SEIU HEALTHCARE NW HEALTH BENEFITS TRUST

SUMMARY PLAN DESCRIPTION WRAP DOCUMENT

August 1, 2021

The SEIU Healthcare NW Health Benefits Trust offers various employee benefit health plans to participating employees and, under certain options, their dependents. The claims administrator or insurer of each benefit option will issue to participating employees a packet, certificate or booklet which will provide a full description of the rules, benefits, and the circumstances under which benefits are provided.

This Summary Plan Description supplements these documents. It provides participants in the SEIU Healthcare NW Health Benefits Trust general information about the Trust and additional information that is required by a federal law known as the Employee Retirement Income Security Act of 1974 (ERISA). The information is provided by the Trustees of SEIU Healthcare NW Health Benefits Trust, who are the Plan Sponsor. This information is not intended to give any substantive rights to benefits that are not already provided by the employee benefit health plans offered.

This Wrap Document includes the following documents:

- **Summary Plan Description**

  This includes information on eligibility and enrollment (Section i); your ability to continue your coverage through self-payments (Section k); and information about how to file claims and pursue appeals (Section o).

  Name of Plan;
  Name, Address and Telephone Number of Organizations that Established Plan;
  Identification Numbers;
  Type of Plan and Benefit Programs;
  Type of Administration and Trust Office;
  Plan Administrator;
  Name and Address for Agent for Service of Process;
  Description of Bargaining Agreements;
  Eligibility and Enrollment;
  Circumstances Which May Result in Ineligibility or Denial of Benefits or Amendment or Termination of the Trust;
  Continuation Coverage;
  Source of Contributions;
  Methods Used for Accumulation of Assets;
  End of Trust Year;
  Procedures for Filing Claims and Appealing Adverse Benefit Determinations;
  Mothers and Newborns Protection Act;
  Women's Health and Cancer Rights Act
  Prescription Drug Coverage and Medicare
  Statement of Legal Rights

- **Notice of Privacy Practices**

  This provides information about how your medical information may be used or disclosed.

- **Children's Health Insurance Program Notice**
- **Extension of Time Limits Due to COVID-19**

SUMMARY PLAN DESCRIPTION

a. Name of Plan

The SEIU Healthcare NW Health Benefits Trust (the "Trust") is an employee welfare benefit plan, as defined in federal law.

b. Name, Address and Telephone Number of Organizations that Established Plan

The Trust was established by the Service Employees International Union 775 and employers who employ home care workers represented by SEIU 775, including the State of Washington. The address and phone number of SEIU 775 is:

SEIU 775
215 Columbia Street
Seattle, WA 98104
Phone: (866) 371-3200

The address and phone number of the Washington State Department of Social and Health Services is:

Washington State Department of Social and Health Services
P.O. Box 45130
Olympia, Washington 98504-5130
Phone: (800) 737-0617

The Plan Sponsor is the Board of Trustees of the SEIU Healthcare NW Benefits Trust. The address and phone number for the Board is:

Board of Trustees
SEIU Healthcare NW Health Benefits Trust
215 Columbia Street, Suite 300
Seattle, WA 98104

A complete list of the employers and employee organizations sponsoring the Trust may be obtained by participants and beneficiaries upon written request to the plan administrator and is available for examination. Participants and beneficiaries may receive, from the plan administrator upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan, and, if so, the sponsor's address.

c. Identification Numbers

The Employer Tax Identification Number assigned to the Trust by the Internal Revenue Service is 20-1842198. The Plan number assigned by the Trust is 501.

d. Type of Plan and Benefit Programs

The Trust is an employee welfare benefits plan. It provides medical, dental and ancillary benefits. The Trust offers both self-funded and insured medical options and a self-funded and insured dental option as well. If you are unaware of which plan options may cover you, please call the Trust Administrative Office at the address and phone number shown below in section e. Currently the plans are as follows:

Medical and Prescription Drug Plans

Self-Funded Medical and Prescription Drug

Kaiser Foundation Health Plan of Washington Options, Inc.
Medical/Prescription Drugs/Vision
(888) 901-4636
www.kp.org/wa

Kaiser Foundation Health Plan of Washington (Core/EPO)
Medical/Prescription Drugs/Vision
(888) 901-4636
www.kp.org/wa

Self-Funded Medical

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(855) 736-9469
www.aetna.com

Prescription Drug with Aetna Medical (Sav-Rx)

Sav-Rx Prescription Services
224 North Park Avenue
Fremont, NE 68025
(800) 228-3108
www.savrx.com

Insured Medical

Kaiser Foundation Health Plan of the Northwest (Oregon and Clark and Cowlitz Counties))
Medical/Vision
(800) 813-2000
www.kp.org

Service area is Oregon and Clark and Cowlitz Counties in Washington

Dental Plans	**Self-Insured Dental Plan** Claims Administration by Delta Dental of Washington Seattle: (800) 554-1907 www.deltadentalwa.com **EPO Dental** Willamette Dental of Washington, Inc. (855) 433-6825 www.willamettedental.com

Summary of Benefits

You may find a summary of the medical and dental benefits applicable to you by referring to the summaries provided by Kaiser Foundation Health Plan of Washington Options, Inc., Kaiser Foundation Health Plan of Washington, Aetna/Sav-Rx, Kaiser Foundation Health Plan of the Northwest, Willamette Dental of Washington, Inc. and Delta Dental of Washington. In addition, a detailed schedule of benefits is available without cost to participants and beneficiaries that request the information from the Trust's Administrative Office.

