

HIPAA NOTICE OF HEALTH INFORMATION 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 Privacy Notice is provided to you in connection with your health plan from one of the following affiliated insurance companies (referred to as “we”, “our” or “us”):

Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio

This notice is effective September 23, 2013 and applies to certain Health Plans such as : Dental, Extended Hospital Expense Rider, Limited Benefit Medical Expense (Retiree Medical), Long Term Care, Medicare Supplement, Prescription Drug Coverage, Student Health, Supplemental Medical Expense and TRICARE.

Our Commitment to Your Privacy

We are committed to maintaining the privacy of your protected health information. This notice will tell you about the ways in which we may use and disclose your protected health information for payment, health care operations, and other circumstances as either required or permitted by law. **Except as outlined below, we will not use or disclose your protected health information without your written authorization, which you may revoke as described in the “Your Privacy Rights” section below.** For example, use or disclosure of your protected health information for marketing, or any disclosure that would constitute a sale of your protected health information, would require your authorization.

We are required by law to: safeguard your protected health information; give you this notice of our duties and privacy practices; notify you in the event of a breach of your unsecured protected health information; and abide by the terms of the Notice of Privacy Practices currently in effect. **The laws of your state may provide additional privacy rights.**

We reserve the right to change any of our privacy practices and the terms of this notice, and to make the new notice effective for all protected health information maintained by us. In the event of a material change, a revised notice will be sent to all of our policyholders.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

- 1. Treatment.** We do not make treatment decisions, but we may disclose your information to those who do. For example, we may disclose information regarding your benefits to doctors, hospitals, long term care facilities, and other health care providers involved in your care.
- 2. Payment.** We may use and disclose your protected health information as necessary for benefit verification and claims

processing purposes. For instance, we may use information regarding health care services you receive from service providers such as physicians, hospitals, pharmacies, nursing homes, assisted living facilities, and home health care agencies to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf. Examples of our payment related purposes also include our collection of premiums, coordinating reinsurance, and care coordination activities.

- 3. Health Care Operations.** We will use and disclose your protected health information as necessary, and as permitted by law to operate our business including performing quality improvement and assurance, conducting cost-management and business planning, enrollment, underwriting, reinsurance, compliance, auditing, rating, customer service, fraud prevention and reporting, research purposes, specialized government functions, payment of agent commissions, and other functions related to your health plan. With the exception of long-term care insurance underwriting, we are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. If our long-term care insurance underwriting uses genetic information it will only be used in a manner allowed by law.
- 4. Family and Friends Involved in Your Care.** We may disclose your protected health information to certain family, friends, and others who are involved in your care or in the payment for your care in order to not hinder that person’s involvement. If you are unavailable, incapacitated, or facing an emergency medical situation, or if we have determined, based on our professional judgment and review of the circumstances, that you would not object and that a limited disclosure may be in your best interest, we may share limited protected health information without your approval. If you have designated a person to help prevent the unintentional lapse of your coverage, we will inform that person prior to terminating the policy for nonpayment of premium. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures by contacting us at the address shown at the end of this notice.
- 5. Business Associates.** Certain services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, claims investigation and adjudication, underwriting support services, care coordination services, etc. We may disclose your protected health information to one or more of these outside persons or organizations that assist us with our health care operations. We obligate business associates to appropriately safeguard the privacy of your protected health information.

- 6. Collection of Information.** To properly underwrite, rate, and administer your health plan, we may collect health and non-health personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, with your authorization, we may also collect or verify information by contacting information sources such as: insurance support organizations (like MIB, Inc.); insurance companies to which you have applied for coverage; and medical professionals and facilities which have provided services to you.
- 7. Agents.** Your agent is our business associate. For customer service purposes, your agent may be notified of certain coverage-related matters and information necessary to assist in servicing your coverage. For example, your agent may be notified if we: decline your application, offer you coverage at a higher than standard rate, or offer to accept the application with modifications to the benefits you requested. We may also notify your agent when there is a change in premium paying status, when we receive notice of a claim, or notice of the cancellation or replacement of your policy. Your agent may be notified on their commission statement that your policy remains in force for as long as you continue to pay your premium.
- 8. Plan Sponsors.** We may also use or disclose protected health information to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.
- 9. Health-Related Benefits and Services.** We or our business associates may contact you regarding health-related benefits and services that may be of interest to you.
- 10. Mergers and Acquisitions.** Your protected health information may also be disclosed as a part of a potential sale, merger or acquisition involving our business.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

Your protected health information may be used or disclosed as applicable without your authorization in the following circumstances:

