

## Introduction Regarding Changes in Health Plans

In 2003, as a result of federal laws, specifically the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and changes in regulations from the Department of Labor (DOL), health insurance plans such as ours must change our guidelines. These changes affect both the House Staff Benefits Plan in California, Massachusetts and New York and the Voluntary Hospitals House Staff Benefits Plan in New Jersey and New York.

The following is the HIPAA notice regarding privacy issues:



### **Committee of Interns and Residents**

*An Affiliate of SEIU*

### **HOUSE STAFF BENEFITS PLAN**

and

### **VOLUNTARY HOSPITALS**

### **HOUSE STAFF BENEFITS PLAN**

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COMMITTEE OF INTERNS AND RESIDENTS, 520 EIGHTH AVENUE, SUITE 1200, NEW YORK, NEW YORK 10018-4181

Telephone: (212) 356-8180

Fax: (212) 356-8181

E-Mail: [www.benefits@cirseiu.org](mailto:www.benefits@cirseiu.org)

**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.**

By law, the House Staff Benefits Plan and the Voluntary Hospitals House Staff Benefits Plan (the "Plans") are required to maintain the privacy of your Protected Health Information (PHI), information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This notice describes how the Plans protect the PHI we have about you and may use your health information, for purposes of making or obtaining payment for your care and conducting health care operations. The Plans have established a policy to guard against unnecessary disclosure of your health information.

The Plans **must** use and disclose your PHI to provide information:

- To you or someone who has the legal right to act for you (your personal representative).

- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.

The Plans **have the right** to use and disclose you PHI for Payment and Health Care Operations For example:

- **Payment.** The Plans may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plans may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.
- **Health Care Operations.** The Plans may use or disclose health information for its own operations to facilitate the administration of health plan and as necessary to provide coverage and services to all of the Plans' participants.

The Plans **may** use or give out your PHI for the following purposes under limited circumstances:

- **For Treatment Alternatives and Health-Related Benefits and Services.** The Plans may use and disclose your health information to tell you about or recommend possible treatment options or alternatives and health-related benefits that may be of interest to you.
- **For Disclosure to the Plan Sponsor (the Trustees of the Plan).** The Plans may disclose your health information to the plan sponsor (the Trustees of the Plan) for plan administration functions performed by the plan sponsor (the Trustees of the Plan) on behalf of the Plan. In addition, the Plan may provide summary health information to the plan sponsor (the Trustees of the Plan) so that the plan sponsor (the Trustees of the Plan) may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plans also may disclose to the plan sponsor (the Trustees of the Plan) information on whether you are participating in the health plan.
- **When Legally Required.** The Plans will disclose your health information when it is required to do so by any federal, state or local law.
- **To Conduct Health Oversight Activities.** The Plans may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plans, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.
- **In Connection With Judicial and Administrative Proceedings.** As permitted or required by state law, the Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but

only when the Plans make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

- **For Law Enforcement Purposes**. As permitted or required by state law, the Plans may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plans have a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.
- **In the Event of a Serious Threat to Health or Safety**. The Plans may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plans, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.
- **For Specified Government Functions**. In certain circumstances, federal regulations require the Plans to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.
- **For Worker's Compensation**. The Plans may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

By law, the Plans must have your written permission (authorization) to use or disclose your PHI for any other purpose that is not set out in this Notice. If you authorize the Plans to use or disclose your health information, you may revoke that authorization in writing at any time.

You have the following rights regarding your health information that the Plans maintain:

- **Right to Inspect and Copy Your Health Information held by the Plans**. A request to inspect and copy records containing your health information must be made in writing. If you request a copy of your health information, the Plans may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.
- **Right to Amend Your Health Information**. If you believe that your health information records are inaccurate or incomplete, you may request that the Plans amend the records. That request may be made as long as the information is maintained by the Plans. The Plans may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plans, if the health information you are requesting to amend is not part of the Plans' records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plans determines the records containing your health information are accurate and complete.
- **Right to Request Restrictions on certain uses and disclosures of your health information**. You have the right to request a limit on the Plans' disclosure of your health information to someone involved in the payment of your care. However, the Plans are not required to agree to your request.

