

Bethany College

SUBJECT: HIPAA Compliance

POLICY NUMBER: 001

EFFECTIVE DATE: April 14, 2004

POLICY: Mountain State Blue Cross/Blue Shield (the "Plan") recognizes the importance of protecting and securing Participant Health Information. The Plan is committed to complying with all applicable Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Title II Administrative Simplification regulations, which cover Electronic Data Interchange, Privacy and Security. In pursuit of this goal, the Plan adopts this policy as a statement of its commitment to achieving compliance with the privacy and security requirements of HIPAA. The provisions of this policy apply to all entities associated with the Plan when performing functions that are regulated by HIPAA either directly as Covered Entities, or indirectly as Business Associates, and all members of the Plan's Workforce.

The specific form of the Plan's HIPAA compliance efforts will necessarily change from time to time as HIPAA regulations continue to be developed and finalized and as new methods of achieving compliance become available. However, the Plan's HIPAA compliance efforts will include the following essential elements:

1. Acknowledgement of HIPAA Covered Entity Status - The Privacy Regulations apply to the identified health care components of the Plan and persons providing services to the Plan as a group health plan. If the Plan contains components that are not subject to HIPAA's privacy rules, the Plan shall be a Hybrid Entity as defined in HIPAA Section 164.504(a), and, as such, the Plan's HIPAA compliance obligations shall apply only to those health care components identified in the Plan.
2. General Rule - The Plan will not Use or Disclose Protected Health Information except as permitted or required by the Plan's Policies and Procedures and the Privacy Regulations.
3. Compliance Date -The Plan will be in compliance with the Privacy Regulations by April 14, 2004.
4. Administrative Requirements -
 - (a) Privacy Officer - The Plan will appoint, and document the choice of, a Privacy Officer and a contact person or a contact office for purposes of implementing and overseeing compliance with the Plan's HIPAA Policies and Procedures and the requirements of the Privacy Regulations.
 - (b) Grievance/Complaint Procedure - The Plan will maintain a process for Individuals to make complaints concerning the Plan's Notice of Privacy Practices or HIPAA Policies and Procedures and/or violations thereof. The Plan may appoint a Complaint Officer to oversee the process. The Plan will document all such complaints and their disposition.
 - (c) Employee Sanctions - The Plan will maintain and apply sanctions against persons performing services for the Plan who violate the Plan's HIPAA Privacy Policies and Procedures or the requirements of the Privacy Regulations.

(d) Training/Education Program - The Plan will, in accordance with the requirements set forth in the Privacy Regulations, train persons performing services for the Plan. On-going training, beyond April 14, 2004, will be conducted. Initial training will be completed by April 14, 2004. The Plan will implement self-audit procedures through which it will monitor compliance with the Plan's HIPAA Policies and Procedures.

(e) Safeguards - The Plan will implement reasonable safeguards, including data security policies and procedures and, as needed, administrative, technical and physical safeguards, to ensure the integrity and confidentiality of Protected Health Information within the possession or control of the Plan.

(f) Documentation - The Plan will be amended, in writing, to incorporate all required rules regarding HIPAA compliance. The Plan will maintain in written or electronic form all documentation required by the Privacy Regulations for 6 years from the date of creation or when the document was last in effect, whichever is longer.

(g) Enforcement; Complaint - The Plan is subject to enforcement action by the HHS Secretary. An Individual that believes the Plan has or is violating the Privacy Regulations may file a complaint with the HHS. The HHS may conduct compliance reviews of the Plan's operations and HIPAA compliance policies and procedures. The Plan will maintain records in such order as to produce privacy compliance reports to the HHS upon request. The Plan will cooperate in good faith with and will provide access during normal business hours to HHS to the Plan's books, records, accounts and other information, including Protected Health Information, without Participant Authorization.

5. Notice of Privacy Practices; Acknowledgment of Receipt of Notice - The Plan has prepared a "Notice of Privacy Practices" according to the specific content requirements of the Privacy Regulations and the Plan's operations. The Plan will not Use or Disclose Protected Health Information in a manner inconsistent with its Notice.

