# NOTICE OF PRIVACY PRACTICES

for the

**Standard Plan, State Maintenance Plan, Medicare Plus $1,000,000**

(currently administered by Blue Cross & Blue Shield of Wisconsin)

and the

**Prescription Drug Benefit Plan**

(currently administered by Navitus Health Solutions)

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US. PLEASE REVIEW IT CAREFULLY.**

You do not need to do anything regarding this notice. It is intended to make you aware of your rights under the privacy rule of the federal Health Insurance Portability and Accountability Act (HIPAA) and to inform you how the Wisconsin Department of Employee Trust Funds (ETF) uses and discloses your protected health information. Protected health information is information about you, including demographic data collected from you, that can reasonably be used to identify you and relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the payment for that care.

Please note that while ETF administers many benefit programs for state and local government employees, this notice applies to only the plans listed above. Different policies and regulations apply to records associated with other benefit programs.

**OUR RESPONSIBILITIES**

ETF receives some protected health information as a necessary part of administering health benefits for members. ETF is required by law to maintain the privacy of your protected health information and to provide you with a notice of the above plans' duties and privacy practices. The term "we" in this notice means ETF and our business associates. Business associates are companies and individuals with whom ETF contracts for services, including but not limited to: claim processing, utilization review, actuarial services, claim appeals services and participant surveys. In order to perform their respective functions for ETF, ETF's business associates sometimes must receive your protected health information. ETF requires a contractual commitment from all business associates to protect the privacy of any health information received in the course of providing services.

Blue Cross & Blue Shield of Wisconsin (BCBSWI) is the current third-party plan administrator for the Standard Plan, State Maintenance Plan, and Medicare Plus $1,000,000. Navitus Health Solutions (Navitus) is the pharmacy benefit manager (PBM) for the prescription drug benefit program. BCBSWI and Navitus are business associates and are required to safeguard your health information according to HIPAA's privacy regulation and their respective contracts with the State of Wisconsin.

If you have health insurance with a health maintenance organization (HMO) or a preferred provider plan (PPP), you should receive a notice from your HMO or PPP regarding its privacy practices relating to your health insurance benefit.

We reserve the right to change the terms of this notice and to make the new notice provisions apply to information we already have about you as well as to any information we may receive in the future. We are required by law to comply with the privacy notice that is currently in effect. We will notify you of any material changes to this notice by distributing a new notice to you and posting the new notice on our Web site (http://etf.wi.gov).

**HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

**Treatment:** We may use or disclose your protected health information for treatment purposes. Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, we may share your health information with a pharmacy in order to verify your eligibility for benefits.

**Payment:** We may use or disclose your protected health information for the payment of covered services that you receive under your benefit plan or to otherwise manage your account or benefits. Payment

includes activities by ETF or by organizations hired by ETF to obtain premiums, to make coverage determinations and to provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing. We may also use and disclose your protected health information to determine premium costs, underwriting, rates and cost-sharing amounts. For example, we may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate the payment of your benefits.

**Health Care Operations:** We may use or disclose your protected health information to administer the plans covered by this notice and to coordinate coverage and services on your behalf. We may also use or disclose your health information during the grievance or claim review process in resolving your insurance complaints. Other examples of health care operations include:

- Quality assessment and improvement activities;
- Activities designed to improve the health plan or reduce costs;
- Reviewing and evaluating health plans, including participant satisfaction surveys;
- Training of ETF personnel and contractors;
- Transfer of eligibility and plan information to business associates (for example, to the PBM for the management of pharmacy benefits;
- Reviews and auditing, including compliance reviews, ombudsperson services, legal services, and audit services; and
- Business management and general administrative activities, including customer service.

**As Permitted or Required By Law:** We may share your protected health information as permitted or required by state and federal law, including but not limited to disclosures to comply with Workers' Compensation laws or similar legal programs; for U.S. Department of Health and Human Services investigations, in judicial and administrative proceedings and as required under Wisconsin law for state auditing purposes.

**Organized Health Care Arrangement:** We may participate in an Organized Health Care Arrangement (OHCA). An OHCA can take several forms under HIPAA, including offering health benefits under a combination of group health plans and HMOs. We may share your protected health information to coordinate the operations of the plans and to better serve you as a participant in the plans.

**For Distribution of Information Related to Health Benefits and Services:** We may use and disclose your protected health information to inform you of treatment alternatives or of other health related services and benefits that may be of interest to you.

**Plan Sponsors:** Your employer is not permitted to receive your protected health information related to the plans covered by this notice for any purpose other than the administration and coordination of your benefit plan. For example, we may disclose to your employer whether an employee is participating in the plans or has enrolled or disenrolled in any available option offered by the plans. We may disclose summary health information to your employer, or someone acting on your employer's behalf, so that it can monitor, audit or otherwise administer the employee health benefit plan that the employer sponsors and in which you participate. Summary health information is data that combines information from many participants and does not include information on the individual level.

