
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

This notice takes effect April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal. We are committed to safeguarding your protected health information (PHI).

PHI is any information that can identify you as an individual and your past, present or future physical or mental health condition.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires us to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to PHI about you; and
- follow the terms of the notice that is currently in effect.

OUR LEGAL DUTY

We (**Excellus BlueCross BlueShield**) are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning PHI. We must follow the privacy practices that are described in this notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the contact information at the end of this notice.

Uses and Disclosures of Nonpublic Personal Information

Nonpublic Personal Information is information you give us on your enrollment form, claim forms, premium payments etc. For example: names, member identification number, social security number, addresses, type of health care benefits, payment amounts, etc.

We will not give out your nonpublic personal information to anyone unless we are permitted to do so by law or have received a signed authorization form from the member.

Uses and Disclosures of Medical Information

The following categories describe different purposes for which we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. If we need to use or disclose your PHI in any other way, we will obtain your signed authorization before our use or disclosure.

Treatment: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to doctors or hospitals involved in your care. For example, we may disclose your medications to an emergency room physician so that he/she can avoid dangerous drug interactions. This allows providers to manage, coordinate and administer treatment.

Payment: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI to collect premiums, to determine our responsibility to pay claims or to notify members and providers of our claim determinations. We may disclose PHI to providers to assist them in their billing and collection efforts. We may also disclose PHI to other insurance companies to coordinate the reimbursement of health insurance benefits. For example, we may disclose PHI to an automobile no-fault insurance company to determine responsibility for claim payment. Also, if you have health insurance through another insurance company, we may disclose PHI to that other health insurance company in order to determine which company holds the responsibility for your claims.

Healthcare Operations: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI for purposes of performing our healthcare operations. Our healthcare operations include using PHI to determine premiums, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to determine eligibility for benefits. For example, we may use or disclose PHI when working with accreditation agencies that monitor and evaluate the quality of our benefit programs.

To You: We must disclose your PHI to you, as described in the Individual Rights section of this notice, below. We may also use and disclose PHI to tell you about recommended possible treatment options or alternatives or to tell you about health related benefits or services that may be of interest to you.

To Family and Friends: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. If you agree or, if you are unable to agree when the situation, (such as medical emergency or disaster relief), indicates that disclosure would be in your best interest, we may disclose PHI to a family member, friend or other person. In an emergency situation, we will only disclose the minimum amount necessary.

To Our Business Associates: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. A business associate is defined as someone that assists us in managing our business. For example, a professional that reviews the quality of our products and services. We may disclose PHI to another company that helps us manage our business. For example, we may disclose PHI to a company that performs case reviews to ensure our members receive quality care. These business associates are required to sign a confidentiality agreement with us that limits their use or disclosure of the PHI they receive.

To Plan Sponsors: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. A plan sponsor is defined as the employer or employee organization that establishes and maintains the employee's benefit plan. If you are enrolled in a group health plan, we may disclose PHI to the plan sponsor to permit the plan sponsor to perform plan administrative functions. For example, the cost analysis of the benefit program. Before PHI is disclosed to your plan sponsor, we will receive certification from the plan sponsor that appropriate amendments have been made to group health plan document(s) and the plan sponsor agrees to limit their use or disclosure of this information to plan administration functions only.

Research: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use or disclose PHI for research purposes in limited circumstances. For example, a research project may involve comparing the health and recovery of all members who received one medication to those who received another, for the same condition. All research projects are required to obtain special approval.

Coroners, Medical Examiners and Funeral Directors: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may release PHI to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release PHI about deceased members to funeral directors in order for the funeral directors to carry out their duties.

Organ Donation: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, to facilitate organ or tissue donation and transplantation. This may include a living donor as well as a deceased donor.

Public Health and Safety: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Victims of Abuse, Neglect or Domestic Violence: We may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use or disclose PHI when we are required to do so by law. For example, we must disclose PHI to the U.S. Department of Health and Human Services upon request to determine whether we are in compliance with federal privacy laws.

Process and Proceedings: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose PHI to law enforcement officials.

Law Enforcement: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to a law enforcement official investigating a suspect, fugitive, material witness, crime victim or missing person. We may disclose PHI of an inmate or other person in lawful custody of a law enforcement official or correctional institution under certain circumstances.

