ALBERTINA KERR EMPLOYEE BENEFITS

Benefits Effective July 1, 2018 | *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.

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.
- ☐ 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.
- ☐ If you are completing paper forms, please scan and email them to the HR Service Center at HR@AlbertinaKerr.org or deliver them to the Gresham Campus at 876 NE 162nd Avenue, Portland, OR 97230.

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 – contact Melinda Hicket at 503-881-1313.

Cigna Life & Disability
800-362-4462

Vanguard (401k Administration)
1-866-794-2145
www.my.vanguardplan.com

Discovery Benefits (FSA)
1-866-451-3399
www.discoverybenefits.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. 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.

Base Plan Contributions	Total Cost Per Month	Kerr's Monthly Benefit Subsidy	Employee's Monthly Contribution	Per Paycheck Deduction
Kaiser Base Plan				
• Employee only	$485.55	$485.55	-0-	-0-
• Employee and Spouse/Partner	$990.52	$485.55	$504.97	$252.49
• Employee and Children	$893.41	$485.55	$407.86	$203.93
• Employee and Family	$1,476.06	$485.55	$990.51	$492.26

BUY-UP PLAN

You may also purchase an enhanced medical insurance or "buy-up" plan. **Kerr's Buy-up Plan is a Kaiser Point of Service (POS)** 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

Buy-Up Plan Contributions	Total Cost Per Month	Kerr's Monthly Benefit Subsidy	Employee's Monthly Contribution	Per Paycheck Deduction
Kaiser Buy-Up Plan: POS				
• **Employee only**	$728.14	$485.55	$242.59	$121.30
• **Employee and Spouse/Partner**	$1,485.41	$485.55	$999.86	$499.93
• **Employee and Children**	$1,339.78	$485.55	$854.23	$497.12
• **Employee and Family**	$2,213.55	$485.55	$1,728.00	$864.00

MEDICAL INSURANCE COVERAGE, DEDUCTIBLE, MAXIMUMS AND CO-PAYS

	BASE PLAN (HMO)
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of Pocket Maximums accumulate.	
Deductible • For one Member per Year • For an entire Family per Year	 • $1,000 • $3,000
Out-of-Pocket Maximum* • For one Member per year • For an entire Family per year	 • $3,000 • $7,500
Office Visits • Routine preventive physical exam • Primary Care • Specialty Care • Urgent Care	**You Pay** • $0 • $20 • $30 • $40
Tests (outpatient) • Preventive Tests • Laboratory • X-ray, imaging, and special diagnostic procedures • CT, MRU, PET scans	**You Pay** • $0 • $20 • $20 • $100
Medications (outpatient) • Prescription drugs (up to a 30 day supply) • Mail Order Prescription drugs (up to a 90 day supply) • Administered medications, including injections (all outpatient settings) • Nurse treatment room visits to receive injections	**You Pay** • $15 generic/$30 preferred brand/$50 non-preferred brand • $30 generic/$60 preferred brand/$100 non-preferred brand • 20% Coinsurance after Deductible • $10
Maternity Care • Scheduled prenatal care and first postpartum visit • Laboratory • X-ray, imaging, and special diagnostic procedures • Inpatient Hospital Services	**You Pay** • $0 • $20 per dept. visit • $20 per dept. visit • 20% Coinsurance after Deductible
Hospital Services • Ambulance Services (per transport) • Emergency department visit • Inpatient Hospital Services	 **You Pay** • 20% Coinsurance after Deductible
Outpatient Services (other) • Outpatient surgery visit • Chemotherapy/radiation therapy visit • Durable medical equipment, external prosthetic devices, and orthotic devices • Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	**You Pay** • 20% Coinsurance after Deductible • $30 after Deductible • 20% Coinsurance after Deductible • $30
Skilled Nursing Facility Services • Inpatient skilled nursing Services (up to 100 days per Year)	**You pay** • 20% Coinsurance after Deductible
Chemical Dependency Services • Outpatient Services • Inpatient hospital & residential Services	**You pay** • $20 • 20% Coinsurance after Deductible
Mental Health Services • Outpatient Services • Inpatient hospital & residential Services	**You pay** • $20 per visit • 20% Coinsurance after Deductible

