COBRA Continuation Coverage Election Notice

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

This notice has important information about your right to continue your health care coverage in the Fairbanks North Star Borough Health Plan (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?
You're getting this notice because your coverage under the Plan ended on [**Date**] due to one of the below qualifying events:

End of employment	Reduction in hours of employment
Death of employee	Divorce or legal separation
Entitlement to Medicare	Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage? COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries? Each person ("qualified beneficiary") can elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

Are there other coverage options besides COBRA Continuation Coverage Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

ELECTION OF COBRA COVERAGE

You, your spouse, and/or dependent children have sixty (60) consecutive days from the later of the date of the qualifying event or the date you receive this Notice of Continuation coverage to elect COBRA coverage. If you do not elect to purchase COBRA coverage within this 60-day period, you will lose your right to elect continuation coverage. Each qualified beneficiary is entitled to make a COBRA election. Thus, an eligible spouse or dependent child is entitled to elect continuation coverage event if the employee does not make that election.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin on the date coverage terminated (see above) and can last

- 18 months
- 36 months

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify Human Resources of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit http://www.dol.gov/ebsa/publications/cobraemployee.html.

How much does COBRA continuation coverage cost?

	Plan A	or	Plan B	or	Plan C (no HRA)	or	Plan C (w/HRA)	Add to Any Plan D/V/A
Employee Only/ Single	$ 1131.79		$ 342.88		$ 678.26		$ 696.11	$ 84.42
Employee + Spouse	$ 1867.45		$ 565.76		$ 1119.13		$ 1148.58	$ 156.17
Employee + Child(ren)	$ 1867.45		$ 565.76		$ 1119.13		$ 1148.58	$ 156.17
Employee + Family	$ 3225.59		$ 977.21		$ 1933.04		$ 1983.91	$ 261.69

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact

Fairbanks North Star Borough School District
Human Resources, 520 Fifth Ave, Fairbanks, Alaska 99701
Phone – 907-452-2000

For more information about your rights under the COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Important Information About Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact:

Fairbanks North Star Borough School District, Human Resources, 907-452-2000 to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

Fairbanks North Star Borough School District
Human Resources Department
520 Fifth Ave
Fairbanks, AK 99701

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

Re: COBRA (Continuing of Benefit Rights Act)

The enclosed *Summary of Rights and Obligations for Continuation of Health Plan C*
(COBRA) contains important information regarding the continuation of health insu

employee's or dependent's own expense. Employees and/or dependents who choose to continue their group health insurance benefits must complete this form and return it to the FNSB School District Human Resources Department (907)452-2000.

COBRA ELECTION FORM - PLAN A

On behalf of myself and my eligible dependents, if any, I hereby elect to participate in COBRA continuation coverage. I understand my eligibility period of coverage will be for a period of 18, 29, or 36 months *(as defined in the Summary of Rights)* commencing on the first day after the qualifying event, which terminated my coverage as an eligible health plan participant.

COBRA Qualifying Event Date: _____

IMPORTANT Qualifying Event Date:
Employee-the first day of the month following termination from the health plan as an eligible participant.
Spouse - divorce or separation date from employee.
Dependent Natural Child – Last day of the month of 26th birthday.
Dependent Step Child-Last day of the month of 26th birthday or, your natural parent's divorce date from School District employee.

Participant Name:_____

Participant Social Security Number:_____

Participant Mailing Address:_____

Participant Relationship to Employee:_____

Employee Name if Dependent Electing Coverage:_____

Employee Social Security Number:_____

Additional Dependents to be covered:

Last Name	First Name	Date of Birth	Relationship to Participant	Sex (M or F)

Important: You must attach a copy of the marriage certificate for a spouse to be eligible and/or attach birth certificate copies for dependent children to be eligible, if the certificate copies are not on file in the FNSBSD Human Resources Department.

For the period of 01/01/19 to 12/31/18, the monthly premiums are as follows: for employee only $1131.79 ($1216.21 w/DVA)**, for employee and spouse $1867.45** ($2023.62 w/DVA)**, for employee and child(ren) $1867.45** ($2023.62 w/DVA)**, and for employee and family $3225.59** ($3487.28 w/DVA)**.** COBRA premiums may be increased or decreased, at the discretion of the FNSBSD, without advance notice to the participants. Payment is due the first day of each month in order for coverage to be continued. There is a grace period of 30 days for payment of the regularly scheduled premium.