Prior to April 14, 2004, the Plan will provide the Notice to its Participants and thereafter prior to or upon enrollment of new Participants and within 60 days of a material revision to the Notice to all Participants then covered by the Plan. No less frequently than every 3 years, the Plan must notify Individuals then covered by the Plan of the availability of the Notice and how to obtain copies of the Notice. If the Plan maintains a website about its customer service or benefits, the Plan will post the Notice on the website and make it electronically available through the website. Although not required by law, the Plan may make a good faith effort to obtain each Participants' written Acknowledgement of receipt of the Plan's Notice. Refusal by a Participant to sign the Acknowledgement will not prevent the Plan from enrolling or providing the Individual with services, but the Plan may document failed attempts to obtain this

6. Permitted Uses and Disclosures - Unless otherwise permitted or required by the Plans HIPAA Policies and Procedures or the Privacy Regulations, the Plan will not Use Protected Health Information obtained from any source or Disclose Protected Health Information maintained by or in the possession or control of the Plan, unless the affected Individual has provided his or her prior written

Authorization approving such Use or Disclosure either directly to the Plan or through a Healthcare Provider or other Covered Entity. The Plan's implementing procedures and Authorization forms will comply with the specific content requirements set forth by the Privacy Regulations. The Plan will permit an Individual to request in the Authorization that restrictions be placed on the Plan's Use and Disclosure of that Individual's Protected Health Information. The Plan will seriously consider each such requested restriction, however, the Plan is not required to accept an Individual's requested restriction. If the Plan does accept an Individual's requested restriction, the Plan is bound to abide by those restrictions. The Plan generally may not condition enrollment or eligibility on the Participant's provision of an Authorization. However, the Plan may condition enrollment in the Plan or eligibility for benefits prior to enrollment if the Authorization sought is for the Plan's own eligibility or enrollment determinations or underwriting or risk rating determinations and is not for Psychotherapy Notes. An Individual may revoke an Authorization at any time by providing written notice of revocation to the Plan. The Plan will not rely on an Authorization that it knows has been revoked. The Plan will not market to Individuals, other than gifts of nominal value, without the Individual's Authorization for such Marketing.

(a) Treatment, Payment, Healthcare Operations - Generally, the Plan will be able to Use or Disclose Protected Health Information for its own purposes of Payment or Healthcare Operations, as defined by HIPAA, without first obtaining the Individual's Authorization or otherwise meeting an exception under the Regulations. Further, the Plan may Disclose Protected Health Information to a provider for that provider's Treatment purposes, or for another Covered Entity's or provider's Payment purposes, without an Authorization. Also, under certain circumstances, the Plan may Disclose Protected Health Information for limited Healthcare Operations of another Covered Entity that also has or has had a relationship with the Individual to whom the information pertains. The Plan will, to the extent possible, request documentation of such recipient's relationship with the Individual prior to disclosing any Protected Health Information to him or her.

(b) De-Identified PHI - Under the Privacy Regulations, de-identified health information is not individually identifiable and, therefore, is not Protected Health Information. The Plan may use and disclose de-identified health information without complying with the requirements of the Regulations, including the requirement to obtain an Individual's prior written Authorization. The Plan may utilize either of the two permitted methods of de-identification under the Privacy Regulations, "statistical de-identification" and/or through the removal of the 18 identifiers enumerated in the Privacy Regulations. The Plan may assign a code to the de-identified health information to permit it to re-identify the data; however, the key to the re-identification code may not be disclosed and the recipient may not be able, through methods of derivation in connection with known information about the Individual or contained in the disclosed information, to determine the identity of the Individual or the key to re-identify the data.

(c) Limited Data Set De-Identification - The Plan may Use or Disclose Protected Health Information, without completely de-identifying the information or obtaining an Individual's prior written Authorization, but only if for public health purposes or certain Healthcare Operations. If the Plan engages in any of these two activities, the Plan will remove all of the direct identifiers of the Individual and/or the Individual's family, employers or household members prior to disclosing the information (unless to an agent or Business Associate).

who will remove the identifiers on the Plan's behalf). The Plan may disclose certain limited data sets regarding the Individual when the information is disclosed, including, without limitation, admission, service and discharge dates, dates of birth and death (day, month and year), five-digit zip code and others. Before disclosing any information containing limited data sets, the Plan will first enter into a Data Use Agreement with such recipient. The Plan's Data Use Agreements will comply with the requirements of the Privacy Regulations and will contain assurances of protection of the information, an agreement not to re-disclose, an agreement not to identify or contact the Individual who is the subject of the disclosed information, set forth permitted Uses and Disclosures, list any permitted recipients and include an obligation to notify the Plan of any improper Uses or Disclosures known to the recipient.