Alternative Care (self referred) **	**You pay**
• Benefit Maximum per Year (all Covered Services combined)	• $1,000
• Acupuncture Services	• $20
• Chiropractic Services	• $20
• Massage Therapy	• $25
• Naturopathic Medicine	• $20
Vision Services	**You pay**
• Routine eye exam (through first month of age 19)	• $20
• Vision hardware and optical Services (through first month of age 19)	• Not covered
• Routine eye exam (age 19 and older)	• $20
• Vision hardware and optical Services (age 19 years and older)	• Not covered

*Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

** Refer to your Evidence of Coverage (EOC) for any applicable visits limits.
Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Member Services (M-F, 8 am-6 pm) or visit kp.org Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

MEDICAL INSURANCE COVERAGE, DEDUCTIBLE, MAXIMUMS AND CO-PAYS

BUY-UP PLAN (POS)	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of Pocket Maximums accumulate.			
Deductible The amounts you pay for covered Services subject to the Deductible in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Deductible in Tier 2, and do not count toward the Deductible in Tier 3. The amounts you pay for covered Services subject to the Deductible in Tier 3 only count toward the Deductible in Tier 3.			
• For one Member per Year • For an entire Family per Year	• $1,000 • $3,000	• $1,500 • $4,500	• $2,250 • $6,750
Out-of-Pocket Maximum* • For one Member per year • For an entire Family per year	 • $3,000 • $7,500	 • $4,500 • $9,000	 • $6,000 • $12,000
Office Visits • Routine preventive physical exam • Primary Care • Specialty Care • Urgent Care	**You Pay** • $0 • $25 • $35 • $45	 • $0 • $35 • $45 • $55	40% Coinsurance after Deductible
Tests (outpatient) • Preventive Tests • Laboratory • X-ray, imaging, and special diagnostic procedures • CT, MRU, PET scans	**You Pay** • $0 • $25 per dept. visit • $25 per dept. visit • $100 per dept. visit	 • $0 • $35 per dept. visit • $35 per dept. visit • 30% Coinsurance after Deductible	40% Coinsurance after Deductible
Medications (outpatient) • Prescription drugs (up to a 30 day supply) • Mail Order Prescription drugs (up to a 90 day supply)	**You Pay** • $15 generic/$30 preferred brand/$50 non-preferred brand • $30 generic/$60 preferred brand/$100 non-preferred brand	• At MedImpact Pharmacy $20 generic/$40 preferred brand/$60 non-preferred brand • Refer to Mail-Delivery Pharmacy 1-800-548-9809 or kp.org/addedchoice	
• Administered medications, including injections (all outpatient settings) • Nurse treatment room visits to receive injections	• 20% Coinsurance after Deductible • $10	• 30% Coinsurance after Deductible • $35	40% Coinsurance after Deductible
Maternity Care • Scheduled prenatal care and first postpartum visit • Laboratory • X-ray, imaging, and special diagnostic procedures • Inpatient Hospital Services	**You Pay** • $0 • $25 per dept. visit • $20 per dept. visit • 20% Coinsurance after Deductible	 • $0 • $35 per dept. visit • $35 per dept. visit • 30% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospital Services • Emergency Ambulance Services (per transport) • Emergency department visit • Inpatient Hospital Services	**You Pay** • 20% Coinsurance after Deductible • $200 after Deductible (Waived if admitted) • 20% Coinsurance after Deductible	 • 20% Coinsurance after Deductible • $200 after Deductible (Waived if admitted) • 30% Coinsurance after Deductible	• 20% Coinsurance after Deductible • $200 after Deductible (Waived if admitted) • 40% Coinsurance after Deductible