Summary of Benefits and Coverage (SBC)–The SBC for each option is available to view and print in

English	Korean
Spanish	Vietnamese
Russian	Somali
Simplified Chinese	Arabic
	Amharic

at www.myseiubenefits.org/sbc. You can also request a written copy of the SBC, free of charge, by calling MagnaCare at (877) 606-6705.

e. Type of Administration and Trust Office

The Trust is fully insured with respect to the medical benefits provided by Kaiser Foundation Health Plan of the Northwest (Oregon) and dental benefits provided by Willamette Dental of Washington, Inc. That means that the benefits are provided under group insurance contracts between the Trust and these insurers. The insurance carriers are responsible for paying benefits, not the Trust. The insurance carriers perform all the claims administration for those benefits.

The Trust is self-funded with respect to the medical benefits administered by Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options, Inc., Aetna/Sav-Rx and dental benefits administered by Delta Dental of Washington. The Trust contracts with Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options, Inc., Aetna/Sav-Rx and Delta Dental of Washington to administer claims made for these self-funded medical and dental benefits. The Trust, however, is financially responsible for payment of all medical and dental claims under these options.

General Trust administration (e.g., premium and eligibility processing, liaison with insurance carriers, customer service, IRS reporting, etc.) is conducted by the Board of Trustees, with the assistance of the following contract administrator:

MagnaCare
P.O. Box 24811
Seattle, WA 98124
Phone: (877) 606-6705
Fax: (516) 723-7395
www.mycreatehealth.com

Covered Employees with questions for the Trust regarding eligibility, premium processing and customer service should contact MangaCare at (877) 606-6705.

f. Plan Administrator

The Board of Trustees of the SEIU Healthcare NW Health Benefits Trust is the Plan Administrator, Plan Sponsor and Named Fiduciary of the Trust. The names and addresses of the members of the Board of Trustees are as follows:

UNION TRUSTEES

Sterling Harders, Chair
President, SEIU 775
215 Columbia Street
Seattle, WA 98104

Adam Glickman
Secretary-Treasurer, SEIU 775
215 Columbia Street
Seattle, WA 98104

Brittany Williams
Member, SEIU 775 and Home Care Aide
215 Columbia Street
Seattle, WA 98104

Gina Denton
Member, SEIU 775 and Home Care Aide
215 Columbia Street
Seattle, WA 98104

Shaine Truscott
Vice President, SEIU 775
215 Columbia Street
Seattle, WA 98104

EMPLOYER TRUSTEES

Bill Moss, Vice Chair
Assistant Secretary, Washington State Department of Social and Health Services,
P.O. Box 45050
Olympia, WA 98504

Mark Robinson, Secretary
Regional Vice President of Operations for Washington, Idaho, Montana, Oregon, and California,
Addus Healthcare, Inc.
c/o SEIU Healthcare NW Health Benefits Trust
215 Columbia Street, Suite 300
Seattle, WA 98104

Eric Erickson
Executive Director, CDM Services
2409 Broadway St
Vancouver, WA 98663

Steven Hill, Retired
c/o SEIU Healthcare NW Health Benefits Trust
215 Columbia Street, Suite 300
Seattle, WA 98104

Diane Lutz
Labor Negotiator, Washington State Office of Financial Management, Labor Relations Division
428 Rogers St. NW
Olympia, WA 98502

Louis McDermott
Deputy Director, Washington State Health Care Authority
628 8th Avenue SW
Olympia, WA 98501

g. Name and Address for Agent for Service of Process

The Compliance Officer is designated as an agent for accepting services of legal process on behalf of the Trust.

For the purpose of service, the Compliance Officer is located at:

SEIU Healthcare NW Health Benefits Trust
215 Columbia St., Suite 300
Seattle, WA 98104

Each Trustee listed above is also authorized to accept services of legal process on behalf of the Trust.

h. Description of Bargaining Agreements

The Trust is maintained pursuant to multiple collective bargaining agreements. You may obtain a copy of the collective bargaining agreement under which you receive your benefits upon written request to the Trust Office. The collective bargaining agreements are also available for examination by participants and beneficiaries at the Trust Office. The Trustees may impose a reasonable charge to cover the cost of providing copies of the agreement. You may wish to inquire as to the amount of the charges before requesting copies.

i. Eligibility and Enrollment

1. Employees–Initial Eligibility. The following summarizes initial eligibility requirements for employees and dependents, what must be done for enrollment in Trust coverage and events that will end eligibility. You must meet the following criteria before you are eligible to participate:

- Be an individual employed by a participating employer that makes contributions to the Trust, pursuant to either a Collective Bargaining Agreement or written Special Agreement;
- Meet the initial eligibility requirements and waiting period applicable to you as described in the Collective Bargaining Agreement between your union and your employer, the Special Agreement between your employer and the Trust, and any relevant Trust eligibility policy. If you have questions about whether you are eligible for the Trust's benefits, you can contact MagnaCare at (877) 606-6705
- Enroll as described in the "Enrollment" section below.

2. Initial Eligibility–Dependents

Some plans offered by the Trust allow dependent children or dependent children and spouses and domestic partners to participate. For a dependent child, spouse or domestic partner to be eligible, the following criterion must be met:

- The employee must be eligible for and enrolled in a benefit option that provides for dependent coverage;
- The employee must complete and provide the necessary enrollment forms and documentation required to cover dependents; and
- Make any payment required for dependent coverage.

