

Medical Benefits

Mastectomy Benefits

The Women's Health and Cancer Right Act of 1998 requires medical plans that offer mastectomy benefits to also provide coverage for reconstructive surgery benefits.

Coverage extends to:

- reconstructive surgery of the breast on which the mastectomy is performed;
- treatment to produce a symmetrical appearance following a mastectomy; prostheses; and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

As with the other covered services provided under your medical plan, annual deductibles, copays, and coinsurance may apply to these mastectomy benefits.

Special Enrollment

Throughout the year, you can enroll or drop medical/dental coverage for yourself and/or your dependents provided you do so within 30 days of the applicable event: marriage, divorce, birth, adoption or placement for adoption of a child, death or ineligibility of a dependent, the involuntary loss of other coverage (including COBRA continuation coverage), termination, commencement, or change in employment status of you or your spouse, a significant change in health coverage attributable to your spouse's employment, a court order, or entitlement to Medicare or Medicaid. Your election change must be consistent with your event/status change.

If you fail to make your request within 30 days, you will have to wait until the next open enrollment period.

Newborns' Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Certificate of Creditable Coverage

HIPAA Certificates of Creditable Coverage certify prior periods of medical coverage and may reduce or eliminate the pre-existing or conditions limitation period for new entrants to the plan. It is your responsibility to submit these certificates to the medical plan. **Note:** Creditable coverage includes group health (including COBRA), comprehensive individual health, Medicare, Medicaid, CHAMPUS, Peace Corp. Act Plan, state risk pool Plans and the Federal Employee Health Benefit Plan.

Medicare Part D

Medicare Part D Prescription Drug Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Seattle Pacific University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Seattle Pacific University has determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Nov. 15 through Dec. 31. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer/ union sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you do decide to join a Medicare drug plan, your Seattle Pacific University coverage will be affected. Benefits will not be coordinated with a Medicare Part D plan.

If you do decide to join a Medicare drug plan and drop your Seattle Pacific University prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. You should also know that if you drop or lose your coverage with Seattle Pacific University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months

without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

Contact Seattle Pacific University for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Seattle Pacific University changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If Medicare eligible, you'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Your Seattle Pacific University prescription drug benefits are as follows:

**Premera Blue Cross
(30-day supply) Option 1/Option 2**

Generic copay:	\$10/\$10
Brand formulary copay:	\$20/\$25
Non-formulary brand copay:	\$45/\$45
<i>\$5 copay for specific generic preventive drugs.</i>	

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

July 1, 2010
Seattle Pacific University
Human Resources

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

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

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 April 16, 2010. You should contact your State for further information on eligibility.

ALABAMA – Medicaid www.medicaid.alabama.gov 1-800-362-1504	CALIFORNIA – Medicaid www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx 1-866-298-8443
ALASKA – Medicaid http://health.hss.state.ak.us/dpa/programs/medicaid/ (Outside of Anchorage): 1-888-318-8890 (Anchorage): 907-269-6529	COLORADO – Medicaid and CHIP Medicaid: www.colorado.gov/ Medicaid: 1-800-866-3513 CHIP: www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP www.azahcccs.gov/applicants/default.aspx 1-877-764-5437	FLORIDA – Medicaid www.fdhc.state.fl.us/Medicaid/index.shtml 1-866-762-2237
ARKANSAS – CHIP www.arkidsfirst.com/ 1-888-474-8275	MONTANA – Medicaid http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml 1-800-694-3084
GEORGIA – Medicaid http://dch.georgia.gov/ (Click on Programs, then Medicaid) 1-800-869-1150	NEBRASKA – Medicaid www.dhhs.ne.gov/med/medindex.htm 1-877-255-3092
IDAHO – Medicaid and CHIP Medicaid: www.accesstohealthinsurance.idaho.gov Medicaid: 1-800-926-2588 CHIP: www.medicaid.idaho.gov CHIP: 1-800-926-2588	NEVADA – Medicaid and CHIP Medicaid: http://dwss.nv.gov/ Medicaid: 1-800-992-0900 CHIP: http://www.nevadacheckup.nv.org/ CHIP: 1-877-543-7669

INDIANA – Medicaid

www.in.gov/fssa/2408.htm
1-877-438-4479

NEW HAMPSHIRE – Medicaid

www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm
1-800-852-3345 x 5254

IOWA – Medicaid

www.dhs.state.ia.us/hipp/
1-888-346-9562

NEW JERSEY – Medicaid and CHIP

Medicaid: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid: 1-800-356-1561
CHIP: <http://www.njfamilycare.org/index.html>
CHIP: 1-800-701-0710

KANSAS – Medicaid

www.khpa.ks.gov
800-766-9012

KENTUCKY – Medicaid

<http://chfs.ky.gov/dms/default.htm>
1-800-635-2570

LOUISIANA – Medicaid

www.la.hipp.dhh.louisiana.gov
1-888-342-6207

NEW MEXICO – Medicaid and CHIP

Medicaid: www.hsd.state.nm.us/mad/index.html
Medicaid: 1-888-997-2583
CHIP: www.hsd.state.nm.us/mad/index.html
(Click on Insure New Mexico)
CHIP: 1-888-997-2583

MAINE – Medicaid

www.maine.gov/dhhs/oms/
1-800-321-5557

NEW YORK – Medicaid

http://www.nyhealth.gov/health_care/medicaid/
1-800-541-2831

MASSACHUSETTS – Medicaid and CHIP

Medicaid & CHIP: www.mass.gov/MassHealth
Medicaid & CHIP: 1-800-462-1120

NORTH CAROLINA – Medicaid

<http://www.nc.gov>
919-855-4100

MINNESOTA – Medicaid

www.dhs.state.mn.us/
(Click on Health Care, then Medical Assistance)
800-657-3739

UTAH – Medicaid

<http://health.utah.gov/medicaid/>
Phone: 1-866-435-7414

MISSOURI – Medicaid

www.dss.mo.gov/mhd/index.htm
573-751-6944

VERMONT – Medicaid

<http://ovha.vermont.gov/>
1-800-250-8427

NORTH DAKOTA – Medicaid	VIRGINIA – Medicaid and CHIP
www.nd.gov/dhs/services/medicalserv/medicaid/ 1-800-755-2604	Medicaid: www.dmas.virginia.gov/rcp-HIPP.htm Medicaid: 1-800-432-5924 CHIP: www.famis.org/ CHIP: 1-866-873-2647
OKLAHOMA – Medicaid	WASHINGTON – Medicaid
www.insureoklahoma.org 1-888-365-3742	http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm 1-877-543-7669
OREGON – Medicaid and CHIP	WEST VIRGINIA – Medicaid
Medicaid & CHIP: www.oregonhealthykids.gov Medicaid & CHIP : 1-877-314-5678	www.wvrecovery.com/hipp.htm 304-342-1604
PENNSYLVANIA – Medicaid	WISCONSIN – Medicaid
www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm 1-800-644-7730	http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm 1-800-362-3002
RHODE ISLAND – Medicaid	WYOMING – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	www.health.wyo.gov/healthcarefin/index.html 307-777-7531
SOUTH CAROLINA – Medicaid	TEXAS – Medicaid
www.scdhhs.gov Phone: 1-888-549-0820	www.gethipptexas.com/ 1-800-440-0493

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security

www.dol.gov/ebsa

1-866-444-EBSA (3272)

**U.S. Department of Health
and Human Services**

Administration Centers for Medicare
& Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Ext. 61565

Continuation of Coverage Rights under COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to Seattle Pacific University Human Resources.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum

of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Please contact Human Resources at **206-281-2676**.

HIPAA Notice of Privacy Practices

This describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Health Information Privacy

This Notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is intended to describe how the Seattle Pacific University health plan will protect your health information with respect to its self-insured health benefits. References below to Health Plan shall mean the medical, dental and health flexible spending account benefits provided by the Health Plan.

"Health information" for this purpose means information that identifies you and either relates to your physical or mental health condition, or relates to the payment of your health care expenses. This individually identifiable health information is known as "protected health information" ("PHI"). Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal or state health information privacy laws.

Health Plan Privacy Obligations

The Health Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this Notice of its legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that are in effect.