(d) Without an Authorization, but with the Individual's Opportunity to Agree or Object - The Plan may Use or Disclose Protected Health Information without obtaining the Individual's prior written Authorization with respect to Disclosures to the Individual's family personal representative or friends; in connection with disaster relief efforts, in emergency circumstances; or when in the best interests of the Individual when the Individual is not present or is incapable of responding. The Plan will inform the Individual in advance in its Notice of Privacy Practices of the possibility of such Uses or Disclosures, and the Individual will be given the opportunity to agree to or prevent or restrict the Use or Disclosure. As an alternative to including this in the Notice, the Plan may notify the Individual, either in writing or verbally, of and prior to each of these Uses and Disclosures in order to afford the Individual the opportunity to agree or object at that time.

(e) Without an Authorization and with No Opportunity to Agree or Object - The Plan may Use or Disclose Protected Health Information without obtaining an Individual's prior written Authorization with respect to the following circumstances: (1) emergency treatment; (2) as required by state or federal law; (3) in judicial or administrative proceedings; (4) for law enforcement purposes; (5) public health activities; (6) health oversight activities and (7) Workers' compensation or work-related illness or injury.

(f) Incidental Uses and Disclosures - The Plan recognizes that this is not a direct exception to the Authorization requirement under the Privacy Regulations, but that Uses and Disclosures of Protected Health Information that are made pursuant to otherwise permitted or required Uses or Disclosures will not be considered violations of the Privacy Regulations. The Plan will make reasonable efforts to prevent incidental Uses and Disclosures of Protected Health Information.

(g) Transition - Under certain circumstances, the Plan may continue to use or Disclose Protected Health Information pursuant to consent, Authorization, or other form of express legal permission obtained from an Individual before April 14, 2004, even though it does not comply with the content requirements of the Privacy Regulations for an Authorization.

(h) Minimum necessary - The Plan will comply with the Minimum Necessary standard as described in the Privacy Regulations with respect to any Use or Disclosure of or request for Protected Health Information, as required by the Privacy Regulations. All Uses or Disclosures of, or requests for, Protected Health Information will be limited to the minimum amount necessary to accomplish the stated purpose or will be in conformity with such other restrictions as the Plan may have agreed to with certain Individuals. The Plan must develop

criteria designed to limit its requests for Protected Health Information to the information reasonably necessary to accomplish the purposes for which the request was made. An entire medical record may not be Used, Disclosed or requested except where specifically justified as the amount that is reasonably necessary to accomplish the stated purpose. However, the Plan may Use and Disclose Protected Health Information for Payment, Healthcare Operations, pursuant to an Authorization or as required by law without complying with this requirement. The Plan will make reasonable efforts to limit access to Protected Health Information by its Workforce and otherwise within its operations to authorized personnel only.

(i) Business Associate Agreements - The Plan will execute Business Associate agreements, or amend existing agreements to include Business Associate language, with any persons or entities performing functions on behalf of the Plan to the extent such persons or entities receive Protected Health Information from or create or receive Protected Health Information on behalf of the Plan in connection with performing those functions. The Plan will execute these agreements or amend existing agreements in accordance with the compliance date set forth in Section 3 above. The Plan acknowledges that the existence of a Business Associate agreement will NOT permit the Plan to disclose Protected Health Information freely to a Business Associate where an Authorization would otherwise be required and will not relieve the Plan from its obligations under the Privacy Regulations to only Use or Disclose Protected Health Information as permitted or required by the Privacy Regulations.

