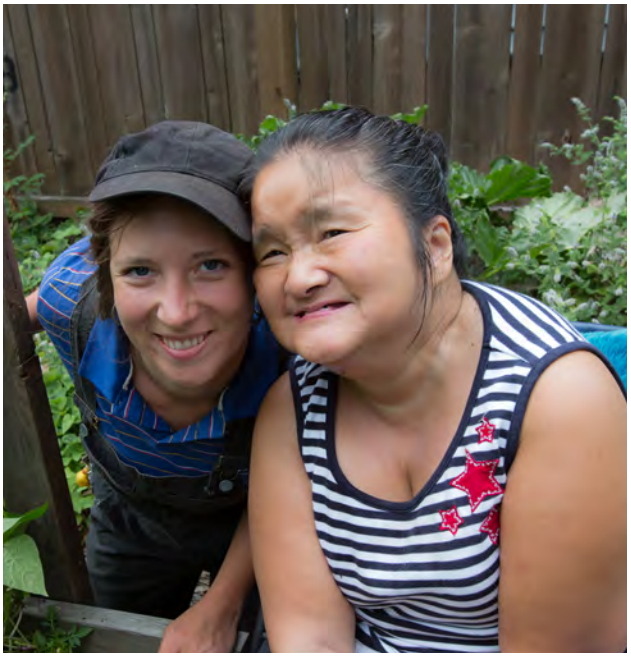

ALBERTINA KERR EMPLOYEE BENEFITS

Benefits Effective July 1, 2017 | *AlbertinaKerr.org*

ALBERTINA KERR

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DEAR ALBERTINA KERR TEAM MEMBER:

Thank you for your commitment to the children, adults, and families served by Albertina Kerr. Every day, you are part of a team that helps people with developmental disabilities and mental health challenges, empowering them to live richer lives. You are part of Albertina Kerr's Army of Angels where we challenge the norm to create a society that has no barriers.

As part of your compensation package, you may be eligible for our employee benefits plans. Generally, regular status employees who work 30 or more hours weekly are eligible to participate in Albertina Kerr benefit plans following 90 days of employment. Please sign up for benefits as soon as possible, as your enrollment period ends 30 days after you become eligible for benefits. Unless you experience a qualifying life event, this is your only opportunity to enroll in benefits during the year, so it's important that you submit your elections within the enrollment period!

Some features of the Albertina Kerr benefit program are featured in this book, but you can also find more information about the benefit plans on the intranet, in the enclosed information, or by calling the HR Service Center at 503-262-0145.

We have made every effort to ensure that this information is accurate, but if there is any conflict between this summary and the plan document or insurance contracts, the plan document will control. Our current offerings do not bind us to offer similar benefits in the future, and plans and offerings may change from time to time.

BENEFITS CHECKLIST

Use this handy checklist to make sure that you have reviewed and completed all the Albertina Kerr benefits information:

- ☐ Review this packet of information.
- ☐ Enroll in medical, dental or vision plans through the Employee Portal or by completing the ***Benefits Enrollment and Change Form.***
- ☐ If you have other private or group (not government) medical insurance and will be waiving medical insurance (and receiving $100 per month), complete the ***Benefit Waiver for Medical .Insurance*** form and send in with a copy of your health insurance ID card. This must be done each year during open enrollment.
- ☐ Participate in the life or disability insurance plans (short-term disability buy up, voluntary life, AD&D) through the Employee Portal or by completing the enrollment form.
- ☐ Establish beneficiaries through the Employee Portal or by filling out the ***"Cigna Beneficiary Designation"*** form.
- ☐ Add, change or discontinue AFLAC coverage by reading the enclosed information page and contacting the agent.
- ☐ Enroll in the Flexible Spending Accounts (FSA) for medical, dependent care, or transit expenses through the Employee Portal or by completing the FSA section on the ***Benefits Enrollment and Change Form.*** You must re-enroll each year during open enrollment.
- ☐ Once you have completed the appropriate forms, please fax them to Human Resources at 503-261-0988, then courier the original to HR.

Remember, to make changes to your insurance mid-year because of a qualifying life event, such as a birth, death, relationship change, or change in other coverage – contact the HR Service Center at 503-262-0145 within 30 days of the event to discuss eligibility for mid-year changes.

If you have questions about plans or coverage, please call the HR Service Center at 503-262-0145.

IMPORTANT CONTACTS

Please contact the individual company/provider listed here to learn more about a specific benefit plan. We also invite you to speak with an HR representative.

Albertina Kerr HR Service Center: 503-262-0145

Kaiser Permanente
503-813-2000 | www.kp.org

Kaiser Permanente Dental
HMO: Same as Medical
PPO: 1-866-498-7916
KP.org/dental/nw

EyeMed Vision Plans
866-723-0596
www.eyemedvisioncare.com

Life Assistance EAP: Cigna
800-538-3543
www.cignabehavioral.com/cgi

AFLAC – Teresa Cravinho
503-319-3989

Cigna Life & Disability
800-362-4462

Ascensus (401k Administration)
866-809-8146
www.myaccount.ascensus.com/rplink

PayFlex FSA
800-284-4885
www.healthhub.com

ABOUT YOUR BENEFITS

The health and happiness of you and your family is a high priority at Albertina Kerr. That's why we offer a comprehensive benefits package as part of your compensation package.

