



October 2015

### SUMMARY OF MATERIAL MODIFICATION

TO: ALL SOUND HEALTH & WELLNESS TRUST  
SOUNDPLUS PPO PLAN AND SOUND PPO PLAN  
PARTICIPANTS AND DEPENDENTS

RE: SOUND PLUS PPO AND SOUND PPO PLAN CHANGES

This insert to your January 2009 Sound Health & Wellness Trust Summary Plan Description (SPD) booklet describes certain changes to your Plan. Please read this information carefully and keep it with your SPD.

#### OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum per calendar year is:

##### SoundPlus PPO Plan

	In-Network	Out-of-Network
Employee only coverage	\$2,250	\$4,500
Family coverage	\$4,500	\$9,000

##### Sound PPO Plan

	In-Network	Out-of-Network
Employee only coverage	\$2,750	\$5,500
Family coverage	\$5,500	\$16,500

For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met.

Note: If an Employee or family fails to earn the maximum HRA funding, the annual out of pocket maximums shown above will increase for that year by the amount of unearned HRA funding.

The Out-of-Pocket Maximum section in the SPD is amended by adding the following language on page 29 of the SoundPlus PPO Plan SPD and page 34 of the Sound PPO Plan SPD:

In addition to the Plan's out-of-pocket maximums stated above, the Affordable Care Act (ACA) imposes limitations on how much you pay out-of-pocket for certain in-network provider covered charges. For claims incurred on or after April 1, 2014, these maximum in-network amounts were \$6,350 per person and \$12,700 per family for medical benefits and a separate \$6,350 per person and \$12,700 per family for prescription drug benefits.

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For covered expenses incurred between April 1, 2015 and December 31, 2015, the ACA medical out-of-pocket maximums and prescription drug out-of-pocket maximums that you pay yourself for in-network covered provider charges are:

	Medical	Prescription Drug
Per Individual	\$4,000	\$2,600
Per Family	\$8,000	\$5,200

For covered expenses incurred between January 1, 2016 and December 31, 2016, the ACA medical out-of-pocket maximums and prescription drug out-of-pocket maximums that you pay yourself for in-network covered provider charges are:

	Medical	Prescription Drug
Per Individual	\$4,250	\$2,600
Per Family	\$8,500	\$5,200

All of the current medical plan in-network provider out-of-pocket amounts will also apply to the above medical ACA out-of-pocket maximums. In addition, the following in-network provider out-of-pocket amounts will apply only to the above medical ACA out-of-pocket maximums:

- The \$100.00 Emergency Room co-pay
- The 9<sup>th</sup> through 12<sup>th</sup> Acupuncture visits
- Allowed amounts above the Plan’s Chiropractic \$30.00 allowed per visit
- Allowed amounts above the Plan’s routine foot care Podiatry \$20.00 allowed per visit
- Amounts billed for routine foot care Podiatry visits beyond the 12 visits allowed by the Plan
- Pediatric vision co-pays

Prescription Drug co-pays will apply to the prescription drug ACA out-of-pocket maximum but any processing fees, cost differentials or non-covered prescription drug expenses will not apply.

Subsequent year’s ACA out-of-pocket maximum amounts will be established by the ACA and will be based on expenses incurred during the calendar year.

**CLAIMS AND APPEALS**

In compliance with the Affordable Care Act (also called Health Care Reform), you will now receive additional information on your notice of denial and, if your appeal is eligible, you will have an opportunity to request an external review (as discussed further below).

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The following replaces the “Notice of Denial” section on page 113 of the SoundPlus PPO Plan SPD and page 117 of the Sound PPO Plan SPD in its entirety:

NOTICE OF DENIAL

A benefit denial will contain this information, and will be provided in a culturally and linguistically appropriate manner:

1. The reason for the denial.
2. The denial code (if any) and its corresponding meaning.
3. A statement regarding the availability of the diagnosis and treatment codes upon request.
4. Information sufficient to identify the claim, including the date of service, health care provider and claim amount, if applicable.
5. Reference to the Plan provision(s) relied on.
6. Description of any additional material needed for the claim, with an explanation of why it is necessary.
7. Reference to any internal rule, guideline or protocol used in denying the claim, with a statement that a copy is available without charge upon request.
8. An explanation of the medical judgment—applying Plan terms to your circumstances—if the denial is based on the service or supply being Medically Necessary or Experimental or Investigational, or an equivalent exclusion.
9. An explanation of the Plan’s appeal procedures and the available external review procedures, including applicable time limits.
10. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman.

