

## NOTICE OF PRIVACY PRACTICES

### **THIS NOTICE OF PRIVACY PRACTICES 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 of Privacy Practices (the “Notice”) describes the legal obligations of the Montana University System’s self-insured group benefits plan (the “Plan”) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

The Plan is required to provide this Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to:

- (1) your past, present, or future physical or mental health or condition; or
- (2) the provision of health care to you; or
- (3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about privacy practices, please contact Mary Lachenbruch, Director of Benefits, Office of the Commissioner of Higher Education, Montana University System, at 406-449-9158.

#### **Effective Date**

This Notice was effective April 14, 2003 and is current as of July 1, 2021.

#### **Our Responsibilities**

The Plan is required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of its legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

The Plan reserves the right to change the terms of this Notice and to make new provisions regarding your protected health information that it maintains, as well as information the Plan receives in the future. If the Plan makes any material change to this Notice, the Plan will provide you with a copy of its revised Notice by posting to [choices.mus.edu](http://choices.mus.edu).

#### **How the Plan May Use and Disclose Your Protected Health Information**

Under the law, the Plan may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that the Plan may use and disclose your protected health information. For each category of uses or disclosures the Plan will explain what it means and present some examples. Not every use or disclosure in a category will be listed. However, all ways the Plan is permitted to use and disclose information will fall within one of the categories.

**For Treatment.** The Plan may use or disclose your protected health information to facilitate medical treatment or services by health care providers. The Plan may disclose medical information about you to health care providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if your prior prescriptions contraindicate a pending prescription.

**For Payment.** The Plan may use or disclose your protected health information to determine your 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, the Plan may tell your health care provider about your medical history to determine whether a certain treatment is experimental, investigational, or

medically necessary, or to determine whether the Plan will cover the treatment. The Plan may also share your protected health information with a utilization review or precertification service provider. Likewise, the Plan may share your protected health 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.** The Plan may use and disclose your protected health information for other Plan operations. These uses and disclosures, are necessary to run the Plan. For example, the Plan 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 & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. Please know that the Plan is prohibited from using or disclosing protected health information that is genetic information about you for underwriting purposes.

**To Business Associates.** The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. To perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with the Plan to implement appropriate safeguards regarding your protected health information. For example, the Plan may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with the Plan.

**As Required by Law.** The Plan will use or disclose your protected health information when required or permitted by federal, state, or local law, or by a court order. For example, the Plan may disclose your protected health information when required by national security laws or public health disclosure laws.

**To Avert a Serious Threat to Health or Safety.** The Plan may use or disclose your protected health information when necessary to prevent a serious and urgent 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, the Plan may disclose your protected health information in a proceeding regarding the licensure of a physician.

**To Plan Sponsors.** To administer the Plan, the Plan may disclose to certain employees of the Montana University System protected health information. However, those employees will only use or disclose that information as necessary to perform their plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

### **Special Situations**

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your protected health information. For each category of uses or disclosures, the Plan will explain what it means and present some examples. Not every use or disclosure in a category will be listed. However, all ways the Plan is permitted to use and disclose information will fall into one of the categories.

**Organ, Eye, and Tissue Donation.** If you are an organ donor, the Plan may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ, eye, or tissue donation and transplantation.

**Military and Veterans.** If you are a member or veteran of the armed forces, the Plan may share your protected health information with the military or as required or authorized by military command authorities. The Plan may also release protected health information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** The Plan may share your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** The Plan may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability.
- to report births and deaths.
- to report child abuse or neglect.
- to report reactions to medications or problems with products.
- to notify people of recalls of products they may be using.
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- to notify the appropriate government authority if the Plan believes that a patient has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if you agree, or when required or authorized by law.

**Health Oversight Activities.** The Plan may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, the Plan may disclose your protected health information in response to a court or administrative order. The Plan may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** The Plan may disclose your protected health information if asked to do so by a law enforcement official –

- in response to a court order, subpoena, warrant, summons or similar process.
- to identify or locate a suspect, fugitive, material witness, or missing persons.
- about the victim of a crime if, under certain limited circumstances, the Plan is not able to obtain the victim's agreement.
- about a death that the Plan believes may be the result of criminal conduct.
- about criminal conduct.

