



TO: All OrthoSynetics Employees Eligible for Insurance

FROM: Human Resources Department

DATE: November 13, 2009

RE: 2010 HEALTH PLAN OPEN ENROLLMENT

The open enrollment period for the 2010 Health Plan year will begin on November 15th and end on December 15th. OrthoSynetics, Inc. (OSI) will continue to offer the same comprehensive benefits package, which provides an array of options for our employees including Medical, Vision and Dental as well as Life and Accidental Death & Dismemberment (AD&D) coverage. During open enrollment, you have the opportunity to review and modify your benefit choices. **All enrollment materials including the enrollment application are available at <http://www.orthodon.com/Humanresources.aspx> under the section titled 2010 OrthoSynetics – Choice POS II Plan.** Please take your time and read this information carefully, so that you may make the best decision for you and/or your family members.

Employee Contributions

We have great news in regards to the employee contributions for the 2010 plan year. Although the nation is still experiencing rising health costs on average of 8%, we are thrilled to announce there will be **no increase** in employee premiums as well as no increases in co-pays or deductibles for the 2010 plan year!! We attribute this to the continued efforts of all plan participants to utilize in-network doctors and facilities as well as to take advantage of cost saving generic drugs.

The plans offered by OrthoSynetics are self funded. What exactly does it mean to be self funded? It means the company assumes the financial liability, and pays all claims incurred by the plan participants in exchange for being able to tailor the plan design to meet the needs of our plan participants. On a self insured plan, the company only pays for any health care services actually received by the plan participants. Whereas, on a fully insured plan, the company would pay a set premium for health care services each plan participant is estimated to receive during the year. Therefore, it is very important for each plan participant to utilize the in-network services, generic drugs and 100% paid well visits in an effort to stay healthy and keep claims and ultimately employee contributions at or below budget.

We are pleased to announce there is also no increase in the Dental Plan premium. In addition, Life and AD&D coverage as well as the Employee Assistance Plan (EAP) will continue to be offered at no additional cost to the employee and their dependents!!

Employee contributions for the 2010 plan year (effective 1/1/10), per pay period, are as follows:

Per Pay Period Cost	Medical Plan	Medical Plan	Medical Plan	Dental Plan
	Platinum	Gold	Silver	
Employee Only	\$54.00	\$40.00	\$19.00	\$5.00
Employee + Spouse	\$315.00	\$264.00	\$223.00	\$23.50
Employee + Child(ren)	\$218.00	\$177.00	\$143.00	\$23.50
Family	\$485.00	\$418.00	\$363.00	\$23.50

WHAT ARE YOUR CHOICES?

Aetna Medical Plan

Aetna will continue as the carrier for OrthoSynetics on claims handling and processing. In addition, the network of physicians and hospitals will still be provided through Aetna's Choice POS II Open Access, a broad network of providers that allow not only choice, but substantial savings on medical expenses for our employees and their dependents. **Please use the Aetna website, www.aetna.com, to find a listing of providers in your area.** Once on the Aetna website, simply click on Find a Doctor and you can perform a General Search (recommended) by Zip Code, City and State. **Please be sure to select Aetna Choice POS II (Open Access) when performing a General Search.**

Employees will continue to have a choice of three Medical Plan offerings. During this open enrollment period, you can decide between the following levels of coverage:

1. **Aetna – PLATINUM PPO Plan** – Coverage is provided in-network at 90% co-insurance and 50% co-insurance out-of-network.
2. **Aetna – GOLD PPO Plan** – Coverage is provided in-network at 80% co-insurance and 50% co-insurance out-of-network.
3. **Aetna – SILVER PPO Plan** – Coverage is provided in-network at 70% co-insurance and 50% co-insurance out-of-network

Benefit summaries are available at <http://www.orthodon.com/Humanresources.aspx> under the section titled 2010 OrthoSynetics – Choice POS II Plan. Please read each summary carefully to choose the Aetna Medical Plan offering which best meets the needs of you and your family.