**Special Circumstances:** If you are unavailable to communicate, such as in a medical emergency or other situation in which you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.

**Authorization**: We will obtain your written permission before we use or disclose your protected health information for any other purpose, unless otherwise stated in this notice. If you grant such permission, you may later withdraw your consent at any time, in writing, using the contact information listed at the end of this notice. We will then stop using your information for that purpose. However, if we have already used or disclosed your information based on your authorization, we cannot undo any actions we took before you withdrew your permission.

**Federal HIPAA Privacy Rule and Wisconsin Privacy Law:** HIPAA is a federal law that supersedes, or preempts, state law under certain conditions. Wisconsin law addresses how ETF is permitted to disclose health-related information. Under section 40.07 (2) of the Wisconsin statutes, ETF is prohibited from disclosing medical records (as defined by section ETF 10.01 (3m) of the Wisconsin Administrative Code)

to anyone, except when a disability application denial is appealed or under a court order. HIPAA supersedes Wis. Stat. § 40.07 (2) to allow your medical records from the health plans listed at the top of this notice to be released to you upon your written request.

However, for all requests for ETF medical records related to programs not covered by HIPAA, such as disability benefits and life insurance, Wis. Stat. § 40.07 (2) continues to require a court order or an appeal of the denial of a disability application before ETF can release your medical records to you or to third parties. Also, please note that state law provides that medical information gathered for any one of the benefit plans established under Chapter 40 of Wisconsin statutes may be used by any other benefit plan established under Chapter 40.

**YOUR HEALTH INFORMATION RIGHTS**

You have rights under federal privacy laws relating to your protected health information. If you wish to exercise any of the following rights, please submit your request in writing to the ETF Privacy Officer using the contact information provided at the end of this notice. We are not required to agree to every request. We will notify you if we approve your request or explain the reason(s) for our decision if we deny your request. We may charge you a fee to cover the costs of processing your request. If so, we will inform you of the fee before proceeding.

**Restrictions/Confidential Communications:** You may request that we not use your protected health information for certain treatment, payment or health care operations or that we communicate with you using reasonable alternative means or locations.

**View or Receive a Copy of Your Health Information:** You have the right to review or obtain a copy of the protected health information that is used to make decisions about you. We are not required to give you certain information, including information prepared for use in legal actions or proceedings.

**Amendment of Your Records:** If you believe that your protected health information is incorrect or incomplete, you may request that your information be changed. Your request must include the reason(s) why you believe the change should be made. In certain situations we will not amend records, such as when we did not create the records that you want amended.

**Request a Listing of Who Was Given Your Information and Why:** Upon request we will provide you with a list of disclosures that we have made since April 14, 2003. The list will not include disclosures you authorized, or disclosures we made for treatment, payment, or health care operations or disclosures for which a listing is otherwise restricted by law.

**Copy of the Privacy Notice:** You have a right to obtain a paper copy of this notice at any time.

**Complaints:** If you feel that your privacy rights have been violated, you may file a complaint by contacting ETF's Privacy Officer using the information provided below. Federal law prohibits any retaliation against you for filing a complaint. You may also file a complaint with the federal Office of Civil Rights.

**Privacy Rights Contact Information**

**Voice:** 1-877-533-5020

**FAX:** (608) 267-0633

**Send written correspondence:**
Department of Employee Trust Funds
Privacy Officer
P.O. Box 7931
Madison, WI 53707-7931

**Send secure e-mail correspondence:**
access our Internet site at
http://etf.wi.gov/contact.htm
and click on the "Email Us" link.

**EFFECTIVE DATE: OCTOBER 11, 2004**

## PATIENT'S RIGHTS AND RESPONSIBILITIES

As a participant in this health insurance program, you have certain rights and responsibilities. By becoming familiar with them, you will be able to make the most of your health care. Our goals are to strengthen your confidence in a fair, responsive and high quality health care system, to provide effective mechanisms to address your concerns and to encourage you to take an active role in improving your health and health care.

The following is a summary of your rights and responsibilities.

