CAREWELL SEIU 503

Guide to Training and Benefits

Carewell SEIU503

2022

Contents

Carewell SEIU503

> “ It has meant the world to me to be able to help others. That’s one of my purposes in life. Fantastic benefits — all that you could ever need.
>
> Aprilla M.

Welcome!

We know that care providers put in the hard work, every single day, supporting and caring for others. Whether you're a homecare or personal support worker or a personal care attendant, Carewell SEIU 503 is here to support you. That's why we've put together this guide with important information about the family of training and benefits hardwon by SEIU 503 care providers like you. These services are delivered clearly and reliably to help give you the stability, health, skills, and training you deserve.

Carewell SEIU 503's family of training and benefits has expanded over time to meet the changing needs of care providers. As recently as 2013, one in four Oregon homecare and personal support workers had no healthcare coverage. That's why SEIU 503 members fought hard for the successful 2013-2015 homecare contract with the State of Oregon. This contract created a new healthcare model that helps eligible Oregon homecare and personal support workers and personal care attendants access affordable healthcare coverage.

That year, the Union became the sponsor of two labor-management trusts. These trusts are partnerships that address the shared needs of workers and employers.

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> "I no longer have to work two jobs to have insurance."
>
> Brenda M.

What care providers *are saying*

> "I was finally able to get glasses. Also, I have been able to get dental and medical work done that otherwise I wouldn't have been able to receive. It's a godsend!"
>
> Amanda S.

> "I am grateful for getting my dental issues fixed. To see better and smile brighter has been a blessing on me that made being a caregiver all worth it."
>
> James P.

Healthcare Cost Assistance

The first trust, the Oregon Homecare Workers Supplemental Trust, provides Carewell SEIU 503 Healthcare Cost Assistance benefits.

These benefits help care providers pay for health insurance premiums and out-of-pocket medical expenses.

The second trust, the Oregon Homecare Workers Benefit Trust, provides Carewell SEIU 503 Dental, Vision, Hearing, Employee Assistance Program (DVE), and Paid Time Off (PTO) benefits.

Dental

Vision + Hearing

Employee Assistance Program

PTO

If eligible, you may receive premium-free dental, vision, and hearing benefits. Through the Employee Assistance Program, you may have access to resources — from help with your taxes to free counseling — for dealing with issues that affect your work or home life. And the Paid Time Off benefit provides compensation for taking time off from work when you need to.

Several years after securing these benefits, a third labor-management trust was created to provide training for homecare workers and personal support workers. In-home care providers had long known that the best way to ensure safe, high-quality care for all consumers — and a career path for all care providers — was to equip homecare and personal support workers with universal training.

So in 2018, Oregon homecare and personal support workers came together with community partners to help pass Senate Bill 1534. This law establishes standards for all Oregon homecare and personal support workers to make sure they have the skills, knowledge, and abilities to provide quality care and support.

Training

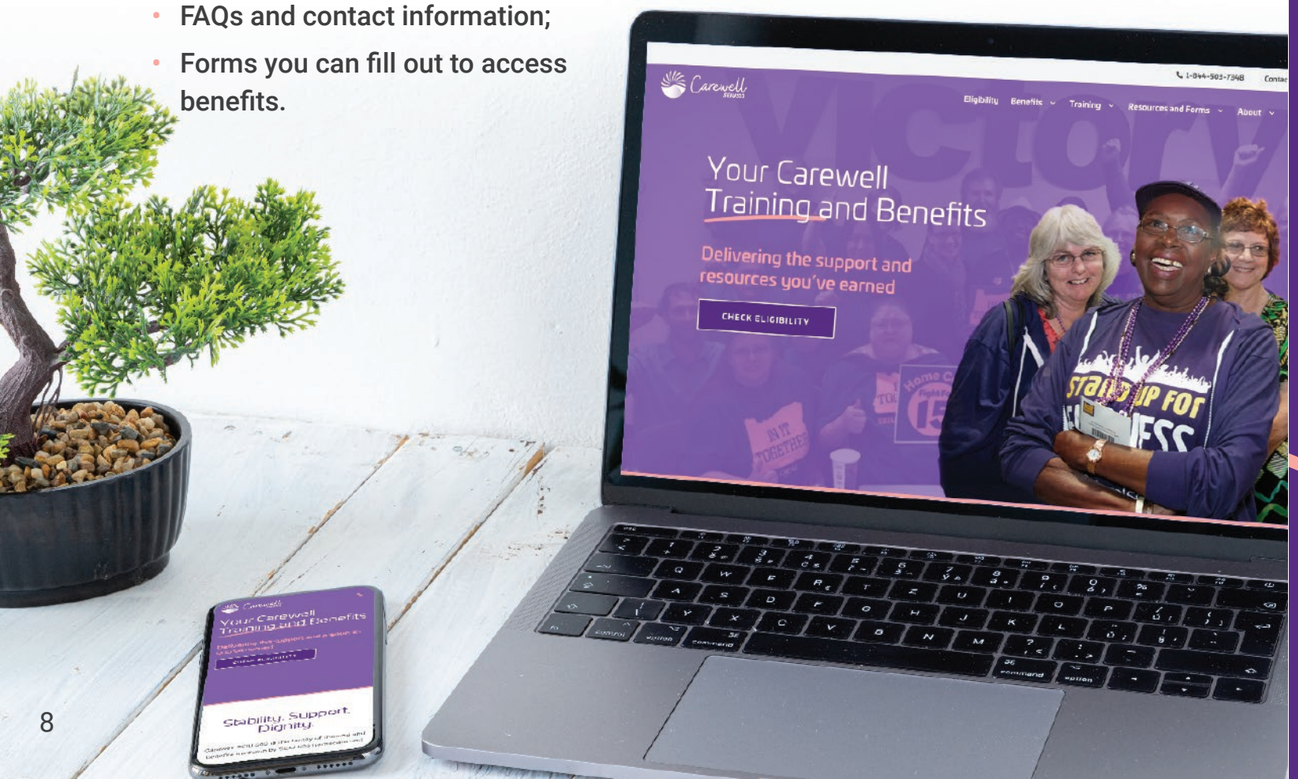
In 2019, homecare and personal support workers helped set up the **SEIU 503 Training Partnership**, the labor-management trust that provides Carewell Training.

By organizing together to create these trusts, SEIU 503 care providers like you have won groundbreaking improvements and a future you can control. The Trusts give you more say in the design of your training and benefits, and provide the funding for these services that Carewell SEIU 503 delivers to you.

Please go to CarewellSEIU503.org to learn more. You'll find helpful information such as:

- **Benefit eligibility questionnaires;**
- **Easy-to-follow steps to enroll in benefits;**
- **The list of qualified approved health insurance plans;**
- **Registration for training and educational events;**
- **FAQs and contact information;**
- **Forms you can fill out to access benefits.**

The work you do as a care provider is vital to our communities. You can rely on Carewell SEIU 503 for the stability, support, and dignity you deserve.



CAREWELL SEIU 503 DENTAL VISION + HEARING EMPLOYEE ASSISTANCE PROGRAM (DVE)

Carewell SEIU 503

Dental

The Carewell SEIU 503 Dental benefit provides insured coverage through Kaiser Permanente, and you don't have to pay premiums for it. Your dental plan pays for preventative and most basic dental services at no cost to you, and it also pays a portion of other more complex dental services.

For more information about what your dental plan covers and how to access services, please visit **CarewellSEIU503.org/benefits/dental/.**

Tip!

The term **DVE** refers to the **D**ental, **V**ision + Hearing, and **E**mployee Assistance Program.

Carewell SEIU 503

Vision + Hearing

The Carewell SEIU 503 Vision and Hearing benefit provides access to vision and hearing services for no monthly premium.

Vision

Vision benefits are insured by Ameritas through the VSP Choice Network. If you use an in-network provider, there is no charge for an annual exam and for most lenses, and you get up to $500 for frames or contacts.

Hearing

Hearing benefits are available through Ameritas SoundCare. SoundCare is not tied to a network. You can go to any provider but you will likely need to pay upfront for services and then request reimbursement.

LASIK

LASIK benefits are available through Ameritas LASIK Advantage. LASIK Advantage is not tied to a network. You can go to any provider but you will likely need to pay upfront for services and then request reimbursement.

Find out more about your vision and hearing benefits at **CarewellSEIU503.org/benefits/vision-and-hearing/.**

Carewell SEIU 503

Employee Assistance Program (EAP)

The Carewell SEIU 503 Employee Assistance Program (EAP) provides resources to help you in your personal life. EAP services are provided by Reliant Behavioral Health. They are free to you and include:

- **24-hour crisis help;**
- **Up to five in-person counseling sessions per issue every 12 months;**
- **Online mental health consultations;**
- **Discounted legal services;**
- **Household financial advice, including tax-filing help;**
- **And much more!**

Explore your EAP benefits and how to access them at **CarewellSEIU503.org/benefits/employee-assistance-program/.**

Am I eligible for these DVE Benefits?

Your eligibility depends on the hours you work and report: to ensure access to Carewell SEIU 503 benefits, please make sure to **turn in your payroll vouchers in a timely manner.**

This is only a summary of eligibility requirements. For complete details, please refer to the list of eligibility requirements on page(s) 43-44 of this guide.

Eligibility

Have you worked as a homecare or personal support worker or personal care attendant for at least 40 hours per month for two months in a row?

YES

Great! You are likely eligible for benefits from Carewell SEIU 503. * There is a one-month waiting period before your benefits start, as your information is being processed. You will stay eligible for Carewell SEIU 503 benefits unless you stop working completely for two consecutive months, i.e. you have zero hours of eligible working hours[1] — also known as bargaining unit hours — for two months in a row. After two months of zero hours, there is a one-month grace period before your benefits end.

NO

It looks like you are not eligible to receive Carewell SEIU 503 Dental, Vision, Hearing, and EAP benefits at this time, but you may still be eligible for Paid Time Off benefits.

Example: These are Lucia's working hours since she started in July.

July	Aug	Sept	Oct	Nov	Dec	Jan
20 hrs	44 hrs	48 hrs	36 hrs	0 hrs	16 hrs	60 hrs

Lucia worked over 40 hours in August and in September, earning her eligibility.

October: waiting month

Benefits start on November 1.

Lucia is not losing benefits even though she didn't work in November, because she started work again with 16 hours in December.

* If you work for the Independent Choices Program and you are not paid through Acumen, then you may not be eligible to receive benefits from Carewell SEIU 503. See page 53 of this guide for additional details or call 1-844-503-7348 to find out more.

[1] Any reference to "work hours" or "working hours" in this guide refers to bargaining unit hours; that is, the hours paid by Acumen, DHS, and/or PPL on behalf of your consumer.

How do the DVE Benefits work?

The Benefits Administrative Office determines eligibility for DVE benefits. We will send notifications to the address you have on file with the State if you become eligible for benefits, and also ahead of losing eligibility. If you have any questions about your eligibility for benefits, you can call 1-844-503-7348.

Dental, Vision, Hearing, and EAP benefits will be set up automatically for you once:

- **You meet the Eligibility Requirements explained above; and**
- **update the Benefits Administrative Office and the State with your name, gender, Social Security Number, and current address.**

You can update your information with the Benefits Administrative Office online at **CarewellSEIU503.org/resources/forms.**

You will receive a dental coverage card from Kaiser Dental (unless you have Kaiser medical insurance, in which case your medical ID is also your dental ID). You will also receive coverage cards from Ameritas for your vision, hearing, and LASIK benefits. There's no coverage card for your EAP benefits.

If you don't want to receive Carewell SEIU 503 Dental, Vision, Hearing, and EAP benefits, you can fill out a Benefits Waiver form at **CarewellSEIU503.org/resources/forms.**

PAID TIME OFF BENEFIT

The Carewell SEIU 503 Paid Time Off (PTO) benefit helps you take time off from work when you need to.

Being able to take time off is important not just for your health, but also for the health of your consumer. Carewell SEIU 503 offers up to 40 hours of PTO benefits per year to eligible care providers.