ELIGIBILITY INFORMATION

As a regular status employee scheduled to work 30 or more hours per week, you are eligible for Medical, Dental, Life/Disability and Vision Insurance benefits once you have met the service requirements. You are also able to pay premiums pretax and enroll in Flexible Spending, Dependent Care and Transportation accounts. Eligible dependents can also receive certain other coverage. As part of your benefits, you also have access to an Employee Assistance Program and, once eligible, active employees may enroll in the 401(k) retirement savings plan. Some benefits are paid entirely by Albertina Kerr at no cost to you. For other benefits, the cost is shared by you and the agency.

MAKING CHANGES DURING THE YEAR

Generally, you can only change your benefit elections during the annual benefits Open Enrollment period. An exception is made for any Qualified Life Event (QLE), such as marriage, divorce, birth, adoption, death or gain/loss of other coverage. You must notify Human Resources within 30 days of any QLE to make changes. Otherwise, you have to wait until the next enrollment period. Any changes you make to your benefit choices must be directly related to the Life Event. Proof of the change may be required (for example, a marriage license or birth certificate).

WHEN COVERAGE ENDS

Most benefits end at termination or the last day of the month of your last day worked. However, under certain circumstances, you may continue your health care benefits through COBRA.

This guide describes the benefits plans and policies available to you. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. This guide is meant only to cover the major points of each plan or policy. You will find additional details in the Summary Plan Descriptions (as required by ERISA) of your additional employee benefit materials. If you have a question about one of these plans and policies, or if there's a conflict between the information in this guide and the formal language of the plan or policy documents, the formal wording in the plan or policy documents will govern.

Note: The benefits described in this guide may be changed at any time and don't represent a contractual obligation – either implied or expressed – on the part of Albertina Kerr.

PERSONAL ACCRUED LEAVE (PAL)

Employees receive paid time off work, Personal Accrued Leave (PAL), to rest, recover, and rejuvenate. PAL is a combination of both sick and vacation time. You will accrue PAL time each pay period based on hours worked and length of service. Also, you may accumulate and roll over up to 120 hours of accrued but unused PAL time from year to year. Hourly employees also have the option to cash out accrued PAL from time to time. Please read your employee handbook for more details about this option and other information about using PAL.

BI-WEEKLY ACCRUAL

(Total for year given in parentheses. Does not include paid holidays.)

Years Served	NON-Exempt Employees	Exempt Employees
0-1	.0385 hours accrued per hour to a maximum of 3.08 hours per pay period (10 days/80 hrs year)	6.15* hrs (20 days/160 hrs year)
1-2	.057625 hours accrued per hour to a maximum of 4.61 hrs per pay period (15 days/120 hrs year)	6.15* hrs (20 days/160 hrs year)
2-3	.077 hours accrued per hour to a maximum of 6.15 hrs per pay period (20 days/160 hrs year)	7.69* hrs (25 days/200 hrs year)
3-4	.096125 hours accrued per hour to a maximum of 7.69 hrs per pay period (25 days/200 hrs year)	9.23* hrs (30 days/240 hrs year)
4 and over	.115375 hours accrued per hour to a maximum of 9.23 hrs per pay period (30 days/240 hrs year)	9.23* hrs (30 days/240 hrs year)

*Accrual rates will be prorated for Exempt employees working less than 40 standard hours per week.

HOLIDAYS

Albertina Kerr provides the following paid holidays:

- New Year's Day
- Observed birthday of Martin Luther King Jr.
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

If you are regularly scheduled to work 20 or more hours per week, you will receive pay for agency holidays. If you are an hourly, direct care worker and work on the holiday, you will also receive time-and-a-half for the hours you work on the holiday. For more details, please see your employee handbook.

MEMBERSHIPS & DISCOUNTS

Albertina Kerr employees are also eligible to receive discounts on hundreds of fitness, life, wellness, and entertainment activities. Visit the Kerr Intranet for more information for your region.

In addition, employees receive a 25 to 30 percent discount (depends on type) on bikes and specialty equipment at Kerr Bikes or a free one-hour rental during the first hour that Kerr Bikes is open. Visit KerrBikes.org for location and hours.

MEDICAL INSURANCE

One way Albertina Kerr helps look after the health and welfare of your family is with comprehensive and flexible Medical/Rx insurance.

Medical and Prescription Drug coverage is provided through plans from Kaiser Permanente, and we offer two plans:

BASE PLAN

Kerr's Base Plan is a Kaiser Permanente HMO, which allows you to receive care through the Kaiser Permanente service network. It does not pay for care outside of the Kaiser network except in emergencies. Kerr pays 100% of the employee premium for the base plan, and this plan has lower dependent premium costs.

