



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.
THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect May 14, 2009, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our Privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Cooperative Health Choices of Western Wisconsin (CHC)

This notice applies to privacy practices of the group health plans and health insurers or HMO's listed below. These organizations' participate in an organized health care arrangement. As such, these organizations may share your medical information and the medical information of others they serve with each other as needed for the payment activities and health care operations relating to our organized health care arrangement.

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Our Uses and Disclosures of Your Medical Information

We use and disclose medical information about you as follows:

Treatment: We may disclose your medical information to a doctor or a hospital which asks us for it to assist in your treatment.

Payment: We may disclose your medical information to pay claims from doctors, hospitals and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, to issue explanations of benefits to the person who subscribes to the health plan in which you participate, and the like.

Health Care Operations: We may use and disclose your medical information to rate our risk and determine our premiums for your health plan, to conduct quality assessment and improvement activities to credential providers, to engage in care coordination or case management, to manage our business and the like.

You and Your Authorization: We must disclose your medical information to you, as described below in the Individual Rights section of this notice. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your medical information for any reason except those described in this notice.

Your Family and Friends: We may disclose to a family member, a friend or other person you indicate are involved in your care or payment for your care, your medical information that is directly relevant to their involvement. We may use or disclose your name, location and general condition or death to notify, or help with notification of a family member, your personal representative, or other person involved in your care about your situation. If you are present, we will give you the opportunity to object before we disclose your medical information to these persons if we determine that the disclosure is in your best interest.

Cooperative Health Choices of Western Wisconsin (CHC): We may disclose your medical information and the medical information of others enrolled in your group health plan to the employer or other organization that sponsors your group health plan to permit it to perform plan administration functions. Please see your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your medical information in providing plan administration. We may also disclose summary information about the participants in your group health plan to the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan or decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarized claims history, claims expenses, or types of claims experienced by the participant in your group health plan but the plan sponsor may still be able to identify you or other participants in your group health plan from the summary information.

Underwriting: We may receive your medical information from underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this medical information for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us. In that case, our use and disclosure of your medical information will only be described in this notice.

Marketing: We may use your medical information to contact you with information about health-related products and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Disaster Relief: We may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts.

Death; Organ Donation: We may disclose the medical information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Research: We may use or disclose your medical information for research purposes, in accordance with certain safeguards.

Public Health and Safety: We may disclose your medical information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your medical information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: We may use or disclose your medical information when we are required to do so by law. For example, we must disclose your medical information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your medical information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards.

Law Enforcement: Under circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose your medical information to law enforcement officials. We may disclose limited medical information to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person. We may disclose the medical information of an inmate or other person in lawful custody to a law enforcement official or correctional institution. We may disclose medical information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and National Security: We may disclose to military authorities the medical information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other nations security activities.

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. **You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$1.00 for each page, \$10.00 per hour of staff time to locate and copy your medical information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of you medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.**

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than for treatment, payment, health care operations and limited other activities. You are entitled to such an accounting for the 6 years prior to your request, though no earlier than May 14, 2009. We will provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your medical information for treatment, payment, health care operations or to persons you identify. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). **Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.**

Confidential Communication: You have the right to request that we communicate with you in confidence about your medical information by alternative means or to an alternative location. **You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request.** We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to

collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate. An explanation of benefits may contain sufficient information to reveal that you obtained healthcare for which we paid, even though you requested that we communicate with you about that health care in confidence.

Amendment: You have the right to request that we amend your medical information. **Your request must be in writing, and it must explain why the information should be amended.** We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: The RiverBank Insurance Center; Carol Bulman

Telephone: 715-483-2318 Fax: 715-483-3456

Email: cbulman@theriverbank.com

Address: 2183 Highway 8, PO Box 747, St. Croix Falls, WI 54024