If you have questions about whether your dependents are eligible for Trust benefits, you can contact MagnaCare at (877) 606-6705

3. Definition of Eligible Dependent

If you participate in a plan that provides dependent coverage, the following individuals are potentially Eligible Dependents. Eligibility will depend on what dependents (if any) may be covered under your plan options, meeting enrollment requirements and making any required premium payment for dependent coverage.

Eligible Dependents are defined as:

- Your legal spouse;
- Your eligible domestic partner as defined by Trust rules;
- Your and your legal spouse's or eligible domestic partner's children under age 26 who are:
    - Your biological and adopted children (or children placed with you for adoption);
    - Stepchildren;
    - Eligible foster children who are defined as children placed with you by an authorized placement agency or by a judgment or other order of a court of competent jurisdiction;
    - Children for whom there is a court order that meets applicable legal requirements, requiring you to maintain coverage, such as for a child in the custody of a former spouse. You may submit a medical child support order to the Trust Office to determine whether it is qualified. Upon request, the Trust Office will provide you with a copy of the procedures for determining the qualified status of a medical child support order;
    - Your and your legal spouse's or your eligible domestic partner's children 26 or older who are incapable of self-support due to a physical or mental disability. The child's disability must have started and been reported to the Trust Office before the child reached age 26. To maintain eligibility under this provision, the child must be unmarried, financially dependent on you and incapable of supporting himself or herself;
    - Children who reside with you, are related to you or your spouse or eligible domestic partner and for whom you are financially responsible and for whom you are the legal guardian or the functional equivalent.

Eligible Domestic Partners

To be an eligible domestic partner, you must complete an Affidavit of Domestic Partnership available from MagnaCare. An eligible domestic partner includes a person of the same or opposite sex with whom you:

- Have shared the same residence for at least six months immediately preceding the date of the Affidavit and intend to continue doing so indefinitely;
- Have a close personal relationship with each other;
- Are not legally married to anyone else;
- Are each at least 18 years of age;
- Are not related by blood to a degree of kinship that would bar marriage in the state where you live;
- Are each other's sole domestic partner;
- Are jointly responsible for each other's welfare, including basic living expenses such as food and shelter.

Please note that if you request coverage of a domestic partner or a domestic partner's children, you will be required to verify whether these individuals qualify as dependents under the Internal Revenue Code. If they do not, the fair market value of the coverage provided may be taxable income. Contact the Trust Office for additional details.

4. Enrollment−Employees and Dependents

Once you meet the eligibility requirements, you and any eligible dependents must enroll in the Trust to have medical or dental coverage. Enrollment procedures and time frames are described below. Enrollment procedures must be completed for you and your eligible dependents to have coverage.

- If you are represented by SEIU 775, please request an application for enrollment from one of the following:
  - MagnaCare—(877) 606-6705;
  - Online from www.myseiubenefits.org;
  - Your employer; or
  - Trust Administrative Office
- If you are not represented by SEIU 775, please contact your employer or Trust Administrative Office for an enrollment form.
- Complete the application and provide dependent verification documentation by submitting it online or by sending it via fax or mail to the Trust's Administrative Office.

  MagnaCare
  P.O. Box 24811
  Seattle, WA 98124
  Phone: (877) 606-6705
  Fax: (516) 723-7395
  www.mycreatehealth.com

- If applicable, pay your co-premium, either by authorizing your employer to deduct the co-premium payment from your paycheck, or, if necessary, by submitting payment for the co-premium directly to the Trust's Administrator.

5. Special Enrollment Rights

Employees may enroll in the Trust or add dependents (if dependent coverage is available) at the following times:

- When initially eligible;
- If your plan provides for an open enrollment period during that period;
- If you have declined coverage for yourself and, if applicable, your dependents because you have other health coverage you may enroll in the Trust if you or your dependents exhaust COBRA continuation coverage, lose eligibility for the other coverage or the employer ceases to contribute toward the cost of the other coverage. To be effective, you must notify the Trust Office within 30 days of the other coverage ending. You will be required to give proof that you have had other group health coverage insurance since the time you elected not to participate in the Trust.
- If you participate in a plan that provides coverage for dependents you may add a new dependent child acquired as a result of marriage, creation of a domestic partnership, birth, adoption or placement for adoption. You must request enrollment for the newly acquired dependent within 30 days after the event in question. Coverage is effective the first of the month following the month in which a special enrollment request is received if the dependent is acquired through marriage or a creation of a domestic partnership. Coverage is effective the date of the birth, adoption or placement for adoption for a new dependent child.

If your plan limits the number of employees who may enroll, this may impact your ability to enroll after a special enrollment event. Please note this time period for exercising special enrollment rights is temporarily extended until 60 days after the COVID-19 national emergency ends. Please see the notice Extension of Time Limits Due to COVID-19 at the end of this document for further details.

6. Events That End Coverage

Coverage will end without notice, except as specified under "Extended Benefits" on the last day of the month in which one of these events occurs:

- The Trust terminates or the benefit option in which you participate is terminated;
- The next monthly premium is not paid when due or within the grace period;
- You die or are otherwise no longer eligible, subject to any applicable election to continue coverage as described in COBRA and "Continuation under USERRA" as described in this document;

- Your employer fails to fulfill its obligations under the applicable collective bargaining agreement through which you have Trust coverage, fails to employ employees covered by the applicable collective bargaining agreement, or ceases participating in the Trust; or
- You or your dependents fail to meet the ongoing eligibility requirements under your Collective Bargaining Agreement, Special Agreement or relevant Trust eligibility policy.

j. Circumstances Which May Result in Ineligibility or Denial of Benefits or Amendment or Termination of the Trust

Circumstances which may result in disqualification, ineligibility, denial, or the loss of benefits include failure to meet the initial or ongoing eligibility requirements in the relevant collective bargaining agreements, special agreements or the relevant Trust eligibility policy, limitations and exclusions in the insurance programs, failure by you or your employer to pay any required premium for coverage, death, or termination of the Plan. The Plan Sponsor retains the unlimited discretionary authority to interpret the terms of the benefit plans provided, determine any individual's eligibility for benefits and to modify, amend or terminate the Trust or any benefit option offered at any time.

k. Continuation Coverage

1. COBRA**.** Continued participation in certain group health and welfare programs is a right governed by federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly referred to as your "COBRA" right. If you are covered by this Trust, you may have the right to make your own contributions to the Trust, in order to receive coverage in certain instances where coverage under this Trust would otherwise end.