Military and National Security: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose to the military, PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

Individual Rights

The following information is effective as of 4/14/03:

Access: You have the right to inspect and/or copy your PHI, with limited exceptions such as information a licensed health care professional, exercising professional judgment, determines that providing access is reasonably likely to endanger the life, physical safety or cause someone substantial harm. On or after 4/14/03, you may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. If you request copies, we reserve the right to charge you a reasonable fee for each copy, plus postage if the copies are mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI. The list will not include disclosures we made for the purpose of treatment, payment, healthcare operations, disclosures made with your authorization, or certain other disclosures. To request a disclosure accounting, on or after 4/14/03, you may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. You may request an accounting of disclosures made on or after April 14, 2003 and the request may not exceed a six year time period. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed and the reason for the disclosure. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. As permitted by law, we will not honor these requests, as it prohibits us from administering your benefits.

Confidential Communication: You have the right to request that we communicate with you confidentially about your PHI. We will honor a request to communicate to an alternative location if you believe you would be endangered if we do not communicate to the alternative location. We must accommodate your request if it is reasonable and specifies the alternative location. To request a form to be completed and returned to us, on or after 4/14/03, you may contact us using the telephone number on the back of your identification card.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or if we determine the information is accurate. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be attached to the information you wanted amended. On or after 4/14/03, you may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the contact information at the end of this notice to obtain this notice in written form.

Safeguards

It is our policy to keep all information about you confidential in all settings. It is so important to us that we take the following steps:

- our employees sign an agreement to follow our Code of Business Conduct;
- our employees are required to complete our privacy training program;
- we have implemented the necessary sanctions for violation of our privacy practices;
- we have a privacy oversight committee that reviews our privacy practices;
- we have a security coordinator to detect and prevent security breaches;
- all computer systems that contain personal information have security protections; and
- we randomly check provider offices on a routine basis to ensure that medical records are kept in secure locations.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information at the end of this notice.

On or after 4/14/03, if you are concerned that we may have violated your privacy rights, as described above, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us confidentially communicate with you at an alternative location, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Complaints:

Contact Office: Privacy Officer
Address: 205 Park Club Lane
Buffalo, New York 14221-5239

Phone: 1-866-584-2313

E-mail: privacy.officer@excellus.com

Privacy Rights or Questions:

Contact Office: Customer Service

Phone: 1-800-424-8110

Note: This phone number will be available for you to call with questions pertaining to this notice until May 5th, 2003. After this date, please call the number on the back of your identification card.



165 Court Street
Rochester, NY 14647

An Independent Licensee of the BlueCross BlueShield Association

Dear Member:

Enclosed you will find a form titled *Authorization to Disclose Protected Health Information*. This form will allow you to authorize us to disclose your protected health information related to your health insurance coverage to another person or organization (referred to as “entity” on the form). Privacy regulations effective April 14, 2003 require that this form be completed in order for us to disclose information to anyone other than the member (there are some exceptions, e.g. your physician). **This includes information about a spouse or for children age 18 and over, when applicable.**

The form can be used to authorize disclosure to only one person or organization. If you need additional forms, you may copy the enclosed form, visit our website at www.excellusbcbbs.com/authform.pdf or contact our office to request additional copies.

Please note: State and federal laws provide special protections for information related to HIV/AIDS, genetic testing, alcohol or substance abuse, mental health, abortion and sexually transmitted diseases. A separate authorization may be required for disclosure of this information.

The following information has been provided to assist you with completing the enclosed form.

- **Psychotherapy Notes**

If you would like another person or organization to have access to psychotherapy notes (when applicable), this box must be checked. In the event that this form is being used for this purpose, it cannot be used as authorization to disclose any other type of information. Therefore, if checking this box, you should disregard Sections 2 and 3 of the form.

- **The Individual (Section 1)**

This is the name, address, identification number and date of birth of the member authorizing us to disclose information. If the member is covered by more than one health insurance contract with our company, and wishes to allow us to disclose under both contracts, please indicate both member identification numbers. Please also include the name of the subscriber’s employer or group through which the health insurance coverage is made available.

- **Purpose of this Authorization (Section 2)**

If you choose, you can limit the reason for disclosing information. For example, if you would like us to disclose information related to a particular surgery or date of service, you would check the box labeled “specific medical condition or service date(s), and indicate the specific reason in the space provided. If you would like us to disclose information for any reason, please check *Any Purpose*.