Outpatient Services (other) • Outpatient surgery visit • Chemotherapy/radiation therapy visit • Durable medical equipment, external prosthetic devices, and orthotic devices • Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	**You Pay** • 20% Coinsurance after Deductible • $35 after Deductible • 20% Coinsurance after Deductible • $35	• 30% Coinsurance after Deductible	• 40% Coinsurance after Deductible
Skilled Nursing Facility Services • Inpatient skilled nursing Services (up to 100 days per Year)	**You pay** • 20% Coinsurance after Deductible	• 30% Coinsurance after Deductible	• 40% Coinsurance after Deductible
Chemical Dependency Services • Outpatient Services • Inpatient hospital & residential Services	**You pay** • $25 • 20% Coinsurance after Deductible	• $35 • 30% Coinsurance after Deductible	• 40% Coinsurance after Deductible
Mental Health Services • Outpatient Services • Inpatient hospital & residential Services	**You pay** • $25 per visit • 20% Coinsurance after Deductible	• $35 • 30% Coinsurance after Deductible	• 40% Coinsurance after Deductible
Alternative Care (self referred) ** • Benefit Maximum per Year (all Covered Services combined) • Acupuncture Services • Chiropractic Services • Massage Therapy • Naturopathic Medicine	**You pay** • $1,000 • $20 • $20 • $25 • $20		
Vision Services • Routine eye exam (through first month of age 19) • Vision hardware and optical Services (through first month of age 19) • Routine eye exam (age 19 and older) • Vision hardware and optical Services (age 19 years and older)	**You pay** • $25 • Not covered • $25 • Not covered	• $35 • Not covered • $35 • Not covered	• 40% Coinsurance after Deductible • Not covered • 40% Coinsurance after Deductible • Not covered

* Tier 3 may be subject to balance billing.
** Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.
***Refer to your Evidence of Coverage (EOC) for any applicable visits limits.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Member Services (M-F, 8 am-6 pm) or visit kp.org Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

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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
Office Visits	$10 copay		
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	

DENTAL INSURANCE COVERAGE, CO-PAYS

	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	 $31.81 $61.09 $65.24 $94.53	 $31.81 $31.81 $31.81 $31.81	 -0- $29.28 $33.43 $62.72	 -0- $14.64 $16.72 $31.36
Dental Buy-Up • Employee only • Employee & Spouse/Partner • Employee & Children • Employee & Family	 $45.39 $87.17 $93.09 $134.88	 $31.81 $31.81 $31.81 $31.81	 $13.58 $55.36 $61.28 $103.07	 $6.79 $27.68 $30.64 $51.54

*** Deductible waived.*

SUMMARY OF DENTAL BENEFITS: DENTAL BASE PLAN (HMO)

Benefit Maximum per Calendar Year (covered Services subject to either Benefit Maximum count toward both Benefit Maximums)	$2,000
	You pay
Dental Office Visit Charge — Applies to all visits	$10
Preventive and Diagnostic Services (Not subject to or counted toward the Deductible)	
• Oral exam • X-rays • Teeth cleaning • Fluoride	$0 $0 $0 $0
Basic Restoration Services	
• Routine fillings • Plastic and steel crowns • Simple extractions	• 20% Coinsurance • 20% Coinsurance • 20% Coinsurance
Oral Surgery Services	
• Surgical tooth extractions	• 20% Coinsurance
Periodontics	
• Treatment of gum disease • Scaling and root planing	• 20% Coinsurance • 20% Coinsurance
Endodontics	
• Root canal therapy	• 20% Coinsurance
Major Restoration Services	
• Gold or porcelain crowns • Bridges	• 50% Coinsurance • 50% Coinsurance
Removable Prosthetic Services	
• Full and partial dentures • Relines • Rebases	• 50% Coinsurance • 50% Coinsurance • 50% Coinsurance
Nitrous oxide (Not surbject to or counted toward the Deductible or Benefit Maximum)	
• Adults and children age 13 years and older	• $25
• Children age 12 years and younger	• $0
Orthodontics	Not a covered benefit
Implants	50% Coinsurance up to the $2,000 Dental Implant benefit maximum
Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.	
Questions? Call Member Services (M-F, 8 am-6 pm) or visit kp.org Portland area: 503-813-2000 All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010	
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SUMMARY OF DENTAL BENEFITS: DENTAL BUY-UP PLAN