   A. COBRA Administration**.** The Trust Office (MagnaCare) is responsible for administering COBRA continuation rights for the Trust. All communications must be made in writing; identify you, the eligible employee; the Trust's name (SEIU Healthcare NW Health Benefits Trust) and be sent to the Trust Office at the following address:

      MagnaCare
      P.O. Box 24811
      Seattle, WA 98124
      Phone: (877) 606-6705
      Fax: (516) 723-7395
      www.mycreatehealth.com

   B. Qualifying Events. You (as the Participating Employee) have the right to elect continuation of coverage if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct). If your dependents are covered, they have the right to elect continuation coverage if they would otherwise lose coverage because of your

reduction in hours or termination of employment, your death, divorce or legal separation, end of a domestic partnership, your entitlement to Medicare or a child no longer qualifying as an eligible dependent.

C. COBRA Notification Responsibilities. The Trust offers continuation coverage only after it has been notified of a qualifying event. While your employer is responsible for informing the Trust of a loss or reduction of employment, we urge you to also notify the Trust of such an event. You or your dependents have the responsibility to notify the Trust of a loss of coverage resulting from a divorce, legal separation, end of domestic partnership or a child's loss of dependent status. The Board of Trustees reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

D. Election of COBRA. Once the Trust Office has received proper notice that a qualifying event has occurred, it will notify you that you have the right to elect continuation coverage. A written election must be made in writing within 60 days from the date coverage would otherwise end or for events for which the Trust has notification responsibility 60 days from the date the notification is received from the Trust Office, if later. Notice must be sent to the Trust Office at the address listed above. Failure to elect continuation within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan.

E. Available Coverage. Individuals who have had a qualifying event may elect to continue the health plan under which they were covered immediately prior to the qualifying event. If you have both medical and dental coverage, you may elect medical only or medical and dental coverage.

F. Continuous Coverage Required. Your coverage under COBRA must be continuous from the date your Trust coverage would have ended if self-payments under COBRA were not made.

G. Cost. A qualified beneficiary must pay the entire cost of the continuation coverage plus a 2% administration fee. The cost for the coverages available through the Trust is set annually. If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the coverage options available to you. If you are eligible for an extension of coverage as a result of you or a Dependent being disabled (see subsection J below), the cost of the coverage will be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your disability.

H. Monthly Self-Payments Required. You are responsible for the full cost of continuation coverage. Self-payments for continuation of coverage are due on the first of each month for that month's coverage and must be sent to the Trust Office at the address listed in Section A. above. Coverage will be terminated if payment is not received by the Trust

Office within 30 days of this due date. The only exception is that the self-payment for the period preceding the initial election of coverage may be made up to 45 days after the date of election. Coverage must be continuous. Your initial payment must cover all months for which you want coverage and be retroactive to when your Trust coverage ended. If your initial payment is not received or postmarked with 45 days of when you elected coverage, your right to continuation coverage will be lost.

I. Length of Continuation Coverage. Continuation of coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours. For all other qualifying events applicable to dependents (your death, divorce, legal separation, end of domestic partnership, you becoming eligible for Medicare or a child no longer qualifying as a dependent), continuation coverage may last for up to 36 months.

However, continuation coverage will end on the last day of the monthly premium payment period if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not paid to the Trust Office on a timely basis for the next monthly coverage period;
- You become covered under any other group health plan after the date of your COBRA election;
- You become entitled to Medicare benefits after the date of your COBRA election; or
- The date the Plan terminates or the date your Employer no longer participates in the Plan unless your Employer or its successor does not offer another health plan for any classification of its employees which formerly participated in the Trust;
- You provide written notice that you wish to terminate your coverage;

J. Length of Continuation Coverage–Disabled Individuals. If you are determined by the Social Security Administration to be disabled before or within the first 60 days of continuation coverage, the disabled individual and any covered family members can receive an additional 11 months of continuation coverage for up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Trust Office in writing within 60 days of receipt of your Social Security Disability Determination and prior to the end of your initial 18-month period of continuation coverage. If the disabled individual is subsequently found to not be disabled, you must notify the Trust Office within 30 days of this determination (which may mean it will end at the end of the 18 months under your initial COBRA election, assuming you properly elected and paid for COBRA).

K. Length of Continuation Coverage–Second Qualifying Event. Dependents who are entitled to continuation coverage as a result of your termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event (an event which would have caused coverage to end it occurred first) occurs during the initial 18 months of continuation coverage. Possible second qualifying events are your death, a divorce, legal separation or termination or end of the domestic partnership, a child losing dependent status, the employee becoming eligible for Medicare during the initial 18 months of continuation coverage. If a dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Trust Administrative Office within 60 days of the second qualifying event. Failure to provide such a timely written notice of the second qualifying event will cause the individual's coverage to end as it normally would under the terms of the plan. In no event will a dependent have continuation coverage that extends beyond a total of 36 months.