Learn more about Paid Time Off at **CarewellSEIU503.org/PTO.**

Eligibility Overview

This is only a summary of how homecare and personal support workers and personal care attendants may become eligible for PTO benefits. For complete details about eligibility, please refer to the list of requirements on page(s) 44-48 of this guide.

To be eligible for Carewell SEIU 503 Paid Time Off benefits you must both:

1. **Work 80 or more eligible working hours — also known as bargaining unit hours — in one of the qualifying months:**

- **To earn 20 hours of PTO benefits in February, you must work 80 or more hours in either October, November, or December of the preceding year;**
- **To earn 20 hours of PTO in July, you must work 80 or more hours in March, April, or May of the same year.**

And

2. **Submit a Form W-9 to the Benefits Administrative Office (you can find a Form W-9 on the Carewell website at CarewellSEIU503.org/forms).**

Tip!

Get your benefits faster! Direct deposit is a great way to get your PTO benefits paid to you quickly and safely. Just complete the Direct Deposit form on the Carewell website and send a copy of a voided check to the Benefits Administrative Office.

How to use the PTO Benefit

Once you've worked the required number of hours to earn PTO benefits, Carewell SEIU 503 will mail you information about the amount of the PTO benefit you qualify for. The letters are usually mailed twice a year: one in mid-February and one in mid-July.

You can request payout from your benefit by filling out the PTO Benefit Request form on the Carewell website at CarewellSEIU503.org/forms. If you don't have access to the website, you can request that a paper form be mailed to you by calling 1-844-503-7348.

Once your PTO request form is processed, you'll receive your payment. For fast and safe payment, sign up for direct deposit into your bank account using the form available on the Carewell website at CarewellSEIU503.org/forms. If you don't sign up for direct deposit, a paper check will be mailed to you.

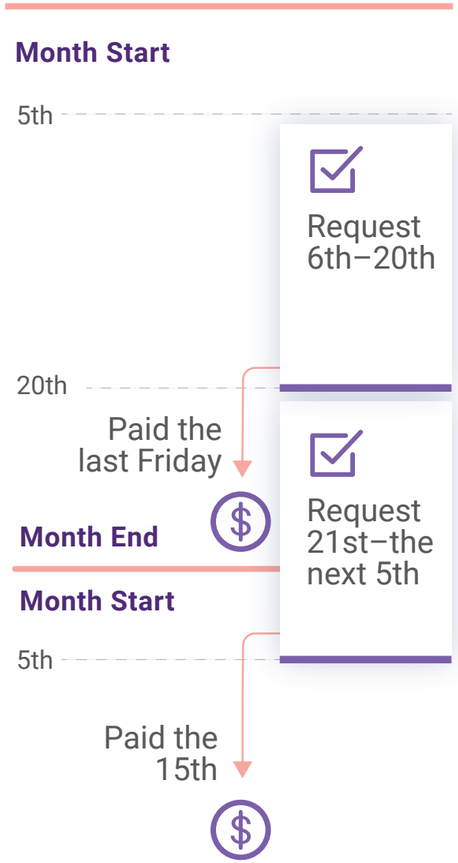
It isn't your responsibility to find your own replacement when you take leave. Your consumer has the primary responsibility for selecting and hiring their providers. However, your consumer must approve your request for time off ahead of time, and relief must be available if necessary. Also, the consumer must notify the appropriate agency to authorize the substitute worker's hours.

When can I expect my PTO Benefit Payout?

Benefits are paid after your PTO Benefit Request form is received and processed.

In February, March, July, and August, PTO Benefit Request Forms are processed once a month. Forms received by the 20th of the month will be processed for payment by the end of the month.

For all other months, payment is made on the following schedule:



- **Request forms received by the 5th of the month are processed for payment on the 15th of the month.**
- **Request forms submitted between the 6th and the 20th of the month are processed for payment on the last Friday of the month.**
- **Request forms submitted after the 20th of the month are processed for payment on the 15th of the following month.**

Tip!

Get your PTO benefit paid faster!

- Be sure you have a Form W-9 on file with the Benefits Administrative Office. You can complete this form at any time.
- Complete your PTO Benefit Request form online as soon as you are notified that you are eligible. Completing the form online is the quickest, easiest, and most error-proof way to submit a PTO request.
- Choose direct deposit. Having your benefit directly deposited into your bank account eliminates mail time and ensures that a check won't be mistaken for junk mail. (This has been known to happen!)

Tip!

PTO Benefit

"Rollover"

Paid Time Off benefits do not "roll over" from year to year. This means that if you don't request all your benefits in the year you earned them, the remaining benefits that you are eligible for but didn't request will be automatically paid out to you in February of the year after you earned them, as long as you have a Form W-9 on file with the Benefits Administrative Office.

This can be confusing because the time between earning the benefits and receiving the funds can be very long if you don't fill out a PTO Benefit Request form. Up to 14 months can go by between the time that you earn the benefits and when you are paid.

> *Ginger is very confused. In February 2022, she received two letters from Carewell: one telling her that she was eligible for 20 hours of PTO benefits, the other telling her that 30 hours of PTO benefits had been direct deposited into her checking account.*

How did this happen? Here's an explanation.

Ginger, a personal support worker in Grants Pass, worked 80 hours in October 2020, so she was eligible for 20 hours of PTO benefits effective February 2021. She could have filled out a PTO Benefit Request form at CarewellSEIU503.org/forms and had the benefit paid to her right away, but she decided she did not want to request the benefit payout at that time. She did, however, fill out a Form W-9.

In May 2021, Ginger worked 80 hours again, earning 20 more hours of PTO benefits effective in July 2021. Once again, she chose not to request a benefit payout. At this point, she had 40 hours in her 2021 PTO "bank."

Ginger requested a PTO benefit payout of 10 hours in September 2021, when she took some time off to visit her mother. In October 2021, Ginger worked 80 hours. This qualified her for 20 hours of 2022 PTO benefits effective February 2022.

In February 2022, Ginger got an automatic direct deposit of her remaining 2021 PTO benefits. Because Ginger had a Form W-9 on file with the Benefits Administrative Office, Ginger received an automatic payout of her remaining 2021 benefits. The payout was equivalent to 30 hours of PTO benefits (20 hours accrued in February 2021 plus 20 hours accrued in July 2021 minus 10 hours paid out in September 2021).

In February 2022, Ginger also earned 20 additional hours of PTO benefits in her 2022 PTO bank. Because she qualified for 20 hours of PTO benefits by working 80 hours in October 2021, Ginger received a letter from Carewell that she earned 20 hours of PTO benefits.

How PTO Works

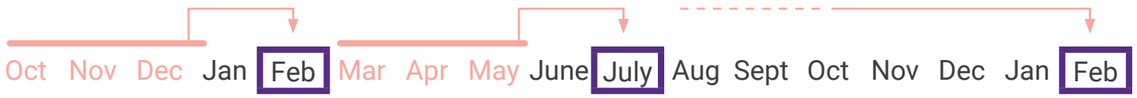
PTO determination letters are sent in **February and July,** announcing number of hours and $ amount, and explaining how to claim this benefit.

You can claim these hours by filling out the Benefit Request form. If hours are unclaimed and the Benefits Administrative Office has your W-9 on file, these hours are paid out **the following February**.

Must work over 80 hours **ONE of these months** to qualify for 20 hrs of PTO the following Feb.

Must work over 80 hours **ONE of these months** to qualify for 20 hrs of PTO the following July.

February cash-out: payment sent for unclaimed PTO from previous February and July cycles.



Beneficiary Designation

Workers who are eligible for the PTO benefit have the option of designating a beneficiary — in other words, you can let us know who should receive your PTO benefit payout if you pass away before your benefits are paid. To designate a beneficiary, please complete the PTO Beneficiary form on the Carewell website at CarewellSEIU503.org/forms.

* In general, rules may change under exceptional circumstances.

Lost PTO Benefit Checks

Every now and then, a PTO benefit payout check will get lost in the mail, or accidentally be recycled by the recipient thinking that it's junk mail. In these cases, the Benefits Administrative Office can issue a new check. However, it's up to you to pay the cost of cancelling the original check. We encourage you to wait a minimum of 10 business days after a check has been issued before requesting a new check.

Lost checks don't happen often, but when they do, it can be disruptive if you were counting on that money. Having to cover the cost of a cancelled check is an additional burden. This is one of the reasons that we strongly recommend using direct deposit if it is an option for you.

PTO Benefits and Taxes

Paid Time Off is taxable income — which is why you are required to have a Form W-9 on file with the Benefits Administrative Office to be eligible for the PTO benefit. If you receive $600 or more of PTO benefits in one year, the Benefits Administrative Office will send you a Form 1099-NEC. However, the PTO benefit is still considered taxable income even if you don't receive a Form 1099-NEC.

Who to contact about the PTO Benefit

If you have questions about your specific Carewell SEIU 503 PTO Benefits, please contact the Benefits Administrative Office at 1-844-507-7554, option 3, option 2. Some reasons that you may want to call them include:

- **You want to ask about your PTO benefits balance (learn how many PTO benefit hours you have left).**
- **You believe the PTO benefit check you received is for the wrong amount.**
- **You didn't receive a packet about your PTO eligibility but believe you should have.**

If you have **general** questions about how Carewell PTO works, you can check out the Paid Time Off section on Carewell SEIU 503's website at **CarewellSEIU503.org/PTO or call 1-844-503-7348.**

OREGONSAVES

OregonSaves is a groundbreaking retirement plan for Oregon workers that is administered by the State of Oregon.

While OregonSaves is not a part of the Carewell SEIU 503 family of benefits, homecare and personal support workers and personal care attendants can now participate in this benefit program thanks to SEIU 503's bargaining agreement with the State of Oregon. You get to choose how much to contribute into your OregonSaves retirement plan. If you take no action, you will be automatically enrolled at 5% of your pre-tax pay. The following is an overview of the OregonSaves program. If you have any questions or would like more information about this program, please contact OregonSaves at Saver.OregonSaves.com or call 1-844-661-6777.

Eligibility Overview

Personal support workers and personal care attendants are eligible for OregonSaves after receiving a provider number and completing a background check. Workers will only receive the OregonSaves invitation letter or email after the system has connected the PSW with a consumer-employer match.

Homecare workers are eligible for the OregonSaves benefit once they receive a provider number. They should receive the OregonSaves invitation letter or email shortly after receiving their provider number.

How to use the OregonSaves Benefit

Once you're eligible for the OregonSaves benefit, you will receive an invitation letter or email. If you'd like to make the automatic contribution of 5% of your pre-tax pay, you don't need to take any action — you're automatically enrolled upon eligibility.

If you don't opt out of receiving the OregonSaves benefit, your contributions, in the form of paycheck deductions, will begin with the first paycheck you receive after the initial 30-day opt out window. Your contributions will go into a Roth IRA savings account, and you can choose from a variety of funds to invest in. Over the course of your career, these savings can have a significant impact on increased financial security at retirement.

If you would like to make any changes to your OregonSaves account (for example, if you'd like to change the amount of your contribution), or if you want to opt out of the benefit, visit the OregonSaves website at Saver. **OregonSaves.com** or call 1-844-661-6777.

You will need the access code from the invitation that OregonSaves mailed (or emailed) to you to make any changes to your account. If you didn't receive an access code, please contact OregonSaves at 1-844-661-6777.

Tip!

Auto Escalation

The OregonSaves benefit includes a feature called "auto escalation" — so, if you made a contribution to your OregonSaves retirement account on or before July 1 of a particular year, then your contribution amount will automatically increase by 1% on the following January 1. Auto escalation continues until you manually turn the function off or your contribution rate reaches 10%.

You can turn off auto escalation at any time by logging in to your OregonSaves account at Saver.OregonSaves.com or by calling 1-844-661-6777.

Auto Escalation Example

Ted is having a hard time understanding what's going on with his paycheck. He just discovered a strange deduction that he hadn't noticed before. He decided to review previous months' paychecks and noticed that this deduction had been there for a while, though in slightly different amounts. What's going on?