BUY-UP PLAN

You may also purchase an enhanced medical insurance or "buy-up" plan. **Kerr's Buy-up Plan is a Kaiser Permanente Added Choice** plan. In the enhanced plan, you have the option of receiving care in any of three tiers. You can choose at the time of service whether to seek care in the Kaiser HMO network, in the contracted PPO network that includes doctors outside of Kaiser, or outside of the network entirely. You can choose the care that makes sense for your needs, your finances, and your preferences when you access care, without being locked into a particular panel of providers. To participate in the enhanced plan, you must contribute to the employee-only premium, and these are higher dependent premiums.

MEDICAL INSURANCE CONTRIBUTIONS

	Total Cost Per Month	Kerr's Monthly Benefit Subsidy	Employee's Monthly Contribution	Per Paycheck Deduction
Kaiser Base Plan				
• Employee only	$464.58	$464.58	-0-	-0-
• Employee and Spouse/Partner	$947.75	$464.58	$483.17	$241.59
• Employee and Children	$854.83	$464.58	$390.25	$195.13
• Employee and Family	$1,412.33	$464.58	947.75	$473.88
Kaiser Buy-Up Plan: Added Choice				
• **Employee only**	$681.85	$464.58	$217.27	$108.64
• **Employee and Spouse/Partner**	$1390.98	$464.58	$926.40	$463.20
• **Employee and Children**	$1254.60	$464.58	$790.02	$395.01
• **Employee and Family**	$2072.83	$464.58	$1608.25	$804.13

MEDICAL INSURANCE COVERAGE, DEDUCTIBLE, MAXIMUMS AND CO-PAYS

	BASE PLAN	BUY-UP PLAN: ADDED CHOICE		
	HMO	Kaiser Tier	PPO Tier	Out-of-Network
Annual Deductible • Individual • Family	 $750 $2,250	 $750 $2,250	 $1,500 $4,500	 $2,250 $6,750
Out-of-Pocket Maximum *(excludes deductible)* • Individual • Family	 $2,250 $6,750	 $2,250 $4,500	 $4,500 $9,000	 $6,000 $12,000
Office Visit: Primary	$20*	$25*	$35*	40%
Office Visit: Specialist	$30*	$35*	$45*	40%
Office Visit: Preventative Care	$0*	$0*	$35*	40%
Immunizations	No charge	No charge	No charge	No charge
Lab & X-Ray	$20* per visit $0 for preventative $100* for MRI/ CT/PET	$25* per visit $0 for preventative $100* for MRI/ CT/PET	$35* per visit 30% after deductible for MRI/CT/PET	40%
Ambulance	20%	20%	20%	20%
Hospital Services	20%	20%	30%	40%
Urgent Care	$40*	$45*	$55*	40%
Emergency Room	20%	$200	$200	$200
Durable Medical Equipment	20%	20%	30%	40%
Prescriptions: Retail *(30-day supply)*	$15/$30/$50 Kaiser Formulary and Pharmacies	$15/$30/$50 Kaiser Formulary and Pharmacies	$20/40/60** Open Formulary, Med-Impact Pharmacies	
Prescriptions: Mail Order *(90-day supply)*	$30/$60/$100 Kaiser mail facility only	$30/$60/$100 Kaiser mail facility only	Mail-Delivery Pharmacy 1-800-548-9809 kp.org/addedchoice	
Alternative Health Coverage	$30 copay for referred acupuncture, max 12 visits/year (Referred Acupuncture in Base Plan and Kaiser Tier of Enhanced Plan only.) Copay on Added Choice increases to $35 (HMO remains at $30.)			
	$20 copay for chiro/naturopath/acupuncture. $25 copay for self-referred massage (max. 12 visits), $1,000 maximum combined benefit.			

**Deductible waived.*
***If a generic drug is available and the member chooses a brand drug, the cost will be the brand copayment plus the difference between generic and brand.*

This is a brief summary of coverages. Please see the plan document for a full and controlling description of benefits.

DENTAL INSURANCE

Kerr provides affordable dental coverage that makes it easy to visit your dentist for regular cleanings and preventive care, as well as for major treatments.

