AGC HEALTH BENEFIT TRUST – OREGON-COLUMBIA CHAPTER

HIPAA PRIVACY POLICY AND PROCEDURES

Effective April 1, 2015

TABLE OF CONTENTS

Page

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PRIVACY POLICY AND PROCEDURES

I. STATEMENT OF PURPOSE

The HIPAA Privacy Rules require that the AGC Health Benefit Trust – Oregon-Columbia Chapter not use or disclose Protected Health Information ("PHI") unless it is for Payment, Treatment or Health Care Operations or authorized by the affected Individual. Under the Privacy Rules, all disclosures of PHI shall be limited to the minimum necessary requirements.

This Policy and Procedures is enacted to document the AGC Health Benefit Trust – Oregon-Columbia Chapter's compliance with the requirements of the HIPAA Privacy Rules and to provide guidance for handling issues which may arise under the HIPAA Privacy Rules. Other Covered Entities with which the Trust contracts will follow their own privacy policies adopted pursuant to the HIPAA Privacy Rules. This Policy and Procedures will be interpreted in accordance with the governing regulations and other legal requirements.

II. DEFINITIONS

2.1 Capitalized terms not otherwise defined in this Policy shall have the meanings given to them in the HIPAA privacy regulations, 45 Code of Federal Regulations ("CFR") Parts 160 and 164.

2.2 "Designated Record Set" means:

A. A group of records maintained by or for a Covered Entity that is:

1. The medical records and billing records about Individuals maintained by or for a covered health care provider;

2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

3. Used, in whole or in part, by or for the Covered Entity to make decisions about Individuals.

B. For purposes of this definition, the term "record" means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a Covered Entity.

2.3 "Electronic PHI" means PHI transmitted by or maintained in electronic media.

2.4 "Individual" means the person who is the subject of PHI.

2.5 "Participant" means the employee or former employee participating in the Trust or another Individual entitled to receive a separate notice under the Privacy Rules.

2.6 "Plan Sponsor" means the Board of Trustees of the AGC Health Benefit Trust – Oregon-Columbia Chapter as the entity which establishes or maintains the Trust and its plans.

2.7 "Policy" means this Privacy Policy and Procedures.

2.8 "Privacy Contact Person" means the individual or office designated by the Board of Trustees to receive complaints and inquiries and who can provide further information about matters covered by the Privacy Notice.

2.9 "Privacy Official" means the individual designated by the Board of Trustees to oversee compliance with the Privacy Rules and this Policy.

2.10 "Privacy Rules" means the privacy rules specified by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and detailed in 45 CFR Parts 160 and 164. References to Privacy Rules shall include any requirements established by the security regulations concerning Electronic PHI.

2.11 "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

2.12 "Security Official" means the individual responsible for the development and implementation of policies and procedures required by the security regulations contained in 45 CFR Parts 160 and 164.

2.13 "Trust" means for purposes of this Policy the AGC Health Benefit Trust – Oregon-Columbia Chapter and the health plans it maintains.

2.14 "Trust Office" means the Trust's administrative office.

2.15 "Summary Health Information" means information that may be individually identifiable health information, and: (1) summarizes the claims history, claims expenses, or type of claims experienced by Individuals for whom the Plan Sponsor has provided health benefits under the Trust; and (2) from which the specific identifiers described in 45 CFR § 164.514(b)(2)(i) have been deleted.

2.16 "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

2.17 "Workforce Members" means the Trust Office employees.

2.18 As used in this Policy the term **"Breach"** shall have the definition set forth in 45 CFR § 164.401.

2.19 As used in this Policy the term **"Protected Health Information"** or **"PHI"** shall have the definition set forth in 45 C.F.R. § 160.103

III. RESPONSIBILITY FOR OVERSEEING COMPLIANCE WITH THE PRIVACY RULES

3.1 Responsibility of Board of Trustees. The Board of Trustees of the Trust is the Plan Sponsor, plan administrator, and named fiduciary of the Trust and is responsible for overseeing the Trust's compliance with the Privacy Rules. The Board of Trustees' oversight activities will be directed and coordinated by the named Privacy Official who will work with the Trust's other advisors.

3.2 Training.

A. Trustees. All members of the Board of Trustees will receive training regarding the Trust's and their individual responsibilities under the Privacy Rules. The Board of Trustees received training in a meeting held before April 1, 2015 and will receive further training periodically thereafter. All Trustees appointed after April 1, 2015 will receive training within a reasonable time following appointment. No Trustee will be allowed to receive PHI or participate in discussions where PHI may be disclosed until training under the Privacy Rules is received. Records of the training will be retained by the Privacy Official.

B. Workforce Members. All workforce members of the Trust will receive training annually regarding the Trust's and their individual responsibilities under the Privacy Rules. The Privacy Official will retain the training records of workforce members.

