Important Notice Information

The following legal notices for participants in group health plans, sponsored by **[COMPANY NAME]** are required to be distributed on an annual basis. While no action is required on your part in relation to these notices, these are provided to you for informational purposes, and you should take time to familiarize yourself with their content.

- HIPAA Special Enrollment Rights Notice
- Women's Health and Cancer Rights Act of 1998
- Newborns' and Mothers' Health Protection Act
- Medicaid and The Children's Health Insurance Program (CHIP)
- Medicare Part D Eligible Employees and Dependents
- COBRA Initial Rights Notice
- Patient Protection Disclosures
- Notice of Privacy Practices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☐ Some employees. Eligible employees are:

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Glossary of Health Coverage and Medical Terms

This glossary defines many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Underlined text indicates a term defined in this Glossary.

See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real-life situation.

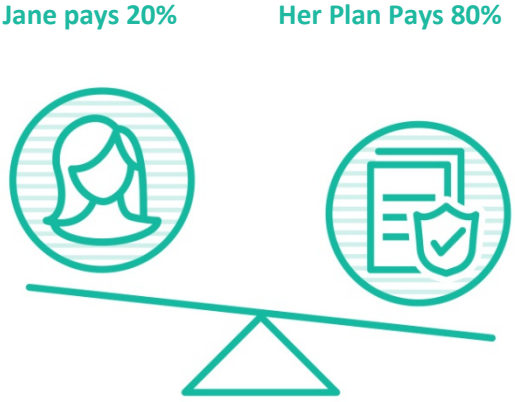
Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal
A request that your health insurer or plan review a decision that denies a benefit or payment either in whole or in part).

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.) See page 6 for detailed example.



Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section generally aren't complications of pregnancy.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

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Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn’t cover usually aren’t considered cost sharing.

Cost-sharing Reductions
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible
An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible.) See page 6 for a detailed example.

Jane pays 100% **Her plan pays 0%**

Diagnostic Test
Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition
An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn’t get medical attention right away. If you didn’t get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation
Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation or may pay less for certain types.

Emergency Room Care / Emergency Services
Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital’s emergency room or other place that provides care for emergency medical conditions.

Excluded Services
Health care services that your plan doesn’t pay for or cover.

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Formulary
A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care
Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

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Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace. Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

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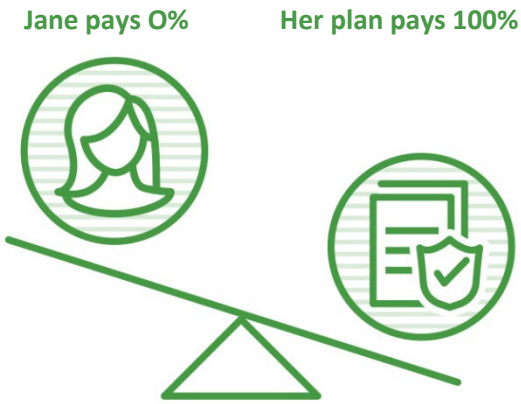
Out-of-pocket Limit
The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit. See page 6 for a detailed example.



Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates. Plan Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called health insurance plan, policy, health insurance policy or health insurance.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease or other health problems.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

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Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

HOW YOU AND YOUR INSURER SHARE COSTS

JANE'S PLAN EXAMPLE

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DEDUCTIBLE: $1,500 | **COINSURANCE:** 20% | **OUT-OF-POCKET LIMIT:** $5,000

Jane pays	Her plan pays	Jane pays	Her plan pays	Jane pays	Her plan pays
100%	**0%**	**20%**	**80%**	**0%**	**100%**

MAY 1 — **BEGIN** *coverage period*

APR 30 — **END** *coverage period*

DEDUCTIBLE

Jane hasn't reached her $1,500 deductible yet. Her plan doesn't pay any of the costs.