Aetna Vision Benefit

Vision coverage will still be provided through Aetna. Aetna allows for one FREE routine eye exam every 24 months to all employees and their dependents that enroll in the Aetna Medical Plan. **Please use the Aetna website, www.aetna.com, to find a listing of providers in your area.** In addition, Aetna Vision Discounts provide special discounts on eyeglasses, contact lens and even Lasik surgery. Additional information is available at <http://www.orthodon.com/Humanresources.aspx>. Click on the link titled Aetna Choice Vision Plan

Express-Scripts Prescription Drug Program

Express-Scripts, Inc. will again provide prescription drug benefits for all OrthoSynetics employees who choose to participate in the Medical Plan. The appropriate Co-pay for each plan is provided in

the table below. Please note all new participants will receive an Express-Scripts ID card for the prescription drug program in the mail. For more information please visit www.express-scripts.com.

Prescription Drug Co-Pays	Platinum	Gold	Silver
Generic	\$10 Co-pay	Greater of \$10 or 30% of Rx	Greater of \$10 or 30% of Rx
Formulary	\$25 Co-pay	Greater of \$25 or 30% of Rx	Greater of \$25 or 30% of Rx
Non-Formulary	\$40 Co-pay	Greater of \$40 or 40% of Rx	Greater of \$40 or 40% of Rx
Maintenance Drugs	Mandatory Mail Order or 0% *	Mandatory Mail Order or 0% *	Mandatory Mail Order or 0% *
Mail Order Program	\$20/\$50/\$80 Co-pay 3 mo. supply	\$20/\$50/\$80 Co-pay 3 mo. supply	\$20/\$50/\$80 Co-pay 3 mo. supply

***Maintenance drugs will ONLY be covered at a retail pharmacy for a maximum of 2 refills. Participants will then be required to utilize the Express-Scripts Mail Order Program.**

MetLife Dental Plan

MetLife is our dental carrier for claims handling and processing. We believe that MetLife provides participants with significant advantages including the ability to choose from nationwide providers and take advantage of several online features located on the MetLife website. **There are no changes to the Dental Plan design for plan year 2010.** Please remember the MetLife Dental Plan is referred to as the Preferred Dentist Program (PDP). This plan allows you to have the freedom of choice to visit any dentist, but if you decide to utilize the services of a dentist in the network, you will benefit from fewer out-of-pocket expenses. Additional information is available in the Human Resources Center at www.orthodon.com. Click on the link titled MetLife Dental Plan. **Please note all new participants will receive a MetLife dental card in the mail upon enrollment.**

To locate a provider for the Preferred Dental Program, please access the MetLife website at www.metlife.com/mybenefits

Life and Accidental Death & Dismemberment (AD&D) Coverage

Regardless if you participate in the OrthoSynetics Medical and/or Dental Plan, the Company will continue to provide \$20,000 of Life and AD&D insurance, at no cost to you. This benefit will be provided by Reliance Standard.

Employee Assistance Program

Personal issues can affect not only our health, but our every day life and even job performance. That's why OrthoSynetics provides all employees with access to an Employee Assistance Program (EAP) through Reliance Standard. This is a voluntary program which allows employees to deal with personal concerns in a completely confidential manner. The EAP provides professional counseling and information on several topics including, but not limited to grief and loss, single parenting, substance abuse, financial planning, and child care.

For quick and easy reference, we have enclosed a magnet with the EAP 1-800 number and website. Additional information is available at <http://www.orthodon.com/Humanresources.aspx>. Click on the link titled Employee Assistance Program to take advantage of the services available with this free benefit!!!

Identification (ID) Cards

As previously mentioned, if you are a new participant or if you make any changes to your health benefit election, you will receive THREE separate identification cards. One will be from Aetna for

the Medical Plan and another from Express-Scripts for the prescription drug program. You will also receive a MetLife dental card from OrthoSynetics. These cards will be mailed in early January.

