INFORMATION FOR ASSOCIATES/DEPENDENTS

ABOUT THE GROUP HEALTH PLAN – AUTHORIZATION FORM

WHAT IS HIPAA AND HOW DOES IT AFFECT ME?

Congress has passed a law called HIPAA (Health Insurance Portability Accountability Act) which restricts who can access certain health information. The information covered by this law is called Protected Health Information (PHI).

There are times, however, when you may want others to have your health information.

These are the main instances in which HIPAA may affect you:

- If you want your Personnel Manager or Benefit Counselor to call the Benefits Department for information about your medical coverage, you will have to give them authorization to speak on your behalf by completing and returning an Authorization Form. If you are present when the Personnel Representative makes the call, you do not have to complete an Authorization.
- If you have received an "Explanation of Benefits" after 4/14/2003 with the Designation of Personal Representatives Statement printed on it and have not objected, we will assume that you want us to speak to your spouse about your benefits. If you are a dependent and have not objected, we will assume that you want us to speak to your acting parents about your benefits.

If you disagree, please call Customer Service at (800) 452-6199.

- If you want a friend or other family member to have access to your Protected Health Information, you will have to complete and return an Authorization Form granting them permission to have this access.
- You do not need to authorize the Associates' Medical Plan to release information to health care providers, such as hospitals and doctors, for routine purposes of treatment, payment, or healthcare administration.

In addition you need to know:

- No one but you can complete your Authorization Form.
- Personnel Managers and Benefit Counselors cannot complete an Authorization Form for any associate, other than themselves.

TERMS YOU NEED TO KNOW

- Authorization (also called a Release): Gives written permission to release Protected Health Information for non-routine purposes beyond treatment, payment, and healthcare administration.
- Participant: Includes associates and covered dependents who are enrolled in the Tyson Associates' Medical Plan.
- Protected Health Information (PHI): Generally any health-related information that could identify a particular individual's personal information.

ADDITIONAL INFORMATION

- Authorizations remain in effect for one (1) year from the date of your signature.
- If you do not receive a response within 45 days, you may assume the request has been granted.

You may return your completed Authorization Form by MAIL, FAX, or by SCAN-SENDING it through EMAIL. You do not need to return this page.

MAIL TO

BlueAdvantage National Accounts
P.O. Box 1460
Little Rock, AR 72203

FAX to the Attention of the BANA Customer Service at (501) 378-2325.

SCAN-SEND to TysonServiceTeamBlueAdvClms@arkbluecross.com

GROUP HEALTH PLAN – AUTHORIZATION

Participant Release Of Protected Health Information

PARTICIPANT INFORMATION

Name of Associate Carrying Medical Coverage _____

Social Security Number of Associate Carrying Coverage _____

Participant (This is the Person whose Protected Health Information will be released) _____

Participant's Date of Birth _____ Telephone Number _____

Participant's Address _____

AUTHORIZATION (This is who will receive the participant's Protected Health Information)

I authorize the Associates' Medical Plan and its business associates to release Protected Health Information to the people, group, or organization listed below:

Full Name _____ **Date of Birth** _____
(person, group, organization other than self) *(person)*

Address _____
(person, group, or organization address needed for verification purposes)

I authorize the Plan to release: (only mark one)

❑ All my Protected Health Information, ***or*** ❑ All my Protected Health Information **except**:

If you have marked **except**, list the information (treatment for the dates of service, diagnosis(es)/condition(s), and/or treatment by the following provider(s) name/address) that you do not want released: *(Attach additional pages if necessary.)*

_____

REASON FOR REQUEST

You may check the box below that states "At participant's request" or you may specify below the reasons you are authorizing the Plan to share your Protected Health Information.

❑ At the participant's request ❑ Other reasons (specify) _____

SIGNATURE

I understand that:

- This authorization is valid for one (1) year from the date of my signature.
- I have the right to cancel this authorization at any time by completing a Cancellation of Authorization Form.
- The Associates' Medical Plan may have already released my health information (due to an earlier authorization). If so, that release of information is proper and is not affected by a Cancellation of Authorization.
- If the person or entity that I authorize to receive my health information is not required to comply with the federal privacy regulations, these regulations will no longer protect my information.

I understand that payment of my claims does not depend upon my signing this form. I understand that if I do not sign this form, the authorization will be invalid.

_____ _____

Participant's Signature (This is the Person whose Protected Health Information will be released) Date

If you are authorizing the release of your own information, you are finished and it is not necessary to complete the below.

If you have completed this form as a legally recognized representative of the participant, it is necessary to complete the following:

Name of Representative (please print your name) _____

State your relationship to the participant (that allows you to act on their behalf) _____

Sign this form on behalf of the participant Representative's Signature _____ Date _____

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Associates' Medical Plan will obtain a valid, signed authorization from a Plan participant prior to using or releasing the participant's Protected Health Information, unless the Plan participant's authorization is not legally required by law.

If you do not receive a response regarding this form within 45 days, you may assume that this request has been granted.

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276.