



**The College of St. Scholastica
Benefits Legal Notices
2009**

FAMILY AND MEDICAL LEAVE ACT

If an employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, your employer will continue insurance coverage under the Plans in accordance with the employer's Human Resource policy on family and medical leaves of absence, as if the employee was actively at work if the following conditions are met:

- Contribution is paid; and
- The employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the employee becomes actively at work:

- No new Waiting Period will apply; and
- Pre-Existing Conditions Exclusion shall not apply.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A dependent child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator if you would like a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

COBRA CONTINUATION OF COVERAGE

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). This summary does not satisfy all notice requirements of federal law. Your employer or the COBRA Administrator will provide additional information to you as required.

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost of the coverage, plus an administrative fee must be paid by the continuing person.

A qualified beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a qualifying event. Generally, you, your covered spouse, and dependent children can elect continuation coverage even if the person is already covered under another employer-sponsored group health Plan or is entitled to Medicare at the time of this COBRA election.

Qualified beneficiary means a person covered by this group health Plan immediately before the qualifying event who is:

- The covered employee; or
- The spouse of a covered employee; or
- The dependent child of a covered employee. This includes a child who is born to or placed for adoption with a covered employee during the employee's COBRA coverage period, if the child is enrolled within the Plan's special enrollment period for newborns and adopted children. This also includes a child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the qualifying event.

Qualifying event means Loss of Coverage due to one of the following:

- The death of the covered employee.
- Voluntary or involuntary termination of the covered employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered employee.
- Divorce or legal separation of the covered employee from the employee's spouse. (Also, if an employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 days after the later divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- Covered employee becomes enrolled in Medicare.
- A dependent child no longer being a dependent as defined by the Plan.
- Employer bankruptcy (only relates to retiree Plan s).

Loss of coverage means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the qualifying event. Loss of coverage does not always occur immediately after the qualifying event, but it must always occur within the applicable 18 or 36-month coverage period.

Payment of Claims: No claims will be paid under this Plan for services that you receive on or after the date you lose coverage due to a qualifying event. If, however, you decide to elect COBRA, your coverage will be reinstated back to the date you lost coverage, provided that you properly elect COBRA on a timely basis and pay the required premium when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives your COBRA election material and required payment.

COBRA ELECTION PROCESS:

NOTICE REQUIREMENTS

When health coverage ends due to divorce, or a dependent child ceasing to be a dependent under the terms of the group health Plan, the covered employee or qualified beneficiary must notify the Plan Administrator within 60 days after the qualifying event occurs, or by the date that coverage under the Plan would be lost, whichever is later. The group health Plan is not required to offer the qualified beneficiary an opportunity to elect COBRA continuation coverage if the qualified beneficiary fails to provide this notice to the Plan Administrator within the allowable time periods as stated above.

The employer must notify the Plan Administrator within 30 days when coverage terminates due to the employee's termination or reduction in hours, death of the employee, employee being entitled and enrolled in Medicare, or employer bankruptcy (for retiree Plan's). The Plan Administrator must provide an election notice to the qualified beneficiary within 14 days of receiving notice of the qualifying event.

APPLYING FOR CONTINUATION COVERAGE UNDER COBRA

A qualified beneficiary may elect COBRA coverage at any time within a 60-day election period. The election period ends 60 days after the later of:

- The date your Plan coverage terminates due to a qualifying event; or
- The date the Plan Administrator provides the qualified beneficiary with an election notice.

A qualified beneficiary must actively elect to continue coverage and must make the required payments when due in order to remain covered. If you do not choose continuation coverage within the allowable timeframe as described above, your group health coverage will remain terminated. Each qualified beneficiary has the independent right to elect continuation coverage.

SPECIAL NOTICE (Read this if you are thinking of declining COBRA continuation coverage):

If you think you might need to get an **individual** health insurance policy soon, then electing COBRA now may protect some of your rights. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing pre-existing condition exclusions, under certain conditions. Some of those conditions pertain to COBRA. To take advantage of this HIPAA right, you must elect COBRA under this Plan and keep it going (by paying the contribution) for the duration of your 18-, 29- or 36-month COBRA coverage period. If you need an individual health insurance policy, you need to apply for coverage with an individual insurance carrier after you have exhausted your COBRA benefits and before you have a 63-day break in coverage.

