

Effective Date of this Notice: 4/14/2003

NOTICE OF PRIVACY PRACTICES

SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK
HEALTH PLANS ADMINISTRATOR : COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY

As Required by the Privacy Regulations Promulgated Pursuant to the Health
Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT
YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET
ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION.**

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

To summarize, this notice provides you with the following important information:

- how we may use and disclose your identifiable health information;
- your privacy rights in your identifiable health information; and
- our obligations concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to health plans pursuant to HIPAA Regulations and all records containing your identifiable health information that are created or retained by our organization. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our organization has created or maintained in the past, and for any of your records we may create or maintain in the future. You may request a copy of our most current notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

C/O Privacy Officer, Plan Administrator 800-422-6200

C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS.

The following categories describe the different ways in which we may use and disclose your identifiable health information.

1. **Treatment.** Our organization may use or disclose your identifiable health information when necessary for your health care/treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your physician, therapists, spouse, children, or parents.
2. **Payment.** Our organization may use and disclose your identifiable health information in order to pay for the services and items you may receive. For example, we may contact your health provider to certify that you received treatment (and for what range of benefits), and we may request details regarding your treatment to determine if your benefits will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members.
3. **Health Care Operations.** Our office may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our claims administrator may use your health information to evaluate the quality of care you received from your provider, or to conduct cost-management and business planning activities for our organization.
4. **Sponsors of Health Plans.** We may use or disclose protected health information to your School or University or University Health Center where necessary to maintain medical records for your further care or treatment.
5. **Release of Information to Family/Friends.** Our organization may release your identifiable health information to a friend or family member that is helping you pay for your health care, or who assists in taking care of you.
6. **Disclosures Required By Law.** Our organization will use and disclose your identifiable health information when we are required to do so by federal, state, or local law. This could include law enforcement, public health risks, lawsuits, court orders and worker's compensation programs as well as other legal obligations.

D. YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

1. **Right of Access.** You have the right to access your records and request that our office communicate with you about your health and related issues. In order to access your records, you must make a written request to the Plan Administrator.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your case or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your identifiable health information, you must make your request in writing to the Plan Administrator. Your request must describe in clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our organization's use, disclosure or both; and (c) to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **c/o Privacy Officer, Plan Administrator** in order to inspect and / or obtain a copy of your identifiable health information. Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to the Plan Administrator. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for us; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our office, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our insureds have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to the Plan Administrator. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our organization may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of Health and Human Services. To file a complaint with our organization, contact the Plan Administrator. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
7. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, contact the Plan Administrator.
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our office will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization, except for the three situations noted below:
 - We have taken action in reliance on your authorization before we received your written revocation;
 - You were required to give us your authorization as a condition of obtaining coverage; or
 - If we are allowed by law to contest a claim under your policy.
9. **Right to Confidential Communication.** You have a right to request that our office communicate with you in a particular manner. For instance, you may request to receive communication at home, at school, etc. Such requests should be in writing.

Address for all communications under this notice:

Plan Administrator c/o Privacy Officer
70 Genesee Street
Utica, New York 13502