M.A. Services
Pullano & Company
PO Box 587
Pittsford, NY 14534
1-800-836-8100
www.flexbene.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND YOUR FAMILY MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

THIS NOTICE TAKES EFFECT APRIL 14, 2003

OUR LEGAL DUTY

We, Marketing Associates & LTD Co. Inc. dba M. A. Services/Pullano & Company, are required by applicable federal and state laws to maintain the privacy of your PROTECTED HEALTH INFORMATION, herein after referred to as "PHI". This PHI consists of any information that can identify you as an individual and your past, present or future physical or mental health condition. We understand that medical information about you and your health is personal, and we are committed to safeguarding your PHI.

The law stipulates that we must ensure that any PHI which may identify you is kept private, as well as provide notice of our legal duties and privacy practices regarding PHI, and follow the terms of the notice which is currently in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such change(s). We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including information we received before we made the changes. Before we make significant changes we will send a new notice. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the contact information at the end of this notice.

USES AND DISCLOSURES OF NONPUBLIC PERSONAL INFORMATION

Nonpublic Personal Information is information you give us in your enrollment form, claim vouchers, Dependent Care forms, etc. For example: names, social security numbers, addresses, type of benefits, payment amounts, claim amounts, etc. We will not give out your nonpublic personal information to anyone unless we are permitted to do so by law or have received a signed authorization form from the member.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Below are the categories that describe different purposes for which we may use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. If we need to use or disclose PHI in any other way, we will obtain your signed authorization before use or disclosure.

Payment: We will not disclose PHI to an unauthorized person, unless we are required to do so by law. We may use and disclose PHI to collect premiums, to determine our responsibility to pay claims or to notify members of our claim determinations.

Operations: We may use and disclose PHI for purposes of performing our operations. Our operations include using PHI to determine eligibility, to conduct quality assessment and improvement activities. For example, we may disclose PHI when working with accreditation agencies that monitor and evaluate the quality of our benefit programs.

To You: We may disclose your PHI to you, as described in the Individual Rights section on this notice. We may also use and disclose PHI to tell you about related benefits or services that may be of interest to you.

To Family and Friends: ***We will not disclose PHI to an unauthorized person, unless we are required or permitted to do so by law.*** We will only disclose PHI to the person you authorize by completing, signing and dating the enclosed Authorization Form. This includes spouses. We will verify authorization upon receipt of this form by social security number, so please be sure to include the social security number of the person you are authorizing. We will renew the authorization annually within the election process. ***Please notify the person you are authorizing to have their social security number handy if they are calling to obtain information about a claim***.

To Our Business Associates: A business associate is defined as someone that assists us in managing our business. For example, a professional that reviews the quality of our products and services. We may disclose PHI to another company that helps us manage our business. For example, we may disclose PHI to a company that performs case reviews to ensure our members receive quality care. These business associates are required to sign a confidentiality agreement with us that limits their use or disclosure of the PHI they receive.

To Plan Sponsors: A plan sponsor is the employer or employee organization that establishes and maintains the employee's benefit plan. We may disclose PHI to the plan sponsor to perform plan administrative functions. For example, the cost analysis of the benefit program. Before PHI is disclosed to your plan sponsor, we will receive certification form the plan sponsor that appropriate amendments have been made to Plan Documents and the plan sponsor agrees to limit their use of this disclosure to plan administration functions only.

Public Health and Safety: We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health and safety, or the health or safety of others. We may disclose PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Victims of Abuse, Neglect or Domestic Violence: We may disclose PHI 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 PHI when we are required to do so by law. For example, we must disclose PHI to the U.S. Department of Health and Human Services upon request to determine whether we are in compliance with federal privacy laws.

Confidential Communication: You have the right to request that we communicate with you confidentially about your PHI. We will honor a request to communicate to an alternative location if you believe you would be endangered if we do not communicate to the alternative location. We must accommodate your request if it is reasonable and specifies the alternative location.

Amendment: You have the right to request that we amend your PHI. 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 if we determine the information is accurate. 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. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be attached to the information you wanted amended.

Questions and Complaints

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

On or after 4/14/2003, if you are concerned that we may have violated your privacy rights, as described above, or you disagree with a decision made about your access to your PHI or in response to a request you make to amend or restrict the use or disclosure of your PHI or to have us confidentially communicate with you at an alternative location, you may contact us using the contact information 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 PHI. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

Privacy Contact Information:

Contact Office: Privacy Officer
Address: PO Box 587
Pittsford, NY 14534

Phone: 1-800-836-8100

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form is used to authorize M. A. Services/Pullano & Co. to release protected health information to one designated person. This authorization is voluntary, and is at the sole discretion of the member. We will not condition our payment activities in connection with your claims, your enrollment or eligibility form benefits on you giving this authorization. Please make copies of this form for each additional person or contact our office to request additional forms.

Please complete the following information. All sections must be completed or the form will be considered incomplete and returned to you.

The Individual

Name:____

Address:____

City:___________________________ **State:**______________________ **Zip:**__________

Social Security Number:_______________________ **Date of Birth:**_________________

Employer:____

Person Authorized to Receive Information

Name:______________________________ **Social Security Number:**________________

Address:____

City:____________________________ **State:**_____________________ **Zip:**_________

Signature: *This form is not valid without a signature.*

I, (*please print*) ________________________________, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that M. A. Services/Pullano & Co. may disclose to the person designated in this form the protected health information described in this form and the Privacy Notice, effective April 14, 2003. I understand that this authorization is only valid while enrolled in the Plan and is subject to reauthorization annually with my reenrollment.

I understand that the person I authorize to receive protected health information is no longer subject to federal health information privacy laws. I understand that I may revoke this authorization at any time by giving *written notice* **of revocation to the office of M. A. Services/Pullano & Co. Revocation of this authorization will not affect any action taken in reliance on this authorization before written notice of this revocation is received.**

Signature:__________________________________ Date:_______________________

Please make a copy of this form for your records.