

MEDICARE PART D CREDIBLE COVERAGE NOTICE

Important Notice 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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. Your Plan has determined that the prescription drug coverage offered by your Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact your Human Resources Department for more information about what happens to your coverage if you enroll in a Medicare Part D prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact your Human Resources Department for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your current drug coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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 drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of 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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Women's Cancer Rights Notification

To All Participants under the Employee Benefit Plan:

Dear Participant or Beneficiary:

As you know, the Employee Benefit Plan provides coverage for mastectomies. As part of this coverage, the Plan also covers the procedures necessary to effect reconstruction of the breast on which the mastectomy was performed, as well as the cost of prostheses and treatment for physical complications of all stages of mastectomy, including lymphedemas. However, we wish to make certain that you are aware that the Plan also covers any surgery and reconstruction of the other breast to achieve a symmetrical appearance.

For any participant or beneficiary of the Plan who is receiving Plan benefits for a mastectomy and who elects breast reconstruction in connection with such mastectomy, the Plan will provide coverage for any necessary surgery and reconstruction of the breast on which the mastectomy was not performed in order to produce a symmetrical appearance.

This coverage will be subject to all other Plan provisions.

**Medicaid and the Children’s Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	

ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
GEORGIA – Medicaid	MISSOURI – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	NEVADA – Medicaid and CHIP
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	

MASSACHUSETTS – Medicaid and CHIP	NEW MEXICO – Medicaid and CHIP
<p>Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120</p>	<p>Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583</p>
MINNESOTA – Medicaid	
<p>Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670</p>	
NEW YORK – Medicaid	TEXAS – Medicaid
<p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p>Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493</p>
NORTH CAROLINA – Medicaid	UTAH – Medicaid
<p>Website: http://www.nc.gov Phone: 919-855-4100</p>	<p>Website: http://health.utah.gov/upp Phone: 1-866-435-7414</p>
NORTH DAKOTA – Medicaid	VERMONT– Medicaid
<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>	<p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
OKLAHOMA – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647</p>
OREGON – Medicaid and CHIP	WASHINGTON – Medicaid
<p>Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678</p>	<p>Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473</p>

PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	WISCONSIN – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Ext. 61565

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT COVERED PARTICIPANTS MAY BE USED AND DISCLOSED AND HOW COVERED PARTICIPANTS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (“Notice”) describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan’s legal obligations concerning a Covered Participant’s protected health information and describes a Covered Participant’s rights to access and control that protected health information.

Protected health information (“PHI”) is individually identifiable health information, including demographic information, collected from a Covered Participant or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Participant’s past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Participant; or (3) the past, present or future payment for the provision of health care to a Covered Participant.

This Notice has been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please your Group Health Plan Privacy Officer or your Human Resources Office.

THE PLAN’S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of a Covered Participant’s PHI. The Plan is obligated to provide you with a copy of this Notice of the Plan’s legal duties and of its privacy practices with respect to PHI, and the Plan must abide by the terms of this Notice. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

Primary Uses and Disclosures of Protected Health Information

The following is a description of how the Plan is most likely to use and/or disclose a Covered Participant's PHI.

- ***Treatment, Payment and Health Care Operations***

The Plan has the right to use and disclose a Covered Participant's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

- ***Treatment***

The Plan will use or disclose PHI so that a Covered Participant may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between one or more of a Covered Participant's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Participant's primary care physician so that the specialist may request medical records from that primary care Physician.

- ***Payment***

The Plan will use or disclose PHI to pay claims for services provided to a Covered Participant and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Participant's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

- ***Health Care Operations***

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Participant with information about a disease management program; (2) to respond to a customer service inquiry from a Covered Participant or (3) in connection with fraud and abuse detection and compliance programs.

- ***Business Associates***

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

- ***Other Covered Entities***

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This

also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Participant has coverage through another carrier.

- ***Plan Sponsor***

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Participant. Also, the Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

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 particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Other Possible Uses and Disclosures of PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

- ***Required by Law***

The Plan may use or disclose PHI to the extent that federal law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

- ***Public Health Activities***

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

- ***Health Oversight Activities***

The Plan may disclose PHI 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: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

- ***Abuse or Neglect***

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Covered Participant’s PHI if there is reason to believe that

the Covered Participant has been a victim of abuse, neglect, or domestic violence.

- ***Legal Proceedings***

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (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 the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

- ***Law Enforcement***

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be 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 Participant or (3) it is necessary to provide evidence of a crime.

- ***Coroners, Medical Examiners, Funeral Directors, and Organ Donation***

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased Participant, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

- ***Research***

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

- ***To Prevent a Serious Threat to Health or Safety***

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- ***Military Activity and National Security, Protective Services***

Under certain conditions, the Plan may disclose PHI if Covered Participants are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Participants are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI 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 a Covered Participant is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Participant; (2) the Covered Participant's health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

- ***Workers' Compensation***

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- ***Others Involved in Your Health Care***

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Participant identifies. This identification must be in writing. Such use will be based on how involved the person is in the Covered Participant's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

The Plan also may disclose PHI to an entity assisting in a disaster relief effort so that a Covered Participant's family can be notified about his/her condition, status, and location.

If a Covered Participant is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Participant's best interest.