3.3 Enforcement. The Board of Trustees shall be responsible for enforcing the Trust's compliance with this Policy. If a violation of the Privacy Rules is discovered or disclosed, the Trustees will take action to correct and/or mitigate the violation of the Privacy Rules or this Policy. Sanctions may include termination of the Trust's relationship with a third party or Business Associate who violates the Privacy Rules or this Policy or if that is not possible reporting the matter to the Secretary for the Department of Health and Human Services (DHHS). Sanctions against a Trustee may include barring him or her from receiving any further PHI, requiring the Trustee to receive additional training concerning the Privacy Rules and the Trust's Privacy Policy and Procedures, reporting the Trustee's violation to the entity which appointed him or her or other sanctions which the Board of Trustees determine to be appropriate. Violations of the Trust's privacy practices by a workforce member will result in disciplinary actions up to and including termination of employment.

3.4 Privacy Official.

A. Appointment. The Board of Trustees will designate a Privacy Official to oversee compliance with this Policy. The Privacy Official is:

Name: Privacy Official
Address: Benefit Solutions, Inc., P.O. Box 6, Mukilteo, WA 98275-0006
Telephone: (206) 859-2600
Toll Free: (877) 694-8291

B. Responsibilities. The Privacy Official's responsibilities shall include the following:

1. Being designated as such in the Privacy Notice;

2. Receiving and answering questions and complaints related to the Privacy Rules and this Policy;

3. Providing leadership in complying with regulations related to the Trust's obligations under the Privacy Rules;

4. Monitoring compliance with the Trust's record retention requirements;

5. Serving as an internal and external liaison and resource between the Trust and outside entities (including other advisors, oversight agencies and other parties) in regard to the Trust's Privacy Policy;

6. Reporting to the Board of Trustees about compliance issues arising under the Privacy Rules, which by law or in the Privacy Official's judgment require immediate attention;

7. Reporting to the Board of Trustees periodically about compliance with the Privacy Rules**;**

8. Ensuring that all documentation required by the Privacy Rules is maintained pursuant to this Policy;

9. Developing systems and processes to monitor Business Associate contracts, including the return or destruction of PHI used, created, or obtained by a Business Associate upon termination of the contract (or the extension of protection if not returned or destroyed);

10. Developing systems and processes to ensure that the rights of Individuals under the Privacy Rules are observed and properly documented;

11. Other duties established by the Board of Trustees.

C. Annual Report. The Privacy Official shall report annually to the Board of Trustees and shall cover the following matters:

1. Suggest any recommended changes to the Policy or the Trust's procedures;

2. Identify requests made under the Privacy Rules by Individuals and the Trust's response;

3. List any complaints made under the Privacy Rules and their resolution;

4. Document compliance with the Trustee training provisions of this Policy, which may be in minutes of Trustee meetings at which training is provided;

5. Comment on compliance by the Trust Office with the notice and recordkeeping provisions of this Policy;

6. Report on any Security Incident or other issues related to the Trust's creation, receipt, maintenance or transmittal of Electronic PHI;

7. Address other matters requested by the Board of Trustees or deemed material by the Privacy Official.

3.5 Privacy Contact Person. The Board of Trustees will also designate a Privacy Contact Person who shall be identified in the Privacy Notice and be available to receive inquiries and complaints about the Privacy Rules. The Privacy Contact Person will serve as the backup Privacy Official in the event the Privacy Official is absent. The initial Privacy Contact Person is:

Name:	Privacy Contact
Address:	Benefit Solutions, Inc., P.O. Box 6, Mukilteo, WA 98275-0006
Telephone:	(206) 859-2600
Toll Free:	(877) 694-8291

3.6 Facilitating Compliance. The Trustees recognize that compliance with the Privacy Rules will require differing expertise, and direct the Trust professional advisers to assist the Privacy Official in facilitating compliance.

IV. DISCLOSURE TO BOARD OF TRUSTEES [§ 164.504(f)]

4.1 Overview. The Trust will not disclose PHI to the Board of Trustees, as the Plan Sponsor, except in the manner and for the purposes specifically permitted under the Privacy Rules and this Policy. The Board of Trustees will certify before any disclosure of PHI is made that the Trust documents have been amended to comply with the Privacy Rules and that PHI will not be used for employment-related purposes.

4.2 Permitted Uses and Disclosures. The Board of Trustees as Plan Sponsor shall use or disclose PHI only in the following situations:

A. Plan administration purposes performed by the Board of Trustees on behalf of the Trust;

B. Enrollment and eligibility information;

C. Summary Health Information provided for purposes of obtaining premium bids or setting or evaluating plan rates;

D. Summary Health Information provided for purposes of evaluating, modifying or terminating benefits provided by the Trust;

E. PHI which an Individual authorizes the Board of Trustees to use or disclose.

V. RIGHTS OF INDIVIDUALS

5.1 Overview and Summary of Individual Rights. This section identifies how the Trust will administer the rights provided Individuals under the Privacy Rules. These rights are:

A. Receive a Privacy Notice upon request;

B. Request restrictions on the use and disclosure of PHI;

C. Request information be communicated in a confidential manner;

D. Request access to PHI;

E. Request to amend PHI;

F. Request an accounting of disclosures of PHI.

5.2 Procedures for Communications To and From the Trust. Unless otherwise specified, the following requirements will apply to communications to and from the Trust related to the Privacy Rules.