The denial will be mailed to you at your last known address.

The following replaces the first two paragraphs of the “Appeal Procedures” section on page 114 of the SoundPlus PPO Plan SPD and page 118 of the Sound PPO Plan SPD:

APPEAL PROCEDURES

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The procedures below and in the external review section are the exclusive procedures available to you if you are dissatisfied with an eligibility determination, benefit denial or partial benefit award by the Trust or its authorized claim payers. These procedures must be exhausted before you may request an external review or file suit under Section 502(a) of ERISA.

**Information to Be Provided upon Request and Automatically (if applicable)**

You and/or your authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents include information relied upon, submitted, considered, or generated in making the benefit determination. They will also include internal guidelines, procedures or protocols concerning the denied treatment, without regard to whether such document or advice was relied on in making the benefit determination.

If a denial is based on a determination as to medical necessity, an explanation of that determination and how it applies to your circumstances also are available upon request.

In addition, you will automatically be provided with any and all new information considered, relied upon or generated in connection with your appeal, and/or any new or additional rationale for the decision, as soon as reasonably possible. You will be offered the opportunity for a full and fair review on appeal.

The following replaces the “Contents of Decision” section on page 116 of the SoundPlus PPO Plan SPD and page 120 of the Sound PPO Plan SPD:

**Contents of Decision**

If the Appeals Committee or Hearings Committee denies an appeal, you will be notified of specific reasons for the denial as well as specific Plan provision(s) involved, the denial code (if any) and its corresponding meaning, and a statement regarding the availability of the diagnosis and treatment codes upon request, and that all information relevant to the claim is available without charge upon request. The notice will also include information sufficient to identify the appeal, including the date of service, health care provider and claim amount, if applicable. If the Committee relied on an internal rule, guideline or protocol, the notice will identify it and explain that a copy is available without charge upon request. If the Committee’s decision was based on a medical or dental judgment, the notice will explain that judgment, applying the terms of the Plan to your circumstances. In the case of an appeal denied by the Hearings Committee, you also will be notified of your rights under Section 502(a) of ERISA and the available external review procedures. You also will be notified of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman.

The following language is added at the end of the Filing an Appeal section of the SPDs, to describe the External Review process:

**Request for External Review**

You must exhaust the Trust's internal claims and appeals process, as described above, before requesting an external review. Once the Trust's internal claims and appeals process is completed, you have four months from the date you receive the final adverse benefit determination (the notice of appeal denial) to file a request for an external review. If the deadline would fall on a Saturday, Sunday or Federal holiday, the deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

You may request external review for any denied appeals that involve (1) a question of medical judgment, which includes decisions about medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that a treatment is experimental or investigational, or (2) a denial due to a rescission of coverage (meaning a retroactive termination of coverage). External review is not available for any other types of denials, including claims related to eligibility or claims related to life/death benefits or disability benefits, or a legal or contractual interpretation of the Plan's terms.

Requests for external reviews must be sent to:

Sound Health & Wellness Trust  
201 Queen Anne Avenue North, Suite 100  
Seattle, WA 98109  
Attn: Appeals Department

**Preliminary Review of External Review Request**

Within five business days of receipt of a request for external review, the Trust will complete a preliminary review of the external review request to determine whether:

- (a) You were covered under the Trust at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Trust at the time the health care item or service was provided;
- (b) The adverse benefit determination that is being appealed does not relate to your failure to meet the applicable eligibility requirements, or to a legal or contractual interpretation of the Plan's terms;
- (c) You have exhausted the Trust's internal claims appeal process; and

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- (d) You have provided all of the information and forms required to process an external review.

Within one business day after completion of this preliminary review, the Trust will issue notification of its decision to you. If the request is not eligible for external review, the Trust's notice will explain the reasons for its ineligibility and provide any other information required, including contact information for the Employee Benefits Security Administration. If the request for external review is incomplete, the Trust will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Trust will refer the matter to an Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization that is independent of the Trust and the IRO.