- for any purpose when required by law;
- for public health and/or law enforcement activities consistent with law if we suspect child abuse, elder abuse, or neglect or believe you to be a victim of abuse, neglect, domestic violence, or other crimes;
- as required by law for governmental oversight agency conducting audits, investigations (such as investigations in to consumer complaints), or civil or criminal proceedings;
- if required by a court or an administrative ordered subpoena or discovery request;

- as required by law for certain law enforcement purposes; about deceased persons to coroners, health examiners, and funeral directors consistent with law;
- if necessary for organ and tissue donation or transplant;
- for certain government-approved research purposes;
- upon reasonable belief to avert a serious threat to health or safety;
- for specialized government functions (such as military personnel and inmates in correctional facilities);
- for national security or intelligence activities;
- to workers' compensation agencies if necessary to make a benefit determination;
- to Non-affiliated organizations or persons, such as other insurance institutions, agents, insurance support organizations (such as MIB, Inc.), or law enforcement and governmental authority as necessary to prevent or investigate criminal activity, fraud, material misrepresentation or material non-disclosure in connection with your coverage or application for coverage;
- to our parent company and affiliates in conjunction with health care operation purposes.

Your Privacy Rights

Your rights are explained below. *Any written requests to exercise those rights should be directed to the address provided at the end of this notice.*

1. **Restrictions.** You have the right to request restrictions on certain of our uses and disclosures of your protected health information for treatment, payment, or health care operations by notifying us in writing. Your request must describe in detail the restriction you are requesting. We will evaluate all requests; however, we are not required to agree to the restriction and we retain the right to terminate a restriction if we believe such termination is appropriate. In the event of a termination by us, you will be notified. You also have the right to terminate a restriction, in writing. You may obtain a Request for Restriction form by contacting us at the phone number listed at the end of this notice.
2. **Confidential Communications.** You may request that we send communications of health information to you by alternative means or to alternative locations, if all or part of that information could endanger you. For example, you may ask that we contact you at work, rather than at home. We will try to accommodate reasonable requests. You may obtain a Request for Confidential Communication form by contacting us at the phone number listed at the end of this notice.
3. **Access.** You have a right to access much of the protected health information that we retain on your behalf. All requests must be made in writing and signed by you or your representative. We may charge a reasonable fee for copies, postage, labor and supplies and, in certain cases, may deny your request. You may obtain a Request for Access form by contacting us at the phone number listed at the end of this notice.
4. **Amendment.** You have the right to request that protected health information we maintain about you be amended or corrected. We will give each request consideration; however we are not obligated to make requested amendments. All

amendment requests must be in writing, signed by you or your representative and state the reason(s) for the request. If an amendment or correction is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain a Request for Amendment form by contacting us at the phone number listed at the end of this notice.

5. **Accounting.** You have the right to receive an accounting of certain disclosures made by us of your protected health information within the six (6) calendar years immediately preceding such a request. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; but we may charge you for additional accountings within the same 12-month period. You will be notified in advance of any fee. You may obtain a Request for Accounting of Disclosure form by contacting us at the phone number listed at the end of this notice.
6. **Revocation of Authorization.** If you have signed an authorization for uses and disclosures not related to payment or health care operations, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance on such authorization, or if other law provides us with the right to contest a claim under the policy or the policy itself. Note: your revocation will not prevent us from using collected information in conjunction with our fraud prevention program.
7. **Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy upon request.

NOTE: The rights granted to you do not extend to information about you relating to or in anticipation of a claim or civil or criminal proceeding.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with us by sending your written complaint to our Consumer Affairs Department at the address given below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

Contacting Us

To file a complaint or to make a request as described in the section entitled "Your Privacy Rights," please send your written request to the company at: 4333 Edgewood Road NE, Cedar Rapids, IA 52499. Requests should be directed to our Customer Service Department and Complaints should be sent to the attention of our Consumer Affairs Department. Please be sure to include the following information:

- Your full name

- Address
- Date of Birth
- Last four digits of your Social Security Number
- Policy number
- The nature of your request or complaint

FOR FURTHER INFORMATION regarding our HIPAA Notice of Health Information Privacy Practices or our general privacy practices, please write to us at the address shown above or call 1-866-512-7495.

THIS NOTICE IS REQUIRED BY FEDERAL LAW. WE MAKE IT AVAILABLE TO THE GENERAL PUBLIC, APPLICANTS AND POLICYHOLDERS. YOUR RECEIPT OF THIS NOTICE IS NOT EVIDENCE OF COVERAGE.