A. Requests must be in writing and addressed to either the Privacy Contact Person or the Privacy Official.

B. The Trust will respond within 60 days of receipt of a request unless the circumstances require otherwise. The Trust may extend this time period by 30 days by notifying the Individual in writing before the end of the 60-day period, specifying the reason(s) for the delay and the date by which the Individual may expect to receive a decision on the request.

C. If a cost-based fee is charged to handle the request, the fee shall include: a charge for labor based on the current hourly rate charged by the entity providing the information

for general administration services; postage; copying at the rate charged by the administrative office; and other reasonable expenses.

D. Responses to Individuals or mass mailings will be sent by first-class mail with the proof of mailing saved.

E. Records of requests made by Individuals shall be retained for seven years pursuant to the Trust's record retention policies detailed in Section 9.

F. Complaints will be handled in accordance with the procedures set forth in Section 12.

5.3 Workforce Training [§ 164.520]. The Privacy Notice will be reviewed with all workforce members during their initial training and annually thereafter.

5.4 Privacy Notice [§ 164.520].

A. Development of Privacy Notice. The Trust's Privacy Notice describes how the Trust will use and disclose PHI and an Individual's rights in regard to such information.

B. Providing to Individuals. The Privacy Notice will be provided to Individuals upon their request.

C. Distribution to Others. In addition, a copy of the Privacy Notice will be provided to all Workforce Members, Trustees**,** Business Associates and other Covered Entities with which the Trust contracts.

D. Revision of Privacy Notice. The Privacy Notice will be revised as needed to reflect any changes to this Policy. Revisions to this Policy will not be implemented prior to the effective date of the revised Privacy Notice. When revisions are necessary, all Trustees, Business Associates and other Covered Entities with which the Trust contracts will receive a copy of the revised Privacy Notice.

E. Web Site. The Privacy Notice will be prominently displayed and available electronically on the Trust's website, to the extent one exists.

F. Workforce Members. The Privacy Notice will be reviewed with all Workforce Members during their initial training and annually thereafter.

5.5 Individual's Request for Restrictions on Use and/or Disclosure of PHI [§ 164.522].

A. Request for Restriction. Individuals may request reasonable restrictions on how the Trust uses and/or discloses their PHI for Treatment, Payment and Health Care Operations.

B. Review. Individual requests will be reviewed by the Trust's Privacy Official, or designee, for approval.

C. Approval of Request. When a request for restrictions is approved:

1. The Individual will receive notification of the approval and a statement of the effect of such a request;

2. The Privacy Official or designee will communicate the request and its approval to the Business Associates and/or Covered Entities necessary to implement the request;

3. A notation will be made in the Individual's record(s);

4. The Trust will not use or disclose PHI inconsistent with the agreed restriction;

5. The Individual will be informed that the Trust is not required to comply with the agreed upon restriction(s) in emergency treatment situations if the restricted PHI is needed for Treatment;

6. The Trust may ask the Individual to modify or revoke the restriction and get written agreement to the modification or revocation or document an oral agreement, if the agreed upon restriction hampers Treatment;

7. The use and/or disclosure of PHI of the Individual will be consistent with any approved restrictions in effect on the date it is used or disclosed.

D. Denial of Request. If a request for restriction is denied, the Individual will be given the opportunity to discuss his or her privacy concerns and, if desired efforts will be made to assist the Individual in modifying the request for restrictions to accommodate his or her concerns and obtain acceptance by the Trust.

E. Termination of a Restriction. The Trust may terminate its agreement to a restriction, if:

1. The Individual agrees to or requests the termination and it is documented in writing;

2. The Trust notifies the Individual that the agreement is being terminated, effective for PHI created or received after the notice.

F. Approval of a Restriction. The Trust will automatically approve an Individual's request to restrict the use and/or disclosure of PHI if the request is related to the treatment by a provider who has been paid in full out-of-pocket and the request is limited to the disclosure of the PHI for the purposes of carrying out payment or health care operations.

5.6 Individual's Request for Confidential Communications of PHI [§ 164.522(b)].

A. Requests for Confidential Communications. Individuals may request in writing that the Trust communicate PHI in a confidential manner. Requests should identify the reason for the request, the specific method of communication or alternative location for communication, and how the restriction is necessary to prevent a disclosure that could endanger the Individual. The Trust will accommodate such a request if administratively feasible.

B. Documentation of Requests. Written documentation of the Individual's request will be noted in the Individual's records.

C. Evaluation of Requests. Requests will be evaluated on the basis of the administrative difficulty in complying with the request and the Trust will accommodate such a request if administratively feasible.

1. It is not administratively feasible for the Trust to communicate confidentially only for a given condition, diagnosis, or treatment. All written communications to an Individual granted confidential communications will be mailed to the alternate address requested.

2. Use of an alternate address or method of communication will not terminate unless requested in writing by the Individual.