DENTAL INSURANCE COVERAGE, CO-PAYS

Kaiser Permanente*			
	Base HMO	**Buy-Up PPO In Network**	**Buy-Up PPO Out of Network**
Annual Deductible (calendar year) • Individual • Family	 $75 $225	 $75 $225	 $75 $225
Prevention and Diagnostic Treatment	100%**	100%**	100%**
Basic Treatment	80%	80%	60%
Major Treatment	50%	50%	
Annual Maximum Benefit	$2,000	$1,500 per person	
Orthodontia Lifetime Maximum	Not covered	50% to 1,500 Adult/Child	
Office Visits	$5	None	

DENTAL INSURANCE CONTRIBUTIONS

	Total Cost Per Month	**Kerr's Monthly Benefit Subsidy**	**Employee's Monthly Contribution**	**Per Paycheck Deduction**
Dental Base • Employee only • Employee & Spouse/Partner • Employee & Children • Employee & Family	 $29.33 $56.33 $60.15 $87.16	 $29.33 $29.33 $29.33 $29.33	 -0- $27.00 $30.82 $57.83	 -0- $13.50 $15.41 $28.92
Dental Buy-Up • Employee only • Employee & Spouse/Partner • Employee & Children • Employee & Family	 $39.82 $76.47 $81.67 $118.33	 $29.33 $29.33 $29.33 $29.33	 $10.49 $47.14 $52.34 $89.00	 $5.25 $23.57 $26.17 $44.50

*** Deductible waived.*

VISION INSURANCE

Vision coverage is available through EyeMed helps pay for periodic eye exams, eyeglasses and contact lenses.

VISION INSURANCE COVERAGE, CO-PAYS

EYEMED*		
	In-Network	**Out-of-Network Reimbursement**
Annual Eye Exam	$25 copay	Up to $50
Frames (every 24 months)	$130 allowance	Up to $65
Prescription Lenses (every 24 months) • Single vision • Bifocal • Trifocal • Lenticular	 $25 copay $25 copay $25 copay N/A	 Up to $50 Up to $75 Up to $100 N/A
LASIK or PRK	15% off retail price	N/A

VISION INSURANCE CONTRIBUTIONS

	Total Cost Per Month	**Kerr's Monthly Benefit Subsidy**	**Employee's Monthly Contribution**	**Per Paycheck Deduction**
Vision				
• Employee only	$4.20	$4.20	-0-	-0-
• Employee & Spouse/Partner	$8.36	$4.20	$4.16	$2.08
• Employee & Children	$8.94	$4.20	$4.74	$2.37
• Employee & Family	$14.31	$4.20	$10.11	$5.06

** If you aren't using a preferred optometrist, all fees are paid at the out-of-network level and you may be subject to balance billing.*

EMPLOYEE ASSISTANCE PROGRAM

Albertina Kerr offers access to confidential help for everyday situations and personal difficulties such as depression, dependency, job-related stress and legal and financial concerns. Call 1-800-538-3543 or visit online: www.cignabehavioral.com/cgi.

EMPLOYEE ASSISTANCE

The Employee Assistance Program (or EAP) is a professional and confidential counseling service designed to help address personal concerns and life issues you might be facing. Staff by experienced professional clinicians, this service is available to you and members of your family at no cost, by calling a toll-free phone line 24 hours a day, seven days a week. The EAP provides personal and confidential phone counseling services and a limited in-person counseling benefit, regardless of need and can help with a variety of concerns, such as: depression, marital and family conflicts, job pressures, stress and anxiety, substance abuse, grief and loss.

KERR WELLNESS

The goal of Albertina Kerr's employee wellness committee is to identify opportunities to support employees in making healthy choices and incorporating wellness into their work and home lives. Watch for wellness tips and information in our employee communications and for special opportunities and activities to help you live well.

SUPPLEMENTAL INSURANCE

Albertina Kerr employees are eligible for special, group pricing with supplemental insurance provider AFLAC. AFLAC provides supplemental insurance to cover a variety of specific concerns, including specified illness coverage, supplemental dental coverage, accident insurance, and others. To learn more about AFLAC product offerings and to get a personalized rate quote, call Albertina Kerr's AFLAC Representative, Melinda Hickey, at 503-881-1313.

LIFE/AD&D & DISABILITY INSURANCE

Life/AD&D and Disability Insurance aren't something you think about everyday. But, they should be an important part of everybody's financial planning – no matter what your age. Your benefits program offers the following coverage to help protect you and your family when it's needed most. Albertina Kerr's life and disability carrier is Cigna. All employees need to designate a beneficiary by completing the Cigna Group Insurance Beneficiary Designation form.

BASIC LIFE AND ACCIDENT (AD&D)

Albertina Kerr provides $25,000 of Life Insurance and an additional $25,000 of AD&D Insurance just for being an employee. You are eligible following 90 days of service.

SUPPLEMENTAL LIFE AND AD&D (YOU PAY FULL COST)

You may also purchase term life insurance at a low group rate for yourself, your spouse or domestic partner, and your children. You can purchase up to five times your base annual earnings, up to $500,000. Premium rates are scheduled by age and are detailed in the Cigna packet. Please contact HR at 503-262-0145 for a packet.

- Employee – Up to five times your base annual earnings in increments of $10,000 to $500,000 max.
- Spouse - $5,000 increments to $250,000 max.
- Children - $2,000 increments to $10,000 (age six months+)
- Maximum benefit is $500 for six months and under.

If you sign up during the initial enrollment period (within 90 days of your hire), you may purchase term life insurance up to five times your annual salary or $200,000 (whichever is lesser) without a medical review. If you enroll after 90 days, you may be subject to a medical review.