If you think you will be getting group health coverage through a new employer, keep in mind that HIPAA requires employers to reduce pre-existing condition exclusion periods if you have less than a 63-day break in health coverage (Creditable Coverage).

HEALTH COVERAGE TAX CREDIT PROGRAM: (TRADE ACT OF 2002)

An individual employee is eligible to elect COBRA during a second election period if he or she:

- Is either an eligible Trade Adjustment Assistance (TAA) recipient or an eligible alternate TAA recipient; and
- Lost group health coverage due to a job loss that results in eligibility for TAA; and
- The eligible employee did not elect COBRA during the regular COBRA election period that was triggered by the job loss.

Only a qualified beneficiary who is the covered employee (not a spouse or dependent child) may elect coverage during the special second COBRA election period. The special second COBRA election period lasts 60 days or less, beginning on the first day of the month in which the worker becomes an eligible TAA recipient or an eligible alternate TAA recipient, but the election must also be made within six months after the initial loss of group health coverage. As a result, if the employee finds out that he or she is eligible for this program with fewer than 60 days remaining in the six month period after initial loss of group health coverage, then this second election period will be less than 60 days.

COBRA coverage elected during the special second election period begins on the first day of the new second election period. There is no retroactive coverage for the gap period from the initial loss of coverage to the first day of the special second election period.

For purposes of pre-existing condition exclusions, the Plan will not count any days between the initial loss of group health coverage and the first day of the special second election period as part of a 63-day significant break in Coverage.

PAYMENT FOR CONTINUATION COVERAGE

Qualified beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

The initial contribution is due no later than 45 days after the qualified beneficiary elects COBRA. This first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated, up to the time you make the first payment. The due date for subsequent contributions is typically the first day of the month for any particular period of coverage, however you will receive specific payment information including due dates, when you become eligible for and elect COBRA continuation coverage. Payments postmarked within a 30 day grace period following the due date are considered timely payments.

If the initial contribution payment is not made within the 45-day period, then your coverage will remain terminated without the possibility of reinstatement.

If, for whatever reason, any qualified beneficiary receives any benefits under the Plan during a month for which the contribution was not paid on time, then you will be required to reimburse the Plan for the benefits received.

NOTE: Payment will not be considered made if a check is returned for Non-Sufficient Funds.

LENGTH OF CONTINUATION COVERAGE

Continuation coverage will terminate on the earliest of the following dates:

- 18 months from the qualifying event if due to the employee's termination of employment or reduction of work hours.
- 29 months from the qualifying event if due to termination of employment or reduced work hours, and the qualified beneficiary is determined by the Social Security Administration to have been disabled within 60 days of the qualifying event. The qualified beneficiary must give the Plan Administrator the determination of disability letter from the Social Security Administration within 60 days after the determination, and before the end of the initial 18-month COBRA period, to be eligible for this extension of coverage. The disability extension will apply to all active qualified beneficiaries in connection with the original qualifying event.
- For Dependents only: 36 months from the first qualifying event if coverage is lost due to:
 - Employee's death.
 - Employee's divorce or legal separation.
 - Employee becomes entitled to and enrolled in Medicare.
 - A dependent no longer being a dependent as defined in the Plan.
- Multiple qualifying events: When a first qualifying event (termination or reduction in hours of the covered employee) is followed, within the original 18-month period (or 29-month period), by a second qualifying event that has a 36-month maximum coverage period, the 18-month or 29-month period is extended to 36 months from the start of the original 18-month COBRA period, under certain circumstances.

SPECIAL ENROLLMENT RIGHTS AND OPEN ENROLLMENT:

A qualified beneficiary who is currently receiving COBRA coverage, has the same right to enroll certain family members under the Health Insurance Portability and Accountability Act (HIPAA) rules as if the qualified beneficiary were an employee or participant in the Plan.