I have received and reviewed the "Summary of Rights and Obligations for Continuation of Health Plan Coverage" for the Fairbanks North Star Borough School District. I understand my right to elect continuation coverage and wish to make the election as indicated above. I understand coverage will be terminated by the School District for failure to make required premium payments in a timely manner. I agree to notify FNSBSD Human Resources if I or any member of my family become(s) covered under another group health plan or entitled to Medicare.

Signed:_____ Date:_____

Return this form to: FNSBSD Human Resources Department, 520 Fifth Avenue, Fairbanks AK 99701

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

Re: COBRA (Continuing of Benefit Rights Act)

The enclosed *Summary of Rights and Obligations for Continuation of Health Plan Coverage (COBRA)* contains important information regarding the continuation of health insurance at an employee's or dependent's own expense. Employees and/or dependents who choose to continue their group health insurance benefits must complete this form and return it to the FNSB School District Human Resources Department (907)452-2000.

COBRA ELECTION FORM - PLAN B

On behalf of myself and my eligible dependents, if any, I hereby elect to participate in COBRA continuation coverage. I understand my eligibility period of coverage will be for a period of 18, 29, or 36 months *(as defined in the Summary of Rights)* commencing on the first day after the qualifying event, which terminated my coverage as an eligible health plan participant.

COBRA Qualifying Event Date: _____

IMPORTANT Qualifying Event Date:
Employee-the first day of the month following termination from the health plan as an eligible participant.
Spouse - divorce or separation date from employee.
Dependent Natural Child – Last day of the month of 26th birthday.
Dependent Step Child - Last day of the month of 26th birthday or, your natural parent's divorce date from School District employee.

Participant Name:_____

Participant Social Security Number:_____

Participant Mailing Address:_____

Participant Relationship to Employee:_____

Employee Name if Dependent Electing Coverage:_____

Employee Social Security Number:_____

Additional Dependents to be covered:

Last Name	First Name	Date of Birth	Relationship to Participant	Sex (M or F)

Important: You must attach a copy of the marriage certificate for a spouse to be eligible and/or attach birth certificate copies for dependent children to be eligible, if the certificate copies are not on file in the FNSBSD Human Resources Department.

For the period of 01/01/19 to 12/31/19, the monthly premiums are as follows: for employee only $342.88 ($427.30 w/DVA)**, for employee and spouse $565.76** ($721.93 w/DVA)**, for employee and child(ren) $565.76** ($721.93 w/DVA)**, and for employee and family $977.21** ($1238.90 w/DVA)**.**
COBRA premiums may be increased or decreased, at the discretion of the FNSBSD, without advance notice to the participants. Payment is due the first day of each month in order for coverage to be continued. There is a grace period of 30 days for payment of the regularly scheduled premium.

I have received and reviewed the "Summary of Rights and Obligations for Continuation of Health Plan Coverage" for the Fairbanks North Star Borough School District. I understand my right to elect continuation coverage and wish to make the election as indicated above. I understand coverage will be terminated by the School District for failure to make required premium payments in a timely manner. I agree to notify FNSBSD Human Resources if I or any member of my family become(s) covered under another group health plan or entitled to Medicare.

Signed:_____ Date:_____

Return this form to: FNSBSD Human Resources Department, 520 Fifth Avenue, Fairbanks AK 99701

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
Re: COBRA (Continuing of Benefit Rights Act)

The enclosed *Summary of Rights and Obligations for Continuation of Health Plan Coverage (COBRA)* contains important information regarding the continuation of health insurance at an employee's or dependent's own expense. Employees and/or dependents who choose to continue their group health insurance benefits must complete this form and return it to the FNSB School District Human Resources Department (907)452-2000.

COBRA ELECTION FORM - PLAN C (no HRA)

On behalf of myself and my eligible dependents, if any, I hereby elect to participate in COBRA continuation coverage. I understand my eligibility period of coverage will be for a period of 18, 29, or 36 months *(as defined in the Summary of Rights)* commencing on the first day after the qualifying event, which terminated my coverage as an eligible health plan participant.