SHORT-TERM DISABILITY (BASE & BUY-UP)

Albertina Kerr provides Short-Term Disability Insurance the first day of the month following 90 days of employment. Kerr pays 100% of the premium for your basic weekly benefit of $100 for a period of up to 22 weeks (or up to 66.667% of base annual salary) after a 30-day elimination period. After 90 days of employment, you have the option of buying additional coverage to up to 60% of your weekly pay, to an additional maximum weekly benefit of $500.

	Employee Cost per Pay Period
Short Term Disability Buy-Up	31 cents per $10 of benefit, up to $7.75 per paycheck

LONG-TERM DISABILITY (COMPANY PAID)

Albertina Kerr provides Long-Term Disability Insurance effective the first day of the month following two years of employment. Kerr pays 100% of the premium for your benefit, which is 60% of your regular pay, to a maximum benefit of $5,000 per month. The length of benefit payments depends on your age when you become disabled. Benefits begin after 180 days of disability.

FLEXIBLE SPENDING

You may set aside pretax dollars out of your paycheck to pay for eligible expenses through a Flexible Spending Account (FSA).

MEDICAL & DEPENDENT FSA

You may set aside a maximum of $2,600 annually for medical expenses and $5,000 annually for dependent care expenses you incur during the plan year. This account allows you to set aside money to pay for eligible dependent care expenses for your child who is under the age of 13 OR for a spouse or dependent who is not able to take care of himself or herself such as: licensed day care provider, in-home provider as long as the care provider is not your child under age 19, or someone you claim as a tax dependent, summer camps (not overnight), tuition through preschool, before and after school care.

TRANSPORTATION REIMBURSEMENT

You may set aside money annually for qualified transit related expenses, like bus and rail passes. This amount can carry over from year-to-year if you remain enrolled but cannot be refunded.

HOW DOES IT WORK?

First, estimate the expenses you plan to incur during the year and determine your contribution amount. The amount you choose to contribute will be taken out of your paycheck in equal amounts each pay period. You then submit a claim for reimbursement. On average an FSA could save you between 23 to 30 percent in taxes depending on your contribution. When you enroll for the healthcare or dependent care FSA, you are enrolling for the full benefit year (July-June), and mid-year changes are generally not allowed. You will not receive a refund on amounts you contribute but do not claim. If you're a Health Care FSA member, you can now carry over up to $500 in unused funds to the next plan year.

REIMBURSEMENTS

To request a reimbursement from your Flexible Spending Account, please visit the PayFlex HealthHub at **www.healthhub.com** or **fax a reimbursement form to 402-231-4310**. Reimbursement forms may be downloaded from the HealthHub website or requested from the HR Service Center at 503-262-0145. Or, download the mobile app for your iPhone or Android to manage your account and submit claims.

ESTIMATE WORKSHEET

This worksheet is for your use to estimate expenses (you do not need to submit it).

Estimated Medical	$
Estimated Vision	$
Estimated Dental	$
Estimated Prescriptions	$
TOTAL	$

Enter in Box E of the Benefits Enrollment and Change Form, "Annual Amount Elected"

Divide the Total Estimate by 24 pay periods (=total/24)	$

Enter in Box E of the Benefits Enrollment and Change Form, "Per Pay Period Election"

- *As of January 1, 2011, OTC drugs must be prescribed to be eligible for reimbursement*
- *All eligible out-of-pocket medical expenses for you, your spouse, and your dependents can be reimbursed regardless of insurance coverage.*
- *The medical spending account categories on this worksheet are intended only for your personal use in estimating your annual medical expenses.*
- *The full annual amount elected is available for eligible medical expenses incurred at any time during the plan year.*

PRIVACY NOTICE

PLEASE CAREFULLY REVIEW THIS NOTICE. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Flexible Spending Account. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Albertina Kerr Centers as an employer — that's the way the HIPAA rules work. Different policies may apply to other Albertina Kerr Centers programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits. The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH ALBERTINA KERR CENTERS

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Albertina Kerr Centers for plan administration purposes. Albertina Kerr Centers may need your health information to administer benefits under the Plan. Albertina Kerr Centers agrees not to use or disclose your health information other

than as permitted or required by the Plan documents and by law. Human Resources, Payroll, and Finance staff are the only Albertina Kerr Centers employees who will have access to your health information for plan administration functions. Here's how additional information may be shared between the Plan and Albertina Kerr Centers, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Albertina Kerr Centers, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Albertina Kerr Centers information on whether an individual is participating in the Plan or has enrolled or unenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Albertina Kerr Centers cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Albertina Kerr Centers from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)

Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made.You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse:

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information:

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information:

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete:

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created

the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information:

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless

otherwise indicated below. You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request:

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on July 1, 2017. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice mailed to your home address.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, please contact Albertina Kerr's HR Service Center at 503-262-0145.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact Matthew Warner, Chief Human Resources Officer at 503-408-5074.

