



2016 PLAN BOOKLET

Supplemental & Benefit Trusts

Revised May 2016

WELCOME

Welcome to your benefit booklet for the Oregon Homecare Workers Supplemental Trust (“Supplemental Trust”) and the Oregon Homecare Workers Benefit Trust (“Benefit Trust”). This booklet is designed to provide you with information on eligibility rules, benefits available to you and resources that may be helpful.

We all need health coverage that is stable and affordable. But as of 2013, one in four Oregon Homecare Workers had no health care coverage.

That’s why SEIU Local 503’s (“Union”) members fought hard to negotiate with the State of Oregon for a new health care model to cover eligible Homecare Workers and Personal Support Workers (“Participants”).

The Supplemental Trust and Benefit Trust were created to provide premium assistance, out-of-pocket expense assistance, dental, vision and employee assistance program benefits to all eligible Participants. The Supplemental Trust assists eligible

Participants in paying for certain premium and out-of-pocket costs relating to the Participant’s health insurance. The Benefit Trust offers insured dental, vision and employee assistance program benefits to eligible Participants.

The Benefit Trust also provides paid time off benefits to eligible Personal Support Workers and eligible Live-In Homecare Workers.

The information in this booklet is also provided online at:
ORHomecareTrust.org.

QUICK REFERENCE: WHO TO CONTACT

If you are new and have not yet enrolled and you want to know your options, please contact the Healthcare Enrollment Team by calling 1-844-507-7554 Option 1 or email acahotline@orhomecaretrust.org.

If you enrolled through a Health Care Exchange and you have questions about the status of your application or need to make a change, please contact Valley Insurance Professionals by calling 1-844-507-7554 Option 2.

If you are enrolled and need assistance accessing services and have a question about eligibility or your benefits, please contact the Trust Administrative Office by calling 1-844-507-7554, Option 3, then Option 2 or by email ohcwt@bsitpa.com.

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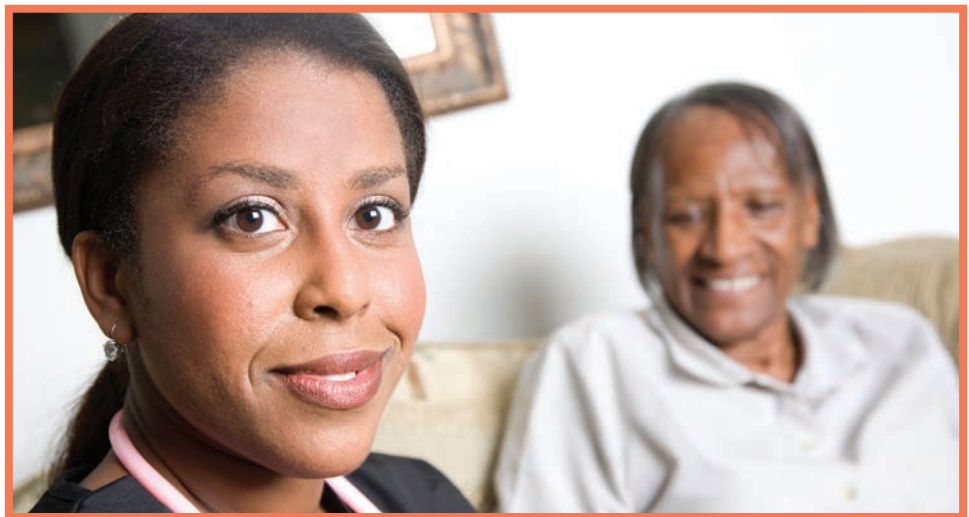
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Supplemental Trust AND Benefit Trust

Frequently Asked Questions



Why did we move to this new system?

The Union's elected leaders and bargaining team negotiated changes to health care based on survey input from thousands of Homecare and Personal Support Workers:

- Previously 1 out of 4 Homecare Workers could not access health care benefits, and that simply was not enough.
- Homecare Workers who had health coverage found it difficult to satisfy the previous eligibility requirement that they perform 80 hours of bargaining unit work per month. For example, if a Homecare Worker lost a consumer, it was difficult for that Worker to get back to 80 hours of bargaining unit work per month before losing eligibility for health coverage.
- There were concerns about proposed cuts to benefits because of a lack of funding, a subject Union members have had to address in bargaining ever since the first contract was negotiated.
- Lastly, your Union's elected leaders and bargaining team heard loud and clear the need for coverage of monthly premiums. Unfortunately this benefit is so rare for other jobs these days—but your Union's leaders and bargaining team were able to bargain this benefit for Homecare and Personal Support Workers.

What are the Trusts?

The Trusts are legal entities created to provide health care related benefits to eligible Participants. The Trusts provide eligible Participants with health care premium coverage and other benefits. The Supplemental Trust is set up to work with the Health Care Exchanges created by the Affordable Care Act. This Trust provides supplemental payments for certain premium

and out-of-pocket expenses related to the Trust-approved health plans offered through the Health Care Exchanges. The Benefit Trust offers insured dental, vision, and employee assistance benefits, to all eligible Participants, as well as paid time off benefits to eligible Personal Support Workers and Homecare Workers.

Is my family eligible for coverage through the Trusts?

No—spouses and children are not eligible for Trust benefits. We do encourage you to review whether coverage is available to your family through the Affordable Care Act,

because it is likely that you can find affordable insurance for them.

Why is my health insurance premium covered by the Supplemental Trust only if I choose specific plans?

In order to work with the insurance carriers to provide the best benefits possible, it is necessary to limit the number of plans available. The Supplemental Trust was able to work out arrangements with certain insurance carriers so that the Trust can assist Participants with paying the monthly

premiums charged by those carriers. If the Trust didn't limit the number of plans, it would not be able to provide this premium assistance. The Trust went through a process of finding high quality plans for Participants that fit into the Supplemental Trust's budget and are available through the Exchanges.

Do I have to sign up for the Oregon Health Plan ("OHP")?

If you are eligible for OHP and you elect not to enroll, the Supplemental Trust won't pay a portion of your premium for another plan. As of January 1, 2014, the Oregon Health Plan will

be called the Oregon Health Plan Plus. With OHP Plus, there are no longer premiums, and co-pays are very minimal.

Who directs the Trusts?

One of your Union's great victories in creating the Trusts was to give Homecare Workers and Personal Support Workers considerably more say in how their benefits are structured. Each Trust is governed by a ten-member Board of Trustees. The current Boards were appointed by the Union's Homecare Council and include

Heather Conroy, Executive Director of your SEIU Local 503 OPEU, eight Homecare and Personal Support leaders and a Union staff person. Through their role on the Boards of Trustees, Homecare and Personal Support Workers will work to make sure the Trusts can adjust to the needs of the workforce.

Eligibility Rules

Eligibility for All Benefits Other Than PTO Benefits

The following rules apply to individuals covered under the SEIU home care bargaining unit and will govern eligibility for coverage under the Benefit Trust and the Supplemental Trust, except paid time off benefits which are addressed below. (Individuals covered under the SEIU Homecare bargaining unit who are eligible to participate in the Trusts are referred to in this booklet as "Participants.")

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 Trust Administrative Office must receive your hours information from the State, so it is important that you turn in your payroll vouchers in a timely manner as there is a natural time lag between your hours worked and when they are reported to the Trust. Once you become eligible for benefits, there will be a one-month waiting period before you are covered by the Trusts as a result of this time lag. For example, if you work 40 hours a month in January and February, you will be covered under the Trusts effective April 1st.

Hours worked for the purposes of these Eligibility Rules will be determined by the Trust Administrative Office based on the most recent agency-reported payroll hours or such other data received by and acceptable to the Trust Administrator, in its sole discretion. The effective date for coverage for the benefits described in Section A.1, A.2, and A.3 on page 13 will be the month following the date that the Trust Administrator verifies your eligibility, subject, in the case of benefits under Section A.3, to processing of your application for coverage through the applicable Exchange.

Ongoing Eligibility

You will continue to be eligible for 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 under the Trusts 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. Also, you will be given a warning letter after the first month in which bargaining unit hours worked drop to zero and advance notice of the termination of eligibility under the Trust(s) after the second consecutive month in which bargaining unit hours drop to zero. Losing eligibility under the Supplemental Trust does not mean that your health insurance plan through the Exchange will terminate. It just means that you will be responsible for paying the premiums and all other out-of-pocket costs relating to that health insurance plan. If you do not pay the premiums, your health insurer will cancel your health insurance plan.

Regaining Eligibility

If you lose eligibility for benefits, 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 again.

Personal Support Worker PTO Benefits Eligibility

The following rules apply to paid time off ("PTO") benefits for Personal Support Workers ("PSWs")

covered under the SEIU home care bargaining unit. These 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, you 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 effective each July 1, you 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 Trust Administrative Office with a completed Form W-9 in order to be eligible for PTO benefits.

Personal Support Worker Rate of Pay

Rate of pay means the Personal Support Worker's gross wages for a month divided by the covered hours worked that month. The rate of pay used to calculate a PSW'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 a PSW worked 80 hours in October, 48 hours in November and 120 hours in December, they will be determined eligible for PTO benefits effective February 1st. In this example, October becomes the month to use for determination of the PTO rate, using the total pay divided by total hours from that month. If the Participant's gross pay in October is \$1000, and their gross hours in that month were 80, their PTO rate of pay for the next benefit period would be \$12.50 per hour.

Each determination period will have a distinct rate of pay determined by its period. A Participant will be paid out from the oldest hours first and once they have been paid out will not accrue additional PTO benefits until they are determined eligible in a future determination period.

Personal Support Worker PTO Accrual

For each benefit period, the eligible PSW will accrue 20 hours of PTO at the rate of pay determined above.

Personal Support Worker PTO Pay Out

Once a Participant is determined eligible for PTO benefits, they may request in writing to be paid

a minimum of 4 hours of PTO benefits at their determined rate of pay up to their maximum of 20 hours for that benefit period. Pay out will take place 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 the Participant is determined eligible in a future determination period.

Personal Support 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 15th of the following year. There will be no rollover of PTO benefits from a benefit period beginning in a given calendar year to a benefit period beginning in a later calendar year.

