steps to cure the breach or end the violation, as applicable. If such steps are unsuccessful, the Health Plan will terminate the contract or arrangement, if feasible, or if termination is not feasible, the Health Plan will report the problem to the Secretary of the U.S. Department of Health and Human Services.

Material Breach By Subcontractor. If a Business Associate knows of a pattern of activity or practice of any Subcontractor that constitutes a material breach or violation of the Subcontractor's obligations under the contract or other written arrangement with the Business Associate, the Business Associate will take reasonable steps to cure the breach or end the violation, as applicable. If such steps are unsuccessful, the Health Plan will terminate the contract or arrangement, if feasible.

Business Associate Safeguards. The Health Plan may disclose Protected Health Information to a Business Associate and may allow a Business Associate to create or receive Protected Health Information on its behalf, if the Health Plan obtains satisfactory assurance that the Business Associate will appropriately safeguard the information. This policy does not apply: (1) with respect to Disclosures by the Health Plan to a Health Care Provider concerning the Treatment of the Participant; or (2) with respect to applicable Disclosures by the Health Plan to the Plan Sponsor in accordance with the terms and conditions of the Health Plan.

Special Transition Rule. If the Health Plan is NOT a "small Group Health Plan" (within the meaning of the HIPAA Regulations), then it may disclose Protected Health Information to a Business Associate and may allow a Business Associate to create, receive, or use Protected Health Information on its behalf pursuant to a written contract or other written arrangement with such Business Associate that does not meet the requirements in the HIPAA Regulations. This exception to entering into a Business Associate Agreement meeting the HIPAA Regulations applies only if the Health Plan had, before October 15, 2002, entered into and is currently operating pursuant to a written contract or other written arrangement with a Business Associate for such Business Associate to perform functions or activities or provide services that

make the entity a Business Associate; and the contract or other arrangement is not renewed or modified from October 15, 2002, until April 14, 2003. Such a prior contract or other written arrangement shall be deemed compliant with the HIPAA Regulations until the earlier of the date such contract or other arrangement is renewed or modified on or after April 14, 2003.

Procedures*:*

Business Associate Agreements. The Health Plan may disclose the Protected Health Information to a Business Associate and allow the Business Associate to create, receive or maintain Protected Health Information on the Health Plan's behalf, provided that the Health Plan has entered into a written contract with the Business Associate(s). The Business Associate Agreement must, to the extent applicable:

1) Uses and Disclosures. Establish permitted and required Use or Disclosures of the Protected Health Information by the Business Associate.

2) Same Uses As Health Plan. Not allow the Business Associate to Use or further disclose the Protected Health Information in ways that are unavailable to the Health Plan.

3) Further Disclosure. Provide that the Business Associate will not further disclose the Protected Health Information other than as allowed by the Business Associate Agreement or Required by Law.

4) Safeguards. Provide that the Business Associate will appropriately safeguard the Protected Health Information, and comply with the HIPAA Electronic Data Security regulations at 45 CFR parts 160, 162, and 164 subpart C with respect to Electronic Protected Health Information, to prevent Use or Disclosure not allowed by the contract.

5) Report Improper Uses or Disclosures. Provide that the Business Associate will report to the Health Plan any improper Uses or Disclosures of the Protected Health Information of which it becomes aware, including breaches of Unsecured Protected Health Information.

6) Subcontractors. Provide that the Business Associate will ensure that any Subcontractors that create, receive, maintain or transmit Protected Health Information on behalf of the Business Associate agrees to adhere to the same privacy and security standards applicable to Business Associate with respect to such information.

7) Designated Record Set. Provide that if the Business Associate has the Protected Health Information in a Designated Record Set, then the Business Associate agrees to provide the Health Plan access, at the Health Plan's request, and in the time and manner upon which the Health Plan agrees, to Protected Health Information in a Designated Record Set, or, at the Health Plan's direction, to a Participant.

8) Amendment to Designated Record Set. Provide that if the Business Associate has the Protected Health Information in a Designated Record Set, then the Business Associate will make any amendment(s) to Protected Health Information in a Designated Record Set that the Health Plan directs or agrees to at the Health Plan's request or at the request of a Participant, and in the time and manner upon which the Health Plan agrees.