2017 REQUIRED NOTICES

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

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

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

If you decide to join a Medicare drug plan, your current Albertina Kerr Centers coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Albertina Kerr Centers coverage, be aware that active employees and

401K RETIREMENT SAVINGS PLAN

The Albertina Kerr 401(k) Retirement Savings Plan is an important tool offered by Kerr to help you reach your retirement savings goals through tax deferred savings.

- **Matching:** Kerr matches 100 percent of the first three percent that you contribute and 50 percent of the next two percent you contribute to your 401(k) retirement savings account, helping you reach your savings goals sooner.

- **Investment options:** Kerr 401(k) investment options include professionally managed funds.

- **Eligibility:** Most employees are eligible to participate in the 401(K) Retirement Savings Plan after 90 days of employment.

- **Enrollment:** You will receive an initial enrollment kit about a month before you are first eligible to enroll, but you may enroll and make changes any time of year following your initial eligibility. Call the HR Service Center at 503-262-0145 to discuss eligibility and start participating today through an automatic payroll deduction.

their dependents who waive this coverage will not be able to get this coverage back until open enrollment or a qualified status change event.

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

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

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

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

Contact Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Albertina Kerr Centers changes. You also may request a copy of this notice at any time.

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

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

Call your State Health Insurance Assistance Program. To find the number for your state, you can go online at www.shiptacenter.org or call the Medicare number shown below:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT NOTICE

MATERNITY BENEFITS

Under Federal and state law you have certain rights and protections regarding your maternity benefits under the Plan.

Under federal law known as the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or

newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH & CANCER RIGHTS ACT ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits,

call the HR Service Center at 503-262- 0145.

PRIVACY NOTICE REMINDER

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Albertina Kerr Centers Health and Welfare Plan (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice contact the HR Service Center at 503-262-0145.

SPECIAL ENROLLMENT RIGHTS NOTICE

Under the special enrollment provisions of HIPAA, you may be eligible, in certain situations, to enroll in an Albertina Kerr Centers medical plan during the year, even if you previously declined coverage. This right extends to you and all eligible family members.

- You will be eligible to enroll yourself (and eligible dependents) if, during the year you or your dependents have lost coverage under another plan because:
    - » Coverage ended due to termination of employment, divorce, death, or a reduction in hours that affected benefits eligibility;
    - » Employer contributions to the plan stopped;
    - » The plan was terminated; or
    - » COBRA coverage ended.

You must notify the plan within 31 days of the loss of coverage in order to enroll on the Albertina Kerr Centers medical plan during the year. Otherwise, you will need to wait until the plan's open enrollment period.

- If you gain a new dependent during the year as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent, as well as yourself and any other eligible dependents in the plan, even if you previously declined medical coverage.

You must notify the plan within 31 days of the event in order to enroll on the Albertina Kerr Centers medical plan during the year. Otherwise, you will need to wait until the plan's open enrollment period. Coverage will be retroactive to the date of birth or adoption for children enrolled during the year under these provisions.

- Effective April 1, 2009, you will be eligible to enroll yourself and eligible dependents if either of two events occur:
    - » You or your dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible.
    - » You or your dependent qualifies for state assistance in paying your employer group medical plan premiums.

Regardless of other enrollment deadlines, you will have 60 days from the date of the Medicaid/CHIP event to request enrollment in the Albertina Kerr Centers medical plan.

Please note that special enrollment rights allow you to either:

- » Enroll in your current medical coverage; or
- » Enroll in any medical plan benefit option for which you and your dependents are eligible.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid
www.myalhipp.com
1-855-692-5447

ALASKA – Medicaid
health.hss.state.ak.us/dpa/programs/medicaid
Outside of Anchorage: 1-888-318-8890
Anchorage: 907-269-6529

COLORADO – Medicaid
Medicaid: www.colorado.gov/hcpf
Medicaid Customer Service Center:
1-800-221-3943

FLORIDA – Medicaid
www.flmedicaidtplrecovery.com
1-877-357-3268

GEORGIA – Medicaid
dch.georgia.gov - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
1-800-869-1150

INDIANA – Medicaid
www.in.gov/fssa
1-800-889-9949

IOWA – Medicaid
www.dhs.state.ia.us/hipp
1-888-346-9562

KANSAS – Medicaid
www.kdheks.gov/hcf
1-800-792-4884

KENTUCKY – Medicaid
chfs.ky.gov/dms/default.htm
1-800-635-2570

LOUISIANA – Medicaid
www.lahipp.dhh.louisiana.gov
1-888-695-2447

MAINE – Medicaid
www.maine.gov/dhhs/ofi/public-assistance/index.html
1-800-977-6740 (TTY 1-800-977-6741)

MASSACHUSETTS – Medicaid and CHIP
www.mass.gov/MassHealth
1-800-462-1120

MINNESOTA – Medicaid
www.dhs.state.mn.us/id_006254
Click on Health Care, then Medical Assistance
1-800-657-3739

