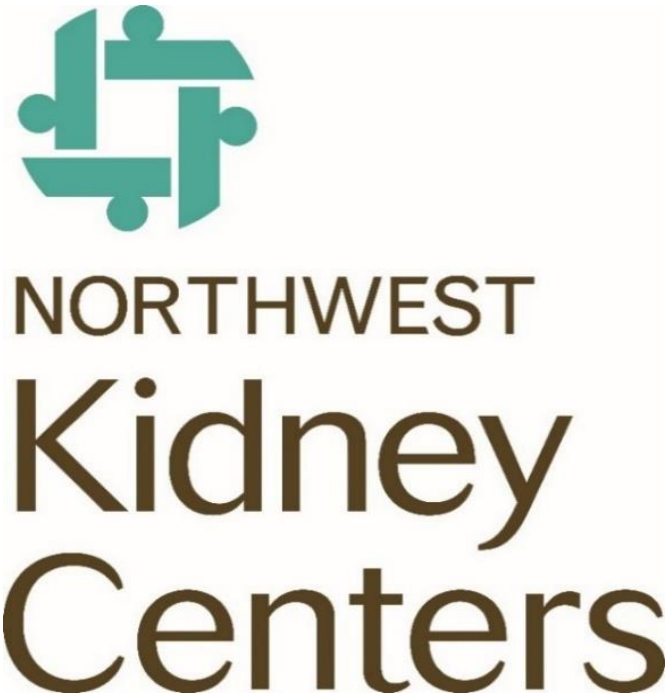

Employee Benefits Guide

January 1, 2023 - December 31, 2023

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WELCOME TO YOUR BENEFITS!

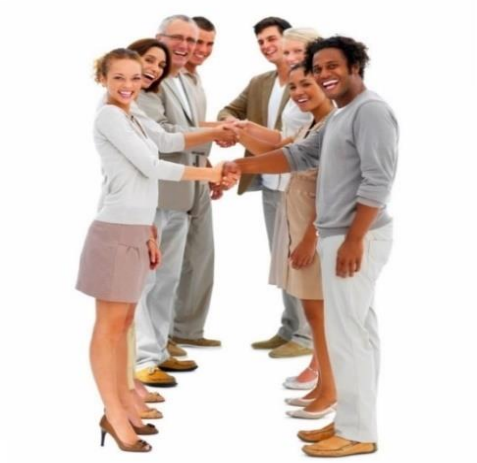
This guide is intended to assist you and your family in understanding and accessing your benefits. We know that occasionally you may need additional information or further explanation about the contents of this booklet. You are welcome to contact Human Resources at your convenience. This booklet provides summary information about:

- **Medical Benefits**
- **Vision Benefits**
- **Dental Benefits**
- **Disability Benefits**
- **Life and AD&D Benefits**
- **Employee Assistance Program**
- **Flexible Spending Account**
- **Health Savings Account**
- **Transit Subsidy**
- **Paid Time Off**
- **Educational Assistance/Tuition Reimbursement**
- **401K Plan**
- **Contacts for Information or Assistance**
- **Legal Notices**

This guide does not constitute a promise or contractual commitment by Northwest Kidney Centers. The company reserves the right to change or terminate any or all benefit plans and programs at any time and without prior notice. Modifications may be necessary to comply with legal requirements at any time.

In the event of inconsistency between statements in this guide and the Plan Documents or Summary Plan Descriptions, the Plan Documents and Summary Plan Descriptions will override the benefit information included here.

If you have questions about your benefits or need assistance with claims resolution, we have a dedicated Employee Benefit Support service provided by AHT Insurance. They offer confidential assistance to you and covered family members. Please see the contact page in this guide.



ELIGIBILITY

Employee

Employees who regularly work 24 hours or more per week are eliglble for our benefits. You are eligible to enroll on the first day of the month following date of hire, or the first day of the month after you enter the eligible class.

Dependents

You may cover your dependents, which include the following:

- Your legal spouse
- Your domestic partner *
- Your children up to the age of 26 (includes stepchildren living with you and/or for whom you legally have financial responsibility)
- Any dependent child who is incapable of self-support due of a physical or mental disability

* Benefits are extended to domestic partners. The IRS requires that benefit values must be included in your gross income, subject to federal income and FICA taxes unless the domestic partner is also your tax dependent. The difference in payroll deductions between the cost to cover you and your domestic partner and the cost to cover just you, is deducted from your pay after taxes have been applied ('post tax'). The contribution that NKC is paying on your behalf for a domestic partner is also added to your taxable income. For more information, please contact Human Resources.

When can you enroll?