9) Accounting for Disclosures. Provide that the Business Associate agrees to provide to the Health Plan, within a reasonable time and in a manner specified by the Health Plan, information regarding certain of its Disclosures of Protected Health Information, to permit the Health Plan to respond to a request by a Participant for an accounting of Disclosures of Protected Health Information.

10) U.S. Department of Health and Human Services. Provide that the Business Associate will make its books and internal practices relating to its Use and Disclosure of Protected Health Information available to the U.S. Department of Health and Human Services.

11) Return or Destroy Protected Health Information. Provide that at the end of the contract, the Business Associate shall return or destroy all Protected Health Information. If return or destruction of the Protected Health Information is not feasible, the Business Associate would be limited to only the Use or Disclosure purposes that make its return or destruction not feasible.

12) Material Breach. Provide that the Business Associate must take reasonable steps to cure a material breach of the contract and authorize the Health Plan to terminate its contract with the Business Associate if the Health Plan determines that the Business Associate has violated a material term of the contract. (The Health Plan may omit the termination requirement from the Health Plan's contract if the termination authorization is inconsistent with any of the statutory obligations of the Business Associate or the Health Plan.)

13) To the extent provided in the Business Associate Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to the Health Plan as permitted by 45 CFR § 164.504(e)(2)(i)(B). Such data aggregation services are intended to de-identify Protected Health Information and allow for the Use and Disclosure of such information without violating HIPAA.

14) To the extent the Business Associate is to carry out the Health Plan's obligation under the Privacy Rule, the Business Associate shall comply with requirements of the Privacy Rule that apply to the Health Plan in the performance of such obligation.

Agreements With Subcontractors. The requirements for agreements between a Health Plan and a Business Associate shall apply to relationships between a Business Associate and a Business Associate that is a Subcontractor in the same manner as such requirements apply to agreements between a Health Plan and a Business Associate.

Health Plan Information Provided To Business Associates.

1) Amendment to PHI. If the Health Plan accepts (in whole or in part) a Participant's request for an amendment to his or her Protected Health Information maintained in a Designated Record Set, the Health Plan will make reasonable efforts to inform and provide the amendment of the Protected Health Information to the Business Associate(s), that the Health Plan knows have the Protected Health Information that is the subject of the amendment and that may have relied on, or could foreseeably rely, on such information to the detriment of the Participant.

2) Limited Data Set. The Health Plan may Use or disclose a Limited Data Set only for the purposes of research, public health, or Health Care Operations. The Health Plan may use Protected Health Information to create a Limited Data Set or if the Health Plan entered into a Data Use Agreement with a Business Associate, the Health Plan may disclose Protected Health Information to such

Business Associate for the purpose of creating a Limited Data Set, whether or not the Limited Data Set is to be used by the Health Plan.

3) Minimum Necessary. With respect to Disclosures of Protected Health Information the Health Plan makes pursuant to the "minimum necessary" requirements, the Health Plan may rely, if such reliance is reasonable under the circumstances, on a requested Disclosure as being the minimum necessary for the stated purpose when the information is requested by a Business Associate, if the Business Associate represents that the information requested is the minimum necessary for the stated purpose(s).

4) De-Identification Information. With respect to Uses and Disclosures to create de-identified information, the Health Plan may Use Protected Health Information to create information that is not Individually Identifiable Health Information or disclose Protected Health Information only to a Business Associate for such purpose, whether or not the de-identified information is to be used by the Health Plan.

5) Accounting of Disclosures. With respect to the content of the accounting of Disclosures, the Health Plan will provide the Participant with a written accounting of Disclosures made by any of the Health Plan's Business Associates. This procedure does not apply to Disclosures not required to be listed in the accounting.

Business Associate Agreements–Not Required.