MISSOURI – Medicaid
www.dss.mo.gov/mhd/participants/pages/hipp.htm or 573-751-2005

MONTANA – Medicaid
medicaid.mt.gov/member
1-800-694-3084

NEBRASKA – Medicaid
www.ACCESSNebraska.ne.gov
1-855-632-7633

NEVADA – Medicaid
Medicaid: dwss.nv.gov
Medicaid: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
www.dhhs.nh.gov/oii/documents/hippapp.pdf
603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid
www.state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid: 609-631-2392
CHIP: www.njfamilycare.org/index.html
CHIP: 1-800-701-0710

NEW YORK – Medicaid
www.nyhealth.gov/health_care/medicaid
1-800-541-2831

NORTH CAROLINA – Medicaid
www.ncdhhs.gov/dma
919-855-4100

NORTH DAKOTA – Medicaid
www.nd.gov/dhs/services/medicalserv/medicaid
1-800-755-2604

OKLAHOMA – Medicaid and CHIP
www.insureoklahoma.org
1-888-365-3742

OREGON – Medicaid
www.oregonhealthykids.gov
www.hijossaludablesoregon.gov
1-800-699-9075

PENNSYLVANIA – Medicaid
www.dpw.state.pa.us/hipp
1-800-692-7462

RHODE ISLAND – Medicaid
www.ohhs.ri.gov
401-462-5300

SOUTH CAROLINA – Medicaid
www.scdhhs.gov or 1-888-549-0820

SOUTH DAKOTA - Medicaid
dss.sd.gov or 1-888-828-0059

TEXAS – Medicaid
www.gethipptexas.com
1-800-440-0493

UTAH – Medicaid and CHIP
health.utah.gov/medicaidhealth.utah.gov/chip
1-866-435-7414

VERMONT– Medicaid
www.greenmountaincare.org
1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid and CHIP: www.coverva.org/programs_premium_assistance.cfm
Medicaid: 1-800-432-5924
CHIP: 1-855-242-8282

WASHINGTON – Medicaid
www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
www.dhhr.wv.gov/bms
1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP
www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

WYOMING – Medicaid
health.wyo.gov/healthcarefin/equalitycare
307-777-7531

To see if any more States have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Centers for Medicare & Medicaid Services:
www.cms.hhs.gov or 1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137

you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Physician Designation Notice

Kaiser Permanente generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact Kaiser at 1-800-813-2000 or kp.org.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact Kaiser at 1-800-813-2000 or kp.org.

COBRA

MODEL COBRA CONTINUATION COVERAGE GENERAL NOTICE

INSTRUCTIONS

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice, to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do not need to include this instruction page with the model general notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Albertina Kerr Human Resources Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

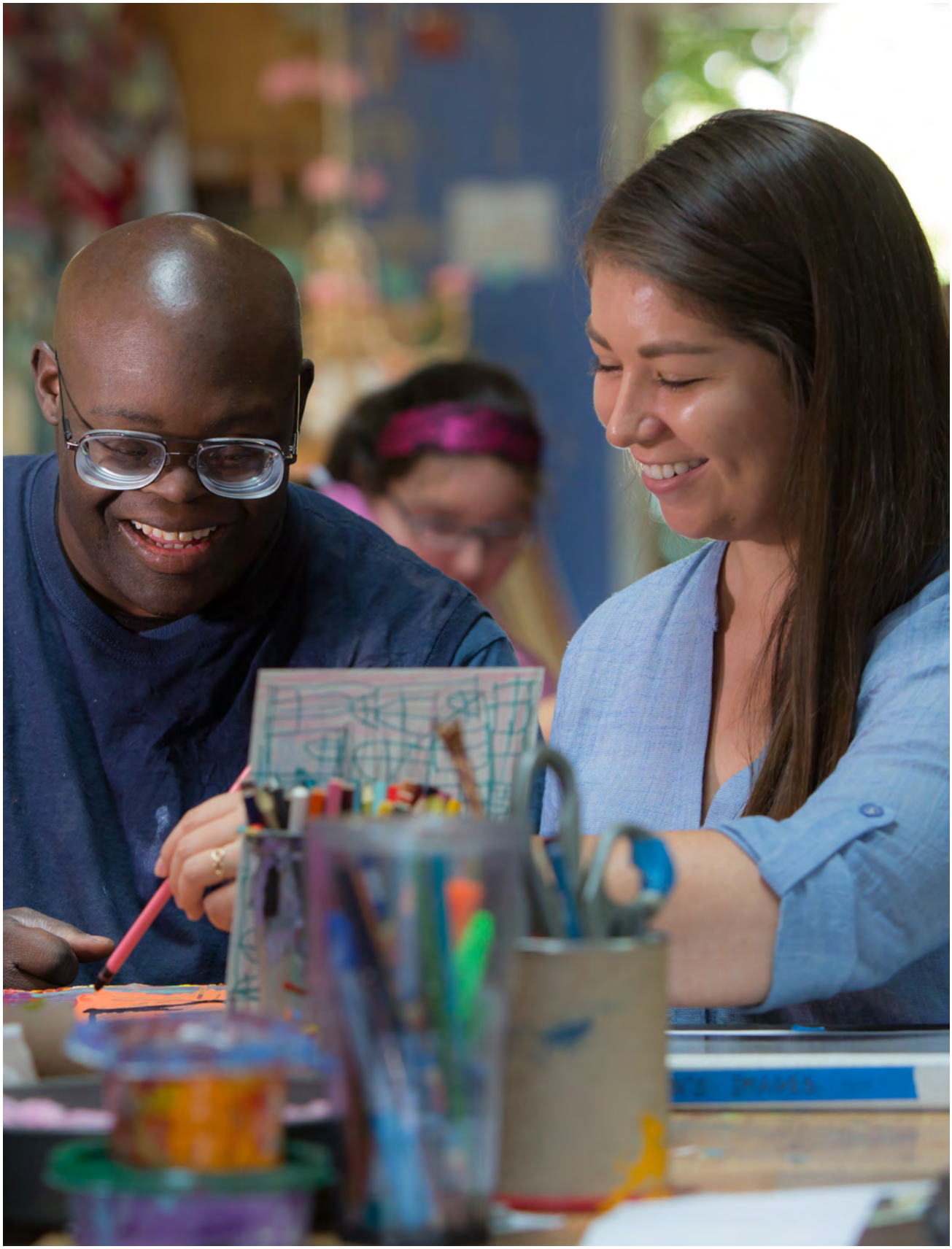
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

