



## **Welfare Fund of Local No. One, I.A.T.S.E.**

320 West 46th Street, 6th Floor • New York, NY 10036 • Tel (212)247-5225 • Fax (212)977-9319 • [www.fundoneiatse.com](http://www.fundoneiatse.com)

### **Summary of Privacy Practices**

This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by the Welfare Fund of Local No. One, IATSE (the “Fund”) or others in the administration of your claims, and certain rights that you have. For a complete, detailed description of all privacy practices, as well as your legal rights, please refer to the enclosed Notice of Privacy Practices.

### **Our Pledge Regarding Medical Information**

We are committed to protecting your personal health information. We are required by law to: (1) make sure that any medical information that identifies you is kept private, (2) provide you with certain rights with respect to your medical information, (3) give you a notice of our legal duties and privacy practices, and (4) follow all privacy practices and procedures currently in effect.

### **How We May Use and Disclose Medical Information About You**

We may use and disclose your personal health information without your permission to facilitate your medical treatment, for payment for any medical treatments, and for any other health care operation. We will disclose your medical information to Fund Trustees and employees for plan administration functions. We may also use and disclose your personal health information without your permission as allowed or required by law. We must obtain your written authorization for any other use and disclosure of your medical information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization given previously.

### **Your Rights Regarding Your Medical Information**

You have the right to inspect and copy your medical information, to request corrections of your medical information and to obtain an accounting of certain disclosures of your medical information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your medical information, or that communications about your medical information be made in different ways or at different locations.

### **How to File Complaints**

If you believe your privacy rights have been violated, you have the right to file a complaint with us or with the Office for Civil Rights. We will not retaliate against you for making a complaint.



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### **Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice describes the legal obligations of the Welfare Fund of Local No. One, IATSE (the “Fund”) and your legal rights regarding your protected health information obtained by the Fund. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practices (the “Notice”) to you pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to: (1) your past, present or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present or future payment for the provision of health care to you.

This Notice is effective June 1, 2011. If you have questions about this Notice or about our privacy practices, please contact Gloria A. Shea, the Fund’s Privacy Official, at (212) 247-5225.

### **Our Responsibilities**

We are required by law to maintain the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information, and follow the terms of this Notice that is currently in effect.

We reserve the right to change the terms of this Notice as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice, mailed to your last known address on file.

### **How We May Use and Disclose Your Protected Health Information**

Under the law, we may use or disclose your protected health information without your permission in the following cases:

**For Treatment.** We may use or disclose your protected health information to facilitate medical treatment or services by providers, including doctors, nurses or other hospital personnel who are involved in taking care of you. Such disclosures will usually be made by CIGNA, not the Fund Office. For example, CIGNA may disclose the name of your treating physician to a treating orthopedist so that the orthopedist can obtain your x-rays from your physician.

**For Payment.** We may use or disclose your protected health information to determine your eligibility for Fund benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility, or to coordinate Fund coverage. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. Such disclosures will usually be made by CIGNA, not the Fund Office. For example, CIGNA may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by CIGNA.

**For Health Care Operations.** We may use or disclose your protected health information for other Fund operations. For example, we may use medical information in connection with conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, creating or renewing insurance contracts, underwriting, premium rating and other activities related to Fund coverage. This may include submitting claims for stop-loss coverage, disease management, case management, conducting or arranging for medical review, audit services including fraud and abuse detection programs, business management and general administrative activities.

**To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to provide support services, such as utilization management or subrogation.

**As Required by Law.** We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

**To Avert a Serious Threat to Health or Safety.** We may use or disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

**To Fund Trustees.** For Fund administration purposes, we may disclose protected health information to the Fund Trustees and certain Fund employees. However, those individuals will only use or disclose that information as necessary to perform Fund administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. For example, we may disclose information to the Fund Trustees to allow them to decide a Level III appeal.

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

**Organ and Tissue Donation.** If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or transplantation, as necessary to facilitate donation or transplantation.

