

**SCANA CORPORATION  
GROUP HEALTH PLANS**

**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.**

**I. Introduction**

This Notice describes Our<sup>1</sup> legal obligations and your legal rights regarding Your Protected Health Information held by Us under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how Your Protected Health Information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to:

1. your past, present or future physical or mental health or condition;
2. the provisions of health care to you; or
3. the past, present or future payment for the provision of health care to you.

The Plan provides health benefits to the eligible employees of SCANA Corporation (the "Plan Sponsor") and their eligible dependents. The SCANA Pharmacy provides covered prescription drugs and services to Plan participants.

**II. Our Privacy Obligations**

We are required by federal and applicable state law to protect the privacy of individually identifiable health information about you that We create or receive (“Your Protected Health Information”), to provide you with this Notice of Our legal duties and privacy practices, to provide notice to affected individuals following a breach of unsecured protected health information, and follow the terms of this Notice that are currently in effect. When We use or disclose Your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

**III. Uses and Disclosures Without Your Written Authorization**

We may use and disclose to others Your Protected Health Information without your written Authorization for the following purposes. For each category, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, the ways We are permitted to use and disclose information will fall within one of the categories. The amount of health information used or disclosed will be

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<sup>1</sup> For purposes of this Notice of Privacy Practices, “Our,” “We,” “Us,” or “Plan” refers to the following components of the SCANA Corporation Organized Health Care Arrangement: the medical benefits, prescription drug benefits, vision benefits, dental benefits, employee assistance program (medical portion only), and SCANA Pharmacy benefits of the SCANA Corporation Health and Welfare Plan; the SCANA Corporation Health Care Flexible Spending Account Plan; and the medical, dental, vision and SCANA Pharmacy benefits under the SCANA Corporation Retiree Welfare Benefits Plan.

limited to information that excludes most direct identifiers, such as name, address, and Social Security number, unless more information is needed. If additional information is needed, it will be limited to the “minimum necessary” to accomplish the purpose of the use or disclosure.

A. Treatment. We may disclose medical information about you to facilitate medical treatment services. For example, the Plan may disclose Your Protected Health Information to your health care provider for its provision, coordination, or management of your health care and related services. SCANA Pharmacy may use or disclose Your Protected Health Information as necessary to maintain a patient profile on you, which may include information about you, your medical condition, medications, and any allergies you may have. SCANA Pharmacy may also use and disclose Your Protected Health Information in dispensing prescription medicines and related products and services, including counseling you and your caregivers about proper use of your medications.

B. Payment. We may use and disclose Your Protected Health Information for payment purposes. For example, the Plan may use or disclose Your Protected Health Information to obtain payment for your coverage and to determine and fulfill the Plan’s responsibility to provide health benefits, to make coverage determinations, administer claims and coordinate benefits with other coverage you may have. The Plan also may disclose Your Protected Health Information to another health plan or a health care provider for its payment activities — for example, for the other health plan to determine your eligibility or coverage, or for the health care provider to obtain payment for health care services provided to you. SCANA Pharmacy may use Your Protected Health Information to obtain payment for covered prescription drugs provided to you, or to assist another provider in obtaining payment for covered services it provides to you.

C. Health Care Operations. We may use and disclose Your Protected Health Information for Our health care operations. For example, We may use and disclose Your Protected Health Information to do business planning, arrange for medical review and conduct quality assessment and improvement activities. We also may disclose Your Protected Health Information to another health plan or a health care provider that has or had a relationship with you for it to conduct quality assessment and improvement activities; accreditation, certification, licensing, or credentialing activities; or for the purpose of health care fraud and abuse detection or compliance — for example, for the other health plan to perform case management or evaluate health care provider performance, or for the health care provider to evaluate the outcomes of treatments or conduct training programs to improve health care skills.

D. To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on Our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use and/or disclose Your Protected Health Information, but only after they agree in writing with us to implement appropriate safeguards regarding Your Protected Health Information. For example, We may disclose Your Protected Health Information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with Us. Business Associates are required to comply with HIPAA requirements to safeguard Your Protected Health Information.