5.7 Individual's Request for Access to PHI for Inspection and/or Copying [§ 164.524].

A. Requests for Access. Individuals have the right to inspect or obtain a copy of their PHI in a Designated Record Set provided that the information does not include psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or is otherwise exempt from disclosure under applicable law. Individuals may request a copy of their PHI in electronic format. Individuals may also direct the Trust to transmit a copy of such PHI to an entity of person designated by the individual.

B. Response. A request for access to PHI will generally be acted upon in accordance with the procedures in Section 5.2, except that if requested information is maintained on site, the Trust will respond in 30 days rather than 60 days.

C. Approved Request. If a request for access is approved, the Individual will be notified of the decision and may choose to inspect and/or copy the PHI in the form or format requested at a mutually agreeable place and time. At the Individual's request, the Trust will mail a copy of the requested PHI. The Trust will charge a reasonable cost-based fee for copying PHI including labor and supplies (i.e., computer disks, paper) and postage if applicable. In lieu of providing access, and if the Individual agrees in advance**,** the Trust may provide a summary of

the requested PHI for an agreed upon additional charge. No fee will be charged**,** however**,** for retrieving or handling the PHI or for processing the Individual's access request. Notwithstanding the foregoing, the fee for a copy of an Individual's PHI in electronic format shall not be greater than the Trust's labor costs in responding to the request.

D. Denial of Request. If a request is denied, the denial of a request for access will be in accordance with the following procedures:

1. The Individual will be given a written statement that includes: the reasons for denial; if applicable, an explanation of how the Individual can have the decision reviewed; and a description of how to file a complaint with the Trust or DHHS, including the title and telephone number of the Privacy Contact Person.

2. If the denial is reviewable under the Privacy Rules and the Individual requests such a review, the Trust will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official. Upon receipt of a review request, the Trust will promptly refer the denial to the reviewing official for reevaluation. The Trust will provide a written notice to the Individual of the reviewing official's determination.

3. If the Trust denies access because it does not maintain the PHI requested, but knows where the requested PHI is maintained, it will inform the Individual where to direct the request.

E. Discretion to Decline Access. The Trust may decline access to a personal representative of an Individual if it has a reasonable belief that the Individual has been or could be subject to domestic violence, abuse or neglect and disclosure could endanger the Individual or another person. The Trust may also decline to disclose PHI to a personal representative if it determines it is not in the best interest of the Individual to do so.

5.8 Individual's Request to Amend PHI [§ 164.526].

A. Request. Individuals may request amendment of incorrect or incomplete PHI in a Designated Record Set. The written request must include a reason to support acceptance of the amendment.

B. Acceptance of Request. If a request for amendment is accepted, in whole or in part, the Trust will identify the records that are the subject to the amendment request and will append the amendment to the records. The Trust will inform the Individual that the request has been accepted and request the identification of and permission to contact other individuals or health care entities that need to be informed of the amendment. The Trust will make reasonable efforts to provide the amendment within a reasonable time to the persons or entities identified by the Individual as well as persons and Business Associates who the Trust knows have the disputed PHI and may rely on it to the Individual's detriment.

C. Denial of Request. A denial of a request for amendment of PHI will be processed as follows:

1. A written notice will be provided to the Individual that states the basis for denial, informs the Individual of the procedures for filing a statement of disagreement and the right to have the request and the denial included with any future release of the disputed PHI and includes a description of the procedure to file a complaint with the Trust or DHHS.

2. If the Individual writes a statement of disagreement, the Trust may write a rebuttal statement and provide a copy to the Individual. The Trust shall include the request for amendment, the Trust's denial of the request, the statement of disagreement and the Trust's rebuttal (if any) with any future disclosure of the PHI.

3. If the Individual does not write a statement of disagreement, the Trust will not include the request for amendment and denial decision letter with future disclosures of the disputed PHI, unless requested by the Individual.

D. Receipt of Request from other Covered Entities. If the Trust receives notification from another Covered Entity that an Individual's PHI has been amended, the Trust will append the amendment to all applicable records of the Individual and inform its Business Associates that may use or rely on the Individual's PHI of the amendment and the need to make the necessary corrections.

5.9 Individual's Request for Accounting of Disclosures [§ 164.528].

A. Request. Individuals may request an accounting of disclosure of their PHI.

B. Purposes for Which an Accounting Is Not Provided. An accounting will not be provided for disclosures which were made:

1. For purposes of Treatment, Payment or Health Care Operations, including disclosures made for these purposes by any Business Associate of the Trust;

2. Pursuant to an authorization;

3. Incidental to another permissible use or disclosure;

4. To the Individual who is the subject of the information;

5. As part of a limited data set;

6. Prior to the compliance date for the Covered Entity.

7. For national security or intelligence purposes;

8. To correctional institutions or law enforcement officials.

C. Fee. If an Individual requests more than one accounting within the same 12-month period, the Trust may charge a reasonable, cost-based fee. The Trust will inform the Individual of the fee in advance and provide an opportunity to modify or withdraw the request.

