Painting Industry

INSURANCE AND ANNUITY FUNDS

8257 DOW CIRCLE
CLEVELAND, OHIO 44136
(440) 260-0615
FAX (440) 260-0597

SHAWN D. KROEGER, CPA, CEBS
Administrative Manager

April 1, 2004

Dear Member:

I am sure you are aware of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a result of this law, which included numerous provisions that were effective at different times, we must make changes to the way we release information regarding your claims, claims of your spouse and claims of your covered adult dependents, eighteen (18) years of age and older.

Effective April 14, 2004 the Fund office must be HIPAA compliant with regard to Privacy and Protected Health Information of any adult (18 years or over) covered under your insurance. This refers to the member, spouse and any other dependent who is at least eighteen (18) years of age.

As part of this compliance our office will not be able to release claims information to **ANYONE, WITHOUT PRIOR WRITTEN CONSENT.**

For your convenience, we are enclosing the HIPAA Procedures Policy and two separate authorization forms, (one for the Member, the other for Dependents). In order to give your spouse permission to call the Fund office on your behalf, this form must be **completed, signed and returned to this office**. The same is true if the member wishes to call the office on behalf of his/her spouse. In addition, for dependents over the age of eighteen, a separate form should be submitted in order for the parents to receive information.

Please be advised, this new policy is mandatory due to HIPAA and is not being put into place either at the request of the Board of Trustees or Painting Industry Insurance Fund.

If you have any questions regarding this matter please contact the Fund office.

Very truly yours,

Shawn D. Kroeger, CPA, CEBS
Enclosures (2)

Painting Industry Insurance Fund
General Authorization for Release of Member's Health Information

I. Information about Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Member's name:_____ SS number:_____
PLEASE PRINT MEMBER'S NAME **MEMBER'S SSN**

Persons/organizations authorized to provide the information: any individuals identified in the Plan's HIPAA Privacy Policy as Plan administrative employees who (i) perform functions directly on behalf of the Plan, or (ii) have access to protected health information ("PHI") on behalf of the Plan for use of PHI in Plan administrative functions.

Persons authorized to receive the health information (Please list an adult who may be inquiring about your claim information by telephoning the Fund Office):_____

_____

_____
PLEASE PRINT AUTHORIZED ADULT PERSON'S NAME AND RELATIONSHIP ABOVE

Specific description of information to be used or disclosed (including date(s)): all health information relating to the period of the participant's coverage under the Plan.

Specific purpose of the disclosure: at the member's request.

Financial or in-kind compensation to be received by the individual requesting the authorization in exchange for using or disclosing the health information described above: NONE.

This authorization will expire upon termination of insurance coverage under the Plan.

II. Important Information about Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information to any other party without my further authorization.

Painting Industry Insurance Fund
General Authorization for Release of Dependent's Health Information

I. Information about Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Adult Dependent/Spouse's name:_____ (Adult = 18 years or older)
PLEASE PRINT

Adult Dependent/Spouse's SS number:_____

Member's name:_____ Member's SS number:_____
PLEASE PRINT

Dependent's relationship to member:_____ Dependent's date of birth:_____
PLEASE PRINT

Persons/organizations authorized to provide the information: any individuals identified in the Plan's HIPAA Privacy Policy as Plan administrative employees who (i) perform functions directly on behalf of the Plan, or (ii) have access to protected health information ("PHI") on behalf of the Plan for use of PHI in Plan administrative functions.

Persons authorized to receive the health information (Please list an adult who may be inquiring about your claim information by telephoning the Fund Office):_____

_____

_____
PLEASE PRINT AUTHORIZED ADULT PERSON'S NAME AND RELATIONSHIP ABOVE

Specific description of information to be used or disclosed (including date(s)): all health information relating to the period of the spouse's/adult dependent's coverage under the Plan.

Specific purpose of the disclosure: at the spouse's/adult dependent's request.

Financial or in-kind compensation to be received by the individual requesting the authorization in exchange for using or disclosing the health information described above: NONE.

This authorization will expire upon termination of insurance coverage under the Plan.

II. Important Information about Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.

Painting Industry Insurance Fund
Notice of 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.

If you have any questions about this notice, please contact the Fund Office by writing to the Painting Industry Insurance Fund, 8257 Dow Circle, Cleveland, Ohio 44136, or by calling 440-260-0615.

Who Will Follow This Notice

This notice describes the medical information practices of the Painting Industry Insurance Plan (the "Plan") and that of any third party that assists in the administration of Plan claims.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

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

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and present 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.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the

treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

Special Situations

Disclosure to Health Plan Sponsor. Medical information may be disclosed to the Board of Trustees of the International Brotherhood of Electrical Workers Northeastern Ohio Health and Welfare Fund and administrative staff solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

To request this list or accounting of disclosures, you must submit your request in writing to the Fund Office. Your request must state a time period which may not be longer than six years and may not include dates before April, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to the Fund Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing the Fund Office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please contact the Fund Office.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain on the first page, in the top right- hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Fund Office by writing to the Painting Industry Insurance Fund, 8257 Dow Circle, Cleveland, Ohio 44136. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical 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 permission, and that we are required to retain our records of the care that we provided to you.

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