1) Disclosures to Plan Sponsor or Health Care Providers. The Health Plan is not required to enter into a Business Associate Agreement as a pre-condition for:

   a) To Plan Sponsor. Disclosures the Health Plan may make to the Plan Sponsor, provided that the Health Plan documents restrict Uses or Disclosures of such information by the Plan Sponsor consistent with the requirements of the HIPAA Regulations.

   b) Summary Health Information. Disclosures of Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from other Health Plans, for providing health insurance coverage under the Group Health Plan, or modifying, amending or terminating the Group Health Plan.

   c) Enrollment or Disenrollment. Disclosures the Health Plan may make to the Plan Sponsor of information on whether an Participant is participating in the Group Health Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Health Plan.

   d) HIPAA Authorization. Disclosures the Health Plan makes pursuant to a valid HIPAA authorization.

   e) Health Care Provider. The Disclosures of Protected Health Information that the Health Plan makes to a Health Care Provider concerning the Treatment of a Participant.

2) Disclosures to Business Associate Required by Law. If a Business Associate is Required by Law to perform a function or activity on the Health Plan's behalf, or to provide to the Health Plan a service described in the HIPAA Regulations, the Health Plan may disclose Protected Health Information to the Business Associate without a HIPAA Business Associate Agreement, provided the Health Plan makes a good faith effort to obtain satisfactory assurances that the Business

Associate will maintain the privacy and security of the Protected Health Information. If such good faith effort fails, the Health Plan will document the Health Plan's attempt and the reasons that such assurances cannot be obtained.

HIPAA Regulations/Citations
45 CFR §§ 160.103, 164.308, 164.314, 164.502(e), 164.504(e)

Plan Document Requirements

Generally, in order for the Health Plan to disclose Protected Health Information to the Plan Sponsor, the Health Plan must ensure that the plan documents expressly permit such Disclosure, and appropriately restrict the Use and Disclosure of such information by the Plan Sponsor. Unlike third-party administrators, Plan Sponsors are not required to enter into Business Associate Agreements in order to have access to the Health Plan's Protected Health Information.

Policies.

Summary Health Information. The Health Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids for providing health insurance coverage under the Health Plan, or modifying, amending or terminating the Health Plan. No particular plan document language is required as a condition for the Health Plan's Disclosure of Summary Health Information to the Plan Sponsor.

Health Plan Enrollment. The Health Plan may disclose to the Plan Sponsor information on whether the Participant is participating in the Health Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Health Plan. No particular plan document language is required as a condition for the Health Plan's Disclosure of such enrollment information to the Plan Sponsor.

Other Health Information. The Health Plan shall not disclose other Health Information that constitutes Protected Health Information to the Plan Sponsor unless the Health Plan has received written certification from the Plan Sponsor that (1) the Health Plan document has been amended to incorporate the conditions and limitations on the Plan Sponsor's Use and Disclosure of Protected Health Information, as required by the HIPAA Regulations; and (2) the Plan Sponsor agrees to comply with all such Health Plan document provisions.

Procedures.

Requirements for Plan Documents. The plan documents for the Health Plan will have been amended to incorporate language that:

1) Uses and Disclosures. Establishes the permitted and required Uses and Disclosures of such Protected Health Information by the Plan Sponsor.

2) Plan Certification. Provides that the Health Plan will disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the plan documents have been amended to incorporate the following provisions and that the Plan Sponsor agrees to:

    a) Not Use or further disclose the information other than as permitted or required by the plan documents or as Required by Law;

b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Health Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

c) 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;

d) Report to the Health Plan any Use or Disclosure of the information that is inconsistent with the Uses or Disclosures provided for of which it becomes aware;

e) Make available Protected Health Information in accordance with the Participant's right of access as provided for under the HIPAA Regulations and the Health Plan's Policies and Procedures;

f) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information as provided for under the HIPAA Regulations and the Health Plan's Policies and Procedures;

g) Make available the information required to provide an accounting of Disclosures as provided for under the HIPAA Regulations and the Health Plan's Policies and Procedures;

h) Make its internal practices, books, and records relating to the use and Disclosure of Protected Health Information received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Health Plan's compliance with the HIPAA Regulations;

i) If feasible, return or destroy all Protected Health Information received from the Health Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which Disclosure was made, except that, if such return or destruction is not feasible, limit further the Uses and Disclosures to those purposes that make the return or destruction of the information infeasible;

j) Ensure that the adequate separation (as discussed below), is established; and

k) Such other provisions that may be included in the HIPAA Regulations from time to time in connection with plan document requirements.