- After completing your initial eligibility period
- During the annual open enrollment period
- Within 31 days of a qualified life event

Qualified Life Event Changes

You can make changes to your choices annually during Open Enrollment. Benefits you select are in force until the next Open Enrollment, unless you leave employment or have a qualified status change defined by the IRS. These qualified status changes are:

- Marriage
- Divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you experience one of these events, you must notify Human Resources and complete the necessary forms within 31 days of the event. For more information, refer to your benefit booklets.

COST SHARING

Medical Choices All plans include VSP Vision	Plan 1 Kaiser HDHP PPO Plan & HSA*		Plan 2 Kaiser HMO Plan		Plan 3 Kaiser Traditional PPO Plan	
Per Pay Period Cost Sharing	You Pay	NKC Pays	You Pay	NKC Pays	You Pay	NKC Pays
Employee Only	$0.00	$305.42	$24.77	$331.38	$96.64	$304.90
Employee & Spouse	$136.66	$514.08	$310.16	$448.66	$355.91	$500.17
Employee & Child	$102.69	$386.21	$116.49	$453.40	$133.63	$509.13
Employee & Children	$153.74	$578.34	$174.47	$679.27	$200.23	$763.03
Employee & Spouse & Child	$175.49	$660.04	$398.17	$575.83	$456.79	$641.82
Employee & Spouse & Children	$226.54	$852.18	$514.13	$743.73	$589.99	$829.13

*** Plan 1. We will contribute $500 to your HSA in 2023: $250 in January and $250 in July, if you are (1) employed by NKC , (2) enrolled on Medical Plan 1, and (3) eligible to contribute to a Health Savings Account on these dates.**

Dental Benefits	Delta Dental Base Plan		Delta Dental Buy-Up Plan	
Per Pay Period Cost Sharing	You Pay	NKC Pays	You Pay	NKC Pays
Employee Only	$0.00	$23.54	$3.83	$23.54
Employee & Spouse	$22.56	$23.54	$30.09	$23.54
Employee & Child	$32.07	$23.54	$47.24	$23.54
Employee & Children	$32.07	$23.54	$47.24	$23.54
Employee & Spouse & Child	$54.62	$23.54	$73.50	$23.54
Employee & Spouse & Children	$54.62	$23.54	$73.50	$23.54

We provide Employee Life, AD&D, and Disability Benefits at no cost to you.

You can purchase additional Life Insurance for yourself and your family by payroll deduction.

OVERVIEW OF MEDICAL PLANS

This is a summary only and does not include all details or plan differences. Visit the Knet or https://workforcenow.adp.com for additional information.

Plan 1 **Kaiser HDHP PPO Plan** ***Health Savings Account Eligible*** ***PPO Providers in all States***	**Plan 2** **Kaiser HMO Plan** ***Flex Plan Eligible*** ***Washington Residents Only***	**Plan 3** **Kaiser Traditional PPO Plan** ***Flex Plan Eligible*** ***PPO Providers in All States***
This plan allows HSA and Flex Dependent Care Accounts. **If not HSA-eligible**, you can elect a Flex Health Care Account.	This plan allows Flex Health Care and Dependent Care Accounts, but **not Health Savings Accounts.**	This plan allows Flex Health Care and Dependent Care Accounts, but **not Health Savings Accounts.**
Once you pay your calendar year deductible, you pay 20% for all covered services up to a defined limit.	You pay $30 for doctor visit, deductible waived. Prescriptions have copays, deductible waived.	You pay $30 for doctor visit, deductible waived. Prescriptions have copays, deductible waived.
Preferred Providers	**Preferred Providers**	**Preferred Providers**
WA: Access PPO & Kaiser HMO **OR, AK, MT, ID & parts of WA:** First Choice Health Network **All Other States:** First Health Network	**WA Residents Only:** Kaiser HMO Only **All Other States:** No providers	**WA:** Access PPO & Kaiser HMO **OR, AK, MT, ID & parts of WA:** First Choice Health Network **All Other States:** First Health Network

For assistance finding a Preferred Provider, call the toll free Member Services number on your Kaiser ID card (also in the Contacts page in this guide).

FIND MEDICAL PREFERRED PROVIDERS

Plans 1 & 3 PPO Plans: Residents in any state

If you have an online Kaiser account, you can easily search providers on your plan. If not, follow the instructions below at kp.org/wa.

1. Visit www.kp.org/wa. Choose 'doctors and locations' at the top of the page.
2. Scroll down to 'what can we help you find' and make a choice. If you're not in Washington or a region listed in the dropdown, click on the link 'search additional regional and national affiliates.
3. choose '+ Access PPO'. Scroll down to find your state and click on the link in that section, which takes you to the provider directory for your state. (The PPO networks are also listed above.)
4. Enter search criteria.

Plan 2 HMO Plan: Washington residents Only

If you have an online Kaiser account, you can easily find providers on your plan. If not, follow the instructions below at www.kp.org/wa

1. Click 'Doctors & Locations'
3. Select 'Core' for Health Plan
4. Enter search criteria.

SUMMARY OF MEDICAL PLANS

All family members must enroll on the same plan. This is a summary only and does not include all benefits and exclusions. Visit https://workforcenow.adp.com or the KNet for additional information.