How the Health Plan May Use and Disclose Health Information about You

The Health Plan may use health information or disclose it to others for a number of different reasons. The following are the different ways that the Health Plan may use and disclose your PHI without your authorization:

- **For Treatment.** The Health Plan may disclose your PHI to a health care provider who provides, coordinates or manages health care treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the Health Plan may advise an emergency room physician about the different medications that you may have been prescribed.
- **For Payment.** The Health Plan may use and disclose your PHI so claims for health care treatment, services, and supplies that you receive from health care providers may be paid according to the Health Plan's terms. The Health Plan may also use your PHI for billing, reviews of health care services received, and subrogation. For example, the Health Plan may tell a doctor or hospital whether you are eligible for coverage or what percentage of the bill will be paid by the Health Plan.
- **For Health Care Operations.** The Health Plan may use and disclose your PHI to enable it to operate more efficiently or to make certain that all of its participants receive the appropriate health benefits. For example, the Health Plan may use your PHI for case management, to refer individuals to disease management programs, for underwriting, premium rating, activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, to arrange for medical reviews, or to perform population-based studies designed to reduce health care costs. In addition, the Health Plan may use or disclose your PHI to

conduct compliance reviews, audits, legal reviews, actuarial studies, and/or for fraud and abuse detection. The Health Plan may also combine health information about participants and disclose it to Seattle Pacific University in a non-identifiable, summary fashion so that Seattle Pacific University can decide, for example, what types of coverage the Health Plan should provide. The Health Plan may also remove information that identifies you from health information that is disclosed to Seattle Pacific University so that the health information that is used by Seattle Pacific University does not identify the specific Health Plan participants.

- **To The Plan Sponsor.** The Health Plan is sponsored by Seattle Pacific University. The Health Plan may disclose your PHI to designated personnel at Seattle Pacific University so that they can carry out related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the individuals authorized to receive such information under the Health Plan. These individuals will protect the privacy of your health information and ensure that it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Health Plan to any other employee or department of Seattle Pacific University and (2) will not be used by Seattle Pacific University for any employment-related actions or decisions, or in connection with any other employee benefit plans sponsored by Seattle Pacific University.
- **To a Business Associate.** Certain services are provided to the Health Plan by third-party administrators known as "business associates." For example, the Health Plan may place information about your health care treatment into an electronic claims

processing system maintained by a business associate so that your claim may be paid. In so doing, the Health Plan will disclose your PHI to its business associates so that the business associates can perform their claims payment functions. However, the Health Plan will require its business associates, through written agreements, to appropriately safeguard your health information.

- **For Treatment Alternatives.** The Health Plan may use and disclose your PHI to tell you about possible treatment options or health care alternatives that may be of interest to you.
- **For Health-Related Benefits and Services.** The Health Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- **To Individuals Involved in Your Care or Payment of Your Care.** The Health Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Health Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death, unless other laws would prohibit such disclosures.
- **As Required by Law.** The Health Plan will disclose your PHI when required to do so by federal, state, or local law, including those laws that require the reporting of certain types of wounds, illnesses or physical injuries.

Special Use and Disclosure Situations

The Health Plan may also use or disclose your PHI without your authorization under the following circumstances:

- **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Health Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other forms of lawful due process.
- **Law Enforcement.** The Health Plan may release your PHI if asked to do so by a law enforcement official, for example, to report child abuse, to identify or locate a suspect, material witness, missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- **Workers' Compensation.** The Health Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.
- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Health Plan may release medical information about you as deemed necessary by military command authorities.
- **To Avert Serious Threat to Health or Safety.** The Health Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- **Public Health Risks.** The Health Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medications or problems with medical products, or to notify people of recalls of products they have been using.
- **Health Oversight Activities.** The Health Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- **Research.** Under certain limited circumstances, the Health Plan may use and disclose your PHI for medical research purposes.
- **National Security, Intelligence Activities, and Protective Services.** The Health Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law, and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- **Organ and Tissue Donation.** If you are an organ donor, the Health Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, Medical Examiners, and Funeral Directors.** The Health Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Health Plan may also release your PHI to a funeral director, as necessary, to carry out his/her responsibilities.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information that the Health Plan maintains about you:

- **Right to Inspect and Copy Your Personal Health Information.** You have the right to inspect and copy your PHI that is maintained in a "designated record set" for so long as the Health Plan maintains your PHI. A "designated record set" includes medical information about eligibility, enrollment, claim and appeal records, and medical and billing records maintained by the Health Plan, but does not include psychotherapy notes, information intended for use in a civil, criminal or administrative proceeding, or information that is otherwise prohibited by law.
- **To inspect and copy health information maintained by the Health Plan, submit your request in writing to the Privacy Official.** The Health Plan may charge a fee for the cost of copying and/or mailing your request. The Health Plan must act upon your request for access no later than 30 days after receipt (60 days if the information is maintained off-site). A single, 30-day extension is allowed if the Health Plan is unable to comply by the initial deadline. In limited circumstances, the Health Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to your health information, you will be informed as to the reasons for the denial, and of your right to request a review of the denial.