For example, if a PSW is determined eligible February 2016 with 20 hours at \$13.00/hour, and then again determined eligible July 2016 with 20 hours at \$14.25/hour, and then elects to receive 8 hours of PTO benefits during 2016, his or her remaining 32 hours of PTO benefits will be cashed out on February 15, 2017 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.

Live-In Homecare Worker PTO Benefits Eligibility

The following rules apply to PTO benefits for eligible Live-In Homecare Workers covered under the SEIU home care bargaining unit ("Live-Ins"). These benefits are available under the Benefit Trust. The determination of eligibility will be made monthly, beginning with the month of September 2015, for benefits accrued as of November 1, 2015. The amount of benefits accrued each month will depend on the number of hours of covered Live-In Homecare work performed in the eligibility month (two months prior to the accrual month), according to the following chart. However, in no event may a Live-In have more than 144 hours of accrued PTO benefits at any given time.

Eligibility Rules

For example, if you work 240 hours of covered employment in September 2015, you will accrue 16 hours of PTO benefits effective November 1, 2015.

An additional eligibility requirement is that you must complete and return to the Trust Administrative Office a Form W-9, Request for Taxpayer Identification Number and Certification. An otherwise eligible Live-In will first become eligible to receive a PTO benefit on the later of November 1, 2015, or the date the Participant performs the required hours of covered employment and completes and returns a Form W-9 to the Trust Administrative Office.

Live-In Homecare Worker PTO Rate of Pay

Rate of pay means the Live-In's gross wages for a month divided by the covered hours worked that month. The rate of pay used to calculate a Live-In's PTO benefit each month will be the rate of pay earned during the eligibility month.

For example, the rate of pay used to determine your PTO benefit for January 2016 will be the rate of pay earned in November 2015. If your gross wages for November 2015 were \$3,136, and you worked 320 hours of covered employment that month, your rate of pay for November would be \$9.80.

Each eligibility month may have a different rate of pay, depending on the gross wages and hours worked each month. When you apply to receive

your PTO benefit, your benefit will be paid from the oldest hours and rate of pay first.

Live-In Homecare Worker PTO Pay Out

Once the Trust Administrative Office determines that you are eligible for PTO benefits, you may send a Paid Time Off Request Form to the Trust Administrative Office to be paid a minimum of 4 hours up to your maximum accrued PTO benefits. The Trust Administrative Office will pay the requested benefit within 30 days of receipt of the PTO benefit request. Once you have received your maximum accrued benefit, no additional PTO benefits will be paid until you are again determined eligible in a future month.

Live-In Homecare Worker PTO Cash-Out and Rollover

If you do not request payment by January 31st of your entire PTO benefit accrued during the prior year, the Trust automatically will cash out to you 50% of your PTO benefit accrued during the prior year. The cash-out amount will be paid in February of the year after the year in which the benefit was accrued. Your remaining accrued PTO benefit will roll over to the next year.

Regardless of whether you elect to receive payment of your full PTO benefit each year, the benefit will be treated as taxable income in the year in which it is accrued, even if the benefit actually is paid in a different year.

Hours Worked per Month	PTO Benefit Accrued
112	8
160	12
222	16
288	20
352 and above	24

Hourly Homecare Worker PTO Benefits Eligibility

The following rules apply to paid time off (“PTO”) benefits for Hourly Homecare Workers (“HCWs”) covered under the SEIU home care bargaining unit and will govern eligibility for paid time off (“PTO”) benefits through the Benefit Trust. These benefits are available under the Benefit Trust effective February 1, 2016, pursuant to the following eligibility rules.

To become eligible for 20 hours of PTO benefits each February 1, you 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, you must perform at least 80 hours of bargaining unit work in 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 Trust Administrative Office with a completed Form W-9 in order to be eligible for PTO benefits.

Hourly Homecare Worker Rate of Pay

Rate of pay means the HCW’s gross wages for a month divided by the covered hours worked that month. The rate of pay used to calculate a 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 a HCW worked 80 hours in October, 48 hours in November and 120 hours in December, they will be determined eligible for PTO benefits effective February 1st. In this example, October becomes the month to use for determination of the PTO rate, using the total pay divided by total hours from that month. If the Participant’s gross pay in October is \$1000, and their gross hours in that month were 80, their PTO rate of pay for the next benefit period would be \$12.50 per hour.

Each determination period will have a distinct rate of pay determined by its period. A Participant will be paid out from the oldest hours first and once they have been paid out will not accrue additional PTO benefits until they are determined eligible in a future determination period.

Hourly Homecare Worker PTO Accrual

For each benefit period, the eligible HCW will accrue 20 hours of PTO at the rate of pay determined above.

Hourly Homecare Worker PTO Pay Out

Once determined eligible for PTO benefits, a Participant may request in writing to be paid a minimum of 4 hours of PTO benefits at their determined rate of pay up to their maximum of 20 hours for that benefit period. Pay out will take place 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 the Participant is determined eligible in a future determination period.

Hourly 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 15th of the following year. There will be no rollover of PTO benefits from a benefit period beginning in a given calendar year to a benefit period beginning in a later calendar year.

For example, if a HCW is determined eligible February 2016 with 20 hours at \$13.00/hour, and then again determined eligible July 2016 with 20 hours at \$14.25/hour, and elects to receive 8 hours of PTO benefits in 2016, that Worker’s remaining 32 hours of PTO benefits will be cashed out on February 15, 2017 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.

Eligibility Rules

Mixed Care Provider Rules

If a Participant works in multiple bargaining unit-covered positions (i.e. Hourly Homecare Worker, Live-In Homecare Worker and Personal Support Worker), they will receive PTO benefits as follows:

1. If the Participant works as a Live-In Homecare Worker, the Participant will receive PTO benefits under the Oregon Homecare Workers Benefit Trust in accordance with its rules relating to PTO benefits for Live-In Homecare Workers, and the Participant will not be eligible for PTO benefits relating to his or her work as an Hourly Homecare Worker and/or a Personal Support Worker.
2. If the Participant does not work as a Live-In Homecare Worker, his or her hours as a Personal Support Worker and Hourly Homecare Worker will be combined for purpose of determining eligibility for PTO benefits.

Rules Applicable to All PTO Benefits

Participants may designate a beneficiary, and an alternate beneficiary, to receive any accrued PTO benefit remaining upon the Participant's death prior to receiving such benefit. If no beneficiary designation is made, the beneficiary does not survive the Participant, or if the beneficiary cannot be found promptly, the accrued balance will be paid to the executor of the Participant's estate.

The value of the PTO benefit is taxable as income to the Participant for the year in which the Participant becomes eligible to receive the benefit payment. As a condition of eligibility for receipt of the PTO benefit, the Participant must provide the Trust 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, the Participant will be considered ineligible for the benefit and will not receive a payment.

Benefit payments are considered compensation from the Trust and are reportable on IRS Form 1099-MISC if the annual total is \$600 or more. If the benefit is less than \$600, no Form 1099 is needed. If the benefit is at least \$600, the Trust Administrative Office will send a Form 1099-MISC to the Participant and to the IRS.

The Trust Administrative Office must receive your hours information from the State, so it is important that you turn in your payroll vouchers in a timely manner as there is a natural time lag between your hours worked and when they are reported to the Trust. Once you have met all of the eligibility requirements for PTO benefits, you may submit a request to receive your PTO benefits to the Trust 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 Trust Administrative Office.

Hours worked for the purposes of these Eligibility Rules will be determined by the Trust Administrative Office based on the most recent agency-reported payroll hours or such other data received by and deemed acceptable to the Trust Administrative Office in its sole discretion.

Enrollment

Enrolling During Open Enrollment

If you enroll for health insurance through a Health Insurance Marketplace (“Exchange”) in Oregon, Washington, California or Idaho you may choose any qualified health plan available through the Exchange, but, to receive the Supplemental Trust payments described in Section A.3 on page 13, you must meet the eligibility criteria described in these Rules, and you must sign up for the plan listed below for the service area in which you live.

Participants Residing In Oregon:

- For 2014 Kaiser Service Area: Kaiser Silver \$1,500 Deductible Plan
- For 2014 Non-Kaiser Service Area: MODA \$1,000 Deductible Silver Plan
- For 2015 Kaiser Service Area: Kaiser Silver \$1,500 Deductible Plan or Oregon Co-Op \$3,000 Deductible Simple Broad HSA Silver Plan
- For 2015 Non-Kaiser Service Area: MODA \$1,150 Deductible Plan or Oregon Co-Op \$3,000 Deductible Simple Broad HSA Silver Plan
- For 2016 Kaiser Service Area: Kaiser Permanente \$1,500 Deductible Silver 1500/30 HMO plan or Oregon’s Health Co-op \$3,500 Deductible SIMPLE Silver HSA Broad Plan
- For 2016 Non-Kaiser Service Area: MODA \$1,550 Deductible Be Prepared Silver plan or Oregon’s Health Co-op \$3,500 Deductible SIMPLE Silver HSA Broad Plan

However, if you reside within the Kaiser service area, but in a zip code which is more than thirty (30) miles from a Kaiser medical facility, you have the option of electing the Trust-approved MODA plan without losing eligibility for the benefits described in Section A.3 on page 13 of these Rules.

