NOTICE OF PRIVACY PRACTICES
FROM YOUR EMPLOYER'S EMERITI RETIREE HEALTH PLAN
(REIMBURSEMENT BENEFIT ONLY)

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.

Introduction. This notice applies to you if you are eligible (or may become eligible) as a participant for the Emeriti Reimbursement Benefit (reimbursement of qualified medical expenses) under your employer's (or former employer's) Emeriti Retiree Health Plan (the "Plan"). It also applies to you if you are a spouse, dependent domestic partner, dependent child, or dependent relative of such a participant, if you or the participant can obtain reimbursement from the Plan for your qualified medical expenses. A separate privacy notice will be provided to you by Aetna if you are covered under one of the Emeriti Health Insurance Plan Options.

Federal and State Law. The portion of the Plan providing the Emeriti Reimbursement Benefit is subject to the

<u>Other Uses and Disclosures Permitted Without Authorization</u>. The Plan may disclose the Plan's enrollment and disenrollment information to your employer without your authorization. This information merely indicates whether you are enrolled in the Plan. Your employer needs this information to properly administer the Plan. The Plan may also disclose your PHI to your employer or the Plan's business associates without your authorization so that your employer

Hospital records and other records not maintained by the Plan must be procured directly from the individual or institution that maintains those records.

You have the right to receive a list of instances where the Plan disclosed your PHI to third parties for reasons other than payment or health care operations, except in cases where you have authorized the disclosure, the disclosure was merely incidental to a disclosure that is otherwise permitted under this privacy policy, or the disclosure was required for law enforcement or national security purposes. You may request one such accounting at no charge every 12 months. For any additional requests, you will be charged a reasonable copying fee. Your request should be made by calling 1-866-EMERITI (1-866-363-7484) at which time you will be given instructions on how to file a written request.

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that the Plan correct existing information or add missing information. Your request should be made by calling 1-866-EMERITI (1-866-363-7484) at which time you will be given instructions on how to file a written request. The Plan has 60 days to respond to your written request, subject to a possible 30-day extension. If your request is denied, you will receive a written explanation of the reasons for the denial.

You have the right to restrict disclosure of your health information to a health plan if you choose to pay out-of-pocket in full for the services at the time they are provided. You have the right to request restrictions on the Plan's use or disclosure of your PHI for payment and health care operations. You may also request restrictions on disclosures to your family members or other individuals who are involved in your care or payment for your care. The Plan will consider your request but is not required to agree to such restrictions and generally will not agree to restrictions on disclosures related to the Plan's payment and health care operations. Your request should be made by calling 1-866-EMERITI (1-866-363-7484) at which time you will be given instructions on how to file a written request. The Plan will respond to your request in writing. The Plan will also accommodate reasonable requests for you to receive communications of your PHI at alternate locations or by alternate methods, if the normal method of communication could endanger you.

You may exercise your rights through a personal representative, provided that such individual produces evidence of his or her authority to act on your behalf. The Plan will only accept the following as evidence of such authority: (1) a power of attorney for health care purposes notarized by a notary public; (2) a court order appointing the individual as your conservator or guardian; or (3) proof that such individual is your parent (if you are a minor). Your personal representative will be treated as you would with respect to access to your PHI and