E. To Comply with the Law. We may use and disclose Your Protected Health Information to the extent required to comply with applicable law.

F. Disclosures to the Health Plan Sponsor. We may disclose Your Protected Health Information to certain employees or other Individuals under the control of the Plan Sponsor as necessary for them to carry out the Plan Sponsor’s responsibilities to administer Plan payment and health care operations activities.

G. Health-Related Communications. We may contact you to give you information about health-related benefits and services that may be of interest to you. We may also contact you to provide appointment or refill reminders or information about treatment alternatives or other health-related benefits and services that may be useful to you.

H. Public Health Activities. As required by law, We may disclose Your Protected Health Information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting births and deaths; notifying people of recalls of products they may be using; reporting child abuse or neglect (only if you agree or when required by law); reporting domestic violence (only if you agree or when required by law); reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

I. Health Oversight Activities. We may disclose Your Protected Health Information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid, or other regulatory programs for which health information is necessary for determining compliance.

J. Judicial and Administrative Proceedings. We may disclose Your Protected Health Information in the course of a judicial or administrative proceeding in response to a subpoena, discovery request or legal order or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested information.

K. Law Enforcement Officials. We may disclose Your Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order or other process authorized by law.

L. Health or Safety. We may disclose Your Protected Health Information to prevent or lessen a serious and imminent threat to the health or safety of an Individual or the public.

M. Organ and Tissue Donation. If you are an organ donor, We may release Your Protected Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

N. Specialized Government Functions. We may disclose Your Protected Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State.

O. Workers' Compensation. We may disclose Your Protected Health Information as necessary to comply with workers' compensation laws.

P. Research. We may disclose Your Protected Health Information to researchers when:

(1) the individual identifiers have been removed; or,

(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

#### **IV. Required Disclosures**

The following is a description of disclosures of Your Protected Health Information We are required to make.

A. Government Audits. We are required to disclose Your Protected Health Information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining Our compliance with HIPAA requirements.

B. Disclosures to You. When you request, We are required to disclose to you the portion of Your Protected Health Information that contains medical records, billing records, and any other records used to make decisions regarding your health care or health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of Your Protected Health Information.

## V. Other Disclosures

A. Personal Representatives. We will disclose Your Protected Health Information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA Privacy Rule, We do not have to disclose information to a personal representative if We have reasonable belief that:

1. you have been, or may be, subject to domestic violence, abuse or neglect by such person;
2. treating such person as your personal representative could endanger you; or,
3. in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

B. Authorizations. Other uses or disclosures of Your Protected Health Information not described above will only be made with your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once We receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

We will obtain a written authorization for any use or disclosure of psychotherapy notes, except:

1. to carry out the following treatment, payment, or health care operations: use by the originator of the psychotherapy notes for treatment; use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual; and
2. a use or disclosure that is: required by the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA privacy rule; permitted by law; for health oversight with respect to the oversight of the originator of the psychotherapy notes; to a coroner or medical examiner for the purpose of identifying a decedent; or to avert a serious threat to health or safety.

Please note that We do not use Your Protected Health Information for marketing or fundraising efforts. We do not sell Your Protected Health Information. We do not use or disclose Your Protected Health Information that is genetic information for underwriting purposes as prohibited by the Genetic Information Nondiscrimination Act (GINA) of 2008.

## VI. Your Individual Rights

A. Right to Inspect and Copy Your Protected Health Information. You may request access to Our records that contain Your Protected Health Information in order to inspect and request copies of the records. If Your Protected Health Information is maintained or used in an “electronic health record”, you may obtain a copy of the information in an electronic format and direct the copied information to be transmitted to another individual or organization. Under limited circumstances, We may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Office and submit the completed form to the Privacy Office. If you request copies, We reserve the right to charge you copying and mailing costs.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Privacy Office at the address below.