	In-network benefit (reimbursement is based on MAC) *	Out-of-network benefit (reimbursement is based on UCC) *
Benefit Maximum per Calendar Year (covered Services subject to either Benefit Maximum count toward both Benefit Maximums)	$1,500	
Dental Office Visit Charge — Applies to all visits	$0	
Deductible (Per Calendar Year; applies to all services unless otherwise indicated) • For one Member • For an entire Family	**You Pay** • $75 • $225	
Preventive and Diagnostic Services (Not subject to or counted toward the Deductible)		
• Oral exam • X-rays • Teeth cleaning • Fluoride	$0 $0 $0 $0	$0 $0 $0 $0
Basic Restoration Services		
• Routine fillings • Plastic and steel crowns • Simple extractions	• 20% Coinsurance • 20% Coinsurance • 20% Coinsurance	• 40% Coinsurance • 40% Coinsurance • 40% Coinsurance
Oral Surgery Services		
• Surgical tooth extractions	• 20% Coinsurance	• 40% Coinsurance
Periodontics		
• Treatment of gum disease • Scaling and root planing	• 20% Coinsurance • 20% Coinsurance	• 40% Coinsurance • 40% Coinsurance
Endodontics		
• Root canal therapy	• 20% Coinsurance	• 40% Coinsurance
Major Restoration Services		
• Gold or porcelain crowns • Bridges	• 50% Coinsurance • 50% Coinsurance	• 50% Coinsurance • 50% Coinsurance
Removable Prosthetic Services		
• Full and partial dentures • Relines • Rebases	• 50% Coinsurance • 50% Coinsurance • 50% Coinsurance	• 50% Coinsurance • 50% Coinsurance • 50% Coinsurance
Nitrous oxide (Not surbject to or counted toward the Deductible or Benefit Maximum)		
• Adults and children age 13 years and older	• $25	
• Children age 12 years and younger	• $0	

Orthodontics	All Members: 50% of Charges after Deductible up to the $1,500 Lifetime Benefit Maximum, and 100% of Charges thereafter.	All Members: 50% of Charges up to the $1,500 Lifetime Benefit Maximum plus any remaining balance above MAC or UCC, and 100% of Charges thereafter.
Implants	50% Coinsurance up to the $1,500 Dental Implant benefit maximum	

*"UCC" means Usual and Customary Charge. "MAC" means Maximum Allowable Charge. See your Evidence of Coverage (EOC) for more details.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.

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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 12 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 one year 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

A Flexible Spending Account (FSA) allows you to budget and save for qualified medical expenses incurred over the course of your plan year. Dollars invested in an FSA are tax-free, and the entire election amount is available on the first day of the plan year through a **Discovery Benefits VISA debit card**.

MEDICAL & DEPENDENT FSA

You may set aside a maximum of $2,650 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.

HOW DOES IT WORK?

Use the "Estimate Worksheet" on the right to determine your yearly out-of-pocket medical costs up to a maximum of $2,650.00. Then divide this total by 24 (the number of pay period deductions for your FSA). For example, if your estimated yearly out-of-pocket expenses are $1,200, the amount deducted from each pay check would be $50. The total amount of your yearly contribution is made available to you on a **Discovery Benefits VISA debit card**.