**Coroners, Medical Examiners and Funeral Directors.** The Plan may release your protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors, as necessary to carry out their duties.

**National Security and Intelligence Activities.** The Plan may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, the Plan may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**Research.** The Plan may disclose your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approve the research.

Most uses and disclosures of psychotherapy notes will be made only with your written authorization.

## **Required Disclosures**

The following is a description of disclosures of your protected health information the Plan is required to make.

**Government Audits.** The Plan is required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

**Disclosures to You.** When you request, the Plan is required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

## **Other Disclosures**

**Personal Representatives.** The Plan will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide the Plan with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA Privacy Rule, the Plan does not have to disclose information to a personal representative if it has a reasonable belief that:

- (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or

- (2) treating such person as your personal representative could endanger you; and
- (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

**Spouses and Other Family Members.** With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

**Authorizations.** Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

### **Your Rights**

You have the following rights with respect to your protected health information:

**Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to the Plan Administrator, Montana University System Group Benefits Plan, P.O. Box 203203, Helena, MT 59620. If you request a copy of the information, the Plan may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

The Plan may deny your request to inspect and copy in certain very limited circumstances. If the Plan denies your request, the Plan will give you the reason why in writing. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan Administrator, Montana University System Group Benefits Plan, P.O. Box 203203, Helena, MT 59620.

**Right to Amend.** If you believe that the protected health information the Plan has about you is incorrect or incomplete, you may ask the Plan to correct or amend the information. You have the right to request a correction or amendment for as long as the information is kept by or for the Plan.

To request a correction or amendment, your request must be made in writing and submitted to the Plan Administrator, Montana University System Group Benefits Plan, P.O. Box 203203, Helena, MT 59620. In addition, you must provide a reason that supports, in writing, why you are asking for the correction or amendment.

The Plan may deny your request for a correction or amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask the Plan to correct or amend information that:

- is not part of the medical information kept by or for the Plan.
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment.
- is not part of the information that you would be permitted to inspect and copy.
- is already accurate and complete.

If the Plan denies your request, you have the right to submit a written statement of 250 words or less that tells what you believe is not correct or is missing. The Plan will add your written statement to your records and include it whenever the Plan shares the part of your medical record that your written record relates to.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator, Montana University System Group Benefits Plan, P.O. Box 203203, Helena, MT 59620. Your request must state a period of time of no longer than six years and may not include dates before April 14, 2003. 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 provided free of charge. For additional lists, the Plan may charge you for the costs of providing the list. The Plan 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 your protected health information that the Plan uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that the Plan discloses to someone who is involved in your care of the payment for your care, such as a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, the Plan is not required to agree to your request. However, if the Plan does agree to the request, it will honor the restriction until you revoke it or the Plan notifies you.

The Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to the Plan Administrator, Montana University System Group Benefits Plan, P.O. Box 203203, Helena, MT 59620. In your written request, you must tell the Plan (1) what information you want to limit; (2) whether you want to limit the Plan's 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 the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Plan Administrator, Montana University System Group Benefits Plan, P.O. Box 203203, Helena, MT 59620. The Plan will not ask you the reason for your request. Your written request must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

**Right to Be Notified of a Breach.** You have the right to be notified in the event the Plan (or a Business Associate) discovers a breach of unsecured protected health information.

**Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice on the website at [choices.mus.edu](http://choices.mus.edu).

To obtain a paper copy of this notice, write to the Plan Administrator, Montana University System Group Benefits Plan, P.O. Box 203203, Helena, MT 59620 and request that one be sent to you at the mailing address you provide in your written request.

### **Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Mary Lachenbruch, Director of Benefits, Montana University System Group Benefits Plan, P.O. Box 203203, Helena, MT 59620. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plan.