

**THE CENTRAL UNION HIGH SCHOOL DISTRICT HEALTH AND WELFARE BENEFITS  
PLAN  
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

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.

This notice is required by law under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is a federal law. One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you. This notice is for participants in The Central Union High School District Health & Welfare Plan (referred to as the “Plan”), including its component plans<sup>1</sup>.

Our pledge regarding health information:

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you about the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that is currently in effect.

The Plan Will Use Your Health Information For:

**Treatment:** The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

**Regular Operations:** We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

**Business Associates:** There are some services provided to our organization through contracts with business associates. Business associate agreements are maintained with claims administrators, benefits providers and insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules.

**As Required by Law:** We will disclose health information about you when required to do so by federal, state or local law.

**Workers' Compensation:** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Law Enforcement:** We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

**Public Health:** We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

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<sup>1</sup> The Plan includes the following component plans: Delta and SIMNSA's Dental Plans, the VSP Vision Plan and the Health Care Flexible Spending Account (FSA) plan administered by AFA.

### **Your Rights Regarding Your Health Information:**

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information;
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the Plan privacy officer;
- Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked “Confidential” or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

### **The Plan’s Responsibilities:**

The Plan is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and
- Maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal health information;
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

### **For More Information or To Report a Problem:**

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan privacy officer. All requests must be submitted in writing to the address shown below.
- If you believe your privacy rights have been violated, you can file a formal complaint with the Plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

### **OTHER USES OF HEALTH INFORMATION**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.