- Office visit costs: $125
- Jane pays: $125
- Her plan pays: $0

COINSURANCE

Jane reaches her $1,500 deductible, coinsurance begins. Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

- Office visit costs: $125
- Jane pays: 20% of $125 = $25
- Her plan pays: 80% of $125 = $100

OUT-OF-POCKET LIMIT

Jane reaches her $5,000 out-of-pocket limit. Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

- Office visit costs: $125
- Jane pays: $0
- Her plan pays: $125

HIPPA Special Enrollment Rights Notice

Our records show that you are either eligible to participate or are participating in **[COMPANY NAME]** health plan (the "Plan"). A federal law called the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we notify you about your right to enroll in the Plan under a "special enrollment provision" if you (i) acquire a new dependent, (ii) decline coverage under the Plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons or (iii) become eligible for premium assistance under the Plan under Medicaid or the Children's Health Insurance Program (CHIP). This notice is being provided to ensure that you understand your right to apply for group health insurance coverage at times other than during an open enrollment period. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage:
If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you decline enrollment for yourself or for an eligible dependent, you must provide a statement to your employer formally declining coverage, stating the reason for declining coverage and identifying the other coverage that is in place. This statement must be provided when the individual declining coverage is first eligible to enroll in the Plan. The statement is also required upon declining coverage at a later date when coverage is available to the individual, such as during an open enrollment period. Failure to provide this statement will result in the loss of special enrollment rights upon the loss of other coverage. Further, if you do not provide this statement, anyone you enroll during an annual open enrollment period at a later date will be treated as a late enrollee (unless the individual happens to be entitled to special enrollment during the annual open enrollment period).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this Plan. You must provide notification within 60 days (i) after your or your dependent's coverage ends under Medicaid or CHIP or (ii) after your or your dependent's determination of eligibility is terminated from, or determined to be eligible for such premium assistance, as applicable.

> **Example:** You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his/her employment. You must submit an enrollment form to Human Resources within 31 days of the date coverage ends under your spouse's plan for you and your eligible dependents to be eligible for coverage under our health plan.

Marriage, Birth, or Adoption: If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

> **Example:** When you were hired, you were single and chose not to elect health insurance benefits. If you later marry, you and your eligible dependents are entitled to enroll in this group health plan. However, you must submit an enrollment form to Human Resources within 31 days from the date of your marriage.

For More Information or Assistance, please contact: Elevanta Health at 866-696-3225.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under this plan. Please review your group health summary plan description for details of the Plan's deductible and co-payment requirements for mastectomies. If you would like more information on WHCRA benefits, please call the CBA Blue Customer Service at the number listed on your ID card.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicaid and Children's Health Insurance Program (Chip)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer- sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444- EBSA (3272).

Medicare Part D Eligible Employees and Dependents

Important Notice from [COMPANY NAME] About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **[COMPANY NAME]** and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll in a Medicare drug plan. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. **[COMPANY NAME]** has determined that the prescription drug coverage offered by **[COMPANY NAME]** medical plan (Excluding MEC Basic) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you decide to join a Medicare drug plan, your current coverage provided by your employer will not be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your **[COMPANY NAME]** medical plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with **[COMPANY NAME]** and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage ("creditable coverage"), your monthly premium will go up at
least 1% per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage, contact our office or call Human Resources.

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through **[COMPANY NAME]** changes. You may also request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare.

You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans, Visit www.medicare.gov, Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help, Call 1-800- MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you may call them at 1-800-772- 1213 (TTY 1- 800-325-0778) Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

COBRA Initial Rights Notice

General COBRA Information for New Plan Participants as required by the Department of Labor for:
[COMPANY NAME] Health Plan.

You are receiving this notice because you have recently become covered under **[COMPANY NAME]** Welfare Benefits Plan (the Plan). The Plan has THREE group health components, MEDICAL, DENTAL, AND VISION, and you may be enrolled in one or more of these components. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by **[COMPANY NAME].**

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's summary plan description or contact [COMPANY NAME], which is the Plan administrator. The Plan provides no greater COBRA rights than what COBRA requires - nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to **[COMPANY NAME].** COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Who Is Entitled to Elect COBRA?

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify **[COMPANY NAME]** of any of these qualifying events.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify **[COMPANY NAME]** in writing within 60 days after the later of:

(1) the date of the qualifying event; and
(2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" (you may obtain a copy of this form from **[COMPANY NAME]** at no charge and you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to **[COMPANY NAME]** during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan's Medical and Dental components can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical and Dental components generally can last for only up to a total of 18 months.

COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred-see the paragraph below entitled "Health FSA Component."

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Plan's summary plan description.

There are two ways (described in the following paragraphs) in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

(1) Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify **[COMPANY NAME]** in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify **[COMPANY NAME]** in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" (you may obtain a copy of this form from **[COMPANY NAME]** at no charge and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to **[COMPANY NAME]** during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

(2) Qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify **[COMPANY NAME]** in writing of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from **[COMPANY NAME]** at no charge and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to

[COMPANY NAME] during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Alternate recipients under QMCSOs
A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by **[COMPANY NAME]** during the covered employee's period of employment with **[COMPANY NAME]** is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

If You Have Questions

Questions concerning your plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep **[COMPANY NAME]** of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to.

Plan Contact Information

You may obtain information about the Plan and COBRA coverage on request from:

Shameka Porter	866-696-3225
Elevanta Health Benefits Manager	health@elevanta.com
1701 Barrett Lakes Blvd. Ste 180	elevantahealth.com/employers
Kennesaw, Ga 30144	elevantahealth.com/employees

This contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent summary plan description (if you do not have a copy, you may request one from Elevanta Health).

Notice Procedures Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices must be written and submitted on plan forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this notice, and you may obtain copies from **[COMPANY NAME]** without charge. Verbal notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

Patient Protection Disclosures

CBA BLUE generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please call the CBA BLUE Customer Service at the number listed on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from CBA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call the CBA Customer Service at the number listed on your ID card.

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Pease review it carefully.

This is the HIPAA Notice of Privacy Practices on behalf of **[COMPANY NAME]** ("Covered Entity" or "We"). This Notice describes how we protect health information that we have about you ("Protected Health Information" or "PHI"), and how we may use and disclose this information.

Protected Health Information is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care. This Notice also describes your rights with respect to the PHI and how you can exercise those rights.

We are required to provide this Notice to you by the federal laws known as the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH ACT"). We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact your HIPAA Privacy Officer identified on the last page of this Notice.

Our Responsibilities:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the medical records we maintain.

We are required by law to:

- make sure that medical information that identifies you is kept private and secure;
- give you this notice of our legal duties and privacy practices with respect to medical information about you;
- follow the terms of the notice that is currently in effect; and
- provide you notice promptly if a breach occurs that may have compromised the privacy or security of your information.

Your Rights:

When it comes to health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Right to Inspect and Copy
You have the right to inspect and receive an electronic or paper copy of your medical record and other health information we have about you. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer identified on the last page of this Notice. If you request a copy of the information, we may charge a fee for the costs of coping, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend
If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer listed on the last page of this Notice. In addition, you must provide a reason that supports your request.

We may deny your request, but we must tell you why in writing within sixty (60) days. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by us;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures" (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer listed on the last page of this Notice. Your request must state a time period, which may not be longer than six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. For example, we do not have to account for disclosure of your PHI (i) to carry out treatment, payment or healthcare operations, (ii) to correctional institution or law enforcement officials, or (iii) for national security or intelligence purposes. We will not include in your accounting any of the disclosures for which there is an exception under HIPAA.

Right to Request Confidential Communications

If you believe that a disclosure of all or part of your medical information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request confidential communications by calling or writing us at the location identified on the last page of this Notice. It is important that you direct your request for confidential communications to this representative so that we can begin to process your request. Requests sent to persons or offices other than the one identified may delay processing your request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us:

(1) that you want us to communicate your medical information with you in an alternative manner or at an alternative location; and
(2) that the disclosure of all or part of the medical information in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your medical information could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

To request restrictions, you must make your request in writing to the HIPAA Privacy Officer identified on the last page of this Notice. In your request, you must tell us

(1) what information you want to limit;
(2) whether you want to limit our use, disclosure or both; and
(3) to whom you want the limits to apply, for example, disclosures to your spouse.

Please note, we are not required to agree to this type of request.

Right to Restrict Disclosure of Services or Health Care Items
You have the right to restrict or limit the disclosure of medical information if you pay for a service or health care item out-of-pocket in full. You can ask us not to share that information for the purposes of payment or our operations. We will grant this request unless a law requires us to share the information.