7. Patient Rights - Designated Record Set/Access/Amendment/Accounting/Copies

(a) Designated Record Set/Access - The Plan will maintain for each Individual a "Designated Record Set" that will be subject to Access by the Individual to whom the information pertains. An Individual's right of Access to his or her Designated Record Set may be denied by the Plan, without the right to contest the denial, with respect to Psychotherapy Notes, information compiled for civil, criminal or administrative actions, information subject to the Federal Privacy Act 5 USC §552(a) and information obtained by the Plan from another entity under a promise of confidentiality if Access would be likely to reveal the source of the information. An Individual's Access to his or her Designated Record Set may be denied by the Plan, with a right of the Individual to contest the denial, when the Plan determines in its discretion that Access by the Individual or the Individual's representative is reasonably likely to endanger the life or physical safety of the Individual or another person identified in the Protected Health Information.

(b) Amendment of Protected Health information -An Individual has the right to have the Plan amend Protected Health Information or a record about the Individual contained in a Designated Record Set for as long as the information is maintained in the Designated Record Set. However, the Plan may deny an Individual's request to amend his or her records if the information was not created by the Plan, it is not part of the Individual's Designated Record Set, would not otherwise be accessible to the Individual or the information is accurate and complete.

The Plan may require that requests for amendment be made in writing and provide a reason to support the requested amendment. The Plan must act on such a request within 60 days after receipt of the request. This time limit may be increased once by no more than 30 days if the Plan provides the Individual with a

written statement of the reasons for the delay and the date by which the Plan will complete the action requested. If the Plan grants the request it must: (1) make the amendment, at a minimum appending the requested amendment to the proper location in the records, (2) inform the Individual that the amendment was accepted. (3) obtain the Individual's identification of and agreement to have the Plan notify relevant persons with which the amendment needs to be shared and (4) make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by the Individual as having received the information prior to its amendment, and persons that the Plan knows have the Protected Health Information that is the subject of the amendment and that may have relied, or could foreseeably rely on it to the detriment of the Individual.

If the Plan, for the reasons stated above, refuses to make the amendment it must: (1) provide the Individual with a written denial within 60 days, as specified above, stating (i) the basis for the denial, (ii) the Individual's right to submit a written statement disagreeing with the denial and how to file this statement, (iii) that if the Individual does not submit a statement of disagreement, that the Individual may request that the Plan attach the Individual's request for amendment and the denial with any future Disclosures of the Protected Health Information that is the subject of the amendment and (iv) how the Individual may complain to the Plan pursuant to the Plan's complaint procedures, including the name or title and telephone number of the Plan's HIPAA contact person or office, or how to complain to the Secretary of HHS, (2) provide the Individual with the ability to submit a written statement of disagreement with the denial and the basis of such disagreement, (the Plan may prepare a written rebuttal to the Individual's statement of disagreement and provide a copy to the Individual) and (3) identify the record or Protected Health Information in the Designated Record Set and append or otherwise link the Individual's request for an amendment, the Plan's denial, the Individual's statement of disagreement and the Plan's rebuttal, to the Designated Record Set. If a statement of disagreement has been submitted by the Individual, the Plan must include items appended to the record with any subsequent Disclosure. However, if the Individual has not submitted a written statement of disagreement, only at the request of the Individual is the Plan required to include the Individual's request for amendment and the Plan's denial, or an accurate summary thereof, with any subsequent Disclosure of the Protected Health Information.

If the Plan is informed by another Covered Entity that an amendment to Protected Health Information has been made, the Plan must make or append the amendment to the records in its possession or control. The Plan must document and retain that documentation of persons or officers in the organization responsible for receiving and processing requests for amendments.

(c) Accounting of Disclosures - The Plan must provide an accounting to an Individual of certain Disclosures of Protected Health Information made during periods up to 6 years prior to the date of the Individual's request. The Plan will maintain policies and procedures for when and how Individual requests for accountings of Disclosures of Protected Health Information will be processed and made. The Plan is not required to account for Disclosures made: to the Individual to whom the information pertains, for purposes of Treatment, Payment, Healthcare Operations, incident to an otherwise permitted Use or Disclosure, pursuant to an Authorization, as otherwise required by law or the Privacy Regulations as part of a limited data set or with respect to Uses or Disclosures that occurred prior to the compliance date.