Participants Residing In Other States:

- For 2014–16 Washington Kaiser Service Area: Kaiser Silver \$1,500 Deductible Silver 1500/30 HMO Plan

- For 2014 and 2015 Washington Non-Kaiser Service Area: Premera Blue Cross \$2,000 Deductible Preferred Silver Plan
- For 2016 Washington Non-Kaiser Service Area: United Healthcare Silver Navigate 2000 or Silver Charter 2000 plan
- For 2014 California: Blue Shield of California \$2,000 Deductible Silver Plan
- For 2015 and 2016 California: Anthem Blue Cross of California Silver 70 HMO \$2,000 Deductible Silver Plan
- For 2014–16 Idaho: Pacific Source \$2,500 Deductible Plan

Enrolling Outside of Open Enrollment

The following rules will apply to Participants who are not enrolled in a Trust-approved qualified health plan through the applicable Exchange, who are not eligible to receive health coverage from another source as described in paragraph B.2 on page 13 of this Booklet and who: (a) first become eligible to participate in the Oregon Homecare Workers Supplemental Trust (“Trust”) outside of the open enrollment period for the applicable Exchange; or (b) were eligible for Trust coverage and enrolled in a Trust-approved Exchange plan during open enrollment, subsequently experienced a termination of their coverage under that Exchange plan and currently are eligible to participate in the Trust:

1. The Trust will, if possible, assist the Participant in enrolling in a Trust-approved qualified health plan through the applicable Exchange, and will pay the premium applicable to the Participant’s coverage consistent with the rules of the Trust.
2. If it is not possible to enroll the Participant in a Trust-approved qualified health plan through the applicable Exchange and the Participant already is enrolled in an individual health insurance plan either through the Exchange or otherwise, the Trust will reimburse the Participant’s monthly health care premium costs up

Eligibility Rules

to the lesser of the Participant's actual premium costs or the average premium amount that the Trust pays to or on behalf of Participants covered under a Trust-approved Exchange plan as of March of the plan year in which the Participant first becomes eligible for Trust benefits. However, if a source other than the Trust is paying all or a part of the Participant's health insurance premium, the Trust will subtract that payment from the amount it reimburses the Participant under this section.

3. If it's not possible to enroll the Participant in a Trust-approved qualified health plan through the applicable Exchange and the Participant is not already enrolled in another individual health insurance plan, the Trust will, if possible, assist the Participant in enrolling directly in a comparable individual health plan and will reimburse the Participant's monthly health care premium costs up to the lesser of either the Participant's actual premium costs or the average premium amount that the Trust pays to or on behalf of Participants covered under a Trust-approved Exchange plan as of March of the plan year in which the Participant first becomes eligible for Trust benefits. However, if a source other than the Trust is paying all or a part of the Participant's health insurance premium, the Trust will subtract that payment from the

amount it reimburses the Participant under this section.

4. At the first opportunity, Participants that receive the average premium reimbursement described in paragraph 2 or 3 above must enroll in a Trust-approved qualified health plan through the applicable Exchange. A Participant's eligibility to receive the average premium reimbursement benefit will terminate as of the date the Participant first would be eligible to receive coverage under a Trust-approved qualified health plan, assuming the Participant enrolled for such coverage at his or her earliest opportunity. This will be the termination date regardless of whether the Participant actually enrolls in an available Trust-approved qualified health plan.

In each of the above-described situations, the Trust also will pay the Participant's deductible, copayment and coinsurance costs pursuant to the Trust rules for claims incurred and covered under the Participant's health plan after the Participant became eligible for Trust benefits. The benefits described above are not available to Participants who were eligible for Trust benefits during the Open Enrollment period but for whatever reason did not enroll in a Trust eligible plan.

Once the next OPEN ENROLLMENT period begins, you must enroll in a Trust-approved plan to continue receiving benefits. To prevent a lapse in coverage, you should apply to enroll in a Trust-approved plan as soon as the next enrollment period begins.

Benefits Information

Summary of Benefits

A Homecare Worker or Personal Support Worker who meets the Trusts' eligibility rules will receive the benefits listed in Section A.1, A.2 and A.3 below, subject to Sections B.1 and B.2 below. A Personal Support Worker or Homecare Worker who meets the applicable Trust's eligibility rules relating to PTO benefits also will receive the benefits listed in Section C.1 or C.2 on the following page, as applicable.

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

A.2 For Participants covered by Medicare, reimbursement from the Supplemental Trust for: a) Medicare Part B premiums in the monthly amount of up to \$104.90 for all Participants eligible for this premium rate from Medicare and in the amount of up to \$121.80 for all other Participants eligible for Medicare Part B; b) up to \$39 per month for 2014 and \$41 per month beginning in 2015 towards either a Medicare Advantage Plan, a Medicare Supplemental Plan or a Medicare Part D Plan; and c) deductible expenses up to \$2,500 per calendar year under a Medicare-related plan for 2014; and beginning in 2015, medical and prescription drug copays, deductibles and co-insurance expenses relating to claims covered by your Medicare plan up to a maximum amount of \$3,000 per year, provided the claims were incurred while you were eligible for Trust benefits.

A.3 Payment from the Supplemental Trust of the individual premium (net of Federal premium tax credits to which you are entitled) for the Exchange plans you select from the above and reimbursement for deductible expenses under such plan for 2014. Beginning in 2015, payment from the Supplemental Trust of the individual premium (net of Federal premium tax credits to which you are entitled) for the Exchange plans you select from the plan list on page 11 and medical and prescription drug copays, deductibles and co-insurance expenses relating to claims covered by your Trust-approved exchange health plan up to a maximum of \$3,000 a year, provided the claims were incurred while you were eligible for Trust benefits. To qualify for the payment of 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

Exchange 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 owe a reconciliation fee to the IRS at the end of the year, you may be eligible for reimbursement of the reconciliation fee 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. Please see pages 20 and 23 of this booklet for more information.

B.1 A Participant will continue to be eligible for the benefits listed in Section A above unless the Participant's bargaining unit hours worked per month drop to zero for two consecutive months. In such cases, there will be a one-month grace period before loss of eligibility. For example, if the Participant works zero hours in December 2015 and January 2016, the Participant will lose eligibility effective March 1, 2016. Also, the Participant will be given a warning letter after the first month in which bargaining unit hours worked drop to zero hours per month and advance notice of the termination of eligibility under the Trust(s) after the second consecutive month in which bargaining unit hours drop to zero.

B.2 A Participant will be eligible to receive the benefits described in Section A.2 or A.3 above only to the extent that the Participant is not receiving, and is not eligible to receive, health coverage or premium assistance from any other source, with the following exceptions: (i) a Participant who is eligible for other health coverage through his or her spouse's employment and chooses not to enroll in such coverage will be eligible to receive the benefits described in Sections A.2 and A.3; (ii) a Participant who is receiving, or is eligible to receive, Veteran's Benefits coverage that does not disqualify the Participant from receiving Federal Advance Premium Tax Credits ("APTC") will be eligible to receive the benefits described in Sections A.2 and A.3; and (iii) a Participant who loses eligibility for an APTC because he or she did not respond to a request for information, or otherwise failed to take any action required to maintain such APTC, only will be eligible to receive the premium assistance benefit that would have been payable under the Trust had the Participant's APTC not been terminated.

Benefits Information

B.3 A Participant who is paid through the Independent Choices program will not be eligible for benefits under the Trusts based on such hours, since no hourly contributions are made to the Trusts for such hours.

C.1 A Participant who works as either a Personal Support Worker or Hourly Homecare Worker (or both) and meets the eligibility requirements for PTO benefits will be eligible to receive 20 hours of paid time off each February 1 and July 1. The amount of a Participant's PTO benefit will be calculated based on her or his gross rate of pay 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). For purposes of determining PTO eligibility, hours worked as a Personal Support Worker and hours worked as an Hourly Homecare Worker shall be combined. If a Participant works as a Live-In Homecare Worker, the Participant shall instead receive the benefit described in C.2.

C.2 A Participant who works as a Live-In Homecare Worker and meets the eligibility requirements for PTO benefits will be eligible to receive monthly PTO benefits based on the number of hours worked in covered employment during the eligibility month (two months prior). The rates of accrual are listed on page 8. If a Participant works as both a Live-In Homecare Worker and either an Hourly Homecare Worker or a Personal Support Worker, the Participant will receive PTO benefits based solely on their work as a Live-In Homecare Worker.

General Information

Payment of Premiums and Out-of-Pocket Expenses

Beginning in 2014 premium payments made by the Supplemental Trust will go directly to the carrier, if possible. However, at least through 2014, the Supplemental Trust will directly reimburse Participants for applicable deductible payments after receiving and processing the Participant's reimbursement request.

Beginning in 2015, the Supplemental Trust will issue Participants a Benefit Convenience Card that will be pre-loaded with both the amount needed for each month's premium and the maximum amount available under the Trust (\$3,000) for the payment of deductibles, co-payments and co-insurance expenses applicable to benefits and services provided to you under your Trust-approved health insurance plan. You may use this Benefit Convenience Card at your doctor's office, the pharmacy and other medical provider locations to pay any deductible, co-payment and co-insurance amounts you owe that relate to services covered under your Trust-approved health plan. Be sure to save your explanations of benefits (EOBs) relating to any expenses paid using your Benefit Convenience Card, because you will be required to provide the Trust with proof that these expenses are covered under the Trust. The card may not be used to pay for any expenses not covered under your Trust-approved health insurance plan, including any expenses applicable to an individual other than the Participant to whom the card has been issued. You may not use the Benefit Convenience Card to pay for dental, vision and Employee Assistance Program benefits or expenses.

Coverage Through a Spouse's Plan

If a Participant who meets the eligibility requirements for the Supplemental Trust is offered insurance through a spouse's employer and elects not to enroll in such coverage, the Participant will be eligible for coverage through the Trust but may not be eligible for Federal premium tax credits. In that case, the Supplemental Trust will pay the Participant's entire Exchange premium. A Participant who elects to take a spouse's coverage still will be eligible for dental, vision and Employee Assistance Program benefits under the Benefit Trust and paid time off benefits under the Benefit Trust or Supplemental Trust, as applicable, if the Participant meets the eligibility requirements for those benefits, but the Participant will not be eligible for any other coverage under the Supplemental Trust.

Married Filing Separately

Generally, a Participant who is married but files income taxes separately from his or her spouse, rather than filing a joint return, cannot receive Federal

premium tax credits for health insurance purchased on an Exchange unless an exception under the law applies. If such a Participant is eligible to participate in the Supplemental Trust, the Supplemental Trust will pay his or her entire Exchange premium.

Undocumented Workers

Under the Affordable Care Act, a Participant who is an undocumented immigrant is not eligible to buy health insurance through an Exchange. Accordingly, such Participant is not eligible for benefits under Sections A.2 or A.3 but is eligible for benefits under Sections A.1, C.1 and C.2 if the Participant meets the eligibility rules of the Trust. See pages 13–15 for more details.