COBRA Qualifying Event Date: _____

IMPORTANT Qualifying Event Date:
Employee-the first day of the month following termination from the health plan as an eligible participant.
Spouse - divorce or separation date from employee.
Dependent Natural Child – Last day of the month of 26th birthday.
Dependent Step Child-Last day of the month of 26th birthday or, your natural parent's divorce date from School District employee.

Participant Name:_____

Participant Social Security Number:_____

Participant Mailing Address:_____

Participant Relationship to Employee:_____

Employee Name if Dependent Electing Coverage:_____

Employee Social Security Number:_____

Additional Dependents to be covered:

Last Name	First Name	Date of Birth	Relationship to Participant	Sex (M or F)

Important: You must attach a copy of the marriage certificate for a spouse to be eligible and/or attach birth certificate copies for dependent children to be eligible, if the certificate copies are not on file in the FNSBSD Human Resources Department.

For the period of 01/01/19 to 12/31/19, the monthly premiums are as follows: for employee only $678.26 ($762.68 w/DVA)**, for employee and spouse $1119.13** ($1275.30 w/DVA)**, for employee and child(ren) $1119.13** ($1275.30 w/DVA)**, and for employee and family $1933.04** ($2194.73 w/DVA)**.** COBRA premiums may be increased or decreased, at the discretion of the FNSBSD, without advance notice to the participants. Payment is due the first day of each month in order for coverage to be continued. There is a grace period of 30 days for payment of the regularly scheduled premium.

I have received and reviewed the "Summary of Rights and Obligations for Continuation of Health Plan Coverage" for the Fairbanks North Star Borough School District. I understand my right to elect continuation coverage and wish to make the election as indicated above. I understand coverage will be terminated by the School District for failure to make required premium payments in a timely manner. I agree to notify FNSBSD Human Resources if I or any member of my family become(s) covered under another group health plan or entitled to Medicare.

Signed:_____ Date:_____

Return this form to: FNSBSD Human Resources Department, 520 Fifth Avenue, Fairbanks AK 99701

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

Re: COBRA (Continuing of Benefit Rights Act)

The enclosed *Summary of Rights and Obligations for Continuation of Health Plan Coverage (COBRA)* contains important information regarding the continuation of health insurance at an employee's or dependent's own expense. Employees and/or dependents who choose to continue their group health insurance benefits must complete this form and return it to the FNSB School District Human Resources Department (907)452-2000.

COBRA ELECTION FORM - PLAN C (w/HRA)

On behalf of myself and my eligible dependents, if any, I hereby elect to participate in COBRA continuation coverage. I understand my eligibility period of coverage will be for a period of 18, 29, or 36 months *(as defined in the Summary of Rights)* commencing on the first day after the qualifying event, which terminated my coverage as an eligible health plan participant.

COBRA Qualifying Event Date: _____

IMPORTANT Qualifying Event Date:
Employee-the first day of the month following termination from the health plan as an eligible participant.
Spouse - divorce or separation date from employee.
Dependent Natural Child – Last day of the month of 26th birthday.
Dependent Step Child - Last day of the month of 26th birthday or, your natural parent's divorce date from School District employee.

Participant Name:_____

Participant Social Security Number:_____

Participant Mailing Address:_____

Participant Relationship to Employee:_____

Employee Name if Dependent Electing Coverage:_____

Employee Social Security Number:_____

Additional Dependents to be covered:

Last Name	First Name	Date of Birth	Relationship to Participant	Sex (M or F)

Important: You must attach a copy of the marriage certificate for a spouse to be eligible and/or attach birth certificate copies for dependent children to be eligible, if the certificate copies are not on file in the FNSBSD Human Resources Department.

For the period of 01/01/19 to 12/31/19, the monthly premiums are as follows: for employee only $696.11 ($780.53 w/DVA)**, for employee and spouse $1148.58** ($1304.75 w/DVA)**, for employee and child(ren) $1148.58** ($1304.75 w/DVA)**, and for employee and family $1983.91** ($2245.60 w/DVA)**.** COBRA premiums may be increased or decreased, at the discretion of the FNSBSD, without advance notice to the participants. Payment is due the first day of each month in order for coverage to be continued. There is a grace period of 30 days for payment of the regularly scheduled premium.