An accounting must include Disclosures of Protected Health Information made by Business Associates of the Plan, and for each Disclosure must include: the date of the Disclosure, the name of the entity or person who received the Protected Health Information and, if known, the person's address, a brief description of the Protected Health Information disclosed and a brief statement of the purpose of the Disclosure. If multiple Disclosures are made to the same entity or person for a single purpose then the accounting may include: the information provided above for the first Disclosure during the accounting period, the frequency, or number of the Disclosures made during the accounting period and the date of the last such Disclosure during the accounting period. The Plan must provide the Individual with the accounting requested no later than 60 days after receipt of the request, or, if unable to do so, the Plan may extend the time to provide the accounting once by no more than 30 days, provided that the Plan notifies the Individual in writing of the reasons for the delay and the date by which the Plan will provide the accounting. The first accounting in any 12-month period must be provided to the Individual free of charge. The Plan may charge reasonable cost-based fees for any subsequent accountings in the same 12-month period. The Plan must document information required to be included in an accounting, the written accounting provided to the Individual and titles of persons or officers responsible for receiving and processing requests for accounting and retain such documentation for the period of time described in Section 4 above.

8. State law - The Plan will comply with state privacy or other laws impacting the Use or Disclosure of a Participant's health information to the extent applicable and not otherwise preempted by ERISA and/or HIPAA. Under state law, the Plan may be required to obtain a Participant's written consent, in addition to any Authorization required under HIPAA, prior to Use or Disclosure of the Participant's health information for certain purposes.

9. Amendment - These Policies and Procedures may be updated and amended as necessary only by the Privacy Officer.

10. Implementing Policies and Defined Terms - The Plan may adopt corresponding policies and procedures to implement the aforementioned required elements of the Plan's HIPAA compliance efforts. Such additional policies shall utilize the defined terms contained in this policy and attached hereto as Appendix A.

Adopted effective April 14, 2004.

Appendix A

The following are definitions of key terms used in this policy and the corresponding implementing procedures. Any terms used in this policy or the corresponding implementing procedures, but not otherwise defined herein, shall have the meanings given them in the standards for Privacy of Individually Identifiable Health Information, Final Rule, Federal Register, Vol. 67, No. 157, August 14, 2002, 45 C.F.R. Parts 160 and 164.

1.1 **Access** means an Individual's right to inspect and obtain a copy of his or her own PHI contained in a Designated Record Set maintained by the Plan.

1.2 **Acknowledgment** means the written documentation of an Individual's receipt of the Plan's Notice of Privacy Practices.

1.3 **Authorization** means the written permission from an Individual that permits the Plan to use or Disclose PHI for purposes beyond the scope of Treatment, Payment or Healthcare Operations.

1.4 **Business Associate** means a person or entity who is not a member of the Plan's Workforce and who, on behalf of the Plan:

(a) Performs or assists in the performance of a function or activity involving the Use or Disclosure of PHI, including, but not limited to, claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management and repricing; or any other function or activity regulated by HIPAA; or

(b) Provides legal, actuarial, accounting, consulting, data aggregation (as defined under HIPAA), management, administrative, accreditation or financial services to or for the Plan, where the provision of the service involves the disclosure of Individually Identifiable Health Information from the Plan, or from another Business Associate of the Plan, to the person.

1.5 **Business Associate Contract** means the contract between the Plan and its Business Associates that allows the Business Associate to create or receive PHI on behalf of the Plan. The term "Business Associate Contract" includes both stand-alone agreements and amendments to existing service agreements, as well as Business Associate Contract language that is part of a new service agreement. A Business Associate Contract is not required for Disclosures by the Plan to a Healthcare Provider regarding an Individual's Treatment.

1.6 **Complainant** means an Individual who reports a privacy-related complaint to the Plan.

1.7 **Complaint Officer** means the person or official designated by the Plan to receive and process privacy-related complaints.

1.8 **Confidential Communication** means a communication regarding PHI between an

individual and the Plan that is sent through alternative means or to an alternative location from the regular method of communication.

1.9 **Covered Entity** means:

- (a) A health plan.
- (b) A healthcare clearinghouse.

(c) A healthcare provider who transmits any health information in electronic form in connection with a transaction covered by the HIPAA privacy rules.