Right to Be Notified of a Breach
You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

Right to Choose Someone to Act for You
You have the right to give someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your health information in the situations described below, please contact the Privacy Officer listed at the end of this Notice.

You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lesson a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of these categories.

For Treatment (as described in applicable regulations)
We may use medical information about you to facilitate medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in the delivery of your medical treatment or taking care of you.

For Payment (as described in applicable regulations)
We may use and disclose medical information about you to determine eligibility for benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility, or to coordinate coverage. For example, we may tell your health care provider about your medical history to determine whether a treatment is experimental, investigational, or medically necessary. We may also share medical information with a utilization review or precertification provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations (as described in applicable regulations)
We may use and disclose medical information about you for other health care operations. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting and soliciting bids from potential carriers, premium rating and setting employee contributions; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; health management services and business management and general administrative activities. We will not use your genetic information for underwriting purposes. Generally, genetic information involves information about differences in a person's DNA that could increase or decrease his or her chance of getting a disease (for example, diabetes, heart disease, cancer or Alzheimer's disease).

As Required by Law
We will disclose medical information about you when required to do so by Federal, State or local law.

To Avert a Serious Threat to Health or Safety
We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.

Other Possible Uses and Disclosures of Medical Information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your medical information.

Business Associates
We may contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose medical information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your medical information to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management.

Public Health Activities
We may use or disclose your medical information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose medical information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities
We may disclose your medical information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect
We may disclose your medical information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

Legal Proceedings
We may disclose your medical information:

(1) in the course of any judicial or administrative proceedings;
(2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and
(3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule.

For example, we may disclose your medical information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

Law Enforcement
Under certain conditions, we also may disclose your medical information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not limited to:

(1) it is required by law or some other legal process;
(2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and
(3) it is necessary to provide evidence of a crime that occurred on our premises.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation
We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Military Activity and National Security, Protective Services
Under certain conditions, we may disclose your medical information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your medical information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

Inmates
If you are an inmate of a correctional institution, we may disclose your medical information to the correctional institution or to a law enforcement official for:

(1) the institution to provide health care to you;
(2) your health and safety and the health and safety of others;
(3) the safety and security of the correctional institution.

Workers' Compensation
We may disclose your medical information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Research
We may disclose your medical information to researchers when their research has been approved by an institutional review board or privacy board that has established protocols to ensure the privacy of your Protected Health Information.

Your Personal Representatives
We may disclose your medical information to your personal representative in accordance with applicable state law (e.g., to parents of unemancipated children under 18, to those with unlimited powers of attorney, or health care proxies etc.).

Under HIPAA, we do not have to disclose information to a personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (ii) treating such person as your personal representative could endanger you; and (iii) in the exercise of personal judgment, it is not in your best interest to treat the person as your personal representative.

Individuals Involved in Your Care or Payment for Your Care
We may disclose your medical information to a family member involved in or who helps pay for your health care, but only to the extent relevant to that family member's involvement in your care or payment for your care and such disclosures will not be made if you request in writing that we do not make these types of disclosures and we have agreed to such request.

Other Required Disclosures of Your Medical Information

The following is a description of disclosures that we are required to make by law:

Other Uses and Disclosures of Your Medical Information
Other uses and disclosures of your medical information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosure of medical information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Potential Impact of State Law
The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) State privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent State law applies, the privacy laws of a state, or other Federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent State privacy laws that relate to uses and disclosures of medical information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Changes to This Notice:
We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If the Notice is changed, we will distribute it to you prior to the effective date of the revised Notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact our HIPAA Privacy Officer listed below. All complaints must be submitted in writing.

You can file a complaint with the Secretary of the United States Department of Health and Human Services Office of Civil Rights at:

200 Independence Ave., S.W.
Washington, D.C. 20201,
or calling 1-877-696-6775, or
visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

You will not be penalized, or any other way retaliated against for filing a complaint with the Secretary or with us.

Who to Contact with Questions or Concerns:

Shameka Porter, Benefits Manager, Elevanta Health
Office Phone: 678-797-5160
Office Fax: 678-797-5170
Email: health@elevanta.com

Mailing Address:
1701 Barrett Lakes Blvd., Ste.180
Kennesaw, GA 30144