Ted started work as a personal support worker for his grandmother on April 15, 2021. On May 20, 2021, he got an invitation letter from OregonSaves, telling him that he was eligible for the retirement plan. Ted set the letter aside and forgot about it.

Beginning on June 19, 2021, 30 days after the invitation letter, OregonSaves contributions began to be automatically deducted from Ted's paycheck. The automatic 5% contribution came out to about $32 per paycheck (Ted worked 80 hours per month at $15.77 per hour).

The following January 1, 2022, Ted's contribution rate increased to 6% because of auto escalation, which came out to about $38 per paycheck.

On June 20, 2022, Ted first noticed the $38 deduction per paycheck, but didn't know why it was coming out. He reached out to Carewell at 1-844-503-7348 to ask for help, and after a short time, the Carewell representative and Ted figured out that the deduction was for Ted's retirement savings through OregonSaves.

Ted wanted to learn more about his account, so he called OregonSaves at 1-844-661-6777. He was pleasantly surprised to learn that, after a year of saving, his account had grown to about $850!

Ted decided that it was a worthwhile investment for his retirement, but he wanted to stop the auto escalation from increasing his contribution every year. The OregonSaves agent helped him end auto escalation, and now Ted rests easy knowing he has a secure, growing retirement account.

Accessing your OregonSaves Contributions

You can withdraw your savings from your OregonSaves retirement account at any time, though there may be significant tax consequences if you withdraw your savings before you reach a certain age. Because OregonSaves accounts are Roth IRAs, any distributions or withdrawals will be subject to taxation in accordance with applicable federal tax rules. Carewell SEIU 503 does not provide tax advice. Please contact your tax adviser for more information.

Who to contact about the OregonSaves Benefit

If you have questions about your specific OregonSaves account, please visit the OregonSaves website at **Saver.OregonSaves.com** or call OregonSaves at **1-844-661-6777**. Some reasons that you may want to contact OregonSaves include to:

- **Find out about your current balance;**
- **Learn more about how to reach your retirement savings goals using the Retirement Savings Calculator;**
- **Change your contribution amounts, or change your allocations; or**
- **Opt out of the benefit.**

Whether you're changing your contribution level or choosing to opt out completely, OregonSaves shares your account updates with the State on a weekly basis. If it has been one week or less since you contacted OregonSaves with account changes, those changes may not have been sent to the State yet.

HCW/PCA

If you are a homecare worker or personal care attendant and

- **more than one week has passed since you contacted OregonSaves with updates to your account, and**
- **you still see incorrect deductions on your paycheck,**

Then please email the Oregon Home Care Commission at OHCC. **CustomerRelations@dhsoha.state.or.us** with your full name, provider number, and contact information. You may also call the Oregon Home Care Commission at **1-877-867-0077.**

PPL-paid PSW

If you are a personal support worker and

- **more than one week has passed since you contacted OregonSaves with updates to your account, and**
- **you still see incorrect deductions on your paycheck,**

Then please email **PSW.Enrollment@dhsoha.state.or.us** with your full name, provider number, and contact information.

If you have **general** questions about how OregonSaves works, please visit the Carewell SEIU 503 website at **CarewellSEIU503.org or call 1-844-503-7348.**

HEALTHCARE COST ASSISTANCE BENEFIT

The Carewell SEIU 503 Healthcare Cost Assistance (HCA) benefit helps make healthcare affordable for Oregon homecare and personal support workers and personal care attendants.

This is not employer coverage or a Health Reimbursement Arrangement (HRA). Instead, if you already have your own medical insurance plan (discussed in more detail below), then the Carewell HCA benefits can help you pay for your insurance premiums and eligible out-of-pocket expenses.

What Healthcare Cost Assistance Benefits am I eligible for?

This is only a summary of eligibility requirements. For complete details, please refer to the list of eligibility requirements on page(s) 43-44 of this guide.

- **To be eligible for HCA Benefits, first you must be found eligible for Carewell SEIU 503 Dental, Vision, Hearing, and EAP benefits. [See page 13 for DVE eligibility graphic flowchart.]**
- **Your eligibility for HCA Benefits then depends on the type of medical coverage you currently have.**

Medical Coverage	Healthcare Cost Assistance Benefits Cover:
Medicare	• **Generally, the full amount of the standard Part B premium **** • **A portion of your premiums for a Part D, Supplemental, or Advantage plan **** Out of-pocket expenses for Medicare covered services up to the annual Benefit Convenience Card (BCC) allowance ***
Trust-approved * Marketplace medical insurance plan	The full amount of your monthly premium (after the maximum available Advance Premium Tax Credit is deducted) Out of-pocket expenses for services covered by your insurance plan up to the annual BCC allowance ***
Marketplace medical insurance plan **not approved** by the Trust	A portion of your monthly premiums corresponding to the average premium reimbursement Out of-pocket expenses for services covered by your insurance plan up to the annual BCC allowance *** To continue receiving HCA benefits, you will need to enroll in an approved qualified health plan on the federal Marketplace at the first opportunity (generally during the Open Enrollment period, which is usually between Nov. 1 and Dec. 15 for coverage starting the following Jan. 1).

Medical Coverage	Healthcare Cost Assistance Benefits Cover:
Uninsured - no medical coverage	You may be eligible for HCA benefits if you enroll in an approved qualified health plan on the Marketplace. Please note: generally, you can only enroll during an Open Enrollment period (for the federal Marketplace, usually between Nov. 1 and Dec. 15 for coverage starting the following Jan. 1).
Spousal coverage	If you enroll in coverage through your spouse's employment, you are not eligible for HCA benefits. If you decide not to enroll in a health plan through your spouse's employment, you may be eligible for HCA benefits if you enroll in a Trust-approved qualified health plan on the Marketplace. Please note: generally, you can only enroll during an Open Enrollment period (for the federal Marketplace, this is usually between Nov. 1 and Dec. 15 for coverage starting the following Jan. 1).
Other employer coverage	If you receive employer-sponsored medical coverage (through another employer, not for your care-providing work), then you are not eligible for HCA benefits.
Medicaid / OHP	You are not eligible for HCA benefits at this time. Please call us if you lose Medicaid coverage.

Don't see your coverage listed above? Please visit the Carewell website at **CarewellSEIU503.org/benefits/healthcare-cost-assistance** or call **1-844-503-7348** to see if you may be eligible for HCA benefits.

* An approved qualified health plan is an insurance coverage option selected by the Board of the Supplemental Trust that is offered on a health insurance marketplace, either the federal Marketplace (healthcare.gov, which is the platform for Oregon consumers) or your state-based Marketplace (in Washington: wahealthplandfinder.org, in California: coveredca.com, in Idaho: yourhealthidaho.org). Approved qualified health plans were chosen by your Board of Trustees for their high quality and affordability. To receive HCA benefits for an approved Marketplace plan, you need to enroll in an approved qualified plan for your area.

** Exact premium amounts vary from year to year. You can generally find the standard Part B premium online at medicare.gov/your-medicare-costs/part-b-costs.

*** The annual BCC allowance may change from year to year. See page 54 for more details.

How does the Healthcare Cost Assistance Benefit work?

Healthcare Cost Assistance for Medicare Recipients

- Fill out the required Medicare paperwork (you only need to submit this once unless your information changes).
- For your premium payments, submit a Medicare Reimbursement form to the Benefits Administrative Office with evidence of your Part B premium and evidence of your Part D, Supplemental, or Advantage plan premiums, if any. (For proof of Part B, use your annual Social Security letter. The most common proof for Part D, Advantage, or Supplemental premiums is the invoice showing the premium amount for that plan.)
- You will receive monthly reimbursements for your premiums, either by check or by direct deposit into your bank account. Direct deposit is generally faster and safer, and you can sign up online at **CarewellSEIU503.org/medicare.**
- Ameriflex will send you a Benefit Convenience Card (BCC), a Mastercard debit card, to pay for your Medicare covered out-of-pocket medical expenses, up to the annual BCC limit. You cannot use the BCC to pay for your Medicare premiums.

ⓘ Visit **CarewellSEIU503.org/medicare** for additional information and required forms that you can submit online.

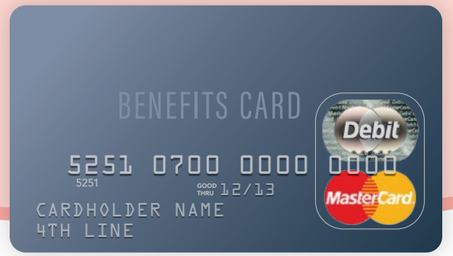
Healthcare Cost Assistance for Approved Qualified Plans:

- Go to **CarewellSEIU503.org/approved-plans** to find approved plans for your area, and for more information about the steps you need to take to enroll.
- **To receive HCA benefits for an approved Marketplace plan, you need to enroll in an approved qualified health plan for your area.** However, if you became eligible for Carewell SEIU 503 benefits after the end of the last Open Enrollment period, and you have a non-approved plan through a health insurance Marketplace, you may qualify for average premium reimbursements. To remain eligible for HCA benefits, however, you must enroll in an approved qualified plan for your area at the next available opportunity — generally during Open Enrollment.
- In general, you can only enroll in or change your Marketplace coverage during Open Enrollment. On the federal Marketplace (healthcare.gov), **Open Enrollment generally runs from November 1 to December 15 for coverage starting the following January 1.** There are some exceptions — qualifying life events can allow you to access a 60-day Special Enrollment Period. Losing medical coverage (for reasons other than nonpayment) may also qualify you for a Special Enrollment Period. If you lose your coverage and you're eligible for Carewell SEIU 503 benefits, call us ASAP at 1-844-503-7348!
- Even with Healthcare Cost Assistance, it is your responsibility to pay your monthly premium to your insurance carrier.
  - Your first premium must be paid before the first date of effective coverage.
  - If you don't pay your first premium before the due date, your medical coverage won't be activated and you may find yourself without any medical coverage for the rest of the year.
- Ameriflex will send you a Benefit Convenience Card (BCC), a Mastercard debit card, to pay for your premiums, after deduction of the maximum Advance Premium Credit available to you, and your out-of-pocket medical expenses for services covered by your medical insurance plan.

Tip! **No internet?** Call us at 1-844-503-7348!

Presenting the Benefit Convenience Card!

The Benefit Convenience Card (BCC) is a Mastercard debit card, sent to you and administered by Ameriflex.



What can I use the Benefit Convenience Card for?

	Monthly premiums	Out-of-pocket expenses
Approved Marketplace Plan	**YES!** Exceptions may apply, see next page. Contact your insurance carrier to set up your card to make automatic premium payments.	**YES!** Covered medical expenses (up to the annual BCC allowance): • **The deductible on your approved Marketplace plan** • **Copayments and coinsurance expenses, including for covered prescriptions**
Medicare	**No.** You will need to use the reimbursement process for your Medicare premium(s). Please go to **CarewellSEIU503.org** for more information.	**YES!** Covered medical expenses (up to the annual BCC allowance): • **Deductibles on your Medicare coverage** • **Copayments and coinsurance expenses, including for covered prescriptions**

Exceptions:

- **If your family is included on your health insurance policy, you may still use the BCC for covered out-of-pocket expenses. However, you must pay your premium directly to your insurance company using your own funds, and then submit a reimbursement form to the Benefits Administrative Office for the amount of your individual premium.**
- **If you receive the average premium reimbursement, you may still use the BCC for covered out-of-pocket expenses. However, you must pay your premium directly to your insurance company using your own funds and then submit a reimbursement form to the Benefits Administrative Office.**

You may be asked to show proof of your covered out-of-pocket expenses, so be sure to keep all your Explanation of Benefits (EOBs) and receipts (especially your prescription receipts, since prescription expenses don't appear on the EOBs issued by your insurance company).

How much money is on the BCC?

There are two separate accounts on your BCC: one for paying your premiums (if applicable), and one for covered out-of-pocket expenses. The 2021 BCC allowance for covered out-of-pocket expenses is $6,500.