**You have the following rights:**

- Considerate, respectful care from all members of the health care system.
- Non-discrimination consistent with state and federal law.
- To change plans annually.
- To a description of benefits presented in an understandable manner. Uniform Benefits are described in Section D of this booklet. Outlines of coverage for the Standard plans are found in Section G of this booklet. If you select one of the Standard plans, you will receive a certificate of coverage that describes your benefits. Your plan may also provide additional information regarding referral requirements, etc.
- To select a primary care physician and to have access to appropriate specialty care. You have the right to a referral to a non-plan specialist for covered services if there is not a plan specialist who is reasonably available to treat your condition.
- A woman has the right to have access to an OB/GYN provider.
- A woman has the right to a minimum hospital stay of 48 hours following a normal delivery of a child or 96 hours following a cesarean delivery. The physician, in consultation with the mother, may discharge the mother and baby prior to the expiration of the minimum stay.
- To have continuous, appropriate access to a provider for the remainder of that calendar year if the provider leaves the plan (other than for misconduct, retirement or a move from the service area). A woman in her second or third trimester of pregnancy has access to that provider until the completion of postpartum care. This right only applies to providers that are listed in the plan’s provider directory available during the Dual-Choice Enrollment period.
- To have access to emergency care without prior-authorization from the plan. If it is not reasonably possible to use a plan hospital or facility, you have the right to obtain treatment at the nearest facility and have those charges covered by the plan as if you did use the plan hospital or facility (however, be aware of your responsibilities when emergency care is received).
- To participate with your provider in treatment decisions.
- To confidentiality of medical information.
- To execute a living will or durable power of attorney for health care if you are 18 years of age or older. These documents tell others what your wishes are in the event that you are physically or mentally unable to make medical decisions or choices yourself.
- To appeal any referral or claim denial through the plan’s grievance process. This review will be conducted in a timely manner. Grievances related to care which is urgently needed must be reviewed by the plan within four working days. If you have exhausted all levels of appeal available through the plan you may submit a complaint to the Department of Employee Trust Funds, in care of the Quality Assurance Services Bureau. You will need to submit a complaint form (ET-2405). You also have the right to request a departmental determination if you believe that a plan did not comply with its contractual obligations.

**In a health care system that protects patients’ rights, it is reasonable to expect and encourage patients to assume certain basic responsibilities. Greater personal involvement in your care increases the likelihood of achieving the best outcomes and helps support quality improvement and a cost conscious environment.**

**You have the following responsibilities:**

- During the Dual-Choice Enrollment period, to review the *It's Your Choice* book and information provided by your plan. This information is important to determine if your plan and/or your providers will continue to be available and whether your current plan continues to best meet your needs for the following calendar year.
- To submit your application for coverage prior to the end of the enrollment period if you select a different plan during the Dual-Choice Enrollment period.
- To select a primary care physician who will oversee your total health care and to make a reasonable effort to establish a satisfactory patient/physician relationship.
- To become involved in your treatment options and/or treatment plan.
- To become knowledgeable about your health insurance coverage and your health plan, including covered benefits, limitations and exclusions and the process to appeal coverage decisions. If you are covered under an HMO or preferred provider plan, to also become knowledgeable about the plan's rules regarding use of network providers, prior authorizations and referrals.
- To authorize the release of relevant personal or medical information necessary to determine appropriate medical care, to process a claim or to resolve a dispute.
- To notify your plan by the next business day, or as soon as reasonably possible, if you receive emergency or urgent care from a non-plan provider.
- To promptly report any family status changes to your payroll representative (or ETF if you are an annuitant or continuant). These changes include marriage, divorce, death, a birth or adoption or a dependent child losing eligibility. You should also report address or name changes, a change in your primary care provider and Medicare eligibility.
- To respond to the plan's annual questionnaire on dependent eligibility if you have a dependent child who is at least 19 years of age and is a full-time student or is disabled. Coverage for dependents could be lost if the questionnaire is not returned to the plan.
- To notify your plan if you obtain or lose other health insurance.
- To submit claims to the plan in a timely manner, if applicable.
- To use the plan's internal grievance process to address concerns that may arise.

## NOTIFICATION OF STATE AND FEDERAL REQUIREMENTS

➔ **INDEPENDENT REVIEW:** In addition to the internal grievance process that all health plans are required to provide, 1999 Wisconsin Act 155 requires all health plans to have an independent review procedure for review of certain decisions. These include denial of, or refusal to pay, for treatment that the insurer considers to be experimental, not medically necessary or appropriate or not the proper level of care or health care setting. The amount or expected cost of treatment must exceed $250 and a $25 fee is required with the request for independent review. The fee will be refunded when the participant prevails.

The Office of the Commissioner of Insurance (OCI) oversees this process, which has been in place since mid-2002. Contact OCI at (800) 236-8517 if you have questions about the independent review law.

➔ **HIPAA/PRE-EXISTING CONDITIONS:** The federal Health Insurance Portability and Accountability Act (HIPAA), effective January 1, 1998, is intended to make it easier for employees to change jobs by limiting waiting periods for coverage of pre-existing health conditions.