If a medical need arises prior to the arrival of your Aetna card, employees will have the ability to print a temporary medical ID card from the Aetna website by logging onto www.aetna.com and signing up for Aetna Navigator. Information for an Express-Scripts prescription drug card may be obtained by contacting Bonnie Buckley in the Human Resources Department at 504-828-5937.

WHAT DO YOU NEED TO DO?

Open Enrollment

During this annual open enrollment, you may add, drop or change coverage for yourself or your eligible dependents. Once elections are made during open enrollment they cannot be changed unless you experience a change in employment or family status (e.g. marriage, divorce, birth, adoption, and loss or addition of other coverage). The duration of the special enrollment period for any change in family status is 30 days, and begins on the date of the marriage, birth, adoption, etc. Further details and required paperwork to enact a qualifying event change can be obtained by contacting the Human Resources Department.

If you **DO NOT want to change any of your current coverage** (Medical/Vision and/or Dental) and/or the dependents currently covered, you **DO NOT have to respond to this mailing.** Your current coverage will carry over to Aetna and/or MetLife for the 2010 plan year.

If you **wish to change plans, enroll or cancel** your current coverage in the Medical/Vision and/or Dental Plan and/or the dependents currently covered, you **MUST complete an Application for Coverage in full.** This means if you currently have medical and want to add dental, you still must elect both medical and dental on the 2010 application in order to continue all coverage's.

The enrollment application is available at <http://www.orthodon.com/Humanresources.aspx>. Click on the link titled Application for Coverage.

IMPORTANT REMINDERS

Please remember that each employee must select the same insurance plan for himself or herself and all of the covered dependents. For example, an employee choosing family medical and family dental coverage must enroll the same family members on both the Medical Plan and the Dental Plan. Also, an employee choosing medical and dental coverage for him or herself may not also choose dental coverage only for his or her children.

Coverage is provided for newborn dependents of a Plan Participant for the first 31 days after birth. A Plan Participant must make written application to the Human Resources Department within those 31 days after birth in order for coverage to continue on the 32nd day forward for the newborn. If written application is not made to add the newborn within 31 days of birth, then the newborn will NOT be allowed on the medical plan until the next open enrollment.

Employees with dependent children must remember that dependent children ages 19 through 25 are allowed to remain on OrthoSynetics Medical and/or Dental Plan only if they are enrolled as full time students at an accredited college or university. Proof of enrollment will be required. Dependent children older than 19 years who are not enrolled in an accredited college or university, and dependent children who are enrolled in an accredited college or university but are older than 25 years, may not remain on the Plan. These dependent children may be eligible for coverage under the COBRA Act of 1985.

If you should terminate employment for any reason, your coverage will terminate on the last day of

month in which your final paycheck is paid.

We realize that you may have questions or concerns regarding the benefits. Please feel free to contact Bonnie Buckley in the Human Resources Department at (888) 622-SMILE or, via E-mail at bbuckley@orthosynetics.com and she will be happy to assist you.

MAILING INSTRUCTIONS

PLEASE MAIL ALL COMPLETED APPLICATIONS DIRECTLY TO THE HUMAN RESOURCES DEPARTMENT AT THE FOLLOWING ADDRESS:

**3850 N. Causeway Blvd Suite 800
ATTN: HUMAN RESOURCES
Metairie LA 70002**

FORMS MUST BE POSTMARKED BY THE DECEMBER 15th OPEN ENROLLMENT DEADLINE IN ORDER FOR YOUR CHOICES TO BE EFFECTIVE JANUARY 1, 2010. LATE SUBMISSIONS WILL NOT BE ACCEPTED AND EXCEPTIONS WILL NOT BE MADE.

WOMEN'S HEALTH AND CANCER RIGHTS ACT of 1998
(P.L. 105-277)

The purpose of this letter is to inform you that the above-referenced Act, which became effective October 21, 1998, requires coverage for reconstructive surgery following mastectomies. Group health plans must provide coverage for:

- ❖ reconstruction of the breast on which the mastectomy has been performed;
- ❖ surgery and reconstruction of the other breast to produce a symmetrical appearance
- ❖ prostheses; and
- ❖ treatment for physical complications related to mastectomy, including lymphedema.