Your BCC works just like a regular debit card, except that:

- **Your card is limited in use, meaning you can only use it for the covered expenses listed above. Please note that you can't use the BCC for out-of-pocket expenses for dental, vision, and/or hearing services.**
- **You can't use your card at an ATM or to get cash back when making a purchase.**

Ameriflex is your BCC administrator. You can check your balance, view your payment history, see the status of a reimbursement, order a replacement card, and much more:

- **Through the Ameriflex online portal: ameriflex.wealthcareportal.com**
- **Through the Ameriflex app: myameriflex.com/participants/the-ameriflex-difference/mobile-app**
- **By calling Ameriflex at 1-888-868-3539.**

TRAINING

Carewell SEIU 503 Training provides homecare and personal support workers and personal care attendants with excellent training to equip you with the tools and confidence you need to give your consumer the most impactful — and safest — support possible.

The Carewell SEIU 503 Training team is dedicated to training and developing caregivers who provide in-home support for older adults and people with physical, intellectual, or developmental disabilities. Together, these trainings offer the tools and skills you need to ensure your safety on the job, as well as the safety of your consumer.

New Worker Training

The three-part New Worker Training helps new care providers learn about their role as a homecare or personal support worker or personal care attendant and gives them an introduction to providing safe, high-quality services to their consumer.

Some of the topics covered in this training include:

- **Your benefits**
- **Rules, regulations, and how to receive pay**
- **Safety**
- **Person-centered services**
- **Self-care**

Refresher Training for Current Workers

Refresher Training helps current workers stay up to date on best practices, and provides an opportunity to share your own on-the-job learning with fellow care providers. All current care providers, with few exceptions, need to complete this training before **March 31, 2022.**

Some of the topics covered in this training include:

- **Communication styles and skills**
- **Compassion fatigue and burnout**
- **Safety**
- **Self-care**
- **Your benefits**

Continuing Education

In order to renew your provider number every two years, you will be required to complete 12 hours of Continuing Education training. These courses cover a wide variety of topics that you can choose from to meet your training needs as you develop your career over time. You'll be able to choose from a diverse menu of training options, including in-person and online training.

Your Training Experience

Carewell SEIU 503 Training is dedicated to delivering the best possible training experience. That's why we offer all our courses online, with in-person options becoming available once it's safe to return to the classroom. We offer the following training options:

- **Self-paced learning modules that you can fit into your busy schedule, giving you the freedom to do a little bit of training each day or all in one sitting.**
- **Trainer-led webinars hosted on a variety of days and times for your convenience, including weekends and evenings. Hear from other care providers and share your experiences as you discuss important topics like communication and self-care.**
- **In-person training (check the website for current availability) once it's safe to return to the classroom. Meet with other care providers and trainers in an interactive environment.**

Do you have a specific need related to training? Limited internet access or access to technology? Do you need an interpreter or course content in your preferred language? We're here to help! Reach out to Carewell by phone at **1-844-503-7348** or email us at **CarewellSEIU503training@RISEpartnership.com**. We can help find an option that works best for you!

ELIGIBILITY RULES

Eligibility for All Benefits Other Than PTO Benefits

The following rules apply to individuals covered under the SEIU 503 Homecare and Personal Support Bargaining Unit (which includes Personal Care Attendants) and will govern eligibility for Carewell SEIU 503 benefits coverage offered through the Benefit Trust and the Supplemental Trust, except for Paid Time Off benefits, which are addressed separately below. For purposes of this guide, “you” or “your” refers to participants covered under the SEIU 503 Homecare and Personal Support Bargaining Unit, including Personal Care Attendants, who are eligible to participate in the Trusts.

Initial Eligibility

To become eligible for benefits under the Trusts, you must work at least 40 hours of bargaining unit work for two months in a row. The Benefits Administrative Office must receive your hours information from the State of Oregon, so it is important that you turn in your payroll vouchers in a timely manner as there is a natural time lag between hours worked and when they are reported to the Benefits Administrative Office. Once you become eligible for Carewell SEIU 503 benefits, there will be a one-month waiting period before you are covered. For example, if you work 40 hours per month in January and February, you will be covered under the Trusts effective April 1.

Hours worked for the purposes of these Eligibility Rules will be determined by the Benefits Administrative Office based on the most recent agency-reported payroll hours. The effective date for benefits coverage described in Sections A.1, A.2, and A.3 will be the month following the date that the Benefits Administrator verifies your eligibility, subject to, in the case of benefits under Section A.3, the processing of your application for coverage through the applicable Health Insurance Marketplace (the “Marketplace”).

You may enroll in an approved qualified health plan on the Marketplace during Open Enrollment or during a Special Enrollment Period. On the federal Marketplace, Open Enrollment is typically between November 1

and December 15 for coverage starting January 1 of the following year. Open Enrollment periods on other health insurance marketplaces (in Washington, California, or Idaho) may happen at different dates.

Ongoing Eligibility

You will continue to be eligible for Carewell SEIU 503 benefits from the Trusts unless your bargaining unit hours worked per month drop to zero for two months in a row.

Losing Eligibility

If you work zero hours of bargaining unit work for two months in a row, you will lose your eligibility for coverage under the Trusts. There will be a one-month grace period before your eligibility for Trust benefits ends. For example, if you work zero hours of bargaining unit work in September and October, your eligibility for benefits under the Trusts will end on December 1. You will be given a warning letter after the first month in which bargaining unit hours worked drop to zero, and advance notice of termination of eligibility under the Trusts after the second consecutive month in which bargaining unit hours drop to zero. Losing eligibility under the Supplemental Trust for Carewell SEIU 503 Healthcare Cost Assistance benefits does not mean that your health insurance plan through the Marketplace will terminate. However, you will be responsible for paying the premiums and other out-of-pocket costs relating to that health insurance plan. If you do not pay the premiums, your health insurance carrier will cancel your health insurance plan. This means you will be without health insurance coverage for the rest of the year unless you have a qualifying life event as described on healthcare.gov.

Regaining Eligibility

If you lose eligibility for Carewell SEIU 503 benefits from the Trusts, you must work 40 hours of bargaining unit work for two months in a row, and have a one-month waiting period, before becoming eligible for Trust benefits again. Please note that regaining eligibility for Trust benefits will not allow you to reenroll in a health insurance plan.

Personal Support Worker and Personal Care Attendant PTO Benefits Eligibility

The following rules apply to Paid Time Off (“PTO”) benefits for Personal Support Workers (“PSWs”), including Personal Care Attendants (“PCAs”), covered under the SEIU 503 Homecare and Personal Support Worker Bargaining Unit. These Carewell SEIU 503 PTO Benefits are available under the Benefit Trust, pursuant to the following Eligibility Rules:

To become eligible for 20 hours of PTO benefits each February 1, a PSW/PCA must work at least 80 hours of bargaining unit work in one of the preceding months of October, November, or December.

To become eligible for 20 hours of PTO benefits each July 1, a PSW/PCA must perform at least 80 hours of bargaining unit work in one of the preceding months of March, April, or May.

These measurement months are referred to as the “Determination Period.” You also must provide the Benefits Administrative Office with a completed Form W-9 in order to be eligible for PTO benefits.

Personal Support Worker and Personal Care Attendant Rate of Pay

Rate of pay means your gross wages for one month (excluding any increase in wage rate due solely to overtime hours worked during the month), divided by the covered hours worked that month. The rate of pay used to calculate the PSW/PCA PTO benefit during the benefit period will be the rate of pay earned during the first month that 80 hours were worked during the Determination Period.

For example, if you worked 80 hours in October, 48 hours in November, and 120 hours in December, then you will be determined eligible for PTO benefits effective February 1. In this example, October becomes the month to use for determination of the PTO rate, using the total pay (excluding any increase in pay resulting from overtime work) divided by total covered hours for that month. If your applicable pay in October is $1,000, and your gross hours in that month were 80, then your PTO rate of pay for the next benefit period would be $12.50 per hour.

Each Determination Period may have a distinct rate of pay as determined by this formula. You will be paid out from the oldest hours first, and once those hours have been paid out, you will not accrue additional PTO benefits until you are determined to be eligible again in a future Determination Period.

Personal Support Worker and Personal Care Attendant PTO Accrual

For each benefit period that you are eligible, you will accrue 20 hours of PTO at the rate of pay determined as set forth above.

Personal Support Worker and Personal Care Attendant PTO Payout

Once you are determined to be eligible for PTO benefits, you must complete a PTO Benefit Request form, to be paid a minimum of 4 hours of PTO benefits at your determined rate of pay up to your maximum of 20 hours for that benefit period. Payout — either through paper check or, at your request, through direct deposit — will occur within 30 days of receipt of the PTO benefit request. Once the maximum benefit has been paid out for that period, no additional benefits will be paid until you are determined to be eligible again for PTO benefits in a future Determination Period.

Personal Support Worker and Personal Care Attendant PTO Cash Out

Any PTO benefits remaining unpaid from the previous year’s benefit periods will be cashed

out in a lump sum no later than February 15 of the following year. There will be no rollover of PTO benefits from year to year.

For example, if you are determined to be eligible in February 2021 with 20 hours of accrued PTO at a pay rate of $13.00/hour, and then again determined to be eligible in July 2021 with 20 hours of accrued PTO at a pay rate of $14.25/hour, and then you elect to receive 8 hours of PTO benefits during 2021, then the remaining 32 hours of accrued PTO benefits will be cashed out on February 15, 2022, for $441.00:

(20 hours x $13.00/hour = $260) – (8 hours cashed out x $13.00/hour = $104)

= net balance of $156, and (20 hours x $14.25/ hour = $285) for a total gross balance of

$156 + $285 = $441.00.

Homecare Worker PTO Benefits Eligibility

The following rules apply to PTO benefits for Homecare Workers ("HCWs") covered under the SEIU 503 Homecare and Personal Support Worker Bargaining Unit and will govern eligibility for PTO benefits through the Benefit Trust. These Carewell SEIU 503 PTO Benefits are available under the Benefit Trust, pursuant to the following Eligibility Rules:

To become eligible for 20 hours of PTO benefits each February 1, an HCW must work at least 80 hours of bargaining unit work in the preceding October, November, or December.

To become eligible for 20 hours of PTO benefits effective each July 1, an HCW must perform at least 80 hours of bargaining unit work in one of the preceding months of March, April, or May.

This measurement period is referred to as the "Determination Period." You also must provide the Benefits Administrative Office with a completed Form W-9 in order to be eligible for PTO benefits.

Homecare Worker Rate of Pay

Rate of pay means your gross wages for one month (excluding any increase in wage rate due solely to overtime hours worked during the month) divided by the covered hours worked that month. The rate of pay used to calculate an HCW's PTO benefit during the benefit period will be the rate of pay earned during the first month that 80 hours were worked during the Determination Period.

For example, if you worked 80 hours in October, 48 hours in November, and 120 hours in December, then you will be determined to be eligible for PTO benefits effective February 1. In this example, October becomes the month to use for determination of the PTO rate of pay, using the total pay (excluding any increase in pay resulting from overtime work) divided by total hours from that month. If your applicable pay in October is $1,000, and your gross hours worked in that month were 80, then your PTO rate of pay for the next benefit period would be $12.50 per hour.

Each Determination Period may have a distinct rate of pay as determined by this formula. You will be paid out from the oldest hours first, and once those hours have been paid out, you will not accrue additional PTO benefits until you are determined to be eligible again in a future Determination Period.

Homecare Worker PTO Accrual

For each benefit period in which you are eligible, you will accrue 20 hours of PTO at the rate of pay determined as set forth above.

Homecare Worker PTO Payout

Once you are determined to be eligible for PTO benefits, you must complete a PTO Benefit Request form, to be paid a minimum of 4 hours of PTO benefits at your determined rate of pay, up to your maximum of 20 hours for that benefit period. Payout — either through paper check or, at your request, through direct deposit —will occur within 30 days of receipt of the PTO benefit request. Once the maximum benefit has been paid out for that period, no additional benefits will be paid until you are determined to be eligible again for PTO benefits in a future Determination Period.