3) Separation Between Health Plan and Plan Sponsor. Provides for adequate separation between the Plan Sponsor and the Health Plan. The plan document must:

a) Describe those 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 Health Plan in the ordinary course of business must be included in such description;

b) Restrict the access to and the Use by such employees and other persons to the plan administration functions that the Plan Sponsor performs for the Health Plan; and

c) Provide an effective mechanism for resolving any issues of noncompliance by such employees and other persons with the plan document provisions required by the Health Plan's procedures.

Documentation. The Health Plan will maintain a written or electronic record of each amendment to the Health Plan document made in accordance with this procedure. The Health Plan will retain such documentation for a minimum of six (6) years from the date of the amendment's adoption or the date when it last was in effect, whichever is later.

Health Plan Component (For Hybrid Entities). The Health Plan's Health Care Component may, unless otherwise provided under the HIPAA Regulations:

1) Plan Administration Functions. Disclose Protected Health Information to the Plan Sponsor to carry out plan administration functions that the Plan Sponsor performs consistent with the procedures listed herein.

2) Health Insurance Insurer/HMO. Not permit a health insurance issuer or HMO with respect to the Health Plan's Health Care Component to disclose Protected Health Information to the Plan Sponsor except as permitted by this procedure.

3) Notice of Privacy Practices. The Health Plan's Health Care Component's Notice of Privacy Practices shall contain a statement that the Health Plan may disclose Protected Health Information to the sponsor of the Health Plan.

4) Employment-Related Actions. Not disclose Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA Regulations/Citations
45 CFR § 164.504(a),(b),(c)

Changes To Privacy Policies And Procedures

The Health Plan must change the Health Plan's Policies and Procedures as necessary and appropriate to comply with changes in the law, including any changes to the HIPAA Regulations, as well as any changes to the Health Plan's administrative processes and procedures.

Policies.

When the Health Plan changes a privacy practice that is stated in the Health Plan's Notice of Privacy Practices and makes the corresponding changes to the Health Plan's Policies and Procedures, the Health Plan may make the changes effective for Protected Health Information that the Health Plan created or received prior to the effective date of the Notice of Privacy Practices revision, if the Health Plan has included in the Health Plan's Notice of Privacy Practices a statement reserving the Health Plan's right to make such a change in the Health Plan's privacy practices. The Health Plan may make any other changes to its Policies and Procedures at any time, provided that the changes are documented and implemented in accordance with the procedures set forth below.

Procedures.

1) Changes to Policies and Procedures Necessitated By Changes in Law. Whenever there is a change in law that necessitates a change to the Health Plan's policies or procedures, the Health Plan will promptly document and implement the revised policy or procedure. If the change in law materially affects the content of the Health Plan's Notice of Privacy Practices, the Health Plan will promptly make the appropriate revisions to the Health Plan's Notice of Privacy Practices.

2) Changes to Privacy Practices Stated in Notice of Privacy Practices. In order to implement a change in the Health Plan's Notice of Privacy Practices, the Health Plan will:

    a) Ensure that the policy or procedure, as revised to reflect a change in a privacy practice as stated in the Health Plan's Notice of Privacy Practices, complies with the HIPAA Regulations;

    b) Document the policy or procedure, as revised, by maintaining a written or electronic record of the revised policy or procedure and retaining such revised policy or procedure for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later;

    c) Revise the Health Plan's Notice of Privacy Practices to state the changed practice and make the revised Notice of Privacy Practices available as follows: The Health Plan will post any revised Notice of Privacy Practices on the Health Plan's web site and will also make it available on request to any person. Additionally, the Health Plan will provide the revised Notice of Privacy Practices within 60 days of any material revision, to Participants then covered by the Health Plan. If the Health Plan has revised more than one of the Health Plan's Notices of Privacy Practices, the Health Plan will provide the revised Notice of Privacy Practices that is relevant to the Participant or other Participant requesting the Notice; and

d) Not implement a change to a policy or procedure prior to the effective date of the revised Notice of Privacy Practices.