Immigrants Who Have Been Legal Residents for Under 5 Years

A Participant who has been a legal resident for less than five years is not eligible for Medicaid/OHP but is eligible for Federal premium tax credits and cost-sharing subsidies relating to Exchange coverage. These Participants should sign up through the Exchange for the applicable plan described above. These Participants will be eligible for premium payments and deductible reimbursement for 2014 and, beginning in 2015, premium payments and medical and prescription drug copays, deductibles and co-insurance expenses relating to claims covered by your Trust-approved exchange health plan under Section A.2 and A.3, as well as other benefits provided through the Benefit Trust under Section A.1 on page 13, if they meet the eligibility rules of the Trusts.



See the “SUPPLEMENTAL TRUST” section of this Booklet for information on your insurance options.

Benefits Information

Supplemental Trust



Coverage Through an Exchange

For Participants who have individual-only health insurance under a Trust-approved plan through the applicable Exchange, the Supplemental Trust covers any amount of the premium above and beyond the Participant's Federal tax credit. For example, if you are entitled to a monthly Federal tax credit of \$500 and the total cost of the health insurance premium for your Trust-approved plan coverage is \$1,000, the Supplemental Trust will provide assistance for \$500 of the premium, your full tax credit will be applied to the premium and you will pay nothing. If, however, you have family coverage, the Supplemental Trust will reimburse only that part of the premium relating to your individual coverage, after applying the Federal tax credit. More detailed information about Trust benefits for Exchange-enrolled Participants can be found on page 17.

Medicare

If you are eligible, the Supplemental Trust will reimburse your Medicare Part B premiums in the monthly amount of up to \$104.90 for all Participants eligible for this premium rate from Medicare and in the amount of up to \$121.80 for all other Participants eligible for Medicare Part B. In addition, the Supplemental Trust will reimburse up to \$39.00 in 2014 and up to \$41.00 beginning in 2015 toward the monthly premium for a Medicare Advantage or Medicare Supplemental product of your choice. If your Supplemental or Advantage plan has a deductible, you are eligible for assistance up to \$2,500 for 2014. In 2015, you are eligible for assistance of up to \$3,000 for medical and prescription drug copays, deductibles and co-insurance expenses relating to claims covered by your Medicare plan.

In order to receive assistance for these expenses from the Supplemental Trust, you will need to attach copies of the proof of premium expense to your completed Reimbursement form and submit

the form to the Trust Administrative Office. You will only need to submit this information once for Part B premium reimbursement, but you will need to submit the information annually to continue receiving reimbursement of the other Medicare-related expenses described above. The Trust will confirm your hours worked each month before your reimbursement is issued.

In 2014, the same Reimbursement form can be used to request reimbursement for the deductibles you are required to pay under Medicare. If you incur medical services and receive an Explanation of Benefits (EOB) form that show charges applied to your Medicare deductible for 2014, simply submit a copy of the EOB with a completed Reimbursement form to the Trust Administrative Office.

Beginning in 2015, you will receive a Benefits Convenience Card that you can use to pay for medical and prescription drug copays, deductibles and co-insurance expenses relating to claims covered by your Medicare plan up to \$3,000 a year, provided the claims were incurred while you were eligible for Trust benefits.

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

Exchange Medical Insurance

The Supplemental Trust helps eligible Participants pay monthly premiums for their individual health care coverage under a Trust-approved health plan offered through the applicable Exchange.

Please refer to the Eligibility Rules section of this Booklet for information on how to become eligible for Trust benefits.

The Trust must receive your name, gender, Social Security Number, birthdate and current address to provide you with your benefits. If this information is not current with the State, you will need to update it. You also can contact your Trust Administrative Office at 1-844-507-7554, option 3, then option 2.

Oregon

The 2014 Trust-approved plans in Oregon are Kaiser Permanente \$1,500 Deductible Silver plan (if you live within the Kaiser Service area) and Moda \$1,000 Deductible Be Prepared Silver plan (if you live outside the Kaiser service area). The 2015 Trust-approved plans in Oregon are Oregon Co-op \$3,000 Deductible Silver HSA Broad plan, Kaiser Permanente \$1,500 Deductible Silver plan (if you live within the Kaiser Service area) and Moda \$1,150 Deductible Be Prepared Silver plan (if you live outside the Kaiser service area). The 2016 Trust-approved plans in Oregon are Oregon's Health Co-op \$3,500 Deductible SiMPLE Silver HSA Broad plan, Kaiser Permanente \$1,500 Deductible Silver 1500/30 HMO plan (if you live within the Kaiser Service area) and MODA \$1,550 Deductible Be Prepared Silver plan (if you live outside the Kaiser service area).

If you live within the Kaiser service area but in a zip code which is more than thirty (30) miles from a Kaiser medical facility, you may elect the Moda \$1,000 Deductible Be Prepared Silver plan for 2014, the MODA \$1,150 Deductible Be Prepared Silver plan for 2015 or the MODA \$1,550 Deductible Be Prepared Silver plan for 2016. The Trust will pay the portion of your individual coverage premium for one of these plans only if you elect to apply the full amount of any Federal premium tax credit available to you to payment of the premium for the plan.

- For 2014, if you are signed up as an individual only, the Trust will pay Kaiser or Moda directly. If you receive a premium bill from Kaiser or Moda and you are enrolled for benefits under

Benefits Information

Supplemental Trust *continued*

the Supplemental Trust, contact the Trust Administrative Office to let them know you received the bill, and the Trust will pay the premium directly to Kaiser or Moda on your behalf.

- Beginning in 2015, if you are signed up as an individual you will receive bill payment directions in your welcome packet. For your first month's premium, you will receive a check from the Trust to cash and use the funds to pay your insurance carrier directly. Once you receive your Benefit Convenience Card, you will be paying your insurance carrier from that Card for as long as you are eligible. In your welcome packet you will also receive information for how to set up your Benefit Convenience Card for automatic payments with your insurance carrier.
- If you are signed up for family coverage, you need to pay your premium bill directly to the insurance carrier and the Trust will reimburse you for the portion of the premium applicable solely to your individual coverage. Pay the bill and then submit a copy of the bill and proof of payment to the Trust Administrative Office along with your Reimbursement form.

In addition to your premium, the Trust reimburses for:

- In 2014: your deductible costs relating to claims covered under your Trust-approved Exchange plan and your co-insurance costs in excess of \$50 for prescriptions covered under your Trust-approved Exchange plan, up to a combined maximum of \$2,500.
- Beginning in 2015: your medical and prescription copays, deductibles and co-insurance expenses relating to claims covered under your Trust-approved Exchange plan, up to a combined total of \$3,000. You will see in-network deductible costs listed in the Explanation of Benefits that you receive from Kaiser, Moda or the Oregon's Co-op.

Washington

The 2014 and 2015 Trust-approved plans in Washington are Kaiser Permanente \$1,500 Deductible Silver plan (if you live within the Kaiser Service area) and the Premera Blue Cross \$2,000 Deductible Preferred Silver plan (if you live outside the Kaiser service area). The 2016 Trust-approved plans in Washington are Kaiser Permanente \$1,500 Deductible Silver 1500/30 HMO plan (if you live within the Kaiser Service area) and the United Healthcare Silver Navigate \$2000 or Silver Charter \$2000 plan (if you live outside the Kaiser service area).

Beginning in 2015, the Trust will fund a Benefit Convenience Card for you to pay your individual premium only if you elect to apply the full amount of any Federal premium tax credit to payment of the premium for the plan. For your first month's premium, you will receive a check from the Trust to cash and use the funds to pay your insurance carrier directly. Once you receive your Benefit Convenience Card, you will be paying your insurance carrier from that Card by as long as you are eligible. In your welcome packet you will also receive information for how to set up your Benefit Convenience Card for automatic payments with your insurance carrier.

In addition to your premium, the Trust reimburses for:

- In 2014: your deductible costs relating to claims covered under your Trust-approved Exchange plan and your co-insurance costs in excess of \$50 for prescriptions covered under your Trust-approved Exchange plan, up to a combined maximum of \$2,500.
- Beginning in 2015: your medical and prescription copays, deductibles and co-insurance expenses relating to claims covered under your Trust-approved Exchange plan, up to a combined total of \$3,000. You will see in-network deductible costs listed in the Explanation of Benefits that you receive from Kaiser or Premera Blue Cross in 2015 or Kaiser or United Healthcare in 2016.

Idaho

The 2014 through 2016 Trust-approved plan in Idaho is the Pacific Source BrightIdea Balance Silver \$2,500 Deductible HMO plan. Beginning in 2015, the Trust will provide you with a Benefits Convenience Card for you to pay your individual premium only if you elect to apply the full amount of any Federal premium tax credit to payment of the premium for the plan. For your first month's premium, you will receive a check from the Trust to cash and use the funds to pay your insurance carrier directly. Once you receive your Benefit Convenience Card, you will be paying your insurance carrier from that Card by as long as you are eligible. In your welcome packet you will also receive information for how to set up your Benefit Convenience Card for automatic payments with your insurance carrier.

In addition to your premium, the Trust reimburses for:

- In 2014: your deductible costs relating to claims covered under your Trust-approved Exchange plan and your co-insurance costs in excess of \$50 for prescriptions covered under your Trust-approved Exchange plan, up to a combined maximum of \$2,500.
- Beginning in 2015: your medical and prescription copays, deductibles and co-insurance expenses relating to claims covered under your Trust-approved Exchange plan, up to a combined total of \$3,000. You will see in-network deductible costs listed in the Explanation of Benefits that you receive from Pacific Source.

California

The 2014 Trust-approved plan in California is Blue Shield of California \$2,000 Deductible Silver plan. The Trust-Qualified plan in California for 2015 and 2016 is Anthem Blue Cross of California Silver 70 HMO \$2,000 Deductible Silver Plan. Beginning in 2015, the Trust will provide you with a Benefits Convenience Card for you to pay your individual premium only if you elect to apply the full amount of any Federal premium tax credit to payment of the premium for the plan. For your first month's premium, you will receive a check from the Trust to cash and use the funds to pay your insurance carrier directly. Once you receive your Benefit Convenience Card, you will be paying your insurance carrier from that Card by as long as you are eligible. In your welcome packet you will also receive information for how to set up your Benefit Convenience Card for automatic payments with your insurance carrier.