Homecare Worker PTO Cash Out

Any PTO benefits remaining unpaid from the previous year's benefit periods will be cashed out in a lump sum no later than February 15 of the following year. There will be no rollover of PTO benefits from year to year.

For example, if you are determined to be eligible in February 2021 with 20 hours of accrued PTO at a pay rate of $15.00/hour, and then again determined to be eligible in July 2021 with 20 hours of accrued PTO at a pay rate of $15.77/hour, and you elect to receive 8 hours of PTO benefits in 2021, then your remaining 32 hours of accrued PTO benefits will be cashed out on February 15, 2022, for $495.40:

(20 hours x $15.00/hour = $300) – (8 hours cashed out x $15.00/hour = $120)

= net balance of $180, and (20 hours x $15.77/ hour = $315.40) for a total gross balance of

$180 + $315.40 = $495.40.

Mixed Care Provider Rules

If you work in multiple bargaining unit–covered positions (i.e., Homecare Worker, Personal Support Worker, and Personal Care Attendant), then your hours as a Personal Support Worker, Personal Care Attendant, and Homecare Worker will be combined for purposes of determining eligibility for PTO benefits.

Rules Applicable to All PTO Benefits

You may designate a beneficiary, and an alternate beneficiary, to receive any accrued PTO benefit remaining upon your death. If no beneficiary designation is made, or if the beneficiary cannot be found promptly, the accrued PTO balance will be paid to the executor of your estate.

The value of the PTO benefit is taxable as income for the year in which you become eligible to receive the benefit payment. As a condition of eligibility for receipt of the PTO benefit, you must first provide the Benefits Administrative Office with a completed Form W-9. If a completed Form W-9 is not received before the date on which benefits otherwise would be payable, you will be considered ineligible for the benefit and will not receive payment.

Benefit payments are considered compensation from the Trust and are reportable on IRS Form 1099-NEC if the annual total is $600 or more. If the benefit is $600 or more, the Benefits Administrative Office will send a Form 1099-NEC to you and to the IRS. If the benefit is less than $600, no Form 1099-NEC is needed, and the Benefits Administrative Office will not send you or the IRS a form.

The Benefits Administrative Office must receive your hours information from the State of Oregon, so it is important that you turn in your payroll vouchers in a timely manner, as there is a natural time lag between hours worked and when they are reported to the Benefits Administrative Office. Once you have met all the eligibility requirements for PTO benefits, you may submit a request to receive your PTO benefits to the Benefits Administrative Office at any time. If you do not request your benefits before January 31 of the year after you earned the benefits, the Benefit Trust will automatically pay the benefits to you, effective February 15 of that year, provided you have submitted a completed Form W-9 to the Benefits Administrative Office.

Hours worked for the purposes of these Eligibility Rules will be determined by the Benefits Administrative Office based on the most recent agency-reported payroll hours.

Enrollment

Enrolling During Open Enrollment

If you enroll for health insurance through a Health Insurance Marketplace in Oregon, Washington, California, or Idaho, you may choose any qualified health plan available through the Marketplace; however, in order to receive the Carewell SEIU 503 Healthcare Cost Assistance benefits from the Supplemental Trust described in Section A.3 below, you must enroll in an "approved qualified health plan," as determined by the Board of Trustees each year. A current list of approved qualified health plans will be made available on the Carewell SEIU 503 website at CarewellSEIU503.org. You can also request a printed list of current approved qualified health plans by calling Carewell Benefits at 1-844-503-7348.

Open Enrollment dates are set by either the federal or state health insurance Marketplace. On the federal Marketplace, Open Enrollment is typically between November 1 and December 15 for coverage starting January 1 of the following year. Open Enrollment periods on other health insurance Marketplaces (in Washington, California, or Idaho) may happen on different dates. There are limited exceptions for enrollment outside of Open Enrollment — for example, if you lost your coverage outside Open Enrollment, you may be permitted to enroll during a Special Enrollment Period.

Enrolling Outside of Open Enrollment

The following rules apply to Homecare Workers and Personal Support Workers, including Personal Care Attendants, who are not enrolled in an approved qualified health plan through the applicable Marketplace, who are not eligible to receive health coverage from another source as described in paragraph B.2 of this guide, and who: (a) first become eligible to participate in Carewell SEIU 503 Healthcare Cost Assistance benefits through the Supplemental Trust outside of the Open Enrollment period on the applicable Marketplace; or (b) were eligible for Carewell SEIU 503 Healthcare Cost Assistance benefits, enrolled in an approved qualified health plan on the Marketplace during Open Enrollment, subsequently experienced a termination of their coverage under that Marketplace plan, and currently are eligible to participate in the Trust.

The Trust will, if possible, assist you in enrolling in an approved qualified health plan through the applicable Marketplace, and will pay the premium applicable to your coverage, consistent with the rules of the Trust. If it is not possible to enroll you in an approved qualified health plan through the applicable Marketplace, and you are already enrolled in an individual health insurance plan either through the Marketplace or otherwise, the Trust will reimburse your monthly health care premium costs, after deduction of the maximum Advance Premium Tax Credit to which you are entitled, up to the lesser of your actual premium costs, or the average premium amount that the Trust pays to participants who are covered under an approved qualified health plan as of March of the plan year in which you first become eligible for Healthcare Cost Assistance benefits through the Trust. However, if a source other than the Trust is paying for all or a part of your health insurance premium, the Trust will subtract that payment from the amount it reimburses you under this section.

If it's not possible to enroll you in an approved qualified health plan through the applicable Marketplace, and you aren't already enrolled in another individual health insurance plan, the Trust will, if possible, assist you in enrolling directly in a comparable individual health plan and will reimburse your monthly health care premium costs, after deduction of the maximum Advance Premium Tax Credit to

which you are entitled, up to the lesser of either your actual premium costs, or the average premium amount that the Trust pays to participants covered under an approved qualified health plan as of March of the plan year in which you first become eligible for Trust benefits. However, if a source other than the Trust is paying for all or a part of your health insurance premium, the Trust will subtract that payment from the amount it reimburses you under this section.

If you receive the average premium reimbursement described in the paragraphs above, at the first available opportunity, you must enroll in an approved qualified health plan through the applicable Marketplace. Your eligibility to receive the average premium reimbursement benefit will automatically terminate as of the date you first would be eligible to receive coverage under an approved qualified health plan, assuming you enrolled for such coverage at your earliest opportunity. This will be the termination date regardless of whether you actually enroll in an available approved qualified health plan.

In each of the above-described situations, you also will be eligible for the covered out-of-pocket expense benefit for your deductible, copayment, and coinsurance costs, pursuant to the Trust rules for claims incurred and covered under your health plan after you became eligible for Healthcare Cost Assistance benefits through the Trust. The benefits described above are not available to you if you were eligible for Healthcare Cost Assistance benefits during the Open Enrollment period but did not enroll in an approved qualified health plan.

Once the next OPEN ENROLLMENT period begins, you must enroll in an approved qualified health plan to continue receiving Healthcare Cost Assistance benefits and covered out-of-pocket expense benefits. To prevent a lapse in coverage, you should enroll in an approved qualified health plan as soon as the next Open Enrollment period begins.

SUMMARY OF BENEFITS

Summary of Benefits

Homecare Workers ("HCWs"), Personal Support Workers ("PSWs"), and Personal Care Attendants ("PCAs") who meet the Trusts' Eligibility Rules will receive the benefits listed in Sections A.1, A.2, and A.3 below, subject to the restrictions in Sections B.1 and B.2 below. HCWs, PSWs, and PCAs who meet the applicable Trust's Eligibility Rules relating to PTO benefits will receive the benefits listed in Section C.1 below.

A.1 Dental, Vision, Hearing, and Employee Assistance Plan coverage through the Benefit Trust, as determined by the Benefit Trust.

A.2 If you are covered by Medicare, you may be eligible for reimbursement from the Supplemental Trust for: (a) Medicare Part B premiums, up to the monthly amount determined each year by the Board of Trustees; (b) either a Medicare Advantage Plan, a Medicare Supplemental Plan, or a Medicare Part D Plan, up to the monthly amount determined by the Board of Trustees each year; and (c) medical and prescription drug copays, deductibles, and coinsurance expenses relating to claims covered by your Medicare plan (provided the claims were incurred while you were eligible for Trust benefits), up to the maximum amount determined each year by the Board of Trustees. For current benefit limits, visit CarewellSEIU503.org or call 1-844-503-7348.

A.3 If you are enrolled in an approved qualified health plan on the Marketplace, you may be eligible for payment from the Supplemental Trust for: (a) your individual plan premium after all available federal premium tax credits have been applied; and (b) medical and prescription drug copays, deductibles, and coinsurance expenses relating to claims covered by your approved qualified health plan, provided the claims were incurred while you were eligible for Trust benefits, up to the maximum amount determined each year by the Board of Trustees. For current benefit limits and a list of approved qualified health plans, visit CarewellSEIU503.org or call 1-844-503-7348.

To qualify for the payment of health plan premiums by the Trust, you must elect to apply the full amount of any federal premium tax credit to which you are entitled to payment of the premium for your Marketplace plan. If you receive a higher advance premium tax credit than you should have because you underestimated your annual household income, and as a result, you must pay back the overpaid tax credit to the IRS at the end of the year, you may be eligible for reimbursement of the overpayment from the Supplemental Trust. This is because the Supplemental Trust may have paid more of your premium during the year if it had known you were entitled to a lower advance premium tax credit. If, on the other hand, you receive an additional premium tax credit from the IRS at the end of the year because you overestimated your annual household income, you are obligated to reimburse the Supplemental Trust for the additional premium tax credit received. This is because the Supplemental Trust would have paid less of your premium during the year if it had known you were entitled to a higher Advance Premium Tax Credit.

B.1 You will continue to be eligible for the benefits listed in Section A above unless you report zero bargaining unit hours for two consecutive months. In such cases, there will be a one-month grace period before loss of eligibility. For example, if you report zero hours in December 2020 and January 2021, you will lose eligibility effective March 1, 2021. Also, you will be given a warning letter after the first month in which reported bargaining unit hours drop to zero hours per month, and advance notice of the termination of eligibility under the Trusts after the second consecutive month in which bargaining unit hours drop to zero.

B.2 You will be eligible to receive the benefits described in Sections A.2 and A.3 above only to the extent that you are not already receiving, and are not eligible to receive, health care coverage or premium assistance from any other source, with the following limited exceptions:

(i) if you are eligible for other health care coverage through your or your spouse's employment but choose not to enroll in such coverage, then you may be eligible to receive the benefits described in Sections A.2 and A.3;

(ii) if you are already receiving, or are eligible to receive, veteran's benefits coverage that does not disqualify you from receiving federal Advance Premium Tax Credits ("APTC"), then you may be eligible to receive the benefits described in Sections A.2 and A.3; and

(iii) if you lose eligibility for an APTC because you did not respond to a request for information, or otherwise failed to take any action required to maintain such APTC, you will be eligible to receive only the premium assistance benefit that would have been payable under the Trust had your APTC not been terminated.

B.3 If you are paid through the Independent Choices program, and your consumer uses Acumen as their fiscal provider, you may be eligible for benefits under the Trusts.

C.1 If you work as a PSW, HCW, and/or PCA and meet the Eligibility Requirements for PTO benefits, you will be eligible to receive 20 hours of paid time off each February 1 and July 1. The amount of your PTO benefit will be calculated based on your gross rate of pay (excluding any increase in wage rate due solely to overtime hours worked) for the first 80 hours of bargaining unit employment accrued during the applicable eligibility period (i.e., October, November, and December for February 1 benefits; and March, April, and May for July 1 benefits). Hours worked as a PSW, HCW, and PCA shall be combined for the purposes of determining PTO eligibility.