D. Accounting. The accounting for each disclosure shall include:

1. The date of the disclosure;

2. The entity or person receiving the disclosure and their address (if known);

3. A brief description of the PHI disclosed;

4. Either a brief statement of the purpose of the disclosure, or a copy of the written request for the disclosure from DHHS or from the appropriate entity;

5. If an accounting includes multiple disclosures to the same person/entity for a single purpose, the accounting will include only the frequency or number of disclosures and the date of the last disclosure made during the accounting period for all disclosures after the first disclosure.

E. Accounting by Business Associates. In responding to a request for an accounting, the Trust shall provide an accounting of disclosures made by the Trust and shall provide a list of all business associates acting on the Trust's behalf, including the business associates' most recent contact information on file. Upon request by an Individual directly to a business associate of the Trust, the business associate shall provide an accounting of the disclosures of PHI made by the business associate.

F. Accounting of Electronic Health Records. Individuals may request an accounting of disclosures of their Electronic Health Records acquired by the Trust in electronic format after January 1, 2009. Such request shall be limited to Electronic Health Records disclosed during the three years prior to the date of the request. The exclusion provided in Section 5.9B.1, regarding disclosures for Treatment, Payment or Health Care Operations, shall not apply to requested accountings of Electronic Health Records.

VI. DISCLOSURE OF PHI IN SPECIFIC SITUATIONS

6.1 Claim Appeals.

A. Overview. The Board of Trustees, or a committee appointed by the Board of Trustees, is designated to hear claim appeals, except as follows. Claims that involve interpretation of an insurance contract or policy purchased by the Trust shall be handled by the insurer. The Trustees and advisors that participate in any other claim appeals will need to receive information about claim appeals to handle them appropriately. Information used and distributed

in the appeal procedures will be subject to the requirements set forth below. In all circumstances, disclosures will be subject to the minimum necessary requirements.

B. Persons Receiving Claim Appeal Documents. Appeal information may be distributed to the following:

1. The claimant;

2. The claimant's personal representative if requested;

3. All Trustees who affirmatively indicate they will be present at a meeting discussing a claim appeal;

4. Trust legal counsel (if attending the hearing);

5. A representative of the claims payer involved (if attending the hearing and different than Trust Office);

6. A representative of the Trust Office;

7. The Trust consultant (if attending the hearing).

C. Method of Distribution. Documents will be mailed in envelopes marked confidential. Material will not be e-mailed or faxed unless the recipient has confirmed that appropriate steps have been taken to ensure the confidentiality of such communications.

D. Protection of PHI. Cover sheets of the appeal packets will not list the claimant's name. Unless the claimant is appearing, the information provided by the Trust Office will ordinarily exclude the "direct identifiers" listed in 45 CFR 164.514(e)(2) except for any "direct identifiers" that may be necessary to resolve the appeal. The Trust Office will also make reasonable efforts to limit the information provided to the minimum necessary to resolve the appeal, in accordance with Part XI, Section 11.1 of this Policy. Appeal Packets will be numbered with the recipient of each numbered packet identified. Packets will be returned after the conclusion of an appeal and destroyed. Copies provided to Trust Legal Counsel, the Trust Office and where applicable the claimant and his personal representative will not be destroyed.

E. Communication of Decision. Decisions on claim appeals will be mailed to the claimant or his or her personal representative in an envelope marked confidential.

6.2 Utilization, Case Management and Large Claim Reports. Utilization, case management, and large claim reports will be de-identified unless there is a specific need for disclosure of PHI, and such disclosure is consistent with the Policy and applicable law.

6.3 Underwriting Information. Information necessary for underwriting purposes, obtaining premium bids including stop loss bids, or setting and evaluating rates and benefits will

be provided as Summary Health Information unless plan administration purposes require additional disclosure and such disclosure is consistent with this Policy and applicable law.

6.4 Psychotherapy Notes.

A. Overview. Notwithstanding any other provision of this Policy, an authorization will be required to use or disclose psychotherapy notes except in the situations set forth below. For purposes of this Policy, psychotherapy notes refer to a mental health professional's notes in any medium which document or analyze the contents of a counseling session and are separated from the rest of the Individual's medical records. Psychotherapy notes do not include information regarding medication, prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary diagnosis, functioning status, the treatment plan, symptoms, prognosis and progress to date.

B. Exceptions to Authorization Requirements. The Trust will use or disclose psychotherapy notes without an authorization only to:

1. Carry out Treatment, Payment or Health Care Operations involving their use by the originator for treatment;

2. Defend itself against a legal proceeding brought by the Individual;

3. As required by law as set forth in 45 CFR § 164.512(a), § 164.512(d), § 164.512(g)(l) or § 164.512(j)(l)(i).

VII. AUTHORIZATIONS [§ 164.508]

7.1 Overview. PHI will not be disclosed without an authorization unless such disclosure is authorized by the Trust's Privacy Notice or applicable law.