3) Changes to Other Policies or Procedures**.** The Health Plan may change, at any time, a policy or procedure that does not materially affect the content of the Health Plan's Notice of Privacy Practices, provided that:

a) The policy or procedure, as revised, complies with the HIPAA Regulations; and

b) Prior to the effective date of the change, the policy or procedure, as revised, is documented in written or electronic format and such documentation is retained for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

4) Amendment of Policies and Procedures. The required documentation of any change to the Health Plan's Policies and Procedures may be accomplished by either:

a) An amendment to the Health Plan's written Policies and Procedure document; or

b) The creation of such other written or electronic record as may be determined appropriate by the Privacy Official.

HIPAA Regulations/Citations
45 CFR § 164.530(i)

Record Retention

If the HIPAA Regulations require that a communication be in writing, the Health Plan must maintain such writing, or an electronic copy, as documentation. If the HIPAA Regulations require an action, activity, or designation to be documented, the Health Plan must maintain a written or electronic record of such action, activity, or designation in accordance with the Record Retention procedures.

Policies.

1) Record Retention. A Health Plan must retain the documentation required by the HIPAA Regulations(in written or electronic form) for a minimum of six (6) years from the date of its creation or the date it was last in effect, whichever is later.

2) Policies and Procedures. The Health Plan must maintain its Policies and Procedures in written or electronic form for a minimum of six (6) years from the date of their creation or the date they were last in effect, whichever is later.

Procedures.

1) Document Retention. The Health Plan shall identify the records and documents that are either required to be retained by the HIPAA Regulations or otherwise reasonably should be retained. These records and documents include:

   a) Records of the Privacy Official

   b) Records of the Contact Person or Contact Office

   c) All Notices of Privacy Practices issued, and the method of their distribution

   d) All Health Information policies and procedures adopted

   e) All Health Plan amendments that are required by HIPAA Regulations

   f) All Business Associate privacy agreements

   g) All complaints alleging Health Plan noncompliance with the HIPAA Regulations or the Health Plan's Policies and Procedures (including all correspondence related to the review and resolution of the complaint)

   h) All sanctions administered for violation of the HIPAA Regulations or the Health Plan's Policies and Procedures

   i) Training records

   j) Authorizations received for Disclosure, and copies of the documentation disclosed in response to the authorization

2) Record Retention Policies. The Plan Sponsor will review the existing record retention polices of the Health Plan and the Plan Sponsor to determine what documentation is currently required to be retained, the period of required retention, and the party responsible for retaining the records.

3) HIPAA Recordkeeping Systems. The Plan Sponsor will design and develop appropriate recordkeeping systems for each type of document or record that is to be retained. As part of the design process, the Health Plan may consider:

   a) Whether the particular category of document or record should be retained in paper or electronic format (or both);

   b) The period of retention (if longer than the six-year period established by the HIPAA Regulations);

   c) The person(s) or department(s) within the Plan Sponsor organization that should be responsible for retaining the documents and records; and

   d) The places/facilities (e.g., computers, file cabinets, etc.) where the documents and records should be stored.

- HIPAA Recordkeeping Systems – Implementation. To implement an appropriate recordkeeping system, the Health Plan may consider, among other things,

   a) Procuring (by reallocation of existing resources or purchase, if necessary) needed document and record storage facilities (e.g., computer, locking file cabinet, warehouse space, etc.);

   b) Identifying and communicating the name and address of the person or office to which the respective types of documents and records should be routed by those within the Plan Sponsor's organization who receive the respective types of documents and records in the course of their regular responsibilities;

   c) Developing a secure methodology for intra-company transfer of any documents and records containing Protected Health Information (e.g., sealed envelopes with special confidentiality seals, etc.), as well as to access to stored records; and

   d) Providing training to the person(s) who will be responsible for retaining the respective documents and records covered by the HIPAA Regulations.

4) Draft Written HIPAA Record Retention Policy. Draft and adopt a formal written policy that sets forth the key provisions of the document and record retention guidelines adopted by the Health Plan.

HIPAA Regulations/Citations
45 CFR § 164.530(j)