In addition to your premium, the Trust reimburses for:

- In 2014: your deductible costs relating to claims covered under your Trust-approved Exchange plan and your co-insurance costs in excess of \$50 for prescriptions covered under your Trust-approved Exchange plan, up to a combined maximum of \$2,500.
- Beginning in 2015: your medical and prescription copays, deductibles and co-insurance expenses relating to claims covered under your Trust-approved Exchange plan, up to a combined total of \$3,000. You will see in network deductible costs listed in the Explanation of Benefits that you receive from Anthem Blue Cross of California.

2014 Prescription Coverage Example:

If you have prescriptions that cost: \$60 for the first, \$250 for the second and \$10 for the third, you can request reimbursement for \$10 on the first, \$200 on the second, and \$0 on the third.

Benefits Information

Supplemental Trust *continued*

What costs are not covered by the Trust?

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

- Expenses relating to services and supplies not covered by Medicare or your Trust-approved Exchange plan.
- Co-Pays, co-insurance and deductibles in excess of the \$3,000 out-of-pocket reimbursement benefit available under the Trust.

What costs are covered by the Trust?

What the Trust Reimburses	Kaiser, MODA, Oregon's Co-op, Pacific Source, Premera Blue Cross, Anthem Blue Cross of California 2015 and Kaiser, MODA, Oregon's Co-op Pacific Source, United Healthcare, Anthem Blue Cross of California 2016
Monthly premium (above and beyond Federal Tax credit)	100%
Deductible	Up to \$3,000 maximum for medical and prescription copays, deductibles and co-insurance expenses
Prescription drug costs for any prescription, to the extent those amounts are over \$50 per prescription	Up to \$3,000 maximum for medical and prescription copays, deductibles and co-insurance expenses
Co-pays	Up to \$3,000 maximum
Co-insurance	Up to \$3,000 maximum
What the Trust does not reimburse	
Expenses for family members	not covered
Dental, Vision and Employee Assistance Program expenses	not covered

Advance Premium Tax Credit Reconciliation Reimbursement

Many Supplemental Trust Participants receive an advance premium tax credit ("APTC") from the Federal government which is used to pay a portion of the Participant's monthly health care premiums. Because the amount of the APTC is based on an estimate of your 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 reimburse a portion of the APTC you received, through no fault of your own, please contact the Trust Administrative Office, as you may be eligible to receive a payment from the Supplemental Trust in an amount sufficient to cover all, or a part of, any reimbursement you owe. 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 your advance premium tax credit been accurate.

It also is possible that you may receive a refund from the Federal government at the end of the year if your actual annual household income was less than you 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 your insurance carrier during the year, because your estimate of your annual household income was incorrect. You are responsible for contacting the Trust Administrative Office immediately in the event that you receive a tax refund relating to the amount of your advance premium tax credit.

Benefits Information

Benefit Trust

The Benefit Trust provides eligible Participants with insured dental, vision and Employee Assistance Program (EAP) benefits that are accessible and affordable with no out-of-pocket monthly premiums. Once you become a Trust-eligible Participant, you will be automatically enrolled in the dental, vision and the Employee Assistance Program benefits offered through the Benefit Trust. The Benefit Trust also provides eligible Personal Support Workers and eligible Live-In Homecare Workers with paid time off benefits.

Please refer to the Eligibility Rules section beginning on page 6 of this Booklet for information on how to become eligible for these benefits.

The Trust Administrative Office must receive your name, gender, Social Security Number, birthdate and current address to provide you with your benefits. If this information is not current with the State, you will need to update it. You also can contact the Trust Administrative Office at 1-844-507-7554, option 3, option 2. If the Trust Administrative Office does not have the data needed to complete your Benefit enrollment, an enrollment form for dental, vision and Employee Assistance Program benefits will be sent to you.

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

If you have any questions about your benefits or if you are experiencing problems with your enrollment, please call the Trust Administrative Office at 1-844-507-7554, option 3, option 2.

If you do not want the dental, vision and Employee Assistance Program benefits offered under the Benefit Trust, you may opt-out by submitting a Waiver form through the Trust website: ORHomecareTrust.org/resources. Waiver forms also may be requested

by calling the Trust Administrative Office at 1-844-507-7554.

Dental Benefits

Summary of dental benefits:

- Trust dental benefits are provided by Kaiser.
- Through your dental benefits, you are eligible for free annual cleanings.
- Other dental services have co-insurances that require you to pay for a portion of the cost.

How to use your dental benefits:

- You will receive a Kaiser dental card in the mail.
- If you live inside the Kaiser service area, you must visit a Kaiser dental clinic.
- If you live outside the Kaiser service area, you can go to any dentist that contracts with Kaiser. If your current dentist does not contract with Kaiser, you can ask them to do so.
- If you receive care from a dentist that does not contract with Kaiser, your costs will be higher.
- Make sure to confirm that the dentist you are visiting currently contracts with Kaiser before you receive care.
- Please visit ORHomecareTrust.org/resources/#dental or call Kaiser Dental at 1-503-286-6868 in the Portland area, 1-503-370-4311 in Salem, or 1-866-498-7912 outside of Portland and Salem areas for more information about your dental benefits.

If you have any questions about your benefits or if you are experiencing problems with your enrollment, please call The Trust Administrative Office at 1-844-507-7554, option 3, option 2.

Benefits Information

Benefit Trust

Vision Benefits

Summary of vision benefits:

- Trust vision benefits are provided by Ameritas through the Vision Perfect plan.
- You are eligible for one eye exam with up to a maximum reimbursement of \$90 every two years. If the eye exam costs more than \$90, you will be responsible for any additional cost, so make sure to confirm the cost of your exam before you receive care.
- Beginning January 1, 2016, you are eligible for up to a \$450 reimbursement for materials—which can include glasses or contacts—every two years.
- Beginning January 1, 2016, you are eligible for a Lasik benefit (both eyes) of up to \$350 in year one, up to \$350 in year two and up to \$700 in year three.
- Beginning January 1, 2016, you are eligible for a hearing benefit (both ears) for materials of up to \$200 in year one, up to \$600 in year two and up to \$800 in year three. There is also hearing exam coverage of \$75 and a maintenance benefit of \$40.

How to use your vision benefits:

- You will receive an Ameritas vision card in the mail.
- You may choose any optometrist or ophthalmologist for your exam, and you may purchase your glasses or contacts wherever you prefer.
- If the vision provider does not bill Ameritas directly, you will need to pay up front and then submit a claim through Ameritas' reimbursement form, available by downloading from your Trusts' website at ORHomecareTrust.org/resources/#vision or by calling Ameritas at 1-877-647-6683.

- Please visit ORHomecareTrust.org/resources/#vision or call Ameritas at 1-877-647-6683 for more information about your vision benefits.

If you have any questions about your benefits or if you are experiencing problems with your enrollment, please call the Trust Administrative Office at 1-844-507-7554, option 3, option 2.

Employee Assistance Program (EAP) Benefits

Summary of EAP benefits:

- Trust EAP benefits are provided by Reliant Behavioral Health.
- Through your Trust EAP benefits, you can access both non-crisis and crisis counseling. You can also get financial counseling, assistance with writing a will, help with resolving identity theft and discounted legal services.

How to use your EAP benefits:

You can access services by visiting myrbh.com or calling 1-866-750-1327. Your access code is: OHWBT.

Paid Time Off Benefits

Summary of PTO benefits:

- Paid time off (PTO) benefits are available to Personal Support Workers, Live-In Homecare Workers and Hourly Homecare Workers who meet the eligibility requirements described in this booklet. PTO benefits for PSWs and Live-Ins are paid directly by the Benefit Trust. PTO benefits for Hourly HCWs are paid directly by the Supplemental Trust. Please refer to page 6 of this booklet for more info on these PTO benefits available under the Trusts.

Forms

Supplemental Trust Reimbursement

To receive reimbursement from the Supplemental Trust, you will need to submit a Reimbursement Form and supporting materials to the Trust Administrative Office. If the required documents are not sent in with the form then your reimbursement cannot be processed. For more information regarding what is reimbursable, refer to page 13.

You may receive reimbursements for:

- Medicare deductibles, co-pays and co-insurance expenses (In 2014 up to \$2,500 for deductibles only, beginning in 2015 up to \$3,000, must attach EOB from Medicare using the Ameriflex Reimbursement Form)
- Medicare Supplemental or Prescription plan premium (Monthly up to \$39 in 2014 and up to \$41 beginning in 2015, must attach invoice and receipt using the Trust Reimbursement Form)
- Medicare Part B Premium (Monthly up to \$104.90, or up to \$121.80, depending on eligibility, must attach invoice and receipt using the Trust Reimbursement Form)
- Exchange Insurance Premium (Monthly, must attach invoice and receipt using the Trust Reimbursement Form)
- Medical Insurance Expenses (For 2014, up to \$2,500 for both medical deductible and prescription copays over \$50. Beginning in 2015, your maximum medical deductible, co-pay, co-insurance and prescription reimbursement is \$3,000 annually. Must attach EOB from your Insurance Company using the Ameriflex Reimbursement Form)
- Advance Premium Tax Credit Reconciliation Reimbursement (Must attach your Form 1095, Form 1040 and Form 8962 using the Premium Adjustment Reimbursement Form)

The Trust Reimbursement Forms are available on the Trust website at ORHomecareTrust.org/reimbursement.

You can print and fill out the form(s) and then mail or fax (along with supporting documents) to the Trust:

Oregon Homecare Worker Trusts

Mailing Address:

PO Box 6
Mukilteo, WA 98275

Phone: 1-844-507-7554, Option 3, then Option 2

Email: OHCWT@BSITPA.com

Fax: 1-866-459-4623

Ameriflex reimbursement forms should be mailed or faxed (along with supporting documents) to:

Ameriflex Claims Department

Mailing Address:

PO Box 269009
Plano, TX 75026

Fax: 1-888-631-1038

If you do not have access to the web, you can call the Trust Administrative Office at the above phone number and ask that a form be mailed to you. If you have any questions about the form or what to submit with it, please call your Trust Administrative Office for assistance.

If you are going to receive your reimbursement check by mail, make sure you keep your address current with your brokerage and/or the State.