**Workers' Compensation.** We may release your protected health information for workers' compensation or similar programs providing benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose your protected health information for public health actions, including prevention or control of disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting reactions to medications or problems with products; notification to affected individuals of recalls of products; notification to affected individuals of exposure to a disease or increased risk for contracting or spreading a disease or condition; notification to appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this last disclosure if you agree, or when required or authorized by law.

**Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order; for example, in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may disclose your protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime, if under certain limited circumstances, we are unable to obtain the victim's agreement; about a death that we believe may be the result of criminal conduct; and about criminal conduct.

**Coroners, Medical Examiners, Funeral Directors.** We may release protected health information to a coroner or medical examiner; for example, to identify a deceased person or determine cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

**Inmates.** If you are an inmate of a correctional institution or are in the custody of law enforcement officials, we may disclose your protected health information if necessary for the institution to provide you with health care or to protect your health and safety or the health and safety of others.

**Research.** We may disclose your protected health information to researchers when the individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established privacy protocols and has approved the research.

### **Required Disclosures**

We are required to make the following disclosures:

**Government Audit.** We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

**Disclosures to You.** When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

## All Other Disclosures

**Personal Representatives.** As permitted by law, we will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, so long as you provide us with a written authorization and any supporting documents (i.e. power of attorney).

**Spouses and other Family Members.** With only limited exceptions, we will send all mail to the Fund participant's last known address on file. This includes mail relating to the participant's spouse and other family members who are covered by the Fund, and includes mail with information on the use of Fund benefits by the participant's spouse and other family members. If a person has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

**Authorizations.** Other uses and disclosures of your protected health information not elsewhere described in this Notice will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Your written revocation, once received by us, will only be effective for future uses and disclosures.

## Your Rights

You have the following rights with respect to your protected health information:

**Right to Inspect and Copy.** You have a right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy such information, you must submit your request in writing to:

Gloria A. Shea, Privacy Official  
Welfare Fund of Local No. One, IATSE  
320 West 46th Street, 6<sup>th</sup> Floor  
New York, NY 10036  
Tel. (212) 247-5225  
Fax (212) 977-9319

If you request a copy of the information, we may charge a reasonable fee for providing the information. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Ms. Shea.

**Right to Amend.** If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Fund. To request an amendment, your request must be made in writing and submitted to Ms. Shea, whose contact information appears in the preceding paragraph. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that is not part of the medical information kept by or for the Fund; was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information that you would be permitted to inspect or copy; or is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

**Right to an Accounting of Disclosures.** You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include: (1) disclosures for purposes of treatment, payment or health care operations, (2) disclosures made to you, (3) disclosures made pursuant to your authorization, (4) disclosures made to friends or family in your presence or because of an emergency, (5) disclosures for national security purposes, or (6) disclosures incidental to otherwise permissible disclosures. To request an account of disclosures, you must submit your request in writing to Ms. Shea, whose contact information appears in the first paragraph of this section entitled “Your Rights.” Your request must state a time period of no longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the information (i.e. paper or electronic). The first request you make for an accounting within a twelve-month period will be provided free of charge. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment or health care operations, or that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could request that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree, we will honor the restriction until you revoke it or we notify you. To request a restriction, you must make your request in writing to Ms. Shea, whose contact information appears in the first paragraph of this section entitled “Your Rights.” In your request, you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Ms. Shea, whose contact information appears in the first paragraph of this section entitled “Your Rights.” We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

**Right to a Paper Copy of this Notice.** You have the right to obtain a paper copy of this Notice from us at any time, even if you have agreed to receive the Notice electronically. You may request a copy by contacting Ms. Shea, whose contact information appears in the first paragraph of this section entitled “Your Rights.” Or you may obtain a copy at our website: [www.FundOneIATSE.com](http://www.FundOneIATSE.com).

## **Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with the Fund or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Fund, contact: Gloria A. Shea, Privacy Official, Welfare Fund of Local No. One, IATSE, 320 West 46th Street, 6<sup>th</sup> Floor, New York, NY 10036, Tel. (212) 247-5225, Fax (212) 977-9319. All complaints must be submitted in writing. You will not be penalized, or in any way retaliated against, for filing a complaint with the Office of Civil Rights or with us.