7.2 Permitted Disclosure Without an Authorization. PHI will be used or disclosed without an authorization when:

A. Disclosing PHI to the Individual;

B. Disclosing information to a personal representative where applicable law does not require an authorization;

C. Using or disclosing PHI for the Trust's Treatment**,** Payment or Health Care Operations;

D. Disclosing PHI to a Health Care Provider for the Individual's Treatment;

E. Disclosing PHI to another Covered Entity or a Health Care Provider for that entity's Payment activities;

F. Disclosing PHI to another Covered Entity for that entity's Health Care Operations if both entities have or had a relationship with the Individual whose PHI is being requested, the PHI pertains to the current or former relationship, and the purpose of the disclosure is for: (i) a Health Care Operations activity for which the Privacy Rules state an authorization is not required; or (ii) detection of health care fraud and abuse or compliance with health care fraud and abuse laws;

G. Disclosing information to another Covered Entity that participates in an organized health care arrangement with the Trust;

H. Using PHI to create information that is not individually identifiable health information, or disclosing PHI to a Business Associate for such purpose, whether or not the de-identified information is to be used by the Trust;

I. Disclosing PHI to a Business Associate, and allowing the Business Associate to create or receive PHI on the Trust's behalf, provided the Business Associate provides satisfactory assurance that it will appropriately safeguard the information;

J. Disclosing PHI to a family member, other relative, or close personal friend of the Individual, or any other person identified by the Individual, provided the PHI is directly relevant to such person's involvement with the Individual's care or payment related to the Individual's health care, and the requirements of 45· CFR § 164.510(b) are satisfied.

K. Otherwise using or disclosing PHI as specifically permitted by the Privacy Rules.

7.3 De-Identified Information. Information that meets the standard and implementation specifications for de-identification under 45 CFR § 164.514(a) and (b) is considered not to be individually identifiable PHI, and the requirements of this Policy shall not apply to such information. Notwithstanding the foregoing, disclosure of a code or other means of record identification designed to enable de-identified information to be re-identified constitutes disclosure of PHI. If de-identified information if re-identified, it may only be used or disclosed in accordance with this Policy and the Privacy Rules.

7.4 Procedure. If an authorization is required under this Policy, the Individual will be provided a copy and asked to sign it. Signing the authorization is voluntary and the Individual may refuse to sign it. A copy of the signed authorization shall be provided to the Individual. The Individual may revoke the authorization, in writing, at any time.

7.5 Revocation. The permissions granted in the authorization shall not be acted upon if the authorization is revoked in writing or the authorized time period has expired.

VIII. PERSONAL REPRESENTATIVES [§ 164.502(g)]

8.1 Overview. A personal representative will be treated as the Individual for purposes of the Privacy Rule.

8.2 Dependent Children.

A. Dependents 18 and Over and Emancipated Minors. The PHI of a dependent 18 or older will not be disclosed without an authorization or appropriate documentation that the requestor is otherwise the Individual's personal representative such as in the case of an incapacitated child. Emancipated minors will be treated as a dependent who is 18 or older.

B. Dependents Under 18 and Unemancipated Minors.

1. Overview. Except as limited in this Policy and under the Privacy Rules, a parent or legal guardian will be treated as the personal representative of an unemancipated minor without an authorization. As such, a parent will be allowed access to an unemancipated minor's PHI, except where a court order or other written restriction recognized by the Privacy Rules exists which limits disclosure to the requestor and has been provided to the Trust or disclosure is limited by state law.

2. Limitations Under State Law. The law of the state where the minor resides will control what PHI may be disclosed to a parent or legal guardian. As a general matter, disclosures involving the following will not be made to a parent or legal guardian absent the express consent of the minor:

(a) The child is 15 years or older, is living separately from parents and is financially independent from parents;
(b) The child at any age is seeking treatment for a sexually transmitted disease, including HIV/AIDS;
(c) The child at any age is seeking treatment for alcohol or substance abuse.
(d) The child is seeking mental health treatment;
(e) The child is seeking treatment related to reproductive services; or
(f) There is evidence of domestic violence, abuse or neglect.

Requests involving for information involving any the foregoing shall be referred to Trust Counsel.

8.3 Incapacitated or Incompetent Individuals. The Trust will recognize personal representatives for incapacitated and incompetent Individuals pursuant to applicable state law. Court orders or other documents which are the basis for the personal representative status should be submitted with the authorization. Questions concerning the sufficiency of the submitted documentation will be referred to Trust Legal Counsel.

8.4 Deceased Individuals. The PHI of a deceased Individual will be disclosed to an individual who has authority under applicable state law to act as the executor, administrator or representative of the deceased Individual or his or her estate, provided that the requested disclosure appears reasonably related to the requestor's status as a personal representative. Questions concerning the requestor's status as a personal representative will be referred to Trust Legal Counsel.

8.5 Trust's Right Not to Disclose. Notwithstanding the foregoing, the Trust may refuse to recognize a person as a personal representative if the Trust has a reasonable basis to believe that the Individual has been or may be subject to domestic violence, abuse or neglect by the personal representative and that treating the requesting person as a personal representative could endanger the Individual or otherwise that disclosure is not in the Individual's best interest. If the Trust refuses to recognize a personal representative, the person may request review of this refusal under the Trust's complaint procedures set forth in Section 12.

8.6 Explanation of Benefits. Explanation of benefits ("EOB") and benefit payments are part of the Trust's Payment operations, and as such may be sent to the participant or custodial parent, on behalf of the Dependent, unless the Trust determines that the information is otherwise protected.

IX. DOCUMENTATION

9.1 Overview. The Trust Office will be responsible for maintaining the records required by the Privacy Rules. The Trust's retention policies will be supervised by the Privacy Official. Records will be kept for seven years from the later of date of the record's creation or the date the record was last in effect.

9.2 Records Retained. The following records will be retained:

A. The Trust's Privacy Policy and any revisions.

B. The Trust's Privacy Notice and any subsequent revisions.

C. Plan Document Amendments.

D. Appointments of Privacy Officials and Privacy Contact Persons.

E. Business Associate Contracts.

F. Board of Trustees certifications.

G. Documentation of Trustee education.

H. Signed authorization forms.

I. Requests for restrictions on uses/disclosures of PHI.

J. Requests for confidential communications and responsive material.

K. Requests for accounting of disclosures and responsive material.

L. Requests for access and responsive material.

M. Requests for amendment of PHI and responsive material.

N. Sanctions that have been applied related to privacy violations.

O. Complaints and their disposition.

P. Communications with regulatory bodies concerning the Privacy Rules.

Q. Policies and Procedures implemented to comply with the security regulations, 45 CFR 164.302 et. seq.

R. A written record of any activity or assessment that is required to be documented by the security regulations, 45 CFR § 164.302, et seq.

S. Other documents the Privacy Official or the Board of Trustees request be maintained, or which are required to be maintained by the Privacy Rules.

X. BUSINESS ASSOCIATES [§ 164.504(c)]

10.1 Overview. Each entity contracting with the Trust will be reviewed to determine if it is another Covered Entity, a Business Associate, or neither. Business Associates will be required to enter into a separate Business Associate agreement, or an addendum to an existing agreement, which provides satisfactory assurances that the Business Associate will comply with the Privacy Rules and meets the requirements of applicable law.

10.2 Negotiation of Agreements. Trust legal counsel shall be responsible for negotiating Business Associate agreements on behalf of the Trust and providing copies of such agreements to the Privacy Official.

10.3 Minimum Necessary. The Trust requires that a Business Associate determine the minimum necessary amounts and type of PHI and represent to the Trust that it has requested the minimum necessary for its purposes. The Trust relies on the professional judgment of Business Associates to determine the type and amount of PHI necessary for their purposes.

10.4 Violations. Violations of the Privacy Rules by a Business Associate shall be reported to the Privacy Official. The Privacy Official shall review the complaints and determine if there is a reasonable basis for believing a violation has occurred. If there is a reasonable basis for believing a violation has occurred, the Privacy Official shall confer with Trust Legal Counsel and report the matter to the Board of Trustees with a recommendation for any corrective action

or mitigation. If correction or mitigation is unsuccessful, the Board of Trustees shall determine whether termination of the agreement is feasible. If not feasible, the Board of Trustees will report the Business Associate's violation to DHHS.

XI. MINIMUM NECESSARY DISCLOSURE [§ 164.502(b)]

11.1 Overview. When using or disclosing PHI, or when requesting PHI from another Covered Entity, the Trust, the Board of Trustees, its Business Associates and entities participating in an organized health care arrangement with the Trust will limit PHI, to the extent practicable, to a Limited Data Set as defined by 45 U.S.C. § 164.514(e)(2) or, if needed, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request in accordance with guidance provided by the Secretary of the Department of Health and Human Services.

11.2 Exceptions. The minimum necessary standard does not apply to:

A. Disclosures to or requests by a Health Care Provider for Treatment;

B. Uses or disclosures made to the Individual or his or her personal representative;

C. Uses or disclosures made pursuant to an authorization;

D. Disclosures to the Secretary of DHHS pursuant to the Privacy Rules; and

E. Uses or disclosures otherwise required by law.

11.3 Minimum Necessary Uses of PHI. The Trust Office has identified workforce members, Business Associates, Trustees, etc., who need access to PHI according to the categories of uses for payment or health care operations and has also identified the type and minimum amount of PHI needed to administer the Plan. The Trust has determined the circumstances under which individuals who perform plan functions may use PHI. All individuals are required to use PHI in accordance with the determination made by the Trust Office of the minimum amount necessary to effectively administer the Plan. When an individual performs more than one function, the types of PHI and conditions of access are dependent on the function that the individual is performing. Newly hired workforce members are provided with information regarding their access to PHI during their initial training.

11.4 Routine and Recurring Disclosures of PHI. The Trust has identified disclosures of PHI it makes on a routine and recurring basis and has determined the minimum amounts of PHI necessary to achieve the purpose of these requests.

11.5 Routine and Recurring Requests for PHI. The Trust has identified requests for PHI it makes on a routine and recurring basis and has determined the minimum amount of PHI that is need to achieve the purpose of these requests.