I have received and reviewed the "Summary of Rights and Obligations for Continuation of Health Plan Coverage" for the Fairbanks North Star Borough School District. I understand my right to elect continuation coverage and wish to make the election as indicated above. I understand coverage will be terminated by the School District for failure to make required premium payments in a timely manner. I agree to notify FNSBSD Human Resources if I or any member of my family become(s) covered under another group health plan or entitled to Medicare.

Signed:_____ Date:_____

Return this form to: FNSBSD Human Resources Department, 520 Fifth Avenue, Fairbanks AK 99701

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.

USE AND DISCLOSURE OF HEALTH INFORMATION

The Fairbanks North Star Borough Health Benefit Plan ("Health Plan") may use your health information, that is, 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"), for purposes of making or obtaining payment for your care and conducting health care operations. Health Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. Health Plan 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, Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits, and/or to adjudicate or subrogate health benefits claims, including but not limited to settlement and reimbursement.

To Conduct Health Care Operations. Health Plan 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 Health Plan's participants. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of Health Plan, including customer service and resolution of internal grievances.

For example, Health Plan may use your health information to conduct case management, quality improvement and utilization review, and provider monitoring activities or to engage in customer service and claim appeal activities.

For Treatment Alternatives. Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor. Health Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of Health Plan. In addition, Health Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. Health Plan also may disclose to the plan sponsor information on whether you are participating in the health plan.

When Legally Required. Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities. Health Plan 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. Health Plan, 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, Health Plan may disclose your health information 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 Health Plan makes 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, Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if Health Plan has 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. Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if Health Plan, in good faith, believes 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 Health Plan 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 Workers' Compensation. Health Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Health Plan will not disclose your health information other than with your written authorization. If you authorize Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Authorization for psychiatric Notes, Genetic Information, Marketing, & Sales

In general, and subject to specific conditions, we will not use or disclose psychiatric notes without your authorization; we will not use or disclose PHI that is genetic information for underwriting purposes; we will not sell your PHI, i.e. receive direct or indirect payment in exchange for your PHI, without your authorization; we will not use your PHI for marketing purposes without your authorization; and we will not use or disclose your PHI for fundraising purposes unless we disclose that activity in this Notice.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Health Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Health Plan's disclosure of your health information to someone involved in the payment of your care. However, Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the designated privacy officer, the Fairbanks North Star Borough Risk Manager at (907) 459-1344.

Right to Receive Confidential Communications. You have the right to request that Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. Health Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. If you request a copy of your health information, Health Plan 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 Health Plan amend the records. That request may be made as long as the information is maintained by Health Plan. A request for an amendment of records must be made in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. Health Plan 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 Health Plan, if the health information you are requesting to amend is not part of Health Plan's 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 Health Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of certain disclosures of your health information that Health Plan is required to keep a record of under the Privacy Rule, 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 to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. The request should specify 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. Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Health Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the designated privacy officer, the Fairbanks North Star Borough Risk Manager (907) 459-1344. A copy of the current version of Health Plan's Notice may be obtained at the Fairbanks North Star Borough web site, http://fnsb.us/hr/HealthBenefits

DUTIES OF HEALTH PLAN

Health Plan is 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. Health Plan is required to abide by the terms of this Notice, which may be amended from time to time. Health 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 Health Plan changes its policies and procedures, Health 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 Health Plan should be made in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. Health Plan encourages 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.

CONTACT PERSON

Health Plan has designated the Fairbanks North Star Borough Risk Manager as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at the Fairbanks North Star Borough, PO Box 71267, Fairbanks, Alaska 99707-1267. Telephone (907) 459-1344, Fax (907) 459-1187.

EFFECTIVE DATE

This Notice is effective September 19, 2013.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT
the Fairbanks North Star Borough Risk Manager at the Fairbanks North Star Borough Human Resources Department, PO Box 71267, Fairbanks, Alaska 99707-1267. Telephone (907) 459-1344, Fax (907) 459-1187.