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## Notice of Privacy Practices (HIPAA)

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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.

### USE AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to regulations issued by the federal government, the Fund is providing you this Notice about the possible uses and disclosures of health information about you. Your health information is information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Fund has established a policy to guard against unnecessary disclosure of your health information. *The following summarizes the circumstances under which and purposes for which your health information may be used and disclosed and your rights in regard to such information.*

### PROTECTED HEALTH INFORMATION

PHI generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearing house; and (2) relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

### USE AND DISCLOSURE OF HEALTH INFORMATION

Your health information may be used and disclosed without an authorization in the following situations:

- **To make or obtain payment:** The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive, to determine benefit responsibility under the plan, or to coordinate Plan coverage. For example, the Fund may provide information regarding your coverage or healthcare treatment to other health plans to coordinate payment of benefits.
- **To facilitate treatment:** The Fund may disclose information to facilitate treatment which involves providing, coordination or management of healthcare or related services. For example, the Fund may disclose the name of your treating Physician to another Physician so that the Physician may ask for your x-rays.
- **To conduct healthcare operations:** The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants.

Healthcare operations include: making eligibility determinations, contacting healthcare providers and participants with information about health-related issues or treatment alternatives and other related functions such as:

- Clinical guideline and protocol development
- Case management and care coordination
- Activities designed to improve health or reduce healthcare costs
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits



- Business management and general administrative activities of the Fund, including customer service and resolution of internal grievances, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs, quality assessment and improvement activities, business planning and development, including cost management and planning-related analyses and formulary development

For example, the Fund may use your health information to conduct case management, quality improvement and utilization review or to engage in customer service and the resolution of claim appeals.

- ***In connection with judicial and administrative proceedings:*** If required or permitted by law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Fund will make reasonable efforts either to notify you about the request or to obtain an order protecting your health information.
- ***When legally required for law enforcement purposes:*** The Fund will disclose your health information when required to do so by any federal, state or local law. In addition, as permitted or required by law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.
- ***For treatment alternatives:*** The Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- ***For distribution of health-related benefits and services:*** The Fund may use or disclose your health information to provide to you health-related benefit and service information that may be of interest to you.
- ***For disclosure to the Plan Trustees:*** The Fund may disclose your health information to the Board of Trustees and necessary advisors for plan administration functions performed by the Board of Trustees on behalf of the Fund, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the Plan.
- ***To conduct health oversight activities:*** The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of healthcare or public benefits.
- ***In the event of a serious threat to health or safety:*** The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.
- ***For specified government functions:*** In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.
- ***For workers' compensation:*** The Fund may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.
- ***For notice of a breach of unsecured health information:*** The Fund may release your health information to notify appropriate authorities of a breach of unsecured protected health information.



- **For emergency situations:** Your health information may be used or disclosed to a family member or close friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Notice.

## **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than as previously stated, the Fund will not disclose your health information other than with your written authorization. If you have authorized the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

In addition, your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

## **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You have the following rights regarding your health information that the Fund maintains:

- **Right to request restrictions:** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund generally is not required to agree to your request. The Fund is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out-of-pocket. If you wish to request restrictions, please make the request in writing to the Fund's Privacy Contact Person listed below.
- **Right to receive confidential communications:** You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain phone number or by email. If you wish to receive confidential communications, please make your request in writing to the individual identified as the Fund's Privacy Contact Person below. The Fund will attempt to honor your reasonable requests for confidential communications.
- **Right to inspect and copy your health information:** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.
- **Right to amend your health information:** If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made if the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Fund's Privacy Contact Person listed below. The Fund may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting be amended is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.





- ***Right to an accounting:*** You have the right to request a list of disclosures of your health information made by the Fund for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the period for which you are requesting the information. Accounting requests may not be made for periods going back more than six years. The Fund will provide the first accounting you request during any 12 month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.
- ***Right to a paper copy of this notice:*** You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You also may obtain a copy of the current version of the Fund Notice at [www.OEWFund.com](http://www.OEWFund.com).