- You may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any must be reasonable and based on the Health Plan's cost.
- **Right to Amend Your Personal Health Information.** If you feel that the health information that the Health Plan has about you is incorrect or incomplete, you may ask the Health Plan to amend it. You have the right to request an amendment for so long as the Health Plan maintains your PHI in a designated record set.
- **To request an amendment, send a detailed request in writing to the Privacy Official.** You must provide the reason(s) to support your request. The Health Plan may deny your request if you ask the Health Plan to amend health information that was: (1) accurate and complete; (2) not created by the Health Plan; (3) not part of the health information kept by or for the Health Plan; or (4) not information that you would be permitted to inspect and copy. The Health Plan has 60 days after the request is received to act on the request. A single, 30-day extension is allowed if the Health Plan cannot comply by the initial deadline. If the request is denied, in whole or in part, the Health Plan will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and, if permitted under HIPAA, have that statement included with any future disclosures of your PHI.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your PHI. This is a list of disclosures of your PHI that the Health Plan has made to others

for the six (6) year period prior to the request, except for those disclosures necessary to carry out treatment, payment, or health care operations, disclosures previously made to you, disclosures that occurred prior to the date on which the accounting is requested, or in certain other situations described under HIPAA.

To request an accounting of disclosures, submit your request in writing to the Privacy Official. Your request must state a time period, which may not be longer than six (6) years prior to the date the accounting was requested. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Health Plan provides you with a written statement of the reasons for the delay and the date by when the accounting will be provided. If you request more than one accounting within a 12-month period, the Health Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- **Right to Request Restrictions.** You have the right to request a restriction on the health information that the Health Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request that the Health Plan limits the individuals (for example, family members) to whom the Health Plan discloses health information about you. For example, you could ask that the Health Plan not use or disclose information about a surgical procedure that you had.

While the Health Plan will consider your request, it is not required to agree to it except in those situations where the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment, and the Protected Health Information pertains solely to a health care item or service that was paid for out of pocket in full. If the Health Plan agrees to the restriction, it will comply with your request until such time as the Health Plan provides

written notice to you of its intent to no longer agree to such restriction, or unless such disclosure is required by law.

To request a restriction or limitation, make your request in writing to the Privacy Official. In your request, you must state: (1) what information you want to limit; (2) whether you want to limit the Health Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. Note: the Health Plan is not required to agree to your request.

- **Right to Request Confidential Communications.** You have the right to request that the Health Plan communicates with you about health matters using alternative means or at alternative locations. For example, you can ask that the Health Plan send your explanation of benefits ("EOB") forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Official. The Health Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you want to be contacted.
- **State Privacy Rights.** You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. You may write to the Privacy Official to request a written copy of this Notice at any time.

Changes to this Privacy Notice

The Health Plan reserves the right to change this Notice at any time and from time to time, and to make the revised or changed Notice effective for health information that the Health Plan already has about you, as well as any information that the Health Plan may receive in the future. The revised Notice will be provided to you in the same manner as this Notice, or electronically if you have consented to receive the Notice electronically.

Complaints

If you believe that your health information privacy rights as described under this Notice have been violated, you may file a written complaint with the Health Plan by utilizing the Benefits “Contact Information.”

You may also file a written complaint directly with the regional office of the U.S. Department of Health and Human Services, Office for Civil Rights.

The complaint should generally be filed within 180 days of when the act or omission complained of occurred. Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this Notice or by the laws that apply to the Health Plan will be made only with your written authorization. If you authorize the Health Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Health Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Health Plan will not reverse any uses or disclosures already made in reliance on your prior authorization. The Health Plan will notify you in the event that there is a breach involving unsecured Protected Health Information.

Contact Information

To receive more information about the Health Plan’s privacy practices or your rights, or if you have any questions about this Notice, please contact the Health Plan at the following address:

Privacy Official
Seattle Pacific University Group
Health Plan
3307 Third Avenue West, Suite 302
Seattle, WA 98119
206-281-2676
www.spu.edu

Copies of this notice are also available on our website at:
<http://www.spu.edu/depts/hr>

Employee Rights and Responsibilities under the Family and Medical Leave Act

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified.

Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For Additional Information

**1-866-4US-WAGE
(1-866-487-9243)**

TTY: **1-877-889-5627**

WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor

Employment Standards Administration

Wage and Hour Division

WHD Public