L. Length of Continuation Coverage–Medicare Entitlement. If you have an 18-month qualifying event after becoming entitled to Medicare, dependents may continue coverage until the later of 18 months from the date coverage would normally end or 36 months from the date the employee becomes eligible for Medicare.

M. Relationship Between COBRA and Medicare or Other Health Coverage. Your COBRA coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election. If you have other health coverage or Medicare that is in place prior to your COBRA election, you may be eligible for both. In such situations, your COBRA coverage will only pay secondary to your group health coverage or Medicare unless your Medicare eligibility is based on end stage renal disease and you are within the 30-month coordination period.

N. Coverage from the Exchanges. Effective January 1, 2014 there are other coverage options for you and your family besides COBRA. You will be able to buy insurance through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for a tax credit through the Health Insurance Marketplace. If you actually enroll in COBRA continuation coverage, however, and drop it before the end of the maximum COBRA continuation period, it can affect your ability to enroll in a plan offered through the Health Insurance Marketplace outside the annual open enrollment period. You also may qualify for a special enrollment opportunity for another group plan for which you are eligible (such as

spouse's plan) even if the plan generally does not accept late enrollees if you request enrollment within 30 days.

O. Continuation Rights Under USERRA. The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Continuation rights under USERRA are administered on the same basis as COBRA continuation rights. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan if you are re-employed within the time periods established by USERRA, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at (866) 4-USA-DOL or visit its Web site at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

Conversion coverage. Kaiser Foundation Health Plan of the Northwest (Oregon and Clark and Cowlitz Counties in Washington) provides "conversion" options or self-payment rights under state laws when your group health coverage under the Trust ends.

Generally, a conversion option would allow you to convert to an individual plan if you apply within strict time limits (often 31 days or less for conversion coverage).

If you want more information, please contact:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, #100
Portland, OR 97232-2099
(800) 813-2000

P. Additional Information. For information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans visit the U.S. Department of Labor Employees Benefit Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at (866) 444-3272. For more information about health insurance options available through the Health Insurance Marketplace for Washington visit www.wahbexchange.org.

Q. Extension of Time Limits Due to COVID-19. Please note the time limits related to the 60-day period to elect COBRA continuation coverage (Subsection D); the 45-day period after you elect COBRA to make your first payment (subsection H); and the 30-day grace period for making monthly payments (subsection H) are temporarily extended after March 1, 2020 by one additional year or until 60 days after the COVID-19 national emergency ends, whichever comes first. Please see the notice Extension of Time Limits Due to COVID-19 at the end of this document for further details.

To help insure you receive necessary notices, you should notify the Trust Office if your address or that of any family member changes. You should retain this notice and also keep a copy of any written notices you send the Trust.

l. Source of Contributions

Contributions (i.e., premium payments) to the Trust are made by Participating Employers and under some options their covered employees. Calculation of the contributions of Participating Employers and covered employees will be made in accordance with the respective Collective Bargaining Agreements and as established by the Trust.

In addition, if covered employees or their covered dependents elect COBRA or coverage under USERRA, the affected individuals must self-pay to continue their coverage.

m. Methods Used for Accumulation of Assets

Contributions from employers and employees are received by and held in trust by the Trust until used to pay any self-funded benefits and necessary expenses incurred in the administration of the plan or transferred to an insurance carrier as a premium payment for coverage.

n. End of Trust Year

The Trust year begins on August 1 and ends on July 31.

o. Procedures for Filing Claims and Appealing Adverse Benefit Determination Claims

The procedures for presenting claims are set forth in detail in the booklets from the entity providing the benefits applicable to you. Basic information about filing claims follows.

Kaiser Foundation Health Plan of Washington Options, Inc.–Medical and Prescription Drug

In most cases, a contracted provider with Kaiser Foundation Health Plan of Washington Options, Inc. will submit a claim on your behalf. If a claim is not submitted or if you receive a claim for services which you believe should be covered either:

- Contact Kaiser Foundation Health Plan of Washington Member Services at (206) 630-4636 or (888) 901-4636;

- Pay the claim and submit a claim for reimbursement of covered services to:

  Kaiser Permanente
  Attn: Claims Processing
  P.O. Box 30766
  Salt Lake City, UT 84130-0766
  (888) 901-4636

- For Prescription Drugs, please attach prescription labels, complete form and mail to:

  OptumRX
  Attn: OptumRX Claims
  P.O. Box 659334
  Dallas, TX 75265-0334

Kaiser Foundation Health Plan of Washington (EPO) Medical and Prescription Drugs

In most cases, a contracted provider with Kaiser Foundation Health Plan of Washington Options will submit a claim on your behalf. If a claim is not submitted or if you receive a claim for services which you believe should be covered either:

- Contact Kaiser Foundation Health Plan of Washington Member Services at (206) 630-4636 or (888) 901-4636;
- Pay the claim and submit a claim for reimbursement of covered services to:

  Kaiser Permanente
  Attn: Claims Processing
  P.O. Box 30766
  Salt Lake City, UT 84130-0766
  (888) 901-4636

- For Prescription Drugs, please attach prescription labels, complete form and mail to:

  OptumRX
  Attn: OptumRX Claims
  P.O. Box 650334
  Dallas, TX 75265-0334

Aetna Self-Funded Medical

If you participate in the Aetna PPO network plan, Aetna contracted providers, as a courtesy, will submit a claim on your behalf. If a claim is not submitted or if you receive a claim for services you believe should be covered either:

- Contact Aetna Customer Service at (855) 736-9469; or
- Pay the claim and submit a claim for reimbursement of covered services to:

Aetna
P.O. Box 14079
Lexington, KY 40512-4079
Fax: (859) 455-8650

Sav-Rx Self-Funded Prescription Drugs

The Sav-Rx prescription drug program is provided to individuals participating in the Aetna medical plan. In most cases, a Sav-Rx contracted provider will submit a claim on your behalf. If a claim is not submitted on your behalf or if you receive a claim for services you believe should be covered you can either:

- Contact Sav-Rx Customer Service at (800) 228-3108; or
- Pay the claim and submit a claim for reimbursement of covered services to:

Sav-Rx Prescription Services
Attn: Reimbursement Department
P.O. Box 8
Fremont, NE 68026

Kaiser Foundation Health Plan of the Northwest (Oregon and Clark and Cowlitz Counties)

If you participate in Kaiser Foundation Health Plan of the Northwest (Oregon and Clark and Cowlitz Counties), it is normally not necessary to submit claims. If you have questions concerning a claim or possible claim contact:

Kaiser Foundation Health Plan of the Northwest
Member Services
500 N.E. Multnomah St., Suite 100
Portland, OR 97232
(503) 813-2000 or (800) 813-2000

Delta Dental of Washington−Self-Funded Dental

If you have questions about submitting claims for the Trust's self-funded dental plan, contact Delta Dental of Washington which administers the plan.

Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983
Phone: (800) 554-1907

Willamette Dental EPO−Insured Dental

Willamette Dental of Washington, Inc.
Attn: Member Services
6950 N.E. Campus Way
Hillsboro, OR 97124

Appeals

Each benefit administrator or provider has its own appeal process which is set forth in its Plan booklet. The procedures for filing an appeal with each entity providing or administering benefits are set out in the Plan booklet from the entity or on the SEIU 775 Benefit Group's website. Please visit 'How to Submit an Appeal to the Health Benefits Trust' - www.myseiubenefits.org/health/submit-an-appeal-to-the-health-benefits-trust/. Please note the time period for filing claims or appealing a claim denial are temporarily extended until 60 days after the COVID-19 national emergency ends. Please see the Notice of Extension of Time Limits Due to COVID-19 at the end of this document for further details.

Eligibility Appeals

For any appeal involving eligibility and enrollment decisions submit a written appeal to:

Appeals Committee
SEIU Healthcare NW Health Benefits Trust
PO Box 24811
Seattle, WA 98124

The appeal must include name, address and date and identify the decision being appealed. These appeals will be reviewed by the Trust's Appeal Committee.

Kaiser Foundation Health Plan of Washington (All Options)

How to initiate an appeal by fax or mail:

Complete the Member Appeals Request form and fax or mail to:

Fax: (206) 630-1859

Mail: Kaiser Permanente Member Appeals
P.O. Box 34593
Seattle, WA 98124-1593

For help, please call (866) 458-5479

There are two appeal levels made available to you by Kaiser Foundation Health Plan of Washington:

Level 1: Appeal a claim denial

Level 2: Request a review by an external health dispute resolution organization

Kaiser Foundation Health Plan of the Northwest (Oregon and Clark and Cowlitz Counties)

How to submit an appeal:

Phone: Customer Service
(503) 813-2000
(800) 813-2000

Fax: (503) 813-3985

Mail: Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

There are three appeal levels available to you:

Level 1: Appeal a claim denial

Level 2: Request a reconsideration of the Level 1 appeal outcome

Level 3: Request a review by an external health dispute resolution organization

Aetna (medical)/Sav-Rx (pharmacy)

How to submit an appeal for a medical claim denial:

Phone: Aetna Member Services
(855) 736-9469

You may also appeal by sending in writing directly to Aetna. Please be sure to include:

- Your Name
- Employer's Name
- Copy of the denial
- Reason for appealing
- And any other information you would like Aetna to consider

Fax: Aetna Medical Claims Appeals
(859) 425-3379

Mail: Aetna – Medical Appeals Resolution Team
P.O. Box 14463
Lexington, KY 40512

There are three appeal levels available to you:

Level 1: Appeal a claim denial

Level 2: Request a reconsideration of the Level 1 appeal outcome

Level 3: Request a review by an external health dispute resolution organization

How to submit an appeal for a pharmacy claim denial:

Phone: Sav-RX Customer Service

(800) 228-3108

Fax: (888) 810-1394

Mail: Sav-Rx
Attn: Clinical Department
P.O. Box 8
Fremont, NE 68026

There are two appeal levels available to you:

Level 1: Appeal a claim denial

Level 2: Request a reconsideration of the Level 1 appeal outcome

Delta Dental of Washington

How to submit an appeal for a dental claim denial:

Phone: (800) 554-1907

Fax: (800) 239-9241

Mail: Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983

There are two appeal levels available to you:

Level 1: Appeal a claim denial

Level 2: Request a reconsideration of the Level 1 appeal outcome

Willamette Dental of Washington, Inc.

How to submit an appeal for a dental claim denial:

Phone: (855) 433-6825

Mail: Willamette Dental of Washington, Inc.
Attn: Member Services
6950 NE Campus Way
Hillsboro, OR 97124

There are two appeal levels available to you:

Level 1: Appeal a claim denial

Level 2: Request a reconsideration of the Level 1 appeal outcome

p. Mothers and Newborns Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in conjunction with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or require that a Provider obtain authorization from the Plan or the insurance issuer who is prescribing a length of stay not in excess of the above periods.

q. Women's Health and Cancer Rights Act

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

a. All stages of reconstruction of the breast on which the mastectomy was performed.

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

c. Prostheses.

d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas.

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

For information on WHCRA benefits or details about any state laws that may apply to your medical plan, please refer to the benefit plan material for the medical plan in which you are enrolled.

r. Prescription Drug Coverage and Medicare

Self-Funded Medical/Prescription Drug plans administered by Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options, Inc., Sav-Rx, and Insured Medical/Prescription Drug plan underwritten by Kaiser Foundation Health Plan of the Northwest – These benefits, for purposes of Creditable Coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Members who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date; however, the Member could be subject to payment of higher Part D premiums if the Member subsequently has a break in creditable coverage of 63 continuous days or longer before

enrolling in a Part D plan. A Member who discontinues coverage must meet eligibility requirements in order to re-enroll.

s. Statement of Legal Rights

As a participant in the Trust you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Trust participants shall be entitled to:

1. Receive Information About Your Plan and Benefits.

    a. Examine, without charge, at the Trust Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

    b. Obtain, upon written request to the Trust Office, copies of documents governing the operation of the Trust, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Trust may make a reasonable charge for the copies.

    c. Receive a summary of the Trust's annual financial report. The Trust Office is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

    Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries

    a. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights

    a. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to

the decision without charge, and to appeal any denial, all within certain time schedules.

b. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Trust and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Trust Office to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Trust's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions

a. If you have any questions about the Trust, you should contact the Trust Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTE: ***This Summary has been designed to provide you with key information about the SEIU Healthcare NW Health Benefits Trust but it does not provide the full details and limitations of the benefit options provided. That information is contained in the Plan booklets or contract for each benefit option. This information is available from the applicable insurer or claims administrator or the Members Resources Center or the Trust Officer.***

NOTICE OF PRIVACY PRACTICES

Purpose of This Notice and Effective Date

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

Effective date: The effective date of this Notice is January 1, 2011, as amended effective September 23, 2013.

This Notice is required by law. The SEIU Healthcare NW Health Benefits Trust ("the Trust") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Trust's uses and disclosures of Protected Health Information (PHI);
2. Your rights to privacy with respect to your PHI;
3. The Trust's duties with respect to your PHI;
4. Your right to file a complaint with the Trust and with the Secretary of the United States Department of Health and Human Services (HHS);
5. The person or office you should contact for further information about the Trust's privacy practices;
6. Any breach of your PHI.

Your Protected Health Information

What is Protected Health Information (PHI)?

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Trust in oral, written, or electronic form.

When Can the Trust Disclose Your PHI Without Your Authorization?

Under the law, the Trust may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

1. *At your request.* If you request it, the Trust is required to give you access to certain PHI in order to allow you to inspect and/or copy it.

2. *As required by HHS.* The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Trust's compliance with the privacy regulations.

3. The Trust and its business associates will use PHI *for treatment, payment or health care operations.*

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

Disclosure to your group health plan's Plan Sponsor. The Trust will also disclose PHI to the Plan Sponsor of your group health plan for purposes related to treatment, payment, and health care operations, if the Plan Sponsor has adopted amendments to its Plan Documents to permit this use and disclosure as required by federal law. For example, the Trust may disclose information to the Plan Sponsor to allow it to decide an appeal or review of an eligibility question or a subrogation claim.

When Does the Disclosure of Your PHI Require Your Written Authorization?

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization. Your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to SEIU Healthcare NW Health Benefits Trust. Also, your written authorization generally will be required before SEIU Healthcare NW Health Benefits Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. Psychotherapy notes do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. SEIU Healthcare NW Health Benefits Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct treatment, payment and health care operations.

When Is the Use or Disclosure of My PHI Permitted and My Consent, Authorization or Opportunity to Object Is Not Required?

The Trust is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. When required by applicable law;
2. Public health purposes;
3. Domestic violence or abuse situations;
4. Health oversight activities;
5. Legal proceedings;
6. Law enforcement health purposes;
7. Law enforcement emergency purposes;
8. Determining cause of death and organ donation;
9. Funeral purposes;

10. Research;
11. Health or safety threats;
12. Workers' compensation programs.

Are there Other Uses or Disclosures?

The Trust may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Trust may disclose protected health information to your group health plan sponsor for reviewing your appeal of a benefit claim or for other reasons regarding the administration of the Trust or your employer's group health plan.

Your Individual Privacy Rights

Can I Request Restrictions on Uses and Disclosures of my PHI?

You may request the Trust to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations,
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care; or
3. Restrict disclosure of your health information to someone involved in payment for your care. SEIU Healthcare NW Health Benefits Trust is not required to agree to your request unless the disclosure relates to payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full.

The Trust is not required to agree to your request if the Trust determines your request to be unreasonable.

Make such requests in writing to The Trust Privacy Contact Person at Benefit Solutions, Inc., P.O. Box 6, Mukilteo, WA 98275.

Can I Request Confidential Communications?

The Trust will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Contact Person at the address above.

Can I Inspect and Copy My PHI?

You have a right to inspect and obtain a copy of your PHI for as long as the Trust maintains the PHI.

The Trust must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Trust is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI. A reasonable fee may be charged. Requests for access to PHI should be made to the Privacy Contact Person.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and HHS.

Do I Have the Right to Amend My PHI?

You have the right to request that the Trust amend your PHI or a record about you for as long as the PHI is maintained subject to certain exceptions.

The Trust has 60 days after receiving your request to act on it. The Trust is allowed a single 30-day extension if the Trust is unable to comply with the 60-day deadline. If the Trust denied your request in whole or part, the Trust must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the Privacy Contact Person.

You or your personal representative will be required to complete a written form to amendment of the PHI and include a reason to support the requested amendment.

Do I Have the Right to Receive an Accounting of the Trust's Disclosures of My PHI?

At your request, the Trust will also provide you with an accounting of certain disclosures by the Trust of your PHI. The Trust is not required to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing.

The Trust has 60 days to provide the accounting. The Trust is allowed an additional 30 days if the Trust gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Trust will charge a reasonable fee for each subsequent accounting.

Do I Have the Right to Receive a Paper Copy of This Notice Upon Request?

Yes. To obtain a paper copy of this Notice, contact the Privacy Contact Person, listed above.

Can My Personal Representative Act On My Behalf Regarding My Privacy Rights?

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Trust Administration Office.

The Trust retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Trust will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Trust will automatically consider a spouse to be the personal representative of an individual covered by a group health plan. In addition, the Trust will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Trust restrict information that goes to family members.

Do I have a Right to opt out of Fundraising Communications?

If SEIU Healthcare NW Health Benefits Trust participates in fundraising, you have the right to opt out of all fundraising communications.

The Trust's Duties Regarding Privacy

Maintaining Your Privacy

The Trust is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This Notice is effective beginning on February 1, 2005 and the Trust is required to comply with the terms of this Notice. However, the Trust reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Trust prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Trust still maintains PHI via mail.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to:

1. The uses or disclosures of PHI,
2. Your individual rights,
3. The duties of the Trust, or
4. Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Trust will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. Disclosures to or requests by a health care provider for treatment,
2. Uses or disclosures made to you,
3. Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
4. Uses or disclosures required by law, and
5. Uses or disclosures required for the Trust's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. De-identified information is information that:

1. Does not identify you, and
2. With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Trust may use or disclose "summary health information" to your group health plan's Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

SEIU Healthcare NW Health Benefits Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

Your Right to File a Complaint with the Trust or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with SEIU Healthcare NW Health Benefits Trust as indicated below.

Privacy Officer
SEIU Benefits Group
privacyofficer@myseiubenefits.org

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Trust will not retaliate against you for filing a complaint.

If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following individual at the Trust Administrative Office:

Privacy Officer
SEIU Benefits Group
privacyofficer@myseiubenefits.org

Conclusion

The federal Health Insurance Portability and Accountability Act, known as HIPAA, regulates PHI use and disclosure by the Trust. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
WASHINGTON – Medicaid	
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

SEIU HEALTHCARE NW HEALTH BENEFITS TRUST

Notice of Extension of Time Limits Due to Covid-19

Please read this notice carefully as it may impact your rights to benefits and coverage.

Pursuant to Federal regulations, the Trust will disregard up to one year during the period from March 1, 2020 until 60 days after the COVID-19 emergency ends for the purpose of counting certain timelines and limitations, described below. Only the time limits described below are affected, and all other provisions of the Plan remain in force.

The Trust will not know the end of this period until the government declares the national emergency over. In general, if the affected time limit began running prior to March 1, 2020, it is paused during this period, and any remaining days will resume 60 days after the emergency's end. If the time limit began running during this period, it will begin 60 days after the emergency's end. In no event will any one time limit be extended more than one additional year.

<u>**COBRA Continuation Coverage**</u>

This temporary extension of time affects the following time limits related to COBRA continuation coverage:

- Your 60-day period to elect COBRA continuation coverage after you experience a qualifying event.
- The 45-day period after you elect COBRA before your first payment is due.
- The 30-day grace period for making each monthly COBRA premium payment.

Please note that COBRA coverage will not be provided in a particular month until you have paid the premium for that month.

The following examples assume that the national emergency will end July 1, 2020:

Example 1: **Qualifying event before Outbreak Period.** Employee A experienced a COBRA qualifying event when his hours were reduced below the hours necessary for eligibility. The plan sent him a COBRA election notice on February 1, 2020. Normally, he would have 60 days to elect COBRA continuation coverage. However, due to the extension of time, the 60-day period stopped on March 1 at 29 days. The 60-day limit then resumes on August 30, 2020, 60 days after the emergency ended. Employee A has 31 days to elect COBRA coverage, until September 30, 2020.

Example 2: COBRA premium payments. On March 1, 2020, Employee B was receiving COBRA continuation coverage and making monthly payments. He made the February payment timely, but did not make the March payment or any subsequent payments during the Outbreak Period. As of September 1, he has not made COBRA premium payments for March, April, May, June, July, or August. Because of the extension of time, the 30-day grace period begins running on each of these payments on August 30, 2020, 60 days after the emergency ended. If Employee B pays all

of the required premiums by September 29, 2020, the plan will provide COBRA coverage during those months.

Special Enrollment

Participants and dependents generally have 30 (sometimes 60) days to enroll in the Plan after losing other coverage or after certain life events such as marriage, birth, or adoption. This 30- or 60-day time limit is temporarily extended.

Claims and Appeals

The Plan limits the time in which you can submit a claim for benefits after receiving services. Generally, you must submit a claim within one year after the date services are provided. If your claim for benefits is denied, you generally have 180 days to request the Plan's review of that denial. You may also have a right to request external review of an appeal decision within the following four months.

These claim and appeal timelines are temporarily extended for the period described above, meaning that you may have additional time to submit claims and request review.

More Information

For more information or if you have specific questions regarding your benefits, please contact the Trust's Administrative Office.