- **Protected Health Information to be Disclosed (Section 3)**

If you choose, you can limit the information we disclose. For example, if you would like only your membership information (e.g. address, effective/termination dates of coverage, etc.) disclosed, you would check only the box labeled *Membership Information*. If you would like to exclude specific information, e.g. everything except address, you can request that by checking the box that indicates *Exclude the following information*.

- **Entity Authorized to Receive Information (Section 4)**

This is the name and address of the person or organization to whom you are allowing us to disclose your protected health information, e.g. spouse, parent (for child age 18 or over), neighbor, employer group benefit administrator, immigrant assistance center, etc. If the organization is the subscriber’s employer, please circle *Y* after the question.

- **Expiration (Section 5)**

This is the date you choose at which time the authorization will no longer be valid. *Disenrollment* is the date you are no longer covered under a health insurance product with us, or if later, the date that all claims have been finalized. *Completion of requested disclosure* refers to Section 2 of this form. If you have indicated a specific condition, service or event, this authorization will no longer be valid once that condition, service or event is finalized.

- **Signature (Section 6)**

You must sign and date the form in order for it to be valid. If a personal representative is signing and dating this form, we must have proof of the relationship giving the person the power to act as your representative. For example, if someone is given Power of Attorney (which must specify that the person can receive medical information), we must have a copy of the Power of Attorney. The signed form must also indicate the description of the personal representative’s authority to act on behalf of the individual, e.g. Power of Attorney.



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Purpose: This form is used to authorize Excellus BlueCross BlueShield to disclose protected health information. This authorization is voluntary. We will not condition our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits on you giving this authorization. **Only one designated person or organization can be authorized using this form.** Please request or make copies for each additional person or organization. Additional forms can also be located on our website www.excellusbcbs.com/authform.pdf

Psychotherapy Notes:

Check here if this authorization is for psychotherapy notes. Disregard sections 2 and 3 only (below) as this authorization cannot be used for any other purpose if psychotherapy notes is checked.

Please complete the following information. All sections (1 through 6, except as noted above) must be completed or the form will be considered incomplete and returned to you.

1. The Individual

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Member Identification Number(s): _____

Birth Date: _____ Subscriber's Employer/Group Name _____

2. **Purpose of this Authorization:** Please note, that by signing this form, you will authorize Excellus BlueCross BlueShield to disclose your protected health information for the following purposes. **Please check one.**

- Any Purpose
- Specific medical condition or service date(s): _____
- Other (briefly describe): _____

3. **Protected Health Information to Be Disclosed:** Please indicate the specific protected health information you authorize us to disclose for the purposes stated above. **Please check all that apply:**

- Claim Information (e.g. status, type of service, diagnosis, provider, dates of service, etc.)
- Membership Information (e.g. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)
- Benefit Information (e.g. benefits available, benefits used, contract limits, etc.)
- Medical Records (e.g. physician or hospital records, case management, etc.)
- Other (briefly describe): _____
- Exclude the following information: _____

4. Entity Authorized to Receive: Please indicate the person and/or organization name and address to whom you are authorizing Excellus BlueCross BlueShield to disclose the protected health information described above:

Name/Organization: _____

Address: _____

City: _____

State: _____ Zip: _____

Is this person or organization the subscriber's employer/group health plan administrator? Circle one.

Y N

5. Expiration: This authorization will expire (please check one):

- Upon my disenrollment from Excellus BlueCross BlueShield or if later, the date that all claims incurred by me while enrolled have been finalized.
- Upon completion of the requested disclosure
- On ___/___/_____

6. Signature: You may refuse to sign this authorization. However, without a signature, the authorization is not valid.

I, (please print) _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Excellus BlueCross BlueShield may disclose to the person and/or organization named in this form the protected health information described in this form for the purposes stated in this form. I understand that this authorization is only valid while enrolled in my current group or direct pay policy.

I understand that, if the person or organization I authorize to receive protected health information described in this form is not a health plan, covered health care provider or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that I may revoke this authorization at any time by giving written notice of revocation to the office listed below. Revocation of this authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Signature: _____ **Date:** _____

If a personal representative on behalf of the individual signs this authorization, please complete the following:

Personal Representative's Name: (please print) _____ Description of Authority: _____

Personal Representative's Signature: _____ Date _____

A personal representative must provide legal proof of representation, e.g. power of attorney.

Please complete and return this form to:

Excellus BlueCross BlueShield
P.O. Box 4839
Syracuse, NY 13221

FAX: 1-315-671-7079

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS