Claims and Appeals Procedures

The law provides that each welfare plan subject to ERISA must set up reasonable rules for filing a claim for benefits. To that end, the description of the benefits in your benefits booklet include specific explanations of the claims procedures for each benefit. This section describes the general rules and procedures, as well as your rights under ERISA, that relate to filing claims for benefits under the MILA Managed Health Care Trust Fund (the Plan). It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

CLAIMS FOR BENEFITS

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form on the appropriate form. However, if you receive in-network benefits from a participating provider (as described in the Summary Plan Description), you do not have to submit a claim.

In general, under the Plan's rules, simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. In addition, when you present a prescription to a pharmacy to be filled out under the terms of this plan that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

A claim form may be obtained from the organization responsible for processing the claim or from your Local Port Administrator.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office or the applicable claims administrator to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

DEFINITION OF CLAIMS – IN GENERAL

For all ERISA plans, the law allows a reasonable amount of time for the plan administrator to evaluate a claim and decide whether to pay benefits based on the information contained in the claim. Under the new ERISA Claims and Appeals rules, these times are dictated by what type of claim is being considered and whether you followed the proper procedures, as described in this section. The claims procedures for Medical, Mental Health and Substance Abuse and Prescription Drug benefits will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim or a Post-Service Claim. Read each section carefully to determine which procedure is applicable to your request for benefits.

PRE-SERVICE AND URGENT CARE CLAIMS

A **Pre-Service Claim** is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Plan, services which require prior approval are described on page 9 of the Summary Plan Description.

Important: For out-of-network providers, the plan will reduce your reimbursement by 20% if you fail to pre-certify. No benefits will be payable for Mental Health and Substance Abuse benefits if you fail to pre-certify. Details about how the process works can be found on page 9 of your benefits booklet.

For properly filed Pre-Service Claims, you and/or your doctor will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the organization responsible for making the determination. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a Pre-Service Claim, you will be notified as soon as possible but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed Pre-service claim if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

If an extension is needed because the organization responsible for making the determination needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have *45 days* from receipt of the notification to supply the additional information. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The responsible organization then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination. You have the right to appeal a denial of your pre-service claim.

An **Urgent Care Claim** is any claim for medical care or treatment with respect to which the application of the time periods for making pre-service claim determinations:

(1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

(2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is determined by the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

If you are requesting pre-certification of an Urgent Care Claim, the time deadlines are different. The organization responsible for making the decision will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than *72 hours* after receipt of the claim. The determination will also be confirmed in writing.

If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, Care review will notify you and/or your doctor as soon as possible, but not later than *24 hours* after receipt of the claim, of the specific information necessary to complete the

claim. You and/or your doctor will have at least 48 hours to provide the specified information. If the information is not provided within that time, your claim will be denied.

Note: Claims involving **Urgent Care** (as defined) must be submitted telephonically to the applicable organization at the number listed on the back of your ID card.

CONCURRENT CLAIMS

A CONCURRENT CLAIM IS A CLAIM THAT IS RECONSIDERED AFTER AN INITIAL APPROVAL WAS MADE AND RESULTS IN A REDUCTION, TERMINATION OR EXTENSION OF A BENEFIT. (AN EXAMPLE OF THIS TYPE OF CLAIM WOULD BE AN INPATIENT HOSPITAL STAY ORIGINALLY CERTIFIED FOR FIVE DAYS THAT IS REVIEWED AT THREE DAYS TO DETERMINE IF THE FULL FIVE DAYS IS APPROPRIATE.) IN THIS SITUATION A DECISION TO REDUCE, TERMINATE OR EXTEND TREATMENT IS MADE CONCURRENTLY WITH THE PROVISION OF TREATMENT.

Post Service Claim

A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

Ordinarily, you will be notified of the decision on your Post-Service claim within *30 days* from the organization responsible for paying the claim from receipt of the claim. This period may be extended one time by the applicable organization for up to *15 days* if the extension is necessary due to matters beyond the control of the organization. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the organization expects to render a decision.

If an extension is needed because the organization needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The organization responsible for paying the claim will then has *15 days* to make a decision on a Post-Service Claim and notify you of the determination.

WHEN TO FILE CLAIMS

Claims should be filed within two years following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time.

WHERE TO FILE CLAIMS

You are generally not required to file a claim for in-network benefits. When you do need to file a claim for out-of-network benefits, submit a completed claim form to the organization responsible for the administration of the benefits you are requesting. When you need to submit a claim, your claim will be considered to have been filed as soon as it is received by the organization responsible for administering and processing the claim for benefits for which you are filing. Claims should be filed with the appropriate claims administrator at the appropriate address as listed below.
When you need to submit a claim:

1. Obtain a claim form and complete the employee's portion of the claim form (including you name and social security number, the patient name, the patients date of birth)
2. Have your Physician either complete the Attending Physician's Statement section of the claim form (including Date of Service,CPT-4 code, ICD-9 (the diagnosis code), Billed charge, Number of Units

(for anesthesia and certain other claims), Federal taxpayer identification number (TIN) of the provider, Billing name and address and If treatment is due to accident, accident details; or

3. Submit a completed HCFA health insurance claim form, or submit an HIPAA-compliant electronic claims submission
4. Attach all itemized Hospital bills or doctor's statements that describe the services rendered. (In most circumstances the hospital will submit these claims directly to the address listed in this section for the applicable benefit.)

MEDICAL COVERAGE

File claims for Medical benefits with:

CIGNA HealthCare Inc.
National Appeals Unit (NAU)
PO Box 5225
Scranton, PA 18505-5225

If sending Overnight to the **National Appeals Unit it** should be directed to the address below.

Diversified/CIGNA HealthCare
Attn: National Appeals Unit
123 Wyoming Ave
Scranton, PA 18503

MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE

File claims for Mental Health and Substance Abuse benefits with:

ComPsych
NBC Tower, 24th Floor
455 North Cityfront Plaza Drive
Chicago, IL 60611-5322

THE PRESCRIPTION MEDICATION PROGRAM

You do not need claim forms when visiting a participating pharmacy. Simply present your card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of this plan, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim under these procedures. If you need to file a claim contact:

CVS/Caremark Appeals
MC109 P.O. Box 52115
Phoenix, AZ. 85072-2136

NOTICE OF DECISION

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical basis for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

Please note that for Urgent Care Claims and Pre-Service Claims, you will receive notice of the care that will be covered by the Plan even when the claim is approved.

REQUEST FOR REVIEW OF DENIED CLAIM

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the organization responsible for making the initial determination *180 days* after you receive notice of denial. Appeals should be made to the address indicated on the Explanation of Benefits you receive from the organization. Appeals involving Urgent Care Claims may be made orally by calling the applicable organization at the number listed on the back of your ID card.

Currently, CIGNA and ComPsych maintain a two level appeal procedure. Advance PCS maintains a one-level appeal procedure.

If you request a review for a claims determination that was not made by one of the above organizations, such requests should be made to the Board of Trustees at MILA Managed Health Care Trust Fund, 111 Broadway, 5th Floor, New York, NY 10006-1901, Phone number: (212) 766-5700, Fax: (212) 766-0844, Email: info@milamhctf.com.

REVIEW PROCESS

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the organization responsible for making the claims determination in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon);it demonstrates compliance with the organization administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal

- **Pre-Service Claims:**

  One-Level Appeals Procedure

  Where the organization responsible for making the determination maintains a one-level appeals procedure, you will be sent a notice of decision on review within 30 days of receipt of the appeal.

Two-Level Appeals Procedure

Where the organization responsible for making the determination maintains a two level appeals procedure, you will be sent a notice of decision on review within 15 days of receipt of the appeal.

If you are dissatisfied with the outcome of your first appeal, you may file another appeal with the applicable organization within 180 calendar days from the date on the notice of the letter denying your first appeal. You will be sent a notice of decision on review of your second appeal within 15 days from receipt of the second appeal.

- **Urgent Care Claims:** You will be sent a notice of a decision on review within 72 hours of receipt of the appeal.

- **Post-Service Claims:**

  One-Level Appeal
  You will be sent a notice of decision on review within 60 days of receipt of the appeal.

  Two-Level Appeal Procedure

  You will receive a notice of decision on review within 30 days of receipt of the appeal by the organization responsible for making the determination.

  If you are dissatisfied with the outcome of your first appeal, you may file another appeal with the organization responsible for making the determination within 180 calendar days from the date on the notice of the letter denying your first appeal. You will be sent a notice of decision on review of your second appeal within 30 business days from receipt of the second appeal.

- **Post-Service Appeals not related to Medical, Mental Health and Substance Abuse or Prescription Drug Claims**

  Ordinarily, decisions on such types of appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination
- Reference to the specific plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical

judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit may be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which services were provided.

MILA Managed Health Care Trust Fund
Privacy Notice

Section 1: Purpose of This Notice and Effective Date

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.

Effective date. The effective date of this Notice is April 14, 2003.

This Notice is required by law. The MILA Managed Health Care Trust Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Plan's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or for payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- At your request, if you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect and/or copy it.
- As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- For treatment, payment or health care operations. The Plan and its business associates will use PHI in order to carry out:

➢ Treatment,

➢ Payment, or

➢ Health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

Disclosure to the Plan's Trustees. The Plan will also disclose PHI to the Plan Sponsor of the MILA Managed Health Care Trust Fund for purposes related to treatment, payment, and health care operations, and the Plan has amended the Plan Documents to permit this use and disclosure as required by federal law.

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care,
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected, and
- Please contact the Fund's Privacy/Security Officer if you wish to limit access to your PHI by any of the persons described above.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. ***When required by applicable law.***

2. ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. ***Domestic violence or abuse situations.*** When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such cases, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4. ***Health oversight activities.*** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is made pursuant to court order.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

7. ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including:

    a. identifying or locating a suspect, fugitive, material witness or missing person, and

    b. disclosing information about an individual who is or is suspected to be a victim of a crime.

8. ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. The Plan may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Research.*** For research, subject to certain conditions.

11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

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

The Plan may disclose protected health information to the sponsor of the Plan for reviewing your appeal of a benefit claim or for other reasons regarding the administration of this Plan. The "plan sponsor" of this Plan is the MILA Managed Health Care Trust Fund Board of Trustees.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy/Security Officer determines it to be unreasonable.

Make such requests to:

LaVerne A. Thompson, Executive Director and Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, 5th Floor
New York, NY 10006

You May Request Confidential Communications

The Plan will accommodate an individual's reasonable request to receive communications of PHI **by alternative means or at alternative locations** where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to:

LaVerne A. Thompson, Executive Director and Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, 5th Floor
New York, NY 10006

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged. Requests for access to PHI should be made to the following officer:

LaVerne A. Thompson, Executive Director and Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, 5th Floor
New York, NY 10006

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and HHS.

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You Have the Right to Amend Your PHI

You have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Plan's Right to Amend Policy for a list of exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend the PHI to the following officer:

LaVerne A. Thompson, Executive Director and Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, 5th Floor
New York, NY 10006

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of certain disclosures by the Plan of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Plan's Accounting for Disclosure Policy for the complete list of disclosures for which an accounting is not required.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the following officer:

LaVerne A. Thompson, Executive Director and Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, 5th Floor
New York, NY 10006

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action on your behalf. Proof of such authority will be a completed, signed and approved. Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse to be the personal representative of an individual covered by the plan. In addition, the Fund will consider a parent or guardian as the personal representative of an un-emancipated minor unless applicable law requires otherwise. A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Spouses and un-emancipated minors may, however, request that the Plan restrict information that goes to family members. Such request will be governed by the provision entitled **You May Request Restrictions on PHI Uses and Disclosures** which appears at the beginning of Section 3 of this Notice.

You should also review the Plan's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Plan will automatically consider an individual to be a personal representative.

Section 4: The Plan's Duties

Maintaining Your Privacy

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of the Plan's legal duties and privacy practices.

This notice is effective beginning on April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI. All notices will be mailed to the participant's address on record.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and

∞ With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the following officer:

LaVerne A. Thompson, Executive Director and Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, 5th Floor
New York, NY 10006

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Plan may not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer at the Fund Office:

LaVerne A. Thompson, Executive Director and Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, 5th Floor
New York, NY 10006

Section 7: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.