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.**

USING FUNDS

For easy access to your FSA funds, you can swipe your **Discovery Benefits Visa debit card** and avoid out-of-pocket costs. If you use your card at a provider with an Inventory Information Approval System (IIAS), the expense will automatically be approved at the point of sale. If the card is swiped at a merchant that meets the IRS' 90% rule, you may need to provide documentation to show the expense is eligible.

ESTIMATE WORKSHEET

Use this worksheet to estimate your yearly out-of-pocket expenses to determine how much you need to contribute to an FSA.

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

This would be the yearly total of your Medical FSA contributions. This amount must not exceed $2,650.00

Divide by 24*	$

ELIGIBLE EXPENSES

Common eligible expenses for a Medical FSA are prescriptions, hearing aids, orthopedic goods, doctor visits and dentist visits, while a Limited FSA is limited to dental and vision expenses. A DCA covers expenses such as work-related daycare and elderly care costs. To find out which specific expenses are eligible, view the searchable eligibility list at: DiscoveryBenefits.com/eligibleexpenses.

The IRS requires FSA participants to provide documentation (e.g. an Explanation of Benefits) to show that an expense is FSA-eligible. You can easily upload documentation to a claim by logging in to your online account or taking a photo of your documentation with your phone's camera and uploading it through the Discovery Benefits mobile app.

2018 REQUIRED NOTICES

Important Notice About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Albertina Kerr Centers medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2018. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2018 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Albertina Kerr Centers and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Albertina Kerr Centers prescription drug plans listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2018. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

2018 Kaiser HMO Plan

2018 Kaiser Added Choice Plan

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop coverage through Albertina Kerr Centers, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event, assuming you remain eligible.

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.

You should know that if you waive or leave coverage with Albertina Kerr Centers and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Contact your State Health Insurance Assistance Program, find contact numbers for your state online at www.shiptacenter.org
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact Human Resources.

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, contact Human Resources.

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 Human Resources.

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 30 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 30 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 Center's 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 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).

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 January 31, 2018. Contact your State for more information on eligibility –

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program:
- myakhipp.com
- 1-866-251-4861
- CustomerService@MyAKHIPP.com
- Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
- healthfirstcolorado.com
- Health First Colorado Member Contact Center: 1-800-221-3943, State Relay 711
- CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
- CHP+ Customer Service: 1-800-359-1991, State Relay 711

FLORIDA – Medicaid
- flmedicaidtplrecovery.com/hipp 1-877-357-3268

GEORGIA – Medicaid
- dch.georgia.gov/medicaid
- *Click on Health Insurance Premium Payment (HIPP)*
- 404-656-4507

INDIANA – Medicaid
- Healthy Indiana Plan for low-income adults 19–64: www.in.gov/fssa/hi
- Phone: 1-877-438-4479
- All other Medicaid: indianamedicaid.com 1-800-403-0864

IOWA – Medicaid
- dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
- 1-888-346-9562

KANSAS – Medicaid
- kdheks.gov/hcf/
- 1-785-296-3512

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

LOUISIANA – Medicaid
- dhh.louisiana.gov/index.cfm/subhome/1/n/331
- 1-888-695-2447

MAINE – Medicaid
- maine.gov/dhhs/ofi/public-assistance/index.html
- 1-800-442-6003
- TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
- mass.gov/eohhs/gov/departments/masshealth/
- 1-800-862-4840

MINNESOTA – Medicaid
- mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
- 1-800-657-3739

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

MONTANA – Medicaid
- dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
- 1-800-694-3084

NEBRASKA – Medicaid
- www.ACCESSNebraska.ne.gov
- (855) 632-7633
- Lincoln: (402) 473-7000
- Omaha: (402) 595-1178

NEVADA – Medicaid
- dhcfp.nv.gov
- 1-800-992-0900

NEW HAMPSHIRE – Medicaid
- www.dhhs.nh.gov/ombp/nhhpp/
- 603-271-5218
- Hotline: NH Medicaid Service Center at 1-888-901-4999