1.10 **Data Use Agreement** means a required agreement between the Plan and a Limited Data Set ("LDS") recipient setting forth the requirements and limitations for the Use or Disclosure of the PHI in the LDS that the recipient must follow, and the consequences for not following them.

1.11 **De-identify or De-identification** means that a data set containing PHI has been determined to be De-identified by a statistical expert or that it has been modified by removing 18 specific PHI identifiers. In either case, there is no reasonable basis to believe that the information in the data set can be used to identify an Individual.

1.12 **Designated Record Set** means a group of records maintained by or for the Plan that is: (i) the medical records and billing records about Individuals maintained by or for a covered Healthcare 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 Plan to make decisions about Individuals.

1.13 **Disclose or Disclosure** means, with respect to PHI, the release, transfer, provision of Access to, or divulging in any other manner, PHI outside of the Plan's internal operations or its Workforce Members.

1.14 **Group Health Plan** (also see definition of Health Plan) means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 ("ERISA"), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act ("PHS Act"), 42 U.S.C. 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents, directly or through insurance, reimbursement or otherwise, that (1) has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or (2) is administered by an entity other than the employer that established and maintains the plan.

1.15 **HHS** means the Department of Health and Human Services.

1.16 **Healthcare Provider** means a provider of services (as defined in section 1861(u) of the Social Security Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Social Security Act, 42 U.S.C. 1395x(s)) and any other person or organization who furnishes, bills or is paid for Healthcare in the normal course of business.

1.17 **Health Information** means any information, whether verbal or recorded in any form or medium, that (1) is created or received by a Healthcare Provider, Health Plan, public health authority, employer, life insurer, school or university or Healthcare Clearing House; and (2) relates to the past, present or future physical or mental health or condition of an individual; the provision of

healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual.

1.18 **Health Insurance Issuer** (as defined in section 2791(b) (2) of the PHS Act, 42 U.S.C. 300gg-91(b) (2) and used in the definition of Health Plan) means an insurance company, insurance service or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a Group Health Plan.

1.19 **Healthcare Operations** means any of the following activities of the Covered Entity to the extent that the activities are related to covered functions:

(a) Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, contacting of Healthcare Providers and patients with information about treatment alternatives; and related functions that do not include treatment:

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

(c) 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 healthcare (including stop-loss insurance and excess of loss insurance), provided that the requirements of HIPAA Section 164.514 are met, if applicable:

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

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

(f) 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 HIPAA;

(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) The 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 HIPAA, creating deidentified health information or a limited data set, and fund raising for the benefit of the covered entity.

1.20 **Health Plan** means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

- (a) Health Plan includes, but is not limited to, the following, singly or in combination, a Group Health Plan, as defined above, a Health Insurance Issuer, as defined above, and an HMO.
- (b) Health Plan excludes any policy, plan or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and a government-funded program (other than one listed in HIPAA), whose principal purpose is other than providing, or paying the cost of healthcare; or whose principal activity is the direct provision of healthcare to persons or the making of grants to fund the direct provision of healthcare to persons.

1.21 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, and the regulations issued thereunder, including but not limited to 45 C.F.R. Parts 160 and 164.

1.22 **Hybrid Entity** means a single legal entity that is a Covered Entity whose business activities includes both covered and non-covered functions and that designates identified healthcare components. For purposes of compliance with HIPAA, the Plan may be a Hybrid Entity consisting of the following identified healthcare components: the medical, dental, vision, prescription drug, mental health, healthcare reimbursement account and employee assistance programs and the Plan's Workforce responsible for performing Plan administrative functions for the identified healthcare components of the Plan.

1.23 **Individual** means the person who is the subject of Protected Health Information and who is also a Participant or former Participant in the Plan or a covered spouse, dependent or beneficiary under the Plan.

1.24 **Individually Identifiable Health Information** is information that is a subset of Health Information, including demographic information collected from an individual. and:

- (a) Is created or received by a Healthcare Provider, Health Plan, employer or Healthcare Clearinghouse; and

- (b) Relates to the past, present or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual: and
- (i) That identifies the individual: or
 - (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

1.25 **Limited Data Set or ("LDS")** means a data set for Use and Disclosure of PHI for the purposes of public health or Healthcare Operations that is not completely De-identified. The data set excludes 16 specified identifiers in accordance with applicable law but includes complete dates, city or town, and five digit zip codes. The Plan must enter into a Data Use Agreement with the recipient of the LDS.