Beginning in 2015, you will have access to the Benefit Convenience Card to pay for your medical and prescription copays, deductibles and co-insurance expenses for claims that are covered by the Trust-approved plan, up to a maximum amount of \$3,000 per year.

Forms

Benefit Convenience Card Affidavit

The Benefit Convenience Card affidavit is available on the Trust website at ORHomecareTrust.org/resources or by calling the Trust Administrative Office at the number below. This affidavit is required from each Participant that receives a Benefit Convenience Card, and can be submitted by mail or fax to:

Oregon Homecare Worker Trusts

Mailing Address:

PO Box 6
Mukilteo, WA 98275

Phone: 1-844-507-7554 Option 3, then Option 2

Email: OHCWT@BSITPA.com

Subject: OHCWT Affidavit

Fax: 1-866-459-4623

Direct Deposit

The direct deposit form for Medicare Monthly Premium Reimbursement is available on the Trust website at ORHomecareTrust.org/resources or by calling the Trust Administrative Office at the number below. Once you submit the form and a copy of a voided check by mail or fax, your Medicare premium reimbursements will be deposited directly into the account you choose.

Submit your completed direct deposit form and voided check to the Trust:

Oregon Homecare Worker Trusts

Mailing Address:

PO Box 6
Mukilteo, WA 98275

Phone: 1-844-507-7554

Email: OHCWT@BSITPA.com

Fax: 1-866-459-4623

Paid Time Off Request

The paid time off request form, beneficiary designee and W9 forms are available on the Trust website at ORHomecareTrust.org/resources or by calling the Trust Administrative Office at the number below. If you wish to request Paid Time Off benefits provided through the Benefit Trust, you will need to fill out and submit the request form by mail or fax to:

Oregon Homecare Worker Trusts

Mailing Address:

PO Box 6
Mukilteo, WA 98275

Phone: 1-844-507-7554 Option 3, then Option 2

Email: OHCWTPTO@bsitpa.com

Subject: OHCWT PTO

Fax: 1-866-459-4623

Waiver Form

The waiver form is available on the Trust website at ORHomecareTrust.org/resources or by calling the Trust Administrative Office and the number below. If you wish to opt out of the dental, vision and employee assistance program benefits provided through the Benefit Trust, you will need to fill out and submit the waiver form by mail or fax to:

Oregon Homecare Worker Trusts

Mailing Address:

PO Box 6
Mukilteo, WA 98275

Phone: 1-844-507-7554

Email: OHCWT@BSITPA.com

Fax: 1-866-459-4623

Once you submit the waiver form, you will be unable to obtain coverage until the next open enrollment period unless you qualify for enrollment under special rules.

Appeals Form

Medical, Vision, Dental and Employee Assistance Program benefits are insured and claims and appeals for Medical, Vision, Dental and Employee Assistance Program benefits must be submitted to the respective insurer under the insurer's claims and appeals procedures.

Claims and appeals relating to your eligibility to participate in the Trusts, or reimbursements from the Trusts, should be submitted to the Trust Administrative Office. A Reimbursement Review and Appeal form for this purpose is available on the Trust website at ORHomecareTrust.org/resources or by calling the Trust Administrative Office at the number below. If you wish to appeal a denial of reimbursement benefits under the Supplemental Trust or a denial of eligibility for coverage under either Trust, please read the below guidelines and submit your form to:

Oregon Homecare Worker Trusts

Mailing Address:

PO Box 6
Mukilteo, WA 98275

Phone: 1-844-507-7554

Email: OHCWT@BSITPA.com

Fax: 1-866-459-4623

Claims and Appeal Procedure

Submitting a Reimbursement Claim to the Supplemental Trust

The request for reimbursement must be sent to the Trust Administrative Office. The Trust Administrative Office will respond to your claim within 30 days of receipt. If the Trust Administrative Office needs additional time to respond, your claim will be decided within 45 days of receipt. You will be notified if the Trust Administrative Office needs additional information. If you do not provide the additional information, the Trust Administrative Office will decide your request based on the information it has. If your claim is filed improperly, you will be notified within 10 days and told how to correct it.

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

- The specific reason for the denial.
- The specific Trust rule on which the decision was based.
- Any additional information necessary to reconsider your claim, including the reason that information is necessary.
- The Trust's appeal procedures and the time limits for those procedures.
- An explanation that the initial decision is final unless the decision is appealed in accordance with the appeal procedures.

It is important to note that you are not required to appeal the decision to the Board of Trustees. However, you must exhaust your administrative remedies by appealing to the Board of Trustees before you have the right to file suit under the Plan rules.

Appeal Procedure

If your initial claim is denied by the Trust Administrative Office, you may request a review by writing to the Board of Trustees within 180 days from receipt of the denial. Your written appeal should state the reason for your request. You may appoint an authorized representative to act on your behalf. To do so, you must notify the Trust 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 new or additional information considered during the appeal.

Your appeal will be decided within 60 days of receipt of the appeal by the Trust Administrative Office. If an extension of time is required for review, you will receive a decision no later than 120 days after receipt of your appeal. You will be notified by mail if an extension is required. The Trustees will send you a notice of the appeal decision within 10 days of the decision.

If your appeal is denied, you will receive a written notice that includes information to identify the claim, the reason for denial, a discussion of the decision, 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 3 years of the date the Trustees denied your appeal.

Resources

CONTACT INFORMATION

Ameritas (Vision Insurance)

Phone: 1-877-647-6683
Group Number: 010-350770
Website: eyemedvisioncare.com

Anthem Blue Cross (Medical Insurance)

Phone: 1-855-634-3381

Benefit Solutions, Inc. (Trust Administrative Office)

For Eligibility, Medical, Dental, Vision or Employee Assistance Program Benefits, or Reimbursement or Paid Time Off Benefits Questions:

Phone: 1-844-507-7554, Option 3, Option 2

For Ameriflex Benefit Convenience Card Claim Status, Card Balance or Replacement Card Questions:

Phone: 1-844-507-7554, Option 3, Option 3

Email: OHCWT@bsitpa.com
Fax: 1-866-459-4623
Mail: PO Box 6, Mukilteo, WA 98275

BlueShield of California (Medical Insurance)

Phone: 1-800-431-2809
Website: www.blueshieldca.com

Healthy Kids:

Phone: 1-877-314-5678

Kaiser Permanente (Dental Insurance)

Phone: 1-503-286-6868 (Portland area),
1-503-370-4311 (Salem area),
1-866-498-7912 (outside of Kaiser network)

In Area Group Number: 19581-001
Out of Area Group Number: 19581-003
Website: www.kp.org/dental/nw

Kaiser Permanente (Medical Insurance)

Member Services: 1-800-813-2000
Billing Department: 1-800-759-0584

MODA (Medical Insurance)

Member Services: 1-877-605-3229
Email: medical@modahealth.com
Website: modahealth.com
Online Billing Customer Service: 888-374-8907

Oregon's Health CO-OP (Medical Insurance)

Phone: 1-844-509-4676
Website: www.ohcoo.org

Oregon Health Plan (Medical Insurance)

Application Status: 1-800-699-9075
Client Services Unit: 1-800-273-0557
After hours assistance,
nurse triage line: 1-800-562-4620

PacificSource (Medical Insurance)

Phone: 1-888-977-9299
Website: PacificSource.com

Premera Blue Cross (Medical Insurance)

Phone: 1-800-722-1471
Website: premera.com/wa/member

Reliant Behavioral Health (EAP Program)

Phone: 1-866-750-1327
Code: OHWBT Website: myrbh.com

United Healthcare (Medical Insurance) Customer Service

Customer Service: 1-800-957-6053
Billing: 1-800-708-2848
Website: uhcexchangebilling.com

Healthcare Enrollment Team

Phone: 1-844-507-7554, Option 1
Phone: 1-855-437-2694
Email: acahotline@ORHomecareTrust.org

SEIU Local 503 MRC (Questions about training, union dues, or other union issues)

Phone: 1-877-451-0002
Email: Homecare@seiu503.org
Website: seiu503.org

SEIU Local 503 Member Benefits (Questions about member benefits, such as life insurance)

Phone: 1-800-452-2146
Website: seiu503.org/Category/Benefits

SHIBA (Senior Health Insurance Benefits Assistance program)

This program uses trained volunteers to educate and advocate for Oregonians with Medicare
Phone: 1-800-722-4134
Website: oregon.gov/dcb/insurance/SHIBA/Pages/shiba.aspx

Valley Insurance Professionals

Phone: 1-844-507-7554, Option 2
Fax: 503-420-8665

I'm enrolled in medical coverage.

What's Next?

Oregon Health Plan

If you enroll in the Oregon Health Plan Plus, you will receive information from the Oregon Health Authority, including your OHP ID card and the Coordinated Care Organization (CCO) you are signed up for. Once you get this information, you can contact the CCO to find your primary care physician.

Oregon Kaiser Permanente/ MODA/Oregon Co-Op Medical

If you have enrolled in a Trust-approved Qualified Health Plan through the Exchange for yourself only and you are eligible for benefits under the Supplemental Trust, the Trust will send you a Welcome Packet specific to your insurance choice. You will also receive a Benefit Convenience Card. If you enrolled in the plan for yourself only, you will receive instructions to set up that Benefit Convenience Card to auto-pay the premium every month. Please call the Trust if you have any questions about the premium bill at 1-844-507-7554, Option 3, Option 2.

If you have enrolled in medical coverage plan that includes your family member(s) and you are eligible for benefits under the Supplemental Trust, the Trust will pay only the portion of the monthly premium related to your own coverage that is not covered by the Federal premium tax subsidy, and you will be responsible for paying any premium amount owed for your family member(s). You will need to pay the bill from Kaiser, MODA or Oregon's Health Co-op, and the Supplemental Trust will reimburse you for the portion of the premium relating to your medical coverage. Once you receive and pay your bill, submit a copy of the bill along with a completed Reimbursement form by mail or fax to the Trust Administrative Office. You will need to repeat this reimbursement process each month.

Once your first premium has been paid, you will be officially enrolled in Kaiser, MODA or Oregon's Health Co-op, and your ID card will be issued.

California/Idaho/Washington Medical

If you have enrolled in a Trust-approved Qualified Health Plan in California, Idaho or Washington, and you are eligible for benefits under the Supplemental Trust, you will need to pay the bill for your medical coverage until your Benefit Convenience Card has been activated, and the Supplemental Trust will reimburse you for the portion of the premium relating to your medical coverage that is not covered by your Federal tax credit. Once you receive and pay your bill, submit a copy of the bill along with a completed Reimbursement form by mail or fax to the Trust Administrative Office.

Medicare

If you have enrolled in Medicare Part B and/or a Medicare Supplemental, Advantage or Part D plan, and you are eligible for benefits under the Supplemental trust, you will need to submit proof of the premium expense along with a completed Reimbursement form by mail or fax to your trust Administrator. For all such expenses except the Medicare Part B premium reimbursement, you also will need to repeat this reimbursement process each year.

Plan Eligible Expenses

Please refer to the Supplemental Benefit section beginning on page 16 of this booklet for more information about your benefits and the Eligibility section for more information about how to qualify for benefits.

Resources

Understanding Your Benefits: Glossary of Health Coverage Terms

Co-Insurance

Health care cost sharing between you and your health insurance company. The cost sharing ranges from 80/20 to 50/50. For example, if your coinsurance is “80/20”, that means that, after the deductible (if any) is paid, your insurance company pays 80% of the covered medical expense and you pay the remaining 20% of the covered claim. The cost sharing stops when the amount that you have paid in covered medical expenses reaches your out-of-pocket limit, which usually is between \$1,000 and \$6,000. If your medical expenses in a calendar year exceed the out-of-pocket limit, then your insurance company covers all the remaining covered costs.

Co-Payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you must pay for the health care services that your health insurance plan covers before your health insurance plan begins to pay, excluding doctor visits. For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Health Insurance

A contract that requires your health insurance plan to pay some or all of your health care costs in exchange for payment of a premium.

Network

The facilities, providers and suppliers your health insurance plan has contracted with to provide health care services.

Out-of-Pocket Limit

The most you pay for covered services during a policy period (usually January through December) before your health insurance plan begins to pay 100% of the allowed amount. This limit never includes your premium, amounts that exceed the covered charge for out-of-network providers (also called “balance-billed charges”) or health care your health insurance plan doesn't cover. Some health insurance plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Premium

The amount that must be paid for your health insurance plan. You usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance that helps pay for prescription drugs and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Provider

A physician (M.D.– Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional or healthcare facility licensed, certified or accredited as required by state law.

High Cost Prescription Resources

There are organizations established to advocate on behalf of individuals who find themselves struggling with the high cost of drugs that are not fully covered by their insurance plans. Listed below are a few that you may find useful:

RxAssist – Patient Assistance Program Center rxassist.org

Once on the website, there is a Patient Center that can be accessed to begin the process of searching for the programs specific to the drug being prescribed. Type in the name of the prescription drug you take, and the site will bring

up a link when you click on the drug that takes you to the instructions on how to submit for assistance.

Patient Access Network Foundation panfoundation.org

The website is similar to RxAssist and is easy to navigate as a patient.

Patient Advocate Foundation patientadvocate.org

The website is similar to RxAssist and is easy to navigate as a patient.

Benefit Convenience Card Frequently Asked Questions

You must meet the eligibility requirements of the Oregon Homecare Workers Supplemental Trust (“Trust”) to be eligible for the benefits described in this document.

Starting in 2015, the Board of Trustees is excited to provide all eligible Participants with a Benefit Convenience Card (“Card”) that will make it possible for Participants to electronically pay: (a) the portion of their Trust-approved exchange health plan premiums that is covered by the Trust; and (b) their medical and prescription copays, deductibles and co-insurance expenses that are covered by the Trust, up to a maximum amount of \$3,000 per year.

What can I use the \$3,000 to pay for?

You can use your Card to pay for medical and prescription drug copays, deductibles and co-insurance expenses relating to claims covered by your Trust-approved exchange health plan or Medicare plan provided the claims were incurred while you were eligible for Trust benefits.

You cannot use the Card for dental claims, vision claims, claims relating to family members or other individuals, claims for services not covered by your Medicare or exchange health plan or claims for services you accessed while you were not eligible for Trust benefits.

You may be asked to show proof of your expenses, **so keep your Explanation of Benefits (EOB) and all receipts** (especially your prescription receipts since prescription expenses do not appear on the EOBs issued by your insurance company).

You will know what services are covered and what you owe for the services you have received by looking at your EOB. The EOB will break out how much the insurance has paid and how much is your responsibility for copayment, coinsurance and deductible. You will receive the EOB electronically or by regular mail from your insurance company.

You may only use your Benefit Convenience Card for deductible, copayment or co-insurance amounts shown on your EOB or your prescription drug receipt.

If you have any questions as to whether or not something is a covered expense under your insurance plan, you should call the insurance company directly. Further, if you believe that your insurance company billed you for certain claims in error, you should contact your insurance company's billing department for more information.

Resources

How does my monthly premium get paid?

If you enrolled into a Trust-approved exchange health plan as an individual, you now can pay your monthly health insurance premium directly to your insurance company using your Card. Thus, as long as you are eligible for benefits under the Supplemental Trust, you should not incur any upfront out-of-pocket expenses relating to your health insurance premium.

Does the \$3,000 benefit have to cover the cost of my premium too?

No. There are two “accounts” on your Card. One account is pre-loaded with \$3,000 for your use in paying medical and prescription copays, deductibles and co-insurance expenses as described above. The other is pre-loaded with the amount necessary to pay that portion of your health insurance premium not covered by your Federal tax subsidy. You will need to contact your health insurance carrier to establish the process by which your health insurance carrier will deduct the necessary monthly premium amounts from your Card. Most health insurance carriers have an online option to set up payment. The Trust website also has information on how to set-up your monthly payments by insurance carrier.

What if I don't have computer access?

There are many ways to pay your premium bill with the Benefit Convenience Card. Contact your insurance carrier to make a payment each month or enroll in autopayment if it is available. Please call the Healthcare Enrollment Team at 1-844-507-7554 Option 1 if you have additional questions.

Can I use the Card for expenses relating to my family?

No. Your card can only be used by you for your eligible expenses.

I enrolled in a plan with family members who are also eligible for benefits. Can we use the Card to pay the family premium?

No. Your insurance carrier cannot take partial payments from each Card, so you will need to use

the reimbursement process described below and pay the family premium directly to your insurance company.

What if my family is included on my insurance plan?

If your family is included on your health insurance policy, you still must pay your insurance company directly for your family premium and then submit a reimbursement form to the Trust Administrative Office for the premium amount relating to your individual coverage only. The Trust Administrative Office then will send you a check for the amount due.

What about dental or vision premiums and expenses?

If you are eligible for benefits under the Oregon Homecare Workers Benefit Trust, the Benefit Trust pays 100% of the premium necessary to provide you with Kaiser dental coverage, Ameritas vision coverage and Reliant Behavioral Health (EAP) benefits. **All out of pocket costs not covered by these programs are your responsibility; the Card cannot be used for these expenses.**

Do I need a PIN because this is a debit card?

No. You do not need a PIN to use your Card.

Can I withdraw cash (to reimburse myself)?

No. If you have paid for services out of pocket, please use the reimbursement process described above. The amount you are reimbursed will be deducted from the \$3,000 annual maximum on your Card.

Who do I call if I lose my Benefit Convenience Card?

If you need to replace your Benefit Convenience Card, you can contact Ameriflex by calling 1-844-507-7554, Option 3, Option 3. Ameriflex is your Benefit Convenience Card administrator and can also assist with questions

regarding your account balance and Ameriflex Reimbursement Claim status.

My Benefit Convenience Card is not working. Who should I call?

If you are experiencing problems with your Benefit Convenience Card, call 1-844-507-7554, Option 3, Option 3, to speak with Ameriflex, your Benefit Convenience Card administrator.

I already incurred medical expenses in 2016 before I got the Card; can I use my Card to pay for those expenses?

Yes. When you receive the bill from your health care provider for services delivered in 2016 you can use your Card to pay for the amount for which you are responsible. Most health care provider bills have a payment section where you can provide your Card information.

If you have already paid eligible out-of-pocket expenses to a provider, you can submit a new Ameriflex reimbursement form, available for download at ORHomecareTrust.org/reimbursement/#reimbform along with a copy of your EOB or receipt of services. To acquire the reimbursement form, you can contact your Trust Administrative Office. The amount you are reimbursed will be deducted from the \$3,000 annual maximum on your Card.

I have medical expenses incurred in 2014 and/or 2015. Can I use my Card to pay?

You may only use the \$3,000 reimbursement benefit on your Benefit Convenience Card to pay covered expenses for services received in the same year to which the reimbursement benefit applies. If you receive claims from a previous calendar year you will need to utilize the reimbursement process. For example, the \$3,000 benefit for 2015 only may be used to pay covered expenses for services received in 2015. You may not use any remaining benefit from 2015 to pay for services received in 2016.

Does my leftover 2015 balance roll over into 2016?

No. The maximum amount you can be reimbursed for covered expenses incurred in each calendar year is \$3,000. Any portion of this \$3,000 that is not used for a calendar year cannot be rolled over for payment of expenses incurred in a future calendar year. If you have not yet exhausted your \$3,000 benefit applicable to a prior calendar year, you may request reimbursement from Ameriflex for claims incurred in that prior calendar year from January 1 until March 31st of the next year. (For example, if you incurred out-of-pocket expenses relating to an eligible claim on December 20, 2015, you have until March 31, 2016 to submit that claim to Ameriflex for reimbursement.) You cannot use your Card directly to pay a previous years claims. After March 31, you will need to send a Reimbursement Form to the Trust Administrative Office. If the Trust Administrative Office receives your reimbursement form within 12 months of the Ameriflex deadline, it will process your claim in accordance with the Trust's rules. (For example, you will have until March 31, 2017 to submit your claim for out-of-pocket expenses relating to services rendered on December 20, 2015.)

You can find the Ameriflex Reimbursement Claim Form and the Oregon Homecare Workers Trust Reimbursement Claim Form on your Trusts' website at ORHomecareTrust.org/reimbursement.

Does my 2015 Benefit Convenience Card work in 2016?

Yes, the Benefit Convenience Card issued to you in 2015 will continue to work as your Benefit Convenience Care in 2016.

When does my card expire?

Your Benefit Convenience Card will expire as of the month and year listed on the front of the Card. Ameriflex will send you a new Benefit Convenience Card when your current Card approaches expiration. If you have questions about this, you can reach Ameriflex by calling 1-844-5077554, Option 3, Option 3.

Resources

How to read an Explanation of Benefits (EOB)

An Explanation of Benefits is a form sent to you by your insurance company after you have received a healthcare service that was paid by the insurance company. Your EOB is not a bill, but it has useful information that helps you track your deductible and out-of-pocket maximum.

In the example provided, a Kaiser Explanation of Benefits is reviewed. The amounts under “Allowed Amount” show the Kaiser Permanente provider charges for services. The amounts under “Kaiser Paid” show what Kaiser Permanente is responsible for paying.

The amounts listed under “Member Responsibility” show what you’re responsible for paying. This is the difference between the “Allowed Amount” and “Kaiser Paid.” What you pay can fall into three categories: “Deductible,” “Not Covered” or “Coinsurance/Copay.” Keep in mind that copays and coinsurance aren’t applied to your deductible, but the amounts listed in the deductible, copay and coinsurance columns do apply towards your out-of-pocket maximum for the calendar year.

Amounts applied so far: These are the total charges applied to your deductible and out-of-pocket maximum for the year. If you reach your deductible and out-of-pocket maximum, you won’t pay a co-pay or coinsurance amount on covered services for the rest of the year.

Tracking individual amounts: These are the deductible and out-of-pocket maximum totals for you and each family member in your household. When a family member reaches his or her deductible, that family member will pay only a copay or coinsurance for most covered services.*

Tracking family amounts: These are the total charges applied to your calendar-year family deductible. After this deductible is met, every family member will pay only copays or coinsurance for most covered services.

* Some plans only feature family deductibles. That means that once the family collectively satisfies the deductible, then all family members pay just a copay or coinsurance for most covered services.



Kaiser Permanente
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St Ste 100
Portland OR 97232-2099



000844-000001-000002-000001 KNB1 2401054
JANE DOE
71234 MAIN ST
ANYWHERE,CA 99999-4444

EXPLANATION OF BENEFITS

Subscriber Name	JANE DOE
Subscriber ID	123456789101
Member Name	JANE DOE
Member ID	123456789101
Group Name	ACME INC
Group ID	1234-001
Product Type	HMO-I
Statement Date	
October 29, 2012	

THIS IS NOT A BILL

B

Service Date From To	Claim Number	Service Provider and Description	Billed Amount	Allowed Amount	Other Insurance Payment	Not Covered	Member Responsibility		Kaiser Paid	Remarks
							Deductible	Coinsurance Copay		
9/11/12	CLM111111111	BROWN, J. / SURGERY	1,454.00	892.00	0.00	0.00	500.00	78.40	313.80	PA001 B1044 BD001
10/10/12	CLM222222222	GREEN,M. / OFFICE-OTHER OUTPATIENT	238.00	184.00	0.00	0.00	0.00	20.00	164.00	PA001 BC002
Claims Grand Total			1,692.00	1,076.00	0.00	0.00	500.00	98.40	477.80	

A

Fraud Warning: Any person who, with intent to defraud, or knowing that they are facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, please call us as soon as possible to explain the situation.

Member Responsibility	Kaiser Paid
598.40	477.80

In addition to any deductible, coinsurance and/or copayment amounts, Member Responsibility may include all or a portion of any amount listed as Not Covered, based on the remark codes. Please see inserts for additional information including your appeal rights.

****Member Responsibility amount does not reflect any payment at the time of service.**

Remarks Area: For any clarification of the remarks below or to report possible fraud, please contact Kaiser Permanente's Membership Services at 503-813-2000, 1-800-813-2000, Option 4, and TTY/TDD 1-800-735-2900.

The following are remarks associated with the claims on this EOB. If a remark repeats on the EOB the description will only be provided once.

Remark	Description
BC002	Member responsible, specialist copay
BD001	Member responsible, deductible, annual deductible
B1044	Member responsible, surgery coinsurance
PA001	Allowed amount

C

Member Liability Satisfied for Contract Year 2012 as of 23-Oct-12

Tier	Deductible	\$ Satisfied	% Satisfied	Out-of-Pocket	\$ Satisfied	% Satisfied
Individual	\$500.00	\$500.00	100.00%	\$2,000.00	\$184.00	9.20%
Family	\$1,500.00	\$500.00	33.33%	\$8,000.00	\$184.00	3.07%

- A Service details:** This includes the service date along with the deductible, coinsurance, or copay amounts applied for each service.
- B Our responsibility:** This column lists any payments we made based on your health plan benefits.*
- C Tracking your expenses:** This section summarizes your deductible and out-of-pocket amounts that have been credited to date, including any amounts reflected on this EOB. Keep in mind that not all member charges apply to the annual out-of-pocket maximum.

Notices

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 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.

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 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 Fund office or the Secretary of the Department of Health and Human Services if you believe that your that 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
 Benefit Solutions Inc.
 12121 Harbour Reach Dr., Suite 105
 Mukilteo, WA 98275

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 health care 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 also may 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 interest 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

Supplemental Trust Notice Of Privacy Practices

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 the 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 also may 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 this document 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 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 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 also may 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 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 used or disclosed to a family member, close Personal friend, or others who the Trust has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case 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 that 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.

Any 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 already has 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 below, you should address such requests to:

HIPAA Privacy Officer
Oregon Homecare Workers Supplemental Trust
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 \$.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.

Supplemental Trust Notice Of Privacy Practices

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 twelve-month period will be free. For additional accountings in a twelve-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 Confidential Communications, or Communications by Alternative Means or at an 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 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 a Paper Copy of This 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 from Benefit Solutions Inc., at:

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

Right to Receive Notice of a Breach of Your Protected Health Information

You will be notified if your protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when

there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of 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 THE TRUST'S PRIVACY POLICIES

The Trust reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Trust materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty 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 Fund 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.

Notices

Benefit Trust Notice Of Cobra Continuation Coverage Rights

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of dental, vision and EAP coverage under the Benefit Trust. This notice does not apply to your out-of-pocket expense benefits under the Supplemental Trust. This notice explains COBRA continuation coverage, when it may become available to you and what you need to do to protect your right to get it. COBRA coverage will not start until payment is received. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when group coverage would otherwise end. For more information about your rights and obligations under the Trust and under Federal law, you should contact the Trust Administrative Office.

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

What is COBRA continuation coverage?

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

You'll become a qualified beneficiary if you lose your vision, dental and EAP coverage under the Benefit Trust because your hours of employment are reduced or your employment ends for any reason other than your gross misconduct.

When is COBRA continuation coverage available?

The Trust will offer COBRA continuation coverage to qualified beneficiaries only after the Trust Administrative Office has been notified that the Participant has experienced a reduction in hours or a termination of employment. The State will notify the Trust Administrative Office if you experience a reduction in hours or a termination of employment. You also should notify the Trust Administrative Office of such a qualifying event by providing notice to:

Oregon Homecare Workers Benefit Trust
c/o Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275

How is COBRA continuation coverage provided?

Once the Trust Administrative Office receives notice that a qualifying event has occurred, you will be offered COBRA continuation coverage for **dental, vision and EAP benefits only**.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you are determined by Social Security to be disabled and you notify the Trust Administrator in a timely fashion, you may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The Trust's Board of Trustees, in its discretion, may require that you submit additional evidence of your disability in order to grant you a disability extension.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You can learn more about many of these options at [healthcare.gov](https://www.healthcare.gov).

If you have questions

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

Keep the Trust Administrative Office informed of address changes

To protect your rights, let the Trust Administrative Office know about any changes in your address. You should also keep a copy, for your records, of any notices you send to the Trust Administrative Office.

Trust contact information

For more information about the Trust and COBRA continuation coverage, please contact the Trust Administrative Office at:

Oregon Homecare Workers Benefit Trust
c/o Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
1-844-507-7554



Notes:

Important Information:

This page is provided for you to track information you will need to navigate your benefits. Please fill it out with your information as applicable and refer to it as needed. Keep it in a secure and safe place.

DENTAL (see page 21)

Insurance Carrier: Kaiser Permanente

Health Record Number: _____

Group ID : 19581-001 [in service area] or 19581-003 [out of service area]

1-503-286-6868 in the Portland Area

1-503-370-4311 in Salem

Phone Number: 1-866-498-7912 outside of Portland and Salem Areas

Website: kp.org/dental/nw

Username: _____ Password: _____

VISION (see page 22)

Carrier: Ameritas

Policy Number: _____

Group ID: 010-350770

Phone Number: 877-647-6683

Website: _____

Username: _____ Password: _____

EMPLOYEE ASSISTANCE PROGRAM (see page 22)

Carrier: Reliant Behavioral Health

Group ID / Access Code: OHWBT

Phone Number: 866-750-1327

Website: myrbh.com

Username: _____ Password: _____

Important Information:

This page is provided for you to track information you will need to navigate your benefits. Please fill it out with your information as applicable and refer to it as needed. Keep it in a secure and safe place.

MEDICAL (see page 17)

Insurance Carrier: _____

Policy Number: _____

Other (Group ID, Billing #, etc.): _____

Phone Number: _____

Website: _____

Username: _____ Password: _____

AMERIFLEX/BENEFIT CONVENIENCE CARD (see page 29)

Employer ID: AMFHOMECA _____

Employee ID (SSN with no dashes): _____

Website: mywealthcareonline.com/ameriflex _____

Username: _____ Password: _____

HEALTH INSURANCE EXCHANGE LOGIN INFORMATION* (see page 5)

Username: _____

Password: _____

Security Question #1: _____

Security Question #2: _____

Security Question #3: _____

**Use this section to record your login information for the Exchange website that is relevant to your coverage, such as Healthcare.gov, OregonHealthcare.gov, WAHealthPlanFinder.org, YourHealthIdaho.org, etcetera.*