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

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

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

NORTH DAKOTA – Medicaid
- www.nd.gov/dhs/services/medicalserv/medicaid/
- 1-844-854-4825

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

OREGON – Medicaid
- healthcare.oregon.gov/Pages/index.aspx
- www.oregonhealthcare.gov/index-es.html
- 1-800-699-9075

PENNSYLVANIA – Medicaid
- www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
- 1-800-692-7462

RHODE ISLAND – Medicaid
- www.eohhs.ri.gov/
- 855-697-4347

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

SOUTH DAKOTA - Medicaid
- http://dss.sd.gov
- 1-888-828-0059

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

UTAH – Medicaid and CHIP
- medicaid.utah.gov/
- CHIP: health.utah.gov/chip
- 1-877-543-7669

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

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

WASHINGTON – Medicaid
- www.hca.wa.gov/free-or-low-cost-healthcare/program-administration/premium-payment-program
- 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
- mywvhipp.com/
- 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
- www.dhs.wisconsin.gov/publications/p1/p10095.pdf
- 1-800-362-3002

WYOMING – Medicaid
- wyequalitycare.acs-inc.com/
- 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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

Non-Grandfathered Patient Protection Notice

Kaiser Foundation Health Plan of the Northwest generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact member services at the number listed on your ID card.

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

You do not need prior authorization from Kaiser Foundation Health Plan of the Northwest 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, contact member services at the number listed on your ID card.

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.

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.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE: OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employmentbased health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the HR Service Center directly, at 503-262-0145.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name **Albertina Kerr Centers**	4. Employer Identification Number (EIN) **93-0386780**	
5. Employer address 424 NE 22nd Ave	6. Employer phone number **503-262-0145**	
7. City **Portland**	8. State **Oregon**	9. ZIP code **97232**
10. Who can we contact about employee health coverage at this job? **Human Resources**		
11. Phone number (if different from above)	12. Email address **Human_Resources@AlbertinaKerr.org**	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to: All employees. Eligible employees are:
  - ☒ Regular employees who work at least 30 hours or more per week. Coverage is effective on the 90th day of employment.
  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are: Spouse, domestic partner, biological, adoptive, step and legal guardianship children up to age 26 (or over age 26 if mentall or physically disabled).
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. **Completing this section is optional for employers**, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☒ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? 90 Days after hire date (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $0.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

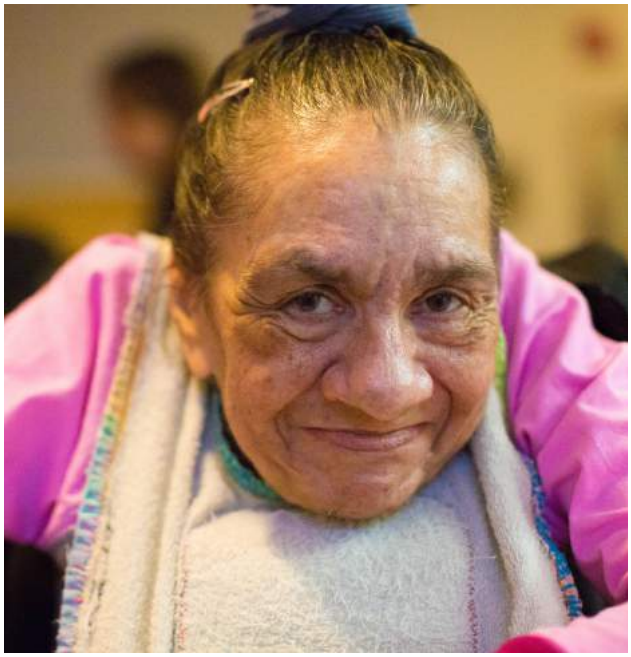
If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? NA
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ NA

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



AlbertinaKerr.org

424 NE 22ND AVENUE, PORTLAND, OREGON 97232 | 503-239-8101