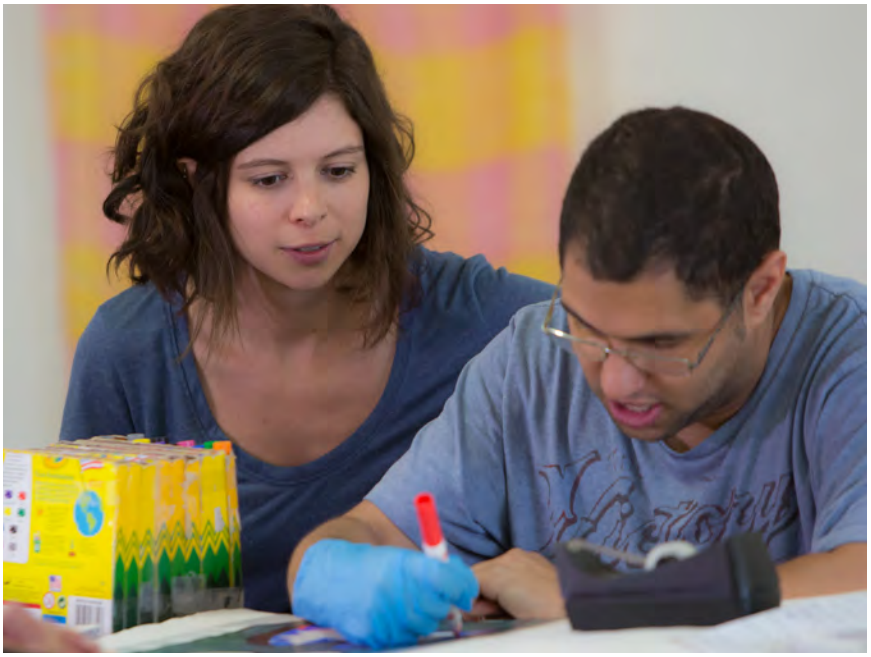
If you have questions

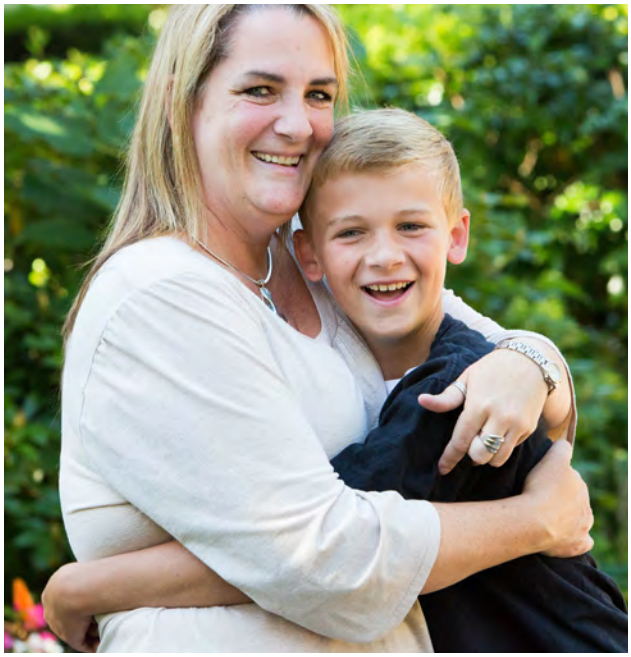
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.







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