Required Disclosures of PHI

The following is a description of disclosures that the Plan is required by law to make.

- ***Disclosures to the Secretary of the U.S. Department of Health and Human Services***

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

- ***Disclosures to Covered Participants***

The Plan is required to disclose to a Covered Participant most of the PHI in a "designated record set" when that Covered Participant requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Participant's health care benefits. The Plan also is required to provide, upon the Covered Participant's request, an accounting of most disclosures of his/her PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Participant's PHI to an individual who has been designated by that Covered Participant as his/her personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Participant must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if the Covered Participant designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Participant's personal representative if a reasonable belief exists that: (1) the Covered Participant has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his/her personal representative could endanger the Covered Participant, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Participant's personal representative.

Other Uses and Disclosures of PHI

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Participant's written authorization. If the Covered Participant provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

A COVERED PARTICIPANT'S RIGHTS

The following is a description of a Covered Participant's rights with respect to PHI:

- ***Right to Request a Restriction***

A Covered Participant has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations. The plan is not required to agree to any restriction that a Covered Participant may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Covered Participant may request a restriction by contacting the individual or office referenced in the beginning of this Notice. It is important that the Covered Participant directs his/her request for restriction to this individual or office so that the Plan can begin to process your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Participant where to send the request when the Covered Participant's call is received. In this request, it is important that the Covered Participant states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

- ***Right to Request Confidential Communications***

If a Covered Participant believes that a disclosure of all or part of his/her PHI may endanger him/her, that Covered Participant may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Participant may ask that the Plan only contact the Covered Participant at a work address or via the Covered Participant's work e-mail.

The Covered Participant may request a restriction by contacting the individual or office referenced in the beginning of this Notice. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Participant where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his/her PHI in an alternative manner or at an alternative location and (2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Participant in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Participant's PHI could endanger that Covered Participant. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Participant's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Participant submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Participant may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Participant has made other payment arrangements, the EOB (in which a Covered Participant's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within two business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Participant contact the Plan at the number listed in this Notice as soon as the Covered Participant determines the need to restrict disclosures of his/her PHI.

If the Covered Participant terminates his/her request for confidential communications, the restriction will be removed for all of the Covered Participant's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Participant should not terminate a request for confidential communications if that Participant remains concerned that disclosure of PHI will endanger him/her.

- ***Right to Inspect and Copy***

A Covered Participant has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Participant's health care benefits. However, the Covered Participant may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Participant must submit a request by contacting the individual or office referenced in the beginning of this Notice. It is important that the Covered Participant contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Participant requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Participant's request to inspect and copy PHI in certain limited circumstances. If a Covered Participant is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Participant must contact the individual or office referenced in the beginning of this Notice. A licensed health care professional chosen by the Plan will review the Covered Participant's request and the denial. The person performing this review will not be the same one who denied the Covered Participant's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Participant through the denial that the decision is not reviewable.

- ***Right to Amend***

If a Covered Participant believes that his/her PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Participant may request that the Plan amend such information by contacting the individual or office referenced in the beginning of this Notice. Additionally, this request should include the reason the amendment is necessary. It is important that the Covered Participant direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Participant's request for an amendment. For example, the Plan may deny the request if the information the Covered Participant wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Participant has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

- ***Right of an Accounting***

The Covered Participant has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Participant or his/her personal representative. The Covered Participant should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Covered Participant may request an accounting by submitting a request in writing to the individual or office referenced in the beginning of this Notice. It is important that the Covered Participant direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

A Covered Participant's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Participant of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

- ***Right to a Paper Copy of This Notice***

The Covered Participant has the right to a paper copy of this Notice, even if he/she has agreed to accept this Notice electronically.

COMPLAINTS

A Covered Participant may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Participant may file a complaint with the Plan by contacting the individual or office referenced in the beginning of this Notice. A copy of a complaint form is available from this contact office.

A Covered Participant also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Covered Participant became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Participant for filing a complaint with the Secretary or with the Plan.

SEMI-ANNUAL NOTICE REGARDING HEALTH INSURANCE COVERAGE FOR DEPENDENTS

Illinois law requires your Health Plan to allow dependents the right to elect or continue coverage until the dependent reaches the age of 26 (and until the age of 30 for military veteran dependents).

Enrollment Period: Aside from your initial eligibility to participate in your Plan, you may make a written election for coverage of any dependent not currently covered under the Plan during the Plan's next annual open enrollment period for dependent coverage, or if the Plan has no open enrollment period, enrollment during the 30 day period prior to the Plan's annual renewal date. The effective date of coverage for each newly enrolled dependent will be governed by the terms of your Plan's summary plan description.

Military Veterans: In connection with military veteran dependents 26 years of age and older, such dependents must 1) reside in Illinois, 2) not be married, 3) have served in the active or reserve components of the United States Armed Forces, including the National Guard, 4) have received a release or discharge other than a dishonorable discharge, and 5) have submitted a proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information as to how to obtain a copy of the DD2-14, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the United States Department of Veterans' Affairs at 1-800-827-1000.

Cost: Your employer may require you to pay all or part of the cost of the extended dependent coverage for military veterans from the age of 26 to 30, which may be taxable. For additional information, please consult with your human resources department.