The coverage is to be determined by the attending physician, in consultation with the patient. The benefits will be payable on the same basis as any other physical illness.

This federal law also requires that we notify all employees and dependents in writing. Your current plan already conforms to the requirements of this Act.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

OrthoSynetics, Inc. also will allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for your state's premium assistance program under Medicaid or Children's Health Insurance Program (CHIP).

For these enrollment opportunities, you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in the OrthoSynetics, Inc. Plan. This 60 day notice deadline does not apply to enrollment opportunities other than the Medicaid/ CHIP eligibility changes.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

EXPANDED PARITY RULES FOR MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Coverage for mental health and substance abuse services for all medical plans will change to mirror the way other inpatient and outpatient services are covered. With these changes, OrthoSynetics medical plans comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

MEDICARE ELIGIBLE EMPLOYEES & DEPENDENTS

Important Notice from OrthoSynetics/Express Scripts About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with OrthoSynetics/Express Scripts and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. OrthoSynetics/Express Scripts has determined that the prescription drug coverage offered by OrthoSynetics/Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current OrthoSynetic/Express Scripts coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current OrthoSynetic/Express Scripts coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with OrthoSynetics/Express Scripts and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through OrthoSynetics/Express Scripts changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	11/15/2009
Name of Entity/Sender:	OrthoSynetics
Contact--Position/Office:	Bonnie Buckley/Human Resources
Address:	3850 N. Causeway Blvd., Suite # 800, Metairie, LA 70002
Phone Number:	504-828-5937

HIPAA NOTICE of PRIVACY PRACTICES
For the Health and Welfare Plan of OrthoSynetics, Inc.
(Regs. Section 164.520(b))

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.

You are receiving this Privacy Notice because you are eligible to enroll or already enrolled in the OrthoSynetics, Inc. Health Plan (“Health Plan”). Health Plan is committed to protecting the confidentiality of any health information we collect about you. This Notice describes how Health Plan may use and disclose your “protected health information” (PHI). PHI is any information created or received by a health care provider, health plan, employer or health care clearinghouse that relates to your past, present or future physical or mental health or condition, or provision of or payment for health care. PHI is information that identifies the individual or may reasonably be used to identify the individual.

Employees of the plan sponsor who administer and manage this Health Plan may use your PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These people must comply with the same requirements that apply to Health Plan to protect the confidentiality of PHI.

Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to you. Additionally, Health Plan is required by law to:

- ◆ maintain the privacy of your “protected health information” (PHI), and
- ◆ provide you with a Privacy Notice of its legal duties and privacy practices with respect to your PHI, and
- ◆ follow the terms of Privacy Notice that is currently in effect.

If you have questions about any part of this Privacy Notice or if you want more information about the privacy practices of Health Plan, please contact the Privacy Compliance Officer listed at the end of this Notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Health Plan is permitted by law to use and disclose your protected health information (PHI) in certain ways. These are described below, with examples of permitted uses. This Notice does not list every permitted use or disclosure the Health Plan may make. However, all the ways Health Plan is permitted to use or disclose PHI will fall within one of the categories below.

1. **Treatment Purposes:** Health Plan may disclose PHI to a health care provider for the health care provider’s treatment purposes, although it is more likely a health care provider would receive your PHI from another health care provider than from the Health Plan. For example, if your Primary Care Physician (PCP) or your treating medical provider refers you to a specialist for treatment, the Health Plan can disclose your PHI so the specialist to whom you have been referred so he or she can become familiar with your medical condition, prior

diagnoses and treatment, and prognosis.