General Information

Payment of Premiums and Out-of-Pocket Expenses

The Supplemental Trust will issue you a Benefit Convenience Card ("BCC") that will be preloaded with both the amount needed for each month's health insurance premium after application of the maximum available Advance Premium Tax Credit, if applicable, and the maximum amount available under the Trust (as determined annually by the Board of Trustees) for the payment of deductibles, copayments, and coinsurance expenses for covered benefits and services provided under your approved qualified health plan.

The BCC may be used at doctors' offices, pharmacies, and other medical provider locations to pay any owed deductible, copayment, and coinsurance amounts related to services covered under an approved qualified health plan. You should save the explanations of benefits ("EOBs") relating to any expenses paid using the BCC, because you may be required to provide the BCC administrator (Ameriflex) with proof that these expenses are covered under the Trust.

The BCC may not be used to pay for any expenses not covered under an approved qualified health insurance plan, including any expenses for any individual other than yourself. The BCC may also not be used to pay for Dental, Vision, Hearing, and Employee Assistance Program ("DVE") benefits or expenses. See page(s) 36-37 of this guide for more information about the BCC.

Coverage Through Spouse's Plan

If you meet the Eligibility Requirements for the Supplemental Trust and are offered insurance through your spouse's employer but elect not to enroll in such coverage, you will be eligible for coverage through the Trust, but you may not be eligible for federal premium tax credits. In that case, the Supplemental Trust will pay your entire approved Marketplace health plan premium. If you elect to take your spouse's coverage, and you meet the Eligibility Requirements under the Benefit Trust, you may still be eligible for DVE Benefits and PTO Benefits; however, you will not be eligible for any other coverage under the Supplemental Trust.

Married Filing Separately

Generally, if you are married but file income taxes separately from your spouse, rather than filing a joint return, you may not be able to receive federal premium tax credits for health insurance purchased on the Marketplace, unless an exception under the law applies. In such cases, if you are eligible to receive Carewell SEIU 503 Healthcare Cost Assistance ("HCA") benefits through the Supplemental Trust, the Supplemental Trust will pay your entire approved Marketplace health plan premium.

Undocumented Workers

Under the Affordable Care Act, if you are an undocumented immigrant, you are not eligible to purchase health insurance through the Marketplace. You may be eligible for benefits if you meet the Eligibility Rules of the Trust. Contact Carewell Benefits to learn more.

Coverage through Medicare

For eligible HCWs, PSWs, and PCAs, the Supplemental Trust, through Carewell SEIU 503 Healthcare Cost Assistance Benefits, will reimburse the costs of monthly premiums for Medicare Part B, up to an amount determined annually by the Board of Trustees.

The Supplemental Trust will also reimburse you for monthly premiums for a Medicare Advantage or Medicare Supplemental product of your choice, up to an amount determined annually by the Board of Trustees. You may also be eligible for reimbursement of certain out-of-pocket expenses, such as deductibles, copayments, coinsurance, and prescriptions for services covered by Medicare, up to an amount determined annually by the Board of Trustees. For the most up-to-date information on the annual amounts for Medicare premiums and covered out-of-pocket expenses, visit CarewellSEIU503.org or call 1-844-503-7348.

In order to receive assistance for these expenses from the Supplemental Trust, you will need to submit a reimbursement claim form (available at the Carewell SEIU 503 website or by calling 1-844-503-7348) with evidence of premium expense to the Benefits Administrative Office. This information only needs to be submitted once for Part B premium reimbursement, but must be submitted annually to continue receiving reimbursement of the other Medicare-related expenses described above. If the Medicare Part B premium amount changes, you will need to submit another Part B reimbursement claim form to receive the increased payment. The Trust will confirm your hours worked each month before reimbursement is issued.

If you are eligible for Healthcare Cost Assistance (HCA) benefits, you will receive a Benefit Convenience Card (BCC) that may be used to pay for medical and prescription drug copays, deductibles, and coinsurance expenses relating to claims covered by your Medicare plan, up to an annual amount determined by the Board of Trustees each year, provided the claims were incurred while eligible for HCA benefits through the Trust. However, if you have been using the BCC to pay premiums for a Marketplace plan, one major difference as you switch to Medicare is that you can no longer use the BCC for Medicare premiums. Instead, you will need to submit a reimbursement claim form for your Medicare premiums.

You may be asked to show proof of expenses, so please keep Explanations of Benefits (EOBs) and all receipts (especially prescription receipts, since prescription expenses do not appear on the EOBs issued by insurance companies).

Coverage through the Marketplace

Carewell SEIU 503 Healthcare Cost Assistance (HCA) benefits, provided through the Supplemental Trust, help eligible workers pay for the costs of monthly premiums for individual health care coverage under an approved qualified health plan offered through the applicable Marketplace.

If you have individual-only health insurance under an approved qualified health plan, Carewell SEIU 503 HCA benefits generally cover the amount of the premium above and beyond your maximum available federal Advance Premium Tax Credit. For example, if you are entitled to a monthly federal Advance Premium Tax Credit of $500, and the monthly health insurance premium for your approved qualified health plan is $1,000, then after your full $500 tax credit is applied, your HCA benefits will provide payment for the remaining $500 balance, and you will pay nothing out of pocket. If, however, you have family coverage, your HCA benefits will reimburse only that part of the premium relating to your individual coverage, after applying the maximum available federal Advance Premium Tax Credit.

The Benefits Administrative Office must receive your name, gender, Social Security Number, birthdate, and current address in order to provide you with Healthcare Cost Assistance benefits. You are responsible for keeping this information current with the State of Oregon and with the Benefits Administrative Office.

Please refer to the Eligibility Rules section of this guide on page(s) 43-44 for information on how to become eligible for Carewell SEIU 503 HCA benefits. If you are eligible for Healthcare Cost Assistance, you will receive a Benefit Convenience Card (BCC), a Mastercard debit card, to pay for your monthly premium and covered out-of-pocket expenses.

The BCC cannot be used for:

- **dental care or vision and hearing services;**
- **expenses for your spouse or dependents;**
- **expenses for services that your healthcare plan does not cover;**
- **expenses incurred while you were not eligible for Healthcare Cost Assistance;**
- **covered medical expenses from a previous calendar year.**

If your family is on your health insurance policy, you will not be able to use the BCC for your premium payments. Instead, you must pay the insurance carrier directly and then submit a copy of the bill and proof of payment to the Benefits Administrative Office, along with a completed reimbursement form. The Trust will then reimburse you for the portion of the premium applicable solely to your individual coverage, after subtracting your maximum available Advance Premium Tax Credit.

This benefit applies only if you are enrolled in an approved Marketplace plan. However, if you became eligible for Carewell SEIU 503 benefits after the end of the last Open Enrollment period, and you are enrolled in a non-approved plan through a health insurance Marketplace, you may qualify for average premium reimbursements under Healthcare Cost Assistance. To continue receiving Carewell SEIU 503 HCA benefits after the end of the year, however, you must enroll in an approved plan at your first opportunity and no later than Open Enrollment (generally between November 1 and December 15). Otherwise, your Carewell SEIU 503 HCA benefits will stop at the end of the calendar year.

To view current approved qualified health plans, visit the Carewell SEIU 503 website at CarewellSEIU503.org or call 1-844-503-7348.

What Expenses are not Covered by the Trust?

The following are some examples of costs not covered by the Supplemental Trust. You are responsible for paying these expenses on your own.

- **Expenses relating to services and supplies not covered by Medicare or your approved qualified health plan.**
- **Copays, coinsurance, and deductibles in excess of the annual out-of-pocket reimbursement benefit.**
- **Expenses for your spouse or dependents.**

Advance Premium Tax Credit Reconciliation Reimbursement

You may receive an Advance Premium Tax Credit (“APTC”) from the federal government that is used to pay a portion of your monthly health care premiums. Because the amount of the APTC is based on your estimate of annual household income, you may be required to reimburse the federal government if you received too much of an APTC during the year. If the federal government notifies you that you must return a portion of the APTC you received because you underestimated your annual household income, you should contact the Benefits Administrative Office, as you may be eligible to receive reimbursement from the Supplemental Trust in an amount sufficient to cover all, or a part of, any amount you owe for reconciliation. In no event will you be entitled to reimbursement for an amount greater than the cost of the premiums that the Supplemental Trust would have paid had the APTC been accurate.

It also is possible that you could receive a refund from the federal government at the end of the year if your actual annual household income was less than you had estimated it to be. If you receive a refund from the federal government for this reason, you must pay that refunded amount to the Trust. This is the amount the Trust overpaid to the insurance carrier during the year because your estimate of your annual household income was incorrect. You are responsible for contacting the Benefits Administrative Office immediately in the event that you receive a tax refund relating to the amount of the APTC.

THE BENEFIT TRUST

The Benefit Trust

The Benefit Trust provides eligible homecare workers, personal support workers, and personal care attendants with Carewell SEIU 503 Dental, Vision, Hearing, and Employee Assistance Program (“DVE”) benefits with no out-of-pocket monthly premiums. Once you become eligible, you will automatically be enrolled in DVE benefits offered through the Benefit Trust. The Benefit Trust also provides eligible homecare workers, personal support workers, and personal care attendants with Paid Time Off (“PTO”) benefits.

Please refer to the Eligibility Rules section for information on how to become eligible for these benefits.

The Benefits Administrative Office must receive your name, gender, Social Security Number, birthdate, and current address to provide benefits. If this information is not current with the State of Oregon, you are responsible for updating it. You can also contact the Benefits Administrative Office at 1-844-507-7554, option 3, option 2 to update your information. If the Benefits Administrative Office does not have the necessary information to complete enrollment, an “Update Your Information” form will be sent to you.

Once you are enrolled in DVE Benefits, Kaiser Permanente will send you a dental insurance card, Ameritas will send you vision, hearing, and Lasik cards, and Reliant Behavioral Health will send you an informational flyer regarding your Employee Assistance Program benefits.

If you do not want Carewell SEIU 503 DVE benefits, you may opt out by submitting a Benefits Waiver Form available at CarewellSEIU503.org. Waiver Forms also may be requested by calling 1-844-503-7348. If you decide to opt back in to these benefits, you will need to contact the Benefits Administrative Office in writing to do so.

Claims and Appeal Procedure

Submitting a Reimbursement Claim to the Supplemental Trust

Requests for reimbursement must be submitted to the Benefits Administrative Office. Forms are available online at the Carewell SEIU 503 website. The Benefits Administrative Office will generally respond to your claim within 30 days of receipt. If the Benefits Administrative Office needs additional time to respond, your claim will generally be decided within 45 days of receipt. You will be notified if the Benefits Administrative Office needs additional information. If you do not provide the additional information, the Benefits Administrative Office will decide the claim based on the information it has available. If your claim was filed improperly, you will be notified within 10 days and provided with information on how to correct it.

If your claim is denied, you will receive a written explanation that will include:

- **The reason(s) for the denial.**
- **The specific Trust rule(s) upon which the decision was based.**

- **Any additional information necessary for reconsideration of your claim, including the reason(s) such information is necessary.**
- **The Trust's appeal procedures and the deadlines for those procedures.**
- **A notification that the initial decision is final unless the decision is appealed in accordance with the appeal procedures.**
- **You are not required to appeal the decision to the Board of Trustees. However, under the Plan rules, you must exhaust your administrative remedies by appealing to the Board of Trustees before you have the right to file suit.**

Appeal Procedure

If your initial claim is denied by the Benefits Administrative Office, you must complete a "Review and Appeal Form," available at CarewellSEIU503.org, within 180 days from receipt of the denial. The written appeal should state the reasons for your appeal request. You may appoint an authorized representative to act on your behalf. To do so, you must notify the Benefits Administrative Office in writing of the representative's name, address, and telephone number. You may receive reasonable access to and copies of documents relevant to your claim. You may submit issues and comments in writing. You may request copies of all information considered during the appeal.

Your appeal will generally be decided within 60 days of receipt of the appeal by the Benefits Administrative Office.

If an extension of time is required for review, you will be notified by mail, and you will generally receive a decision no later than 120 days after receipt of your appeal. The Trustees will send you a notice of the appeal decision within 5 days of the decision.

