SPELMAN COLLEGE

HIPAA Privacy
Policy for
Fully Insured Health Plans
(effective April 14, 2004)

Introduction

Spelman College (the Company) sponsors the fully insured group health plans listed at Exhibit A (the Plans), which are subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations at 24 C.F.R. part 160 and part 164, subparts A and E (the Privacy Rule).

This HIPAA Privacy Policy (the Policy) establishes the Company's internal framework for ensuring that the Plans comply with the Privacy Rule. This Policy is binding on all Company personnel, but does not create third party rights, including but not limited to rights of Plan participants, beneficiaries, covered dependents, business associates or insurers. In its settlor capacity as sponsor of the Plans, the Company reserves sole and absolute discretion to amend, interpret, or change this policy at any time (prospectively or retroactively) with or without notice. This Policy does not address requirements under other federal or under state laws.

Our Policy

I PLAN DISCLOSURE OF PHI TO THE COMPANY IS RESTRICTED

Except as set forth in Article II of this Policy, no Plan shall disclose "protected health information" or "PHI" to the Company. For purpose of this policy, the term "Plan" shall also include the Plan's insurers and business associates (e.g., brokers, third party administrators and other parties who assist the insurer and the Company in administering the Plan).

PHI means information that a Plan creates or receives, and that -

(a) (i) relates to the past, present, or future physical or mental health or condition of an individual; (ii) the provision of health care to an individual; or (iii) the past, present or future payment for the provision of health care to an individual, and

(b) that either identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

PHI includes information of persons living or deceased. De-identified Information described at Exhibit B of this Policy is not PHI.

II PERMITTED PLAN DISCLOSURE OF PHI TO THE COMPANY

A Plan and its Business Associates (within the meaning of HIPAA) may disclose PHI to the Company only in the following circumstances:

(a) *Summary Health Information*. The Company may receive "summary health information" for purposes of obtaining premium bids for providing health coverage under the Plan (e.g., for underwriting) and for purposes of modifying, amending, or terminating the Plan (i.e., settlor functions).

(i) *Examples of Settlor Functions*. The Company may receive summary health information in order to evaluate whether the Company should provide an additional benefit under a Plan or to change its insurance contract for a Plan from a PPO to an HMO.

(ii) *Summary Health Information Defined*. Summary health information (1) summarizes the claims history, claims expenses, or type of claims experienced by Plan participants or dependents, and (2) does not contain identifiers listed in the definition of de-identified information in Exhibit B, except that the Plan may disclose aggregated five digit ZIP codes.

(b) *Enrollment/Disenrollment Information*. A Plan may disclose to the Company information regarding whether an individual is a participant in the Plan or has enrolled or disenrolled from a health insurance issuer offered by the Plan.

(c) *Assisting Participants with Claims Disputes or Answering Plan Questions*. A Plan or Business Associate may disclose PHI to the Company for the purpose of assisting individuals with benefit claims and appeals and answering questions regarding the Plan, but only if the individual who is the subject of the PHI first signs an authorization substantially in the form attached hereto as Exhibit C (or such other form as may be required by the Plan), authorizing disclosure of this information to the Company.

III NO INTIMIDATING OR RETALIATORY ACTS; NO WAIVER OF PRIVACY RULE RIGHTS

Neither the Company, any Plan, nor any Business Associate shall intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under HIPAA.

No individual shall be required to waive his or her rights under the Privacy Rule as a condition of eligibility, enrollment or the receipt of benefits under any Plan.

IV INSURERS WILL PROVIDE PRIVACY NOTICE

The insurers for the Plans will provide the Notice of Privacy Practices for the Plans and will satisfy the other requirements under the Privacy Rule relating to the PHI used or disclosed by the Plans. The Notice of Privacy Practices will notify participants of the potential disclosure of summary health information and enrollment/disenrollment information to the Company and the fully-insured .

EXHIBIT A

List of Fully-Insured Plans

CIGNA Dental

CIGNA HMO

CIGNA PPO

Magellan Employee Assistance Plan (EAP)

EXHIBIT B

De-identified Information

De-identified Information is not PHI and may be freely disclosed to the Company. De-identified information is health information that does not identify an individual and for which there is no reasonable basis to believe that the information can be used to identify an individual. Information will be deemed to be de-identified if the following identifiers of the individual or relatives, employers, or household members of the individual are removed and the Plan does not have actual knowledge that the information could be used alone or in combination with other information to identify the individual who is the subject of the information:

- names;
- all geographic subdivisions smaller than a state including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of a ZIP code if, according to current publicly available data from the Bureau of Census (a) the geographical unit form by combining all ZIP codes within the same three initial digits contains more than 20,000 people, and (b) the initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000;
- all elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of "age 90 or older";
- telephone numbers;
- fax numbers;
- e-mail addresses;
- Social Security numbers;
- medical record numbers;
- health plan beneficiary numbers;
- account numbers;
- certificate/license numbers;
- vehicle identifiers and serial numbers, including license plate numbers;
- device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) addresses;
- biometric identifiers, including finger and voice prints;
- full-face photographic images and any comparable images; and
- any other unique identifying number, characteristic or code.

EXHIBIT C

MODEL AUTHORIZATION

I INFORMATION ABOUT THE USE OR DISCLOSURE

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Individual's name:_____ ID Number:_____

Persons/organizations authorized to provide the information:_____

_____

Persons/organizations authorized to receive the information:_____

_____

Specific description of information to be used or disclosed (including date(s)):_____

_____

Specific purpose of the disclosure:_____

_____

Will the Plan receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No_____ Yes (describe)_____

This authorization will expire _____ (indicate date, or an event relating to you personally or to the purpose of the authorization (e.g., upon the resolution of my claim for benefits).

II IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.

- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

- This Agreement is subject to the Plan's privacy policy as described in the privacy notice that the Plan's insurer previously delivered to you. If you would like another copy of the privacy notice, please contact the Plan's insurer.

_____ _____

Signature of individual or individual's representative **Date**
(Form MUST be completed before signing.)

Printed name of the individual's personal representative:_____

Relationship to the individual, including authority for status as representative:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

[Please make and copy of the completed authorization and give it to the authorizing individual].