These rights occur upon the loss of other group health coverage for the family member, or upon the former employee's acquisition of a new spouse or dependent as a result of marriage, birth, adoption or

Placement for Adoption, if certain requirements are met. You must complete enrollment material within 30 days of the event.

Neither a qualified beneficiary who is not currently receiving COBRA continuation coverage, nor a former qualified beneficiary has any special enrollment rights under these rules.

Open Enrollment: If your employer offers open enrollment opportunities for active employees, each qualified beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for dependents).

EARLY TERMINATION OF COBRA CONTINUATION

Continuation coverage under COBRA may terminate before the end of the above maximum coverage periods for any of the following reasons:

- This employer ceases to maintain a group health plan for any employees. (Note that if the employer terminates the group health plan that you are under, but still maintains another group health plan for other similarly-situated employees, you will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).
- The required contribution for the qualified beneficiary's coverage is not paid on time.
- After electing COBRA continuation, the qualified beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation, the qualified beneficiary becomes covered under another group plan that does not contain any exclusion or limitation with respect to any pre-existing condition(s) for the beneficiary.
- The qualified beneficiary is found not to be disabled during the disability extension.
- Termination for cause, such as submitting fraudulent claims.

YOUR OBLIGATIONS WHILE ON COBRA CONTINUATION:

You or a family member must promptly notify the COBRA Administrator in writing when any of the following events occur:

- Any qualified beneficiary becomes entitled to and enrolls in Medicare.
- Any qualified beneficiary becomes covered by another employer-sponsored group health plan.
- If a disabled employee or family member is determined by the Social Security Administration to no longer be disabled.
- Any qualified beneficiary's marital status changes.
- Any dependent child ceases to meet the eligibility requirements for plan coverage.
- When a child is born to or adopted by any qualified beneficiary.
- If the mailing address changes for you or your spouse.

The written notice should include all necessary information such as the person's name, group number, name of company that employee was with, description of change, effective date of change, new address if applicable, and complete phone number (if possible) in case the COBRA Administrator has any questions.

Send the written notice to:

PREFERREDONE ADMINISTRATIVE SERVICES
COBRA ADMINISTRATION
6105 GOLDEN HILLS DRIVE
GOLDEN VALLEY, MN 55416

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

Employers are required to offer COBRA-like continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. The maximum length of continuation coverage required under USERRA is the lesser of 18 months beginning on the day that the Uniformed Service leave begins, or a period beginning on the day that the Service leave begins and ending on the day after the employee fails to return to or

reapply for employment within the time allowed by USERRA. If an employee elects to continue health coverage pursuant to USERRA, such employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected. If, however, the military leave orders are for a period of 30 days or less, the employee is not required to pay more than the amount he or she would have paid as an active employee.

Reinstatement following the military leave absence cannot be subject to pre-existing conditions and waiting periods. The employer must offer non-health welfare benefits to an employee on active military leave on the same basis as those benefits are provided to other employees.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health coverage 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 normal 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, health plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above periods. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. Also under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

MASTECTOMY PROVISION (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)

Federal law requires group health plans providing medical and surgical benefits for mastectomy to provide the following coverage to a plan participant who elects breast reconstruction in connection with such mastectomy: 1) reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce symmetrical appearance; and 3) coverage for prostheses and physical complications of all stages of mastectomy, including lymph edemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductible and coinsurance provisions as may be deemed appropriate and that are consistent with those established for other benefits provided under the plan or coverage. Plans not already providing this type of coverage must do so beginning with the first plan renewal after the enactment date shown above. Refer to your Summary Plan Description for further information.

SUMMARY OF MATERIAL REDUCTIONS RULE

HIPAA requires group health plans to furnish each participant with a summary of any material reductions in covered benefits no later than 60 days after the adoption of the change.

This group health plan also complies with the provisions of the:

- Mental Health Parity Act.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby employers will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent children in cases of adoption or placement for adoption as required by ERISA.
- Health Insurance Portability and Accountability Act (HIPAA).
- Medicare Secondary Payer regulations, as amended.