If your appeal is denied, you will receive a written notice that includes information identifying the claim, the reason(s) for denial, a discussion of the decision, and the provisions of the Plan document on which the decision was based.

If you wish to file suit regarding the Board of Trustees' denial, you must do so within three years of the denial of your appeal.

Overpayments

Each Trust has a constructive trust, lien, and/or an equitable lien by agreement in favor of the Trust on any overpaid or advanced benefits received by you or your representative (including an attorney) that are due to the Trust, and any such amount is deemed to be held in trust by you for the benefit of the Trust until paid to the Trust. By accepting benefits from the Trusts, you consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of each applicable Trust exists with regard to any overpayment or advancement of benefits. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you agree to cooperate with the Trust in reimbursing the Trust for all of its costs and expenses related to the collection of those benefits.

The Trust may recover overpaid benefits by offsetting all future benefits otherwise payable by the Trust on your behalf.

If you fail to reimburse the Trust and the Trust is required to pursue legal action against you to obtain repayment of the benefits advanced by the Trust, you shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Trust in connection with the collection of any amounts owed to the Trust or the enforcement of any of the Trust's rights to reimbursement. The Trust has a right to file suit against you or your representative in any state or federal court that has jurisdiction over the Trust's claims.

Any refusal by you to reimburse the Trust for any overpaid amounts will be considered a breach of your agreement with the Trust — that the Trust will provide the benefits available under this guide, and that you, in turn, will comply with the rules of the Trust. Further, by accepting benefits from the Trust, you affirmatively waive any defenses you may have in any action by the Trust to recover overpaid amounts or amounts due under any rule of this guide, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

NOTICES

Benefit Trust Notice of Privacy Practices

Oregon Homecare Workers Benefit Trust

NOTICE OF PRIVACY PRACTICES

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

The Trust's Commitment to Privacy

The Oregon Homecare Workers Benefit Trust (the "Trust") is committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Trust's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- **to maintain the privacy of your health information;**
- **to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and**
- **to abide by the terms of this Notice.**

This Notice also informs you how the Trust uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Trust. For purposes of this Notice, "you" or "your" refers to participants who are eligible for benefits under the Trust.

Information Subject to This Notice

The Trust collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Trust obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Trust's administrative staff and health care professionals, and from reports and data provided to the Trust by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Notice. The health information the Trust has about you may include, among other things, your name, address, phone number, birth date, Social Security Number, employment information, and health claims information.

The Trust provides not only health care benefits but also other non-health care benefits, such as paid time off ("PTO") benefits. It is the intent of the Trust, as permitted by the privacy regulations issued under HIPAA, to limit the application of those regulations to health care components of the Trust. Thus, the components under the Trust

subject to HIPAA Privacy regulations shall include all the health care components of the Trust, including all dental, vision, and EAP benefits, but shall not include the non-health care components.

Summary of the Trust's Privacy Practices

The Trust's Uses and Disclosures of Your Health Information

The Trust uses your health information to determine your eligibility for benefits, to process and pay for your benefit premiums, and to administer its operations. The Trust discloses your health information to insurers, third party administrators, and health care providers for treatment, payment, and health care operations purposes. The Trust may also disclose your health information to third parties that assist the Trust in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Trust will only use or disclose your health information pursuant to your written authorization. In other cases, authorization is not needed. The details of the Trust's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- **Inspect and/or copy your health information;**
- **Request that your health information be amended;**
- **Request an accounting of certain disclosures of your health information;**
- **Request certain restrictions related to the use and disclosure of your health information;**
- **Request to receive your health information through confidential communications;**
- **Request access to your health information in an electronic format;**
- **Receive notice of a breach of unsecured protected health information if it affects you;**
- **File a complaint with the Trust or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and**
- **Receive a paper copy of this Notice.**

These rights and how you may exercise them are detailed below.

Changes in the Trust's Privacy Practices

The Trust reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Trust's privacy practices, or about this Notice, or if you wish to obtain additional information about the Trust's privacy practices, please contact:

HIPAA Privacy Officer

Oregon Homecare Workers Benefit Trust
Vimly Benefit Solutions, Inc.
12121 Harbour Reach Dr. , Suite 105
Mukilteo, WA 98275

DETAILED NOTICE OF THE TRUST'S PRIVACY POLICIES

THE TRUST'S USES AND DISCLOSURES

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Trust uses and discloses your health information only for the administration of the Trust and the processing of your benefits.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. For Treatment. Although the Trust does not anticipate making disclosures "for treatment," if necessary, the Trust may make such disclosures without your authorization. For example, the Trust may disclose your health information to a health care provider to assist the provider in treating you.

2. For Payment. The Trust may use and disclose your health information so that claims for treatment, services, and supplies that you receive from health care providers can be paid according to the Trust's program of benefits. For example, the Trust may share your enrollment, eligibility, and claims information with the Trust's claim processors, so that they may process your claims. The Trust may use or disclose your health information to health care providers to notify them as to whether certain health benefits are covered. The Trust may also disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, the Trust may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.

3. For Health Care Operations. The Trust may use and disclose your health information to enable it to operate efficiently and in the best interests of its participants. For example, the Trust may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Trust.

Uses and Disclosures to Business Associates

The Trust shares health information about you with its "business associates, " which are third parties that assist the Trust in its operations. The Trust discloses information, without your authorization, to its business associates for treatment, payment, and health care operations. For example, the Trust shares your health information with the Trust's claim processors so that it may

process your claims. The Trust may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Trust may disclose your health information to a translator; and the Trust may provide names and address information to mailing services.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected.

Uses and Disclosures to Plan Sponsor

The Trust may disclose your health information to the Plan Sponsor, which is the Trust's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Trust, without your authorization. The Trust may also disclose your health information to the Plan Sponsor for purposes of hearing and deciding your appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Trust that it will protect your health information and that it has included language in the Trust rules to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Trust may make without your authorization.

1. Required by Law. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:

- **For judicial and administrative proceedings pursuant to court or administrative order, legal process, and/or authority.**
- **To report information related to victims of abuse, neglect, or domestic violence.**
- **To assist law enforcement officials in their law enforcement duties.**
- **To notify the appropriate authorities of a breach of protected health information.**

2. Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information may also be disclosed for public health activities, such as preventing or controlling disease, injury, or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the U.S. Food and Drug Administration.

3. Government Functions. Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities, and protection of public officials.

Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure, and other oversight activities.

4. Active Members of the Military and Veterans. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans affairs.

5. Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

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

7. Others Involved In Your Care. Under limited circumstances, your health information may be disclosed to a family member, close personal friend, or others whom the Trust has verified are directly involved in your care (for example, if you are seriously injured and unable to communicate with the Trust). Also, upon request, the Trust may advise a family member or close personal friend about your general condition, location (such as in the hospital), or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. Personal Representatives. Your health information may be disclosed to people whom you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

9. Treatment and Health-Related Benefits Information. The Trust and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services, and medication.

10. Research. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

11. Organ, Eye, and Tissue Donation. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

12. Deceased Individuals. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Trust and its business associates do not

use your health information for fundraising or marketing purposes.

Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information other than those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Trust will not use or disclose your health information, except to the extent that the Trust has already relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

Your Health Information Rights

You have the following rights regarding your health information that the Trust creates, collects, and maintains. If you are required to submit a written request related to these rights, as described herein, you should address such requests to:

HIPAA Privacy Officer

Oregon Homecare Workers Benefit Trust
Vimly Benefit Solutions, Inc.
12121 Harbour Reach Dr. , Suite 105
Mukilteo, WA 98275

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records. For health records that the Trust keeps in electronic form, you may request to receive the records in an electronic format.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Trust will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, then the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a two-year period, state that in your written request, and that request will be accommodated. If you request a paper copy of your underlying health record or a portion of your health record, the Trust will charge you a fee of $0.25 per page for the cost of copying and mailing the response to your request. Records provided in electronic format also may be subject to a small charge.

In certain limited circumstances, the Trust may deny your request to inspect and copy your health record. If the Trust does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request that Your Health Information be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Trust may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- **Was not created by or for the Trust, unless you provide the Trust with information that the person or entity that created the information is no longer available to make the amendment;**
- **Is not part of the health information maintained by or for the Trust;**
- **Is not part of the health record information that you would be permitted to inspect and copy; or**
- **Is accurate and complete.**

The Trust will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Trust denies your request, it will explain how you may continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Trust to others. The accounting covers up to six years prior to the date of your request. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. In response to your request for an accounting of disclosures, the Trust may provide you with a list of business associates who make such disclosures on behalf of the Trust, along with contact information so that you may request the accounting directly from each business associate. The first accounting that you request within a 12-month period will be free. For additional accountings in a 12-month period, you will be charged for the cost of providing the accounting, but the Trust will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on

your health information that the Trust uses or discloses about you to carry out treatment, payment, or health care operations. You also have the right to request restrictions on your health information that the Trust discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Trust is generally not required to agree to your request for such restrictions, and the Trust may terminate its agreement to the restrictions you requested. The Plan is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out of pocket.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Trust will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Communications by Alternative Means or at Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason(s) for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible, and you will be notified appropriately.

Right to Complain

You have the right to complain to the Trust and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Trust, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Trust or with the Department of Health and Human Services.

Right to Paper Copy of Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy of this Notice by submitting a written request to:

Oregon Homecare Workers Benefit Trust

Vimly Benefit Solutions, Inc.
12121 Harbour Reach Dr. , Suite 105
Mukilteo, WA 98275

Right to Receive Notice of Breach

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

Changes in Trust's Privacy Policies

The Trust reserves the right to change its privacy practices and make the new practices effective for health information that it maintains, including health information that it created or received prior to the effective date of the change and health information it may receive in the future. If the Trust materially changes any of its privacy practices, it will revise this Notice and provide you with the revised Notice, either by U.S. Mail or email, within 60 days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be made available for review at the Trust Office.

Effective Date

This Notice was first effective on May 31, 2017. This Notice will remain in effect unless and until the Trust publishes a revised Notice.

Supplemental Trust Notice of Privacy Practices

Oregon Homecare Workers Supplemental Trust

NOTICE OF PRIVACY PRACTICES

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

The Trust's Commitment to Privacy

The Oregon Homecare Workers Supplemental Trust (the "Trust") is

committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Trust's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- **to maintain the privacy of your health information;**
- **to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and**
- **to abide by the terms of this Notice.**

This Notice also informs you how the Trust uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Trust. For purposes of this Notice, " you" or " your" refers to participants who are eligible for benefits under the Trust.

Information Subject to This Notice

The Trust collects and maintains certain health information about you to help provide benefits to you, as well as to fulfill legal and regulatory requirements. The Trust obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Trust's administrative staff and health care professionals, and from reports and data provided to the Trust by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Notice. The health information the Trust has about you may include, among other things, your name, address, phone number, birth date, Social Security Number, employment information, and health claims information.

Summary of the Trust's Privacy Practices

The Trust's Uses and Disclosures of Your Health Information

The Trust may use your health information to determine your eligibility for benefits, to process and pay for your benefit premiums, and to administer its operations. The Trust may disclose your health information to insurers, third party administrators, and health care providers for treatment, payment, and health care operations purposes. The Trust may also disclose your health information to third parties that assist the Trust in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Trust will only use or disclose your health information pursuant to your written authorization. In other circumstances, authorization is not needed. The details of the Trust's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- **Inspect and/or copy your health information;**
- **Request that your health information be amended;**
- **Request an accounting of certain disclosures of your health information;**
- **Request certain restrictions related to the use and disclosure of your health information;**
- **Request to receive your health information through confidential communications;**
- **Request access to your health information in an electronic format;**
- **Receive notice of a breach of unsecured protected health information if it affects you;**
- **File a complaint with the Trust or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and**
- **Receive a paper copy of this Notice.**

These rights and how you may exercise them are detailed below.