- **Right to Receive Confidential Communications.** You have the right to request that the Plans communicate with you in a certain way if you feel the disclosure of your health information could endanger you. The Plans will attempt to honor your reasonable requests for confidential communications.
- **Right to an receive listing of those receiving your PHI from the Plans.** You have the right to request a list of certain disclosures of your health information, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing, specifying the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years.
- **Right to a Paper Copy of this Notice,** at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

The Plans are required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to

***Madeleine Pelfrey, Privacy Officer  
520 Eighth Avenue, Suite 1200  
New York, NY 10018***

The Plans encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Any written requests should be submitted to

***Michelle Cordova, Benefits Supervisor  
520 Eighth Avenue, Suite 1200  
New York, NY 10018***

This Notice is effective April 14, 2003.

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If you, the member/participant, wish to authorize another individual, possibly your spouse or attorney, to receive Protected Health Information on your behalf, you can use this form:

**HOUSE STAFF BENEFITS PLAN**  
**and**  
**VOLUNTARY HOSPITALS HOUSE STAFF BENEFITS PLAN**  
520 Eighth Avenue, Suite 1200, New York, NY 10018-4181 Phone: (212) 356-8180  
Fax: (212) 356-8181  
E-Mail: [www.benefits@cirseiu.org](mailto:www.benefits@cirseiu.org)

**AUTHORIZATION FOR RELEASE OF INFORMATION**

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**Section A: Your information and information of authorized individuals (completed for all authorizations)**

I hereby authorize the Fund to use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, subject to the conditions stated in Section C below. I understand that my health information may be re-disclosed if the person or organization authorized to receive the information is not required by law to protect the privacy of the information.

Patient Name: \_\_\_\_\_ ID Number: \_\_\_\_\_  
DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I authorize the Fund to disclose my Protected Health Information to the following person(s) (please include the name, address and phone #): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize the Fund to disclose Protected Health Information to the persons identified above (mark ALL that apply):  
 Hospital / Medical Claims     Prescription Claims     Vision & Dental Claims     Mental Health  
Claims  Specific description of information (including date(s)): \_\_\_\_\_  
\_\_\_\_\_

Purpose of the requested use or disclosure (if other than for payment/claims information): \_\_\_\_\_  
\_\_\_\_\_

**Section B: Must be completed only if a health plan or a health care provider has requested the authorization**

The health plan or health care provider must complete the following:

1. If the purpose of the authorization is for marketing, will the health plan or health care provider requesting the authorization receive money or anything of value in exchange for using or disclosing the health information described above? Yes: \_\_\_\_ No: \_\_\_\_

**Section C: Must be completed for all authorizations**

The patient or the patient's representative must read and initial the following statements:

1. Unless I am participating in clinical research, I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that a separate informed consent/clinical research authorization form must be signed if I participate in research or clinical trials. Initials: \_\_\_\_\_

2. I understand that if I am requesting an examination only for purposes of sending information about my health status to a third party such as an employer, a health care provider can refuse to conduct such examination unless I sign this form. Initials: \_\_\_\_\_
3. A health plan may condition enrollment in the health plan or eligibility for benefits on this authorization if I am not yet enrolled in the health plan, the purpose of this authorization is to allow the health plan to obtain the information it needs to make an eligibility, enrollment, underwriting or risk rating determination and psychotherapy notes are not requested. If I refuse to sign this authorization I may be denied enrollment in the health plan or eligibility for health care benefits. Initials: \_\_\_\_\_
4. I understand that this authorization shall remain in effect for two years unless one of the following occurs: 1) I lose my coverage; 2) I write a letter requesting the ending of the authorization; or 3) the date I select comes first: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (DD/MM/YR) Initials: \_\_\_\_\_
5. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.
  - 5.1. Right to Revoke. I understand that I have the right to change or revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact Madeleine Pelfrey or Michelle Cordova at Phone: (212) 356-8180; Fax (212) 356-8181; E-Mail: [www.benefits@cirseiu.org](mailto:www.benefits@cirseiu.org). I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections A of this form have already made in reliance upon this authorization. Initials: : \_\_\_\_\_
  - 5.2. Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it. Initials: : \_\_\_\_\_

I, \_\_\_\_\_ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
Signature of patient or patient's personal representative

\_\_\_\_\_  
Date

**Instructions to help you complete the Authorization Form**

**Section A:**

1. Please print your name, phone number, ID number (if different than social security number) SS# and date of birth.
2. In the spaces provided, please provide contact information of the individual(s) for to whom you authorize the Fund to disclose your Protected Health Information. If you want to authorize the Fund to be able to disclose your Protected Health Information to more than two individuals, please complete more than one form.
3. Indicate which payment/claim based information of which you are authorizing disclosure. If you want specific information disclosed, indicate in the space provided for "Specific," including dates. Also indicate the purpose of the requested use or disclosure (if other than for payment/claims information).