11.6 Non-Routine Requests for PHI. Requests for non-routine disclosure of PHI from another Covered Entity or Business Associate will be reviewed by the Privacy Official on a case-by-case basis to ensure that the amount of PHI requested is the minimum necessary to achieve the purpose of the request. The Trust may rely on representations that the PHI requested is the minimum necessary if the request is for a use or disclosure permitted under the Privacy Rules and is from a public official, Health Care Provider or a professional providing services to the Trust who is a Business Associate and who represents in writing that the PHI requested is the minimum necessary to perform services for the Trust.

11.7 Entire Medical Record Set. The Trust will not use, request, or disclose the entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure, or request.

XII. COMPLAINTS AND MITIGATION [§ 164.530(d)]

12.1 Complaints. Any person may make complaints concerning the Trust's compliance with the Privacy Rules or this Policy or the application of this Policy in a particular situation. Complaints must be in writing and directed to the Privacy Official or Privacy Contact Person. The Privacy Official will investigate any complaint in conjunction with any Trust advisers or providers whose involvement is necessary to evaluate the complaint. The Privacy Official will respond within the 60-day time period provided under Section 5.2B of this Policy.

The Privacy Official will inform the Board of Trustees of all complaints, the results of the Privacy Official's review and any recommended corrective action or mitigation. The Board of Trustees is authorized to act on the Privacy Official's review and recommendations concerning a particular complaint. The person who has complained will be informed in writing of the Trust's decision.

12.2 Mitigation. The Trust will mitigate, to the extent practicable, any harmful effect that is known to the Trust of a use or disclosure of PHI in violation of the Trust's policies and procedures or the requirements of the Privacy Rules by the Trust or a Business Associate.

12.3 No Retaliation. The Trust will not intimidate, coerce, or retaliate against any Individual who makes a complaint to the Trust or to DHHS, provides testimony, assists in investigations or chooses to exercise any of the rights granted by the Privacy Rule.

12.4 Notification in the Event of a Breach. In the event a Breach or unauthorized disclosure of PHI by the Trust or one of its Business Associates is discovered, the Privacy Official, the Board of Trustees and the Trust's legal counsel shall be notified. The Trust shall provide notice to each Individual affected by the Breach, as well as the Department of Health and Human Services and local media, as required. Such notice shall describe the Breach, the type of information disclosed, the steps the Trust is taking to mitigate the Breach and the steps Individuals can take to protect themselves. The notice will be provided within 60 days of the date the Breach is discovered.

The Privacy Official shall maintain a log of all Breaches and submit the log to the Department of Health and Human Services annually.

XIII. MARKETING AND SALES OF PHI

The Trust will not engage in marketing as defined by the Privacy Rules or the sale of PHI. The Trust shall ensure that its Business Associates comply with all restrictions on marketing and the sale of PHI.

XIV. IDENTITY VERIFICATION

Prior to disclosing PHI, the Trust will verify the identity of the Individual pursuant to procedures established by the Trust Office. Business Associates who routinely receive telephone calls from Participants for the Trust shall establish procedures for verifying the identity of Individuals calling and shall inform the Trust of these procedures.

XV. ELECTRONIC PHI [§ 164.302, et. seq.]

15.1 Overview. The Board of Trustees will oversee the Trust's compliance with the security standards concerning Electronic PHI under 45 CFR §164.302, et. seq. The Board of Trustees' oversight activities will be directed and coordinated by the named Privacy Official who will work with the Trust's Business Associate.

15.2 Certification of Plan Amendment. The Board of Trustees certifies that it, as Plan Sponsor, will reasonably and appropriately safeguard Electronic PHI created, received, maintained, or transmitted to or by the Trustees on behalf of the Trust.

15.3 Actions Taken in Regard to Electronic PHI. The Trust shall take the following action in regards to Electronic PHI:

A. Ensure Confidentiality, Integrity and Availability. The Trust shall ensure the confidentiality, integrity and availability of all Electronic PHI that the Trust creates, receives, maintains or transmits.

B. Protection Against Anticipated Threats. The Trust will protect against any reasonably anticipated threats or hazards to the security or integrity of Electronic PHI.

C. Protection Against Unauthorized Disclosures. The Trust shall protect against any reasonably anticipated uses or disclosures of Electronic PHI that are not permitted or required under applicable law.

D. Contracts with Business Associates. Business Associates that may create, receive, maintain or transmit Electronic PHI must agree to written contractual provisions which impose at least the same obligations in regards to Electronic PHI as apply to the Trust and must agree to otherwise meet the requirements of 45 CFR §164.314(a).

E. Reporting Security Incidents. The Board of Trustees collectively, and each Trustee individually, will report to the Trust any Security Incident of which it or the individual Trustee becomes aware.

F. Security Official. The Privacy Official appointed by the Trust shall also serve as Security Official.

XVI. MISCELLANEOUS

16.1 Governing Law. This Policy shall be governed by Oregon law to the extent not preempted by federal law.

16.2 Amendment. The Board of Trustees may amend this Policy by written amendment.

16.3 Interpretation. The Board of Trustees has discretion to interpret the terms of this Policy and to handle issues not specifically addressed herein. This Policy will be interpreted in a manner to assure compliance with applicable law.

Adopted at the meeting of the Board of Trustees held on the 16th day of March, 2015.