B. Right to Request Amendment of Your Records. You have the right to request that We amend Your Protected Health Information that you believe is incorrect or incomplete. To make such a request, please obtain an amendment request form from the Privacy Office and submit the completed form, including the reason for the amendment, to the Privacy Office. We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, We may deny your request if you ask Us to amend information that:

1. is not part of the medical information kept by or for Us;
2. was not created by Us, unless the person or entity that created the information is no longer available to make the amendment;
3. is not part of the information that you would be permitted to inspect and copy; or,
4. is already accurate and complete.

If We deny your request, you have the right to file a statement of disagreement with Us and any future disclosures of the disputed information will include your statement.

C. Right to Receive An Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of Your Protected Health Information. The accounting will not include:

1. disclosures for purposes of treatment, payment or health care operations (except to the extent required by law, if the Plan maintains Your Protected Health Information as an electronic health record);
2. disclosures made to you;
3. disclosures made pursuant to your authorization;
4. disclosures made to friends or family in your presence or because of an emergency;
5. disclosures for national security purposes; and,
6. disclosures incidental to otherwise permissible disclosures.

To request this list of accounting of disclosures, you must submit your request in writing to the Privacy Office. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Additional Restrictions. You may request restrictions on Our use and disclosure of Your Protected Health Information. For example, you could ask that We not use or disclose information about a surgery you had or a prescription drug you take. While We will consider requests for additional restrictions carefully, We are not required to agree to a requested restriction unless your request is to restrict Our disclosure of Your Protected Health Information to a health plan when such information would be used for healthcare operations or payment, the disclosure is not otherwise required by law, and Your Protected Health Information relates solely to a health care item or service paid for entirely out of pocket by you (or a person other than the Plan on your behalf). If you wish to request additional restrictions, please obtain a request form from the Privacy Office and submit the completed form to the Privacy Office. You will be given a written response.

E. Right to Receive Confidential Communications. We will accommodate any reasonable request for you to receive Your Protected Health Information by alternative means of communication or at alternative locations. Your request must specify how or where you wish to be contacted. Please note that in certain situations, such as eligibility and enrollment information, the Plan (but not the SCANA Pharmacy) is obliged to communicate directly with the employee rather than a dependent unless the request clearly states that disclosure of that information to the employee could endanger you.

F. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically. You may obtain a copy of this Notice at the “Health, Wealth, and Career” Web page on the SCANA Intranet site or you may contact the Privacy Office at the address below.

G. Right to Receive Notification. You are entitled to receive notice from Us if the confidentiality of any of Your Protected Health Information maintained in an unsecured form is compromised.

H. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that the Plan or SCANA Pharmacy has violated your privacy rights or disagree with a decision that We made about access to Your Protected Health Information, you may contact the Plan’s Privacy Office. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Secretary. The Plan will not retaliate against you if you file a complaint with it or the Secretary.

## **VII. Effective Date and Duration of This Notice**

A. Effective Date. This Notice is effective on September 9, 2013<sup>2</sup>

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If We change this Notice, We may make the new notice terms effective for all of Your Protected Health Information that We maintain, including any information created or received prior to issuing the new notice.

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<sup>2</sup> This Notice was subsequently modified on September 15, 2016, to reflect the adoption of the SCANA Corporation Retiree Welfare Benefits Plan.

If We change this Notice, We will send the new notice to you if you are then covered by the Plan. You also may obtain any new notice by contacting the Privacy Office.

C. Limitation on Application of Notice. This Notice does not apply to information that does not identify an Individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an Individual. In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for its purposes of obtaining premium bids (although the Plan will not use or disclose genetic information for this purpose) or modifying, amending or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses or types of claims experienced by Individuals for whom the Plan Sponsor provides benefits under the Plan and from which the Individual identifying information, except for five-digit zip codes, has been deleted. The Plan and Plan Sponsor also may use or disclose eligibility and enrollment information without your Authorization.

#### **VIII. Privacy Office**

SCANA Corporation  
220 Operations Way  
Cayce, SC 29033-3701  
Telephone: 1-800-335-6974; E-mail: [Privacy@scana.com](mailto:Privacy@scana.com)