**Section B:**

- Must be completed only if a health plan or a health care provider has requested the authorization. If this applies, the health plan or health care provider must claim if there will be remuneration for the information.

**Section C:**

- This section outlines the rights you have protecting your privacy. It also indicates when the authorization will expire. Read this section in its entirety and initial that you have read and understand the information.
- Sign and date the document.

The form can be mailed, hand-delivered or faxed to the Fund. If there are any questions, please contact Madeleine Pelfrey or Michelle Cordova, CIR – HSBP/VHHSBP, 520 Eighth Avenue, Suite 1200, New York, NY 10018-4181; Fax: (212) 356-8181.

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The following is a summary of the regulations from the Department of Labor:



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*Department of Labor Claims Processing Regulations In Effect*

*for House Staff Benefits Plan and Voluntary Hospitals*

*House Staff Benefits Plan of the*

*Committee of Interns and Residents*

Benefit claims submitted on or after January 1, 2003, are subject to compliance with the U.S. Department of Labor's Benefit Processing Regulations. The regulations are intended to formalize many procedures already used by employee benefit plans, including House Staff Benefits Plan, as well as inform participants of required Plan information of benefit determination. The key factors of the regulations are listed below.

#### **Regulates Time Periods for Processing:**

##### **Initial Claim Determination**

- Urgent Care – ASAP, but no more than 72 hours after submission.
- Pre-Service (non-urgent) – 15 days. Possible additional 15-day extension for “reasons beyond control of Plan.”
- Post-service
  - Health: 30 days; possible additional 15-day extension for “reasons beyond control of Plan.”
- Concurrent Care – Sufficient advance notice of reduction or final treatment allowed.

##### **Notices and Disclosure Requirements**

An individual must be given written or electronic notice of an adverse benefit decision that includes:

1. The specific reason for the denial;
2. The specific plan provisions on which the denial is based;

3. Any additional material or information needed to perfect the claim and an explanation of why the material or information is needed;
4. The plan's review procedures, any applicable time limits and a statement of the individual's right to sue;
5. Any specific rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, and that a copy of that information will be provided free;
6. Whether the decision is based on a medical necessity or experimental treatment or similar limit, an explanation of the scientific or clinical judgment, or a statement that the explanation will be provided free upon request; and
7. Whether the request involves a group health plan urgent care decision, as well as the applicable expedited review process.

## **Appeals**

### ***Participant Notice***

- Participants are allowed 180 days from receipt of initial denial to file an appeal.

### ***Time Periods for Appeal Process***

- Urgent Care – ASAP (not to exceed 72 hours – no extensions)
- Pre-Service (urgent & non-urgent) – 30 days – no extensions. Fifteen days if two levels of appeal.
- Post-Service Health – 60 days – no extensions. Thirty days if two levels of appeal.

### ***Appeals Procedure:***

- Independent Review – Persons making initial determination (or subordinate) cannot also determine appeal.
- De Novo Review on Appeal – Must review whole file and make new determination.
- Independent Medical Expertise – For all appeals involving medical judgment (e.g., Medical Necessity, Experimental).
- Appeal Level Limit – No more than two levels of appeal.

### **Claims Procedure Disclosure Requirements:**

- SPD clarifies that Pre-service claims can be appealed.
- SPD states the internal rules, guidelines, protocols, etc. which can be reviewed.
- SPD states that documents created in claims process can be reviewed.

## **Definitions**

- Pre-service claim: a claim for a benefit for which prior authorization from the Plan must be received before any part of the benefit can be obtained. This includes receiving a larger benefit than would otherwise be paid.
- Post-service claim: a claim for a benefit made after medical treatment is rendered.

- Concurrent care claim: a pre-service claim involving ongoing treatment approved for a period of time or number of treatments (e.g., “treatments to be allowed as long as medically necessary”).
- Urgent care claim: Any type of claim that delaying determination could “seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of the physician with knowledge of the claimant’s condition, would subject the claimant to severe pain that cannot be adequately managed without care or treatment.”

For more information, please call the House Staff Benefits Plan office at (212) 356-8180, by e-mail at [www.benefits@cirseiu.org](mailto:www.benefits@cirseiu.org) or by writing the Plan at 520 Eighth Avenue, Suite 1200, New York, New York 10018.  
(April 1, 2003)