**Review by Independent Review Organization**

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Upon receipt of any information you submitted, the assigned IRO will within one business day forward the information to the Trust. Upon receipt of any such information, the Trust may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Trust will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Trust decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Trust will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Trust, and the Trust will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo, which means that it is not bound by any decisions or conclusions reached during the Trust's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO will consider the following in reaching a decision:

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1. Your medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Trust, you and your treating provider;
4. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines;
6. Any applicable clinical review criteria developed and used by the Trust, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Section to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The IRO will provide written notice of the final external review decision to the Trust and to you within 45 days after the IRO has received the request to review. The assigned IRO's decision notice will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the availability of diagnosis codes and their corresponding meaning, the availability of treatment codes and their corresponding meaning, the denial codes (if any); and the reason for the previous denial);
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards considered in reaching its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Trust or to you;
6. A statement that judicial review may be available to you; and

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act to assist individuals with the internal claims and appeals and external review process.

After a final external review decision, the IRO will make the record available for examination by you, the Trust or State or Federal oversight agency upon request, except where such disclosure would violate State and Federal privacy laws.

### **Expedited External Review**

You may request an expedited external review if you receive:

- (a) An adverse benefit determination involving your medical condition for which the time frame for completion of the Trust's expedited internal review process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- (b) A final adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but have not been discharged from a facility.

If the Trust receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Trust determines that you are eligible for a standard external review, the Trust will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by telephone or facsimile or by any other available expeditious method.

The assigned IRO will consider other appropriate information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo, which means that it is not bound by any decisions or conclusions reached during the Trust's internal claims and appeals process.

The IRO will notify the Trust and you of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to you and the Trust.



### **Actions Following the Decision of the IRO**

If the IRO directs that benefits be paid, the Trust will provide benefits under its Plan in accordance with the decision. If the decision is adverse to you, you have the right to pursue a suit pursuant to ERISA Section 502(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected you must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Trust; or the IRO's denial.

### **NOTICE OF PRIVACY PRACTICES**

The following replaces the "Notice of Privacy Practices (HIPAA)" section beginning on page 133 of the SoundPlus PPO plan SPD and page 138 of the Sound PPO plan SPD in its entirety:

#### **NOTICE OF PRIVACY PRACTICES (HIPAA)**

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 Trust 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 Trust 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:

***To make or obtain payment:*** The Trust 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.

*For example, the Trust may provide information regarding your coverage or healthcare treatment to other health plans to coordinate payment of benefits.*

***To facilitate treatment:*** The Trust may disclose information to facilitate treatment which involves the provision, coordination or management of healthcare or related services.

*For example, the plan may disclose the name of your treating dentist to a treating orthodontist so that the orthodontist may ask for your dental x-rays.*

***To conduct healthcare operations:*** The Trust may use or disclose health information for its own operations to facilitate the administration of the Trust

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*and as necessary to provide coverage and services to all of the Trust's participants. Healthcare operations include*

*contacting healthcare providers and participants with information about 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 Trust, 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 Trust 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 Trust 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 Trust 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 Trust 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 Trust may disclose your health information to a law enforcement official for certain law enforcement purposes including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.*

***For treatment alternatives:*** *The Trust 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 Trust 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 Trust 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 Trust, 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 Trust 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 Trust, 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 Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, 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 Trust 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 Trust 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 Trust 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 personal 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 Trust will not disclose your health information other than with your written authorization. If you have authorized the Trust 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 Trust 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 Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust generally is not required to agree to your request. The Trust 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 Trust's Privacy Contact Person listed below.

***Right to receive confidential communications:*** You have the right to request that the Trust 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 Trust 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 Trust's Privacy Contact Person below. The Trust 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 Trust 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 Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust 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 Trust, if the health information you are requesting be amended is not part of the Trust'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 Trust 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 Trust 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, but may not start earlier than April 14, 2003,

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*when the Privacy Rule became effective. Accounting requests may not be made for periods going back more than six years. The Trust 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 Trust 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 Trust Notice at [www.soundhealthwellness.com](http://www.soundhealthwellness.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  
201 Queen Anne Ave. N. Suite 100  
Seattle, WA 98109  
Phone: (206) 352-9730 or 1 (866) 277-3927  
Fax: (206) 285-1701  
[Contactperson@zenith-american.com](mailto:Contactperson@zenith-american.com)*

The Trust 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 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 TRUST**

The Trust 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 Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust 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 Trust changes its policies and procedures, the Trust 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 Trust 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 Trust should be made in writing to the Privacy Official identified above. The Trust 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.