



Wilbert Funeral Services, Inc. Health Benefit Plan

## HIPAA HEALTH INFORMATION PRIVACY NOTICE

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.

HIPAA Privacy is a new federal regulation that was effective April 14, 2004. It affects health care providers, doctors, hospitals, pharmacies, WFSI and you. HIPAA H e a l t h i n s u r a n c e p o r t a b i l i t y a n d A c c o u n t a b i l i t y A c t of 1996 (HIPAA) requires covered entities such as WFSI and your health plan to comply with various requirements to protect the privacy of Protected Health Information and to provide individual rights to participants regarding their own Protected Health Information.

### Permitted Uses and Disclosures

- 1) The WFSI Health Benefit Plan is permitted to make uses and disclosures of health information about you for treatment, payment and health care operations, but not limited to, the following. See examples below:
  - Treatment Purposes: For example, if your Primary Care Provider refers you to a specialist for treatment, the Plan can furnish information about your health plan eligibility.
  - Payment Purposes: For example, the Plan can disclose your Protected Health Information to another health plan or payer for purposes of coordinating payment of benefits.
  - Health Care Operations Purposes: Include underwriting, premium rating and other activities related to plan coverage; these activities could include, for example quality assessment and improvement activities.
- 2) The plan is permitted to make the following additional uses and disclosures for the above purposes, to the minimum extent necessary, without your written authorization:
  - To a Business Associate of the Health Plan: Includes the Health Plan's Third Party Administrator (TPA), broker and attorneys.
  - To the Health Plan Sponsor: For case management purposes, or to Human Resources representatives that are assisting plan members in getting their claims resolved.
  - Where required by law or requested as part of a regulatory or legal proceeding: May disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.
  - For Public Health Activities or to avert a serious threat to health or safety: May disclose Protected Health Information to public health authorities for purposes such as preventing or controlling diseases, injury or disability.
  - For Law Enforcement or Specific Government Functions: May disclose Protected Health Information to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person.
- 3) Other uses and disclosures will be made only with your written authorization, which you may revoke in accordance with applicable regulations.
- 4) The Plans below may disclose Protected Health Information to WFSI, the sponsor of the Plan.
  - GPA – Medical
  - Guardian - Dental
  - Assurant Vision Plan – Vision Plan
  - WFSI – Dependent Care Account
  - Lincoln Financial Insurance –Disability Plan
  - USAbLe – Life Plans



### **Your Individual Rights**

You have the following rights in accordance with regulations of the Department of Health and Human Services.

1. The right to request restrictions on certain uses and disclosures of protected health information, although the Plan is not required to agree to requested restriction.
2. The right to receive confidential communication of your Protected Health Information.
3. The right to amend your Protected Health Information.
4. The right to receive an accounting of your Protected Health Information.
5. The right to receive a paper copy of this notice, even if you have previously agreed to receive it electronically.

### **The Plan's Duties**

1. The Plans are required by law to maintain the privacy of Protected Health Information and to provide you with this notice of its legal duties and privacy practices with respect to protected health information.
2. The Plans are required to abide by the terms of this notice as currently in effect.
3. The plans reserve the right to change the terms of this notice and to make the new notice provisions effective for the Protected Health Information that it maintains, whether created or received before or after the notice of the change. Any such revised notice will be provided by interoffice mail, first class mail or electronically.

### **Complaints**

Individuals may complain to the Plans or to the Secretary of Health and Human Services if they believe that their privacy rights have been violated. Complaints may be filed with the *HIPAA Privacy Officer* as explained below. A complaining individual will not be retaliated against for filing a complaint.

### **Contact**

For further information, you may contact:

HIPAA Privacy Officer – Wilber Funeral Services, Inc.  
Steve Williams  
10965 Granada Lane, Suite 300  
Overland Park, KS 66211  
Ph# (913) 345-2120 / Fax# (913) 491-5024

Additionally, you can file a complaint with the Secretary of Health and Human Services (HHS) at the following address:

[www.hhs.gov/ocr](http://www.hhs.gov/ocr)  
Department of Health and Human Services  
The Hubert H. Humphrey Building  
200 Independence Ave., S.W.  
Washington, D.C. 20201



**HIPAA NOTICE  
(Health Insurance Portability and Accountability Act)**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future, be able to enroll yourself or your dependents in the plan, provided that you request enrollment 31 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself within 31 days after the marriage, birth, adoption or placement for adoption.

I acknowledge that I have received a copy, read and understand the above information regarding the HIPAA Act from WFSI.

\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature