GENERAL NOTICE OF COBRA CONTINUATION RIGHTS

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as it applies to State governmental entities through the Public Health Services Act ("PHSA") requires most employers with twenty (20) or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. At the end of the maximum coverage period (described below), individual conversion coverage will be offered if it is otherwise available under the plan.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of this law. It is intended that no greater rights be provided than those required by the law. It does not fully describe continuation coverage or other rights under the plan. For additional information about your rights and obligations under the plan and under federal law, you should review the Plan's descriptive information or contact the Plan.

This notice covers the following group health plan(s) sponsored by Northfield Public Schools (your "Employer"):

$1,500 CMM Plan $2,000 HRA Plan Dental Plan Health Reimbursement Account (HRA)
Section 125 Cafeteria Plan (Health Flex) Vision Plan Employee Assistance Program (EAP)

Each person covered under one of these plans should read this notice carefully.

Qualifying Events. Upon the commencement of a "qualifying event" each person that loses coverage has rights as a "qualified beneficiary."

Qualifying event. A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the group health plan.

Qualifying beneficiary. A qualified beneficiary is the employee, employee's spouse and/or employee's dependent children who on the day before the qualifying event was covered under the group health plan. In addition, a child born to or placed for adoption with a qualified beneficiary who was the employee is a qualified beneficiary is if he or she was covered under the group health plan on the day before the qualifying event.

Employee Loss. If covered by any of the group health plans described above, the employee has the right to elect continuation coverage if he or she loses coverage under the plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.

Spouse's Loss. If covered by any of the group health plans described above, a spouse has the right to elect continuation coverage if he or she loses coverage under the plan due to any of the following:

- the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment
- the employee's death
- divorce or legal separation from the employee [Please note: If an employee eliminates coverage for his or her spouse from coverage in anticipation of a divorce of legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.]
- the employee's entitlement to (actual coverage under) Medicare.

Dependent Child's Loss. If covered by any of the group health plans described above, a dependent child has the right to elect continuation coverage if he or she loses coverage under the plan due to any of the following:

- the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment
- the employee's death
- divorce or legal separation of the employee and the child's other parent
- the employee's entitlement to (actual coverage under) Medicare
- the child ceasing to be a "dependent child" under the terms of the plan.

Employer's Bankruptcy. Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the employer commences a Chapter 11 bankruptcy proceeding.

Responsibility to Notify. Under the law, the employee or a family member (or a representative acting on behalf of the employee or a family member) has the responsibility to inform the Plan of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the latest of: (1) the date of the qualifying event; (2) the date coverage would be lost because of the qualifying event; or (3) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be provided in writing and be mailed to the Plan at the address listed below. The notice must include: (1) date of the qualifying event; (2) the qualifying event.

Also, an employee or any family member (or a representative acting on behalf of the employee or a family member) must notify the Plan when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (1) the date of the disability determination; (2) the date of the qualifying event; (3) the date coverage would be lost because of the qualifying event; or (4) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. [Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.] The notice must be provided in writing and be mailed to the Plan at the address identified below. The notice must include: (1) date of the qualifying event; (2) the qualifying event.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Plan of that determination within thirty (30) days of the later of: (1) the date of such determination; or (2) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be provided in writing and be mailed to the Plan at the address identified below.

Failure to provide timely notice ends the right to COBRA continuation coverage.

Election Rights. When a qualifying event occurs, or the Plan is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the Plan must notify the qualified beneficiaries of the right to elect continuation coverage. Under the law, qualified beneficiaries have at least sixty (60) days to elect continuation coverage measured from the later of (1) the date coverage would be lost because of a qualified event, or (2) the date a notice of election rights is provided. An election is considered "made" on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under the Plan ends. Each qualified beneficiary has an independent right to elect continuation coverage. However, a third person can elect continuation coverage on behalf of a qualified beneficiary.

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS

Duration. The law requires that qualified beneficiaries be allowed to maintain continuation coverage as follows:

Eighteen (18) Months. If the qualifying event is the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date of the coverage would otherwise be lost because of the qualifying event.

Disability Extension. The eighteen (18) month continuation period may be extended to twenty-nine (29) months where a qualified beneficiary receives a determination under the Social Security Act that at the time of the employee's termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

Pre-Qualifying Event Medicare Extension. The eighteen (18) month continuation period may be extended if the employee became entitled to (actually covered under) Medicare prior to the employee's termination of employment (other than for gross misconduct) or a reduction in hours. Qualified beneficiaries other than the employee are entitled to the greater of (1) eighteen (18) months measured from the qualifying event, or (2) thirty-six (36) months measured from the date of the employee's Medicare entitlement.

Thirty-six (36) Months. For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is 36 months measured from the date of the date coverage would otherwise be lost because of the qualifying event.

Second Qualifying Events. If during the initial eighteen (18) month continuation period a second qualifying event occurs (e.g., divorce or legal separation, death of employee, loss of dependent status), the continuation period for the particular qualified beneficiary is extended to thirty-six (36) months. Under no circumstances may the total continuation period be greater than thirty-six (36) months from the date of the original qualifying event that triggered the continuation coverage.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees or family members that have not experienced a qualifying event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will apply to those who have elected COBRA.

Cost. A person electing continuation coverage may be required to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the plan of providing the coverage. The amount may be increased to 150% for the months after the eighteenth (18th) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

Pre-Mature Ending. The law provides that continuation coverage shall automatically end for any of the following reasons:

- the Employer no longer proves group health coverage to any of its employees;
- the premium for continuation coverage is not paid on time (including any applicable grace period);

- after electing COBRA, the qualified beneficiary becomes covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then COBRA coverage terminates after the exclusion or limitation no longer applies (for example, after a twelve (12) month preexisting condition waiting period expires). [Please note that under HIPAA, an exclusion or limitation of the other group health plan might not apply at all, depending on the length of the qualified beneficiary's creditable coverage prior to enrolling in the other group health plan.]
- after electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare.
- with respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled. [This cuts short the coverage for all qualified beneficiaries with extended coverage.]
- termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

Insurability & Conversion. A qualified beneficiary does not have to demonstrate insurability to elect continuation period. At the conclusion of the available continuation coverage, there must be an opportunity to convert to individual coverage if such coverage is offered under the plan.

Trade Act of 2002. Pursuant to the Trade Act of 2002, certain employees and former employees who are receiving trade adjustment assistance ("TAA") may be eligible for a special second COBRA election and a tax credit for premiums paid for continuation coverage. TAA is generally available to those employees who have lost their jobs or suffered a reduction in hours because of import competition and shifts in production to other countries. If you are potentially eligible for these rights under the Trade Act, you will receive additional information regarding it at the time of your qualifying event.

Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Employees covered by the health plans described above who are absent from employment due to military service have additional rights to continue coverage for themselves, their spouses and dependants under USERRA. Generally, the rights to continuation coverage provided under USERRA are similar to the rights provided by COBRA. If you are covered by USERRA, you will receive additional information regarding your rights at the time of a qualifying event.

Address Changes: Important information is distributed by mail. In order to protect your family's rights, if a qualified beneficiary's address changes, the qualified beneficiary or someone on his/her behalf should notify the Plan immediately.

More Information: All questions, notices, and other communications regarding COBRA and the Plan should be directed to: Andrea Nelson-Walker, 1400 Division St. S., Northfield, MN 55057. 507-645-3406.

THIS NOTICE OF CONTINUATION RIGHTS IS FOR COBRA (FEDERAL LAW) PURPOSES ONLY.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number.

The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Health Insurance Portability and Accountability Act "HIPAA"

Federal HIPAA law requires us to notify you about two very important Plan provisions prior to your enrollment. You have the right to enroll under a "Special Enrollment Provision" if you acquire a new dependent, or you or an eligible dependent declines coverage because of alternative coverage and later lose such coverage due to certain qualifying reasons.

1. Your health premiums are deducted on a pre-tax basis and are therefore subject to the rules and regulations of IRS Code Section 125.

2. Once you have made your health plan elections during the Annual Benefits Enrollment or during your initial enrollment period, there are limited circumstances under which you can make changes known as family status or HIPAA Special Enrollment events:
   - If you have a family status change as defined by IRS Code Section 125 during the plan year, you are allowed to make coverage level changes to your coverage that are consistent with that event.
   - If you have a family status change that is also a HIPAA Special Enrollment event and your employer offers more than one health plan, you will also be able to move to another health plan offered by the employer.

Example: You currently have "single" Plan 1 health coverage, but will have a new dependent as a result of marriage: this is a HIPAA Special Enrollment. You can add your new spouse to your health insurance coverage (change from "single" to "family" coverage) and you may also move to a different plan (Plan Option 2, Plan Option 3, etc).

A family status change may also be a HIPAA Special enrollment. What makes a family status change ALSO a HIPAA Special Enrollment is when the event involves circumstances previously unknown which necessitate the addition of coverage for yourself or your dependent. Please refer to the "Special Enrollment Provisions" on the next page for details.

Special Enrollment Provisions

1. Loss of Coverage

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, and that coverage terminates due to certain qualifying reasons (i.e., COBRA exhaustion or state law continuation rights; eligibility loss due to legal separation, divorce, death, employment termination, or reduction in hours; or because employer contributions for other coverage cease) you may in the future be able to enroll

yourself or your dependents in the benefit plans, provided that you request enrollment within 30-days after your other coverage ends - and that you meet certain other important conditions described in the Summary Plan Description. You must inform us in writing at the time you decline coverage that you are declining coverage because of other health insurance coverage in order to be eligible for this special enrollment period.
In general, coverage will become effective the day following the date on which your other coverage would normally end.

Effective April 01, 2009, two additional special enrollment provisions have been added:

- If you or a dependent lose eligibility for Medicaid or coverage under a state children's health insurance program (SCHIP)
- If you or a dependent become eligible for a state premium assistance subsidy under the plan through Medicaid or SCHIP.

Special enrollment for these two new special enrollment provisions must be requested within 60-days after the termination of coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

2. Marriage, Birth, or Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30-days after the marriage, birth, adoption, or placement for adoption - and that you meet certain other important conditions as described in your Summary Plan Description. In general, coverage will become effective the date of marriage, birth, adoption, or placement for adoption.

All coverage request changes must be consistent with the family status change.

Should you wish to receive a replacement copy of our HIPAA privacy notice please contact your benefit administrator and they will mail one to you. This privacy notice is the one you received when you first become enrolled into our health benefit plan.

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
- Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives,

close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of non-routine disclosures of protected health information.

- We have the obligation to provide and you have the right to obtain a paper copy of this notice from us every three years.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April14, 2004, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Molly Viesselman
Director of Human Resources
Title IX Coordinator
1400 Division St. S.
Northfield, MN 55057

507-663-0624

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: (877) 696-6775

WHCRA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator (507) 663-0624.