2. **Payment Purposes:** Health Plan may use your PHI to evaluate and process any requests for coverage and claims for benefits you make, and may review PHI included with claims to reimburse providers for treatment and services rendered. Additionally, Health Plan may disclose PHI to another group health plan or to a health care provider for the payment purposes of this Health Plan, the other group health plan, or the health care provider. For example, Health Plan can disclose your PHI to another health plan or payer for purposes of coordinating payment of benefits.
3. **Health Care Operations Purposes:** Health Plan may use PHI for its own health care operations and may disclose PHI to another group health plan, a health care provider, a medical group or a hospital for the health care operations purposes of this Health Plan, or for certain health care operations purposes of the other entities. Examples of this Health Plan's "health care operations" include underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of Health Plan.
4. **To a Business Associate of the Health Plan:** Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, if a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so, or provides services to the Health Plan such as legal, actuarial, accounting, consulting or administrative services. Examples of Business Associates include Health Plan's Third-Party Administrator (TPA) and broker.
5. **To the Health Plan Sponsor:** but only if the sponsor has amended its plan document as required by the Privacy Rule, certified to the Health Plan as required by the Privacy Rule, and established certain safeguards and firewalls to limit the classes of employees who will have access to PHI and to limit the use of PHI to plan purposes and not for non-permissible purposes. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Examples would include: for claims appeals to the Plan's Benefits Committee, for case management purposes, or to Human Resources representatives of the plan sponsor who are assisting plan members in getting their claims resolved.

The plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "summary health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

6. **Where Required by Law or Requested as Part of a Regulatory or Legal Proceeding:** Health Plan may disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

7. **For Public Health Activities or to avert a Serious Threat to Health or Safety:** Health Plan may disclose PHI to public health authorities for purposes such as preventing or controlling diseases, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration on products and reactions to medications; and reporting disease or infection exposure.
8. **For Law Enforcement or Specific Government Functions:** Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with your written authorization or that of your legal representative, and you may revoke such authorization as provided by section 164.508(b)(5) of the Privacy Rule. Any disclosures that were made when your Authorization was in effect will not be taken back.

NOTICE OF BREACH OF PROTECTED HEALTH INFORMATION (PHI)

Notices to Individuals: Under the HITECH Act, an employer health plan will have to notify each individual whose unsecured PHI was, or is believed to have been, improperly used or disclosed. These notices are required to be provided “without unreasonable delay” and “in no case later than 60 calendar days” after discovery. The preamble to the regulations clarifies that if an employer has the necessary information to notify individuals within 10 days of discovery of the breach, but does not notify individuals until 60 days after discovery of the breach, that employer would be in violation of the rules. “Discovery” is defined as actual knowledge of the breach by a member of the plan’s workforce or an agent of the plan, or deemed knowledge if the breach would have been discovered by exercising reasonable diligence.

These individual notices must be written in plain language and include basic information such as: (1) the date of the breach, if known; (2) a brief description of the breach and what the plan is doing to mitigate damages and protect against future breaches; and (3) steps affected participants should take to protect themselves. The notices may be sent by first-class mail to the individual’s last known address or by e-mail if the individual has agreed to receive electronic notices (and has not withdrawn that agreement). If there is insufficient or out-of-date contact information, substitute notice may be provided by an alternative form of written notice, or by phone or other means – if there are fewer than 10 affected individuals. If there are more than 10 affected individuals, substitute notice would be in the form of a notice posted for a specified period on the home page of a relevant website or notice in major print or broadcast media.

Notices to Media: In addition to notifying affected individuals, if a breach affects more than 500 residents of one state or other smaller jurisdiction (such as a county, city or town), prominent media outlets serving that jurisdiction must be notified. This notice must be provided without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. This notice must include the same basic information as the individual notice. Health and Human Services (HHS) clarifies in the preamble to the regulations that it expects this notice would usually be done in the form of a press release.

Notices to HHS: In addition to the required notices to individuals and any potential notices to media outlets, employer-sponsored health plans will have to notify HHS of any breaches of participant unsecured PHI. If a breach involves 500 or more individuals, a plan must notify HHS at the same time it notifies the individuals. The manner and content of this notice are expected to be specified on the HHS website. As required by the HITECH Act, HHS will post on its website a list of HIPAA-covered entities, including employer-sponsored health plans, that submit reports of breaches involving more than 500 individuals. If a breach involves fewer than 500 individuals, the plan will have to track these breaches and notify HHS of them no later than 60 days after the end of the relevant calendar year. Note that the HHS reporting requirements do not depend on where an affected participant resides.