Request access to your health information in an electronic form by writing to the Privacy Contact Person listed below.

Receive notice of a breach of unsecured protected health information if it affects you by writing to the Privacy Contact Person listed below.

### **PRIVACY CONTACT PERSON/PRIVACY OFFICIAL**

To exercise any of these rights related to your health information, contact: Privacy Contact Person at the Fund Office.

Privacy Contact Person  
c/o Welfare & Pension Administration Service, Inc.  
P.O. Box 34203  
Seattle, WA 98124-1203  
Phone No: (833) 389-0027 Fax No: (206) 441-9110

The Fund has also designated the Client Service Manager as its Privacy Official. This person has the same address and phone/fax numbers as listed above.

You will be notified if your protected health information has been breached. You will be notified by first class mail within 60 days of discovery of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured – for example, computer data that is encrypted and inaccessible without a password – or if it is determined that there is a low probability that your health information has been compromised.

### **DUTIES OF THE FUND**

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of duties and privacy practices. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.



You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Privacy Official identified above. The Fund encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

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October 11, 2022

## No Surprises Act Notice

The Oregon Essential Workforce Health Care Fund is providing you this notice as a participant in the Trust's Health Plan. This notice provides you with important information regarding protections available under a new law called the No Surprises Act.

### 1. What is the No Surprises Act?

The No Surprises Act is a new law that was part of the Consolidated Appropriations Act. This new law is intended to protect Plan participants from balance billing for the following services:

- Emergency Services at an out-of-network facility
- Air Ambulance services
- Services provided at an in-network facility by an out-of-network provider (a common example is an anesthesiologist).

The law's protections against balance billing are effective January 1, 2022.

Generally, your Plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

### 2. What is a balance bill?

If you obtain services or treatments from an out-of-network health care provider, your provider can bill you for the balance of costs not covered by the health plan. This is called "balance billing." Balance billing charges are often significant and do not count towards your deductible or annual out-of-pocket maximum.

### 3. How does the new law protect me from balance bills?

The new law prohibits health care providers from balance billing you when you obtain emergency care at an out-of-network facility; when you receive care by an out-of-network provider at an in-network facility; or when you receive emergency air ambulance services.

The law provides that your costs for these services must be limited to no more than what you would have paid, had you gone to an in-network facility (determined based on the median allowed amount for in-network providers) and any cost sharing must count towards your in-network deductible and annual out-of-pocket maximums.



**4. What if a provider asks me to waive my rights and permit balance billing?**

**Always remember: You are never required to give up your protections from balance billing and you should review any document you are asked to sign regarding billing.**

The law's protections do not apply if you sign a consent to be balance billed by the provider. Certain non-emergency physician specialties, however, are not eligible to qualify for this exception and may not request a waiver. These physicians include assistant surgeons and hospitalists, anesthesiologists, pathologists, radiologist, laboratories, and other specialists that a patient typically does not select.

If a health care provider requests consent to balance bill:

- The written consent must be clear and understandable.
- Generally, the written consent form must be provided at least 72 hours prior to the date of the item or service.
- The written consent form must state that payment of the out-of-network bill may not accrue towards the individual's deductible or annual out-of-pocket maximum.
- The written consent form must state that by signing the consent, the individual agrees to be treated by the non-participating provider and understands the individual may be balance billed and subject to cost-sharing requirements that apply to services furnished by the nonparticipating provider.
- The written consent form must document the time and date on which the individual received the written notice and the time and date on which the individual signed the written consent form.

You must also be provided with an estimate of the cost for the service or treatment and additional information.

**5. What if I receive a balance bill for services or treatments received after January 1, 2022 from an out-of-network emergency department, air ambulance, or out-of-network provider at an in-network facility and I did not sign a consent form?**

First, request a copy of any consent form from your provider or the facility in which you were treated. If they are unable to provide you one, then you have options under federal law to enforce your right to not be balance billed. Please contact [800-985-3059](tel:800-985-3059) if you believe you have been balance billed inappropriately. You may also visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

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