Changes in the Trust's Privacy Practices

The Trust reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Trust's privacy practices, or about this Notice, or if you wish to obtain additional information about the Trust's privacy practices, please contact:

HIPAA Privacy Officer

Oregon Homecare Workers Supplemental Trust
Vimly Benefit Solutions Inc.
12121 Harbour Reach Dr., Suite 105
Mukilteo, WA 98275

Detailed Notice of the Trust's Privacy Policies

The Trust's Uses and Disclosures

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Trust uses and discloses your health information only for the administration of the Trust and the processing of your benefits.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. For Treatment. Although the Trust does not anticipate making disclosures "for treatment," if necessary, the Trust may make such disclosures without your authorization. For example, the Trust may disclose your health information to a health care provider to assist the provider in treating you.

2. For Payment. The Trust may use and disclose your health information so that claims for treatment, services, and supplies that you receive from health care providers can be paid according to the Trust's program of benefits. For example, the Trust may share your enrollment, eligibility, and claims information with the Trust's claim processors, so that they may process your claims. The Trust may use or disclose your health information to health care providers to notify them as to whether certain health benefits are covered. The Trust may also disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, the Trust may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.

3. For Health Care Operations. The Trust may use and disclose your health information to enable it to operate efficiently and in the best interests of its participants. For example, the Trust may disclose your health information to actuaries and accountants for business planning purposes or to attorneys who are providing legal services to the Trust.

Uses and Disclosures to Business Associates

The Trust shares health information about you with its "business associates," which are third parties that assist the Trust in its operations. The Trust discloses information, without your authorization, to its business associates for treatment, payment, and health care operations. For example, the Trust shares your health information with the Trust's claim processors so that it may process your claims. The Trust may disclose your health information to auditors, actuaries, accountants, and attorneys as described above, and the Trust may provide names and address information to mailing services. In addition, if you are a non-English speaking participant who has questions about a claim, the Trust may disclose your health information to a translator.

The Plan enters into agreements with its business associates to protect the privacy of your health information.

Uses and Disclosures to Plan Sponsor

The Trust may disclose your health information without your authorization to the Plan Sponsor, which is the Trust's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Trust. The Trust may also disclose your health information to the Plan Sponsor for purposes of hearing and deciding your appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Trust that it will protect your health information and that it has included language in the Trust rules to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures that May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Trust may make without your authorization.

1. Required by Law. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:

- **For judicial and administrative proceedings pursuant to court or administrative order, legal process, and/or authority.**
- **To report information related to victims of abuse, neglect, or domestic violence.**
- **To assist law enforcement officials in their law enforcement duties.**
- **To notify the appropriate authorities of a breach of unsecured health information.**

2. Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information may also be disclosed for public health activities, such as preventing or controlling disease, injury, or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the U.S. Food and Drug Administration.

3. Government Functions. Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure, and other oversight activities.

4. Active Members of the Military and Veterans. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans affairs.

5. Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

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

7. Others Involved in Your Care. Under limited circumstances, your health information may be disclosed to a family member, close personal friend, or others whom the Trust

has verified are directly involved in your care (for example, if you are seriously injured and unable to communicate with the Trust). Also, upon request, the Trust may advise a family member or close personal friend about your general condition, location (such as in the hospital), or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. Personal Representatives. Your health information may be disclosed to people whom you have authorized to act on your behalf or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

9. Treatment and Health-Related Benefits Information. The Trust and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services, and medication.

10. Research. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

11. Organ, Eye, and Tissue Donation. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

12. Deceased Individuals. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals may perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Trust and its business associates do not use your health information for fundraising or marketing purposes.

Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information other than those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Trust will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Trust has already relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information and that information may be re-disclosed by the recipient without your knowledge or authorization.

Your Health Information Rights

You have the following rights regarding your health information that the Trust creates, collects, and maintains. If you are required to submit a written request related to these rights, as described herein, you should address such requests to:

HIPAA Privacy Officer

Oregon Homecare Workers Supplemental Trust
Vimly Benefit Solutions, Inc.
12121 Harbour Reach Dr., Suite 105
Mukilteo, WA 98275

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records. For health records that the Trust keeps in electronic form, you may request to receive the records in an electronic format.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Trust will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, then the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a two-year period, please state that in your written request and that request will be accommodated. If you request a paper copy of your underlying health record or a portion of your health record, the Trust will charge you a fee of $0.25 per page for the cost of copying and mailing the response to your request. Records provided in electronic format also may be subject to a small charge.

In certain limited circumstances, the Trust may deny your request to inspect and copy your health record. If the Trust does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request that Your Health Information be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Trust may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- **Was not created by or for the Trust, unless you provide the Trust with information that the person or entity that created the information is no longer available to make the amendment;**

- **Is not part of the health information maintained by or for the Trust;**
- **Is not part of the health record information that you would be permitted to inspect and copy; or**
- **Is accurate and complete.**

The Trust will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Trust denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Trust to others. The accounting covers up to six years prior to the date of your request. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. In response to your request for an accounting of disclosures, the Trust may provide you with a list of business associates who make such disclosures on behalf of the Trust, along with contact information so that you may request the accounting directly from each business associate. The first accounting that you request within a 12-month period will be free. For additional accountings in a 12-month period, you will be charged for the cost of providing the accounting, but the Trust will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Trust uses or discloses about you to carry out treatment, payment, or health care operations. You also have the right to request restrictions on your health information that the Trust discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Trust is generally not required to agree to your request for such restrictions, and the Trust may terminate its agreement to the restrictions you requested. The Plan is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out of pocket.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Trust will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Communications by Alternative Means or at Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you may ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason(s) for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible, and you will be notified appropriately.

Right to Complain

You have the right to complain to the Trust and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Trust, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Trust or with the Department of Health and Human Services.

Right to Paper Copy of Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy by submitting a written request to:

HIPAA Privacy Officer

Oregon Homecare Workers Supplemental Trust
Vimly Benefit Solutions, Inc.
12121 Harbour Reach Dr., Suite 105
Mukilteo, WA 98275

Right to Receive Notice of Breach

You will be notified if your health information has been breached. You will be notified by first-class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured — for example, computer data that is encrypted and inaccessible

without a password — or if it is determined that there is a low probability that your health information has been compromised.

Changes in Trust's Privacy Policies

The Trust reserves the right to change its privacy practices and make the new practices effective for health information that it maintains, including health information that it created or received prior to the effective date of the change and health information it may receive in the future. If the Trust materially changes any of its privacy practices, it will revise this Notice and provide you with the revised Notice, either by U.S. Mail or email, within 60 days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be made available for review at the Trust Office.

Effective Date

This Notice was first effective on August 1, 2013. This Notice will remain in effect unless and until the Trust publishes a revised Notice.

Benefit Trust Notice of COBRA Continuation Coverage Rights

Notice of Right to Continue Coverage through Self Payments under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA")

This Notice has very important information about your right to continue your job-provided coverage under the Benefit Trust via COBRA, as well as OTHER health coverage options that may be available to you, including coverage through the Health Insurance Marketplace or another group health plan (such as your spouse's plan). Information on the Health Insurance Marketplace and other coverage options is located beginning on page 82 of this Notice. Please read the information in this Notice carefully before you make your decision.

How do I elect COBRA continuation coverage? To elect continuation coverage, complete the enclosed COBRA Election Notice and send it to the Trust Office. You have 60 days from the later of the date you lost coverage or the date of the enclosed COBRA Election Notice.

How long does continuation coverage last? Your COBRA continuation coverage is effective the first of the month following the date of your loss of coverage. In the case of a loss of coverage due to the end of employment or reduction in hours of employment, COBRA coverage generally may be continued for up to a total of 18 months.

How may the length of COBRA continuation coverage be extended? If you elect COBRA coverage, an extension of the maximum period of coverage may be available if you are disabled. You must timely notify the Trust office of any disability in order to extend the period of continuation coverage. Failure to provide timely notice of a disability, as described below, will result in the denial of any COBRA coverage extension.

How much does COBRA continuation coverage cost? The cost for COBRA continuation coverage is listed in the enclosed COBRA Election Notice and may include a 2% administration fee as allowed by federal law. Please note, other continuation options (such as through the Health Insurance Marketplace or through a spouse's plan) may be less expensive than COBRA. Additional information on those options can be found beginning on page 82 of this Notice.

When and how must payment for COBRA continuation coverage be made?

First Payment for Continuation Coverage

You must make your first payment for COBRA continuation coverage no later than 45 days after the date of your election. The 45 days is measured from the date your Election Notice is postmarked. Note that your COBRA benefits will not begin until payment is received. Your first payment must be made in full, including all payments due back to the effective date of your COBRA coverage. Failure to make timely payment within the 45-day period will result in termination of your continuation coverage and loss of all COBRA rights.

Monthly Payments for Continuation Coverage

After you make your first payment for COBRA continuation coverage, you are required to make monthly payments for each subsequent coverage period. Payments are due on the first day of each coverage month. Generally, if you make your payment on or before the first day of the coverage period, your coverage will be in effect for that coverage period without any break. The Trust Office will send you a monthly statement reflecting the premium due; however, the bill is provided as a courtesy only and is not required by law. The Department of Labor (DOL) states that COBRA participants are required to make their payments on time, even if they do not receive regular billing statements.

Grace Periods for Periodic Payments

Although monthly payments are due on the first day of the month of coverage, the law allows a grace period of 30 days after the first day of the coverage period. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period. However, your benefits will be suspended during the grace period until your premium payment is received. Failure to make payment in full before the end of the 30-day grace period will result in termination of your coverage and loss of all COBRA rights. COBRA coverage will not be reinstated. In the event that you do not

receive a monthly billing statement, it is still your responsibility to make your payment no later than the end of the 30-day grace period.

Keep the Benefits Administrative Office Informed of Address Changes: If you elect COBRA coverage, you should keep the Benefits Administrative Office informed of any changes to your address to ensure that billings and other communications are sent to the correct address. You should also keep a copy of any notices you send to the Benefits Administrative Office for your records. Please send any address changes to:

Vimly Benefit Solutions, Inc.
COBRA Dept.
P.O. Box 6
Mukilteo, WA 98275

For more information: This Notice does not fully describe COBRA continuation coverage or other rights that may be available under the Plan. More information about continuation of coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions about the information in this Notice or your rights to COBRA continuation coverage, please contact Vimly Benefit Solutions, Inc. at 1-844-507-7554 or OHCWT@vimly.com.

Employees seeking more information about rights under ERISA, including COBRA, HIPAA, the Patient Protection and Affordable Care Act (PPACA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa.

Health Insurance Marketplace and Continuation Coverage Options Other Than COBRA To Consider

WHAT IS THE HEALTH INSURANCE MARKETPLACE? The Marketplace offers "one-stop shopping" to find and compare health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and your out-of-pocket costs for deductibles, coinsurance, and copayments, and you can see what your premium, deductibles, and out-of-pocket costs will be before you decide to enroll. Through the Marketplace you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov or by calling 1-800-318-2596.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage does not limit your eligibility for coverage or for a tax credit through the Marketplace.

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE? You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a Marketplace "Special Enrollment" event. After 60 days, your Special Enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an annual "Open Enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, when the next Open Enrollment period will be, and what you need to know about qualifying events and Special Enrollment periods, visit www.HealthCare.gov.

IF I SIGN UP FOR COBRA, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA? If you sign up for COBRA, you can switch to a Marketplace plan during a Marketplace Open Enrollment period. You can also choose to end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event, such as marriage or birth of a child, which is also a "Special Enrollment" event. But be careful — if you terminate your COBRA early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open Enrollment Period, and you could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage ends, you'll be eligible to enroll in Marketplace coverage through a Special Enrollment period, even if Marketplace Open Enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

CAN I ENROLL IN ANOTHER GROUP HEALTH PLAN? You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment in that plan within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan if you enroll within 30 days of losing your COBRA continuation coverage.

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

When considering your options for health coverage, you may want to think about:

- **Premiums: Your previous plan may charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.**
- **Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.**

- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication — and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance Payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas — so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.















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