Notices by Business Associates to Plan: A third-party administrator, claims administrator, pharmacy benefit manager or other business associate to an employer-sponsored health plan will be required to notify the plan itself in the event of a breach of unsecured PHI. Again, the notice must be provided without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. Discovery is defined in terms of actual knowledge by an employee, officer or other agent of the business associate, or deemed knowledge if the breach would have been discovered by exercising reasonable diligence.

Under the HITECH Act, notices are generally required upon a “breach” of “unsecured” PHI, and the regulations clarify both terms:

- For purposes of the regulations, the term “breach” means the “acquisition, access, use or disclosure” of PHI in a manner not permitted by the HIPAA privacy rules which “compromises the security or privacy” of the PHI. Security and privacy are considered to be compromised when a breach poses a “significant risk of financial, reputational or other harm” to an individual. Importantly, breach is specifically defined to exclude certain situations, such as a disclosure where there is a good faith belief that the unauthorized person who received PHI could not have retained it.
- Under the HITECH Act and follow-up HHS guidance, notices are required only for breaches of “unsecured” PHI. “Unsecured” is defined as information that has not been destroyed under an approved method or secured by a technology that renders the PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or accredited by the American National Standards Institute. The new regulations clarify that electronic information that has been encrypted pursuant to the HIPAA security rules will be considered secure for these purposes.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI. To submit one of the requests listed below, you must submit a written request to OrthoSynetics, Inc., Privacy Compliance Officer, Dept of Human Resources, 3850 North Causeway Blvd, Suite 800, Metairie, LA 70002.

1. The right to inspect and copy PHI, as provided by section 164.524 of the Privacy regulations.
2. The right to request restrictions on certain uses and disclosures of PHI, as provided by section 164.522(a) of the Privacy regulations (although the Group Health Plan is not required to agree to a requested restriction).

3. The right to receive confidential communications of PHI, if you believe Health Plan's usual method of communicating PHI may endanger you, as provided by section 164.522(b) of the Privacy regulations.
4. The right to amend PHI you feel is incorrect, as provided by section 164.526 of the Privacy regulations. Health Plan may deny your request, but must respond to you in either case.
5. The right to receive an accounting of disclosures we have made of your PHI, as provided by section 164.528 of the Privacy regulations. We are not required to, and we will not, account for disclosures made for treatment, payment or health care operations, national security, law enforcement or to corrections personnel, pursuant to your Authorization, or to you. Please note the time period for which you want an accounting, and the format in which you wish to receive it (e.g., paper or electronically). Note that we will not account for disclosures made more than six years prior to your request, nor for disclosures made before HIPAA became effective for Health Plan [April 14, 2003]. We will provide one accounting of disclosures free of charge once every twelve months.
6. The right to file a complaint if you feel your privacy rights have been violated. For details, see subsequent section of this Privacy Notice entitled "The Health Plan's Grievance Procedures."
7. The right to receive a paper copy of this Notice of Privacy Practices upon request to the Group Health Plan, even if you have previously agreed to receive this Notice electronically.

THE HEALTH PLAN'S RESPONSIBILITIES REGARDING YOUR PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises its Notice, it will notify you of these changes by posting the revised Notice on www.orthodon.com under Human Resources Center.

THE GROUP HEALTH PLAN'S GRIEVANCE PROCEDURES

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Health Plan or with the Secretary of Health and Human Services (HHS). To file a complaint, you must submit a written request by fax or mail to OrthoSynetics, Inc., Privacy Compliance Officer, Dept of Human Resources, 3850 North Causeway Blvd, Suite 800, Metairie, LA 70002 or (504) 832-0156. Additionally, you can file a complaint with the Secretary of HHS at the following addresses: www.hhs.gov/ocr

Or Department of Health and Human Services

The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

You will not be retaliated against for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE

This Notice is effective as of April 14, 2003.