STATEMENT OF ERISA RIGHTS

As a participant in this group health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered persons shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a

copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage:

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. you or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Pre-Existing Conditions Exclusion Period:

There will be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have credible coverage from another plan. You should be provided a Certificate of Credible Coverage free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months if you apply when first eligible, or 18 months for late enrollees, after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for covered persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "Fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

No Discrimination:

No one, including the employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights:

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an employee can take to enforce the above rights. For instance, if you request a copy of the Plan document or the latest annual report from the Plan and you do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the covered person may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds the claim to be frivolous).

Assistance with Your Questions:

If there are any questions about this plan, the Plan Administrator should be contacted. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA MEDICAL PRIVACY PROVISION

PROTECTED HEALTH INFORMATION PROVISION

- **Permitted and Required Uses and Disclosure of Protected Health Information.** Subject to obtaining written certification pursuant to paragraph 3 of the plan, the plan may disclose protected health information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such protected health information except for the following purposes:
 - To perform plan administrative functions which the Plan Sponsor performs for the Plan.
 - Obtaining premium bids from insurance companies or other health plans for providing insurance coverage under or on behalf of the group health plan; or
 - Modifying, amending, or terminating the group health plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

- **Conditions of Disclosure.** The plan or a health insurance issuer or HMO with respect to the plan, shall not disclose protected health information to the Plan Sponsor unless the Plan Sponsor agrees to:
 - Not use or further disclose the protected health information other than as permitted or required by the plan or as required by law.
 - Ensure that any agents, including independent contractors, to whom it provides protected health information received from the plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to protected health information.
 - Not use or disclose the protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
 - Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
 - Make available to individual plan members their own protected health information in accordance with 45 CFR §164.524, if so requested by the member.
 - Allow the individual plan member to request an amendment to their protected health information if so requested, and incorporate any amendments to the participant's protected health information in accordance with 45 CFR §164.526.
 - Make available to individual plan members who request an accounting of disclosures of the participant's protected health information, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
 - Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).

- If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that the adequate separation between Plan and Plan sponsor required in 45 CFR §164.504(f)(2)(iii) is satisfied and that terms set forth in Section 5 of this Amendment are followed.
- **Certification of Plan Sponsor.** The Plan shall disclose protected health information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 2 of this Amendment.
- **Permitted Uses and Disclosure of Summary Health Information.** The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor, provided such summary health information is only used by the Plan Sponsor for the purpose of:
 - Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or
 - Modifying, amending, or terminating the Plan.
- **Adequate Separation Between Plan and Plan Sponsor.** The Plan Sponsor shall only allow HR Specialist access to the protected health information. Such employees shall only have access to and use such Protected Health Information protected health information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to Plan sponsors employee discipline and termination procedures.

HIPAA MEDICAL PRIVACY DEFINITIONS

Covered Entity means:

- A health plan;
- A health care provider who transmits any health information in electronic form in connection with a covered transaction. (See definition of transaction); or
- A health care clearinghouse (that handles electronic claims from a provider).

Business Associate

A person who, on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement:

- Performs, or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or
- Provides, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

Health Plan

Any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulation, 65 Fed. Reg No. 250 (82463).

Plan Sponsor

Distinguished from Health Plan for privacy purposes. Defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).

Plan Administrative Functions

Activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the plan or solicit bids from prospective issuers. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans – such as vision and dental. Protected health information for these purposes may not be used by or between covered entities or business associates of a covered entity in a manner inconsistent with HIPAA's Privacy Regulation, absent an authorization from the individual. Plan administration specifically does not include any employment-related functions.

Protected Health Information

Information that is created or received by Plan, or a business associate of the Plan, whether in oral, written, or electronic form, and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Individually identifiable health information includes information of persons living or deceased. The following components of a member's information also are considered Individually Identifiable health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member's receipt of healthcare treatment, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

Summary Health Information

Information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.