1.26 **Marketing** means a communication about a product or service, a purpose of which is to encourage recipients of the communication to purchase or use the product or service. Marketing does not include communications made by the Plan to describe a health related product or service or Payment for a product or service that is provided or included in the Plan's benefits: for Treatment: or for case management or care coordination. If there is an arrangement between a Covered Entity and such other entity whereby the Covered Entity Discloses PHI to the other entity, in exchange for direct or indirect remuneration by an entity or its affiliate, Marketing also means to make a communication about an entity's own product or service that encourages recipients of the communication to purchase or use that product or service.

1.27 **Minimum Necessary** means the least amount of PHI needed to accomplish the intended purpose of a Use, Disclosure or request.

1.28 **Notice of Privacy Practices or Notice** means the Notice of Privacy Practices which describes the Plan's Uses and Disclosures of PHI.

1.29 **Participant** means the employee or former employee who is eligible to be and is covered under the Plan by reason of his or her employment relationship.

1.30 **Payment** means:

- (a) 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; or
 - (ii) A Healthcare Provider or Health Plan to obtain or provide reimbursement for the provision of healthcare: and
- (b) The activities in paragraph (a) of this definition relate to the Individual to whom healthcare is provided and include, but are not limited to:
 - (i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

- (ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- (iii) Billing, claims management, collection activities, obtaining Payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related healthcare data processing;
- (iv) Review of healthcare services with respect to medical necessity. Coverage under a Health Plan, appropriateness of care or justification of charges;
- (v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
- (vi) Disclosure to consumer reporting agencies of any of the following Protected Health Information relating to collection of premiums or reimbursement:
 - (A) Name and address,
 - (B) Date of birth,
 - (C) Social security number,
 - (D) Payment history,
 - (E) Account number, and
 - (F) Name and address of the Healthcare Provider and/or Health Plan.

1.31 **Plan** means the components of the _____ [Plan name] that are subject to HIPAA. Whenever reference is made to the Plan's action, the activities of the Plan Sponsor on the behalf of the Plan shall be treated as the action of the Plan.

1.32 **Plan Sponsor** has the meaning as defined in section 3(16) (B) of ERISA, 29 U.S.C. 1002(16) (B) and means _____ [Employer] and employees and agents of the Plan Sponsor who are responsible for Plan administration functions.

1.33 **Privacy Officer** means the person or officer designated by the Plan to oversee compliance with these policies and procedures and with HIPAA generally.

1.34 **Promotional Communication** means communications excluded from the definition of Marketing because they are made for the purpose of: (a) describing the entities participating in a Healthcare Provider network or a Health Plan network; or (b) describing (i) health related products or services provided by a Healthcare Provider, or (ii) included in Health Plan benefits and (c) are communications that are tailored to the circumstances of the Individual and are: (i) made by a Healthcare Provider as part of Treatment, case management and care coordination of the Individual for the purpose of furthering the Individual's Treatment, or (ii) made by a Healthcare Provider or Health Plan to an Individual in the course of managing the Individual's Treatment or (iii) made to recommend alternative treatments, therapies, Healthcare Providers or care settings.

1.35 **Protected Health Information ("PHI")** means Individually Identifiable Health Information that is transmitted by electronic media or is transmitted or maintained in any other form or medium.

1.36 **Psychotherapy Notes** means notes recorded (in any medium) by a Healthcare Provider who is a mental health professional, documenting or analyzing the contents of conversations with Individuals 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. The definition of 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, Treatment plan, symptoms, prognosis and progress to date.

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

1.38 **Use or Uses** means, with respect to PHI, the sharing, employment, application, utilization, examination or analysis of such information within the Plan's internal operations or to a member of the Plan's Workforce.

1.39 **Workforce or Workforce Member** means employees and other persons whose conduct, in the performance of work for the Plan, is under the direct control of the Plan or Plan Sponsor on behalf of the Plan, whether or not they are paid by the Plan or Plan Sponsor.