Under this health insurance program, employees who did not enroll for coverage when first offered but later enroll are limited to coverage under the Standard Plan with a 180-day waiting period for pre-existing conditions. As a non-federal, self-insured

governmental plan, HIPAA allows this policy to continue. The Group Insurance Board has determined that this is necessary to avoid potential anti-selection. There are certain situations where the employee may enroll as a late enrollee without these restrictions, such as loss of other group coverage, marriage and birth or adoption of a child. (See **Other Enrollment Opportunities** in Section C)

➔ **HIPAA/PRIVACY, ELECTRONIC TRANSACTIONS STANDARDS, AND SECURITY:** HIPAA's administrative simplification rules are intended to simplify and streamline the healthcare claims and payment process through the implementation of national standards. The rules also require that your health information be protected from unauthorized use or disclosure. The three components of the rules are privacy, electronic data transaction standards, and security. The privacy rule came into effect on April 14, 2003, and establishes limits on how your health information can be used and disclosed. The transaction standards rule, which sets out uniform methods for conducting electronic transactions, is effective on October 16, 2003. The security rule requires safeguards for health information maintained in electronic form, and is effective on April 21, 2005.

The DETF is covered by HIPAA by virtue of the Group Insurance Board's Standard Plans that are administered by DETF. As a covered entity, the DETF must comply with the applicable HIPAA regulations. A Notice of Privacy Practices (NPP) was sent out to all members of the Standard Plans in April 2003 and is posted on the DETF web site. If you have insured health coverage from a Health Maintenance Organization (HMO) you should have received a NPP from your HMO.

If you have any questions about HIPAA and need further information, please contact the Department's Privacy Officer at 1-877-533-5020.

➔ **WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998** requires annual notification of coverage under this program for the following treatments in connection with a mastectomy:

> Reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

➔ **COBRA: CONTINUATION OF COVERAGE PROVISIONS FOR THE GROUP HEALTH INSURANCE PROGRAM**

**This notice is provided to meet Federally required notification for continuing your health insurance in the event that you or a covered dependent lose eligibility for coverage.** Both you and your spouse should take the time to read this information carefully.

If active coverage is lost, the State Employees and Wisconsin Public Employers (local government) Group Health Insurance Programs have routinely permitted continuation of coverage for a:

- Retired employee
- Surviving spouse of an active or retired employee
- Surviving dependent child of an active or retired employee

The coverage for a retired employee and surviving spouse may be continued for life; the children may continue coverage for only as long as they meet the definition of a

dependent child. This is not considered to be continuation of coverage as discussed below.

Current federal law, known as COBRA, is somewhat more broad and requires that this notification, regarding additional continuation rights, be given to you and your spouse at the time group health insurance coverage begins.

If you are the actively employed subscriber, you have the right to apply for continuation of coverage if you lose coverage because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct).

If you are the spouse of the subscriber (active or retired), you have the right to apply for continuation if you lose coverage for any of the following reasons:

1. The death of your spouse

2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment

3. Divorce from your spouse

Dependent children have the right to continuation if coverage is lost for any of the following reasons:

1. The death of a parent

2. A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment

3. Parents' divorce; or

4. The dependent child loses dependent status.

**The employee or a family member has the responsibility to inform the employer of a divorce or a child losing dependent status**. Under the law, you must inform Employee Trust Funds that you want to continue coverage within 60 days from the termination of your current coverage or within 60 days of the date you were notified by your employer, of the right to choose continuation coverage, whichever is later.

Continuation coverage is identical to the former coverage, and you have the right to continue this coverage for up to three years from the date of the qualifying event (e.g., such as divorce or a dependent reaching the limiting age) that caused the loss of eligibility. However, your continuation coverage may be cut short for any of the following reasons:

1. The premium for your continuation coverage is not paid

2. You or a covered family member become covered under another group health plan that does not have a pre-existing conditions clause which applies to you or your covered family member or

3. You were divorced from a covered employee, subsequently remarry, and are covered under your new spouse's group health plan.

If you do not choose continuation coverage, your group health insurance coverage will end. You do not have to show that you are insurable to choose continuation coverage.

However, you will be required to pay all of the premium (both your share and any portion previously paid by your employer). At the end of the three-year continuation coverage period, you will be allowed to enroll in an individual conversion health plan.

**If you are an active employee, you or your dependents should contact your employer regarding continuation (including any changes to your marital status or addresses). If you are a retired employee, you or your dependents should contact our office regarding continuation, at toll free 1-877-533-5020 or (608) 266-3285 (local Madison).**

Additional information may be found under **Continuation of Health Coverage** in Section C of this booklet.

➔ **NATIONAL MEDICAL SUPPORT NOTICE:** State and Federal law provides for a special enrollment opportunity for children in certain cases when ordered by a court. The enrollment opportunity is for eligible children who are not currently covered, and may provide for an enrollment opportunity not otherwise available. When the court orders such coverage for a child or children, a copy of the National Medical Support Notice should be attached to the application.