PLAN NAME	Plan 1 Kaiser HDHP PPO Plan & HSA	Plan 2 Kaiser HMO Plan	Plan 3 Kaiser Traditional PPO Plan
PREFERRED PROVIDERS	**WA:** Access PPO & Kaiser HMO **OR, AK, MT, ID & parts of WA:** First Choice Health **All Other States:** First Health	**WA Residents Only:** Kaiser HMO Only **All Other States:** No providers	**WA:** Access PPO & Kaiser HMO **OR, AK, MT, ID & parts of WA:** First Choice Health **All Other States:** First Health
There are no pre-existing condition limitations on any of our medical plans.			
Calendar Year Deductible	$2,000 single $4,000 family of two or more **If insuring family:** family deductible must be paid before benefits are available for any family member, except preventive care.	$1,000 single $2,000 family of two $3,000 family of three or more	$1,000 single $2,000 family of two $3,000 family of three or more
Calendar Year Maximum Out of Pocket Limit	$3,500 single $7,000 family of two or more	$2,200 single $4,400 family of two $6,600 family of three or more	$2,500 single $5,000 family of two $7,500 family of three or more
Preventive Care	Covered in full, deductible waived. (listed services pp. 16-18)	Covered in full, deductible waived. (listed services pp. 16-18)	Covered in full, deductible waived. (listed services pp. 16-18)
Office Visits	You pay 20% (10% at Kaiser) after deductible.	You pay $30 copay, deductible waived.	You pay $30 copay ($20 at Kaiser) deductible waived.
Chiropractic Visits	You pay 20% after deductible. Up to 15 visits per calendar year.	You pay $30 copay, deductible waived. Up to 10 visits per calendar year.	You pay $30 copay, deductible waived. Up to 8 visits per calendar year.
Emergency Services	You pay 20% after deductible at any Emergency facility.	You pay $150 copay then 20% after deductible at any Emergency facility.	You pay $150 copay then 20% after deductible at any Emergency facility.
Outpatient Rehab including massage therapy	You pay 20% after deductible. Up to 60 visits per calendar year.	You pay $30 copay, deductible waived. Up to 60 visits per calendar year.	You pay $30 copay ($20 at Kaiser) deductible waived. Up to 60 visits per calendar year.
Inpatient Facility	You pay 20% after deductible.	You pay 20% after deductible.	You pay 20% after deductible.

SUMMARY OF MEDICAL PLANS

All family members must enroll on the same plan. This is a summary only and does not include all benefits and exclusions. Visit https://workforcenow.adp.com or the KNet for additional information.

PLAN NAME	Plan 1 Kaiser HDHP PPO Plan & HSA	Plan 2 Kaiser HMO Plan	Plan 3 Kaiser Traditional PPO Plan
PREFERRED PROVIDERS	**WA:** Access PPO & Kaiser HMO **OR, AK, MT, ID & parts of WA:** First Choice Health **All Other States:** First Health	**WA Residents Only:** Kaiser HMO Only **All Other States:** No providers	**WA:** Access PPO & Kaiser HMO **OR, AK, MT, ID & parts of WA:** First Choice Health **All Other States:** First Health
Inpatient Rehab	You pay 20% after deductible. Up to 60 days per calendar year.	You pay 20% after deductible. Up to 60 days per calendar year.	You pay 20% after deductible. Up to 60 days per calendar year.
Prescriptions	**Plan deductible waived**	**Plan deductible waived**	**Plan deductible waived**
Retail Pharmacy 30 day supply	You pay 20% (10% at Kaiser) after deductible.	You pay Pref. Generic $20 Pref. Brand $40 NonPref. All $60 Must purchase at Kaiser.	You pay Pref. Generic $20 Pref. Brand $45 ($40 at Kaiser) All NonPreferred $65 ($60 at Kaiser)
Mail Order 90 day supply	You pay 2 times the Kaiser pharmacy coinsurance.	You pay 2 times the copays shown above.	You pay 2 times the Kaiser copays shown above.
All medical plans have the same Kaiser mail order prescription system. It is the most cost-effective and convenient way to purchase your medications.			
Devices, Supplies, Equipment	You pay 20% after deductible.	You pay 20%, deductible waived.	You pay 20% after deductible.
Diagnostic Lab & X-ray	You pay 20% after deductible.	Covered in full, deductible waived.	You pay 20% after deductible.
	Pre-authorization is required for high end outpatient radiology such as CT, MRI and PET unless associated with emergency care.		
Non-preferred Providers	You pay 50% of allowed amount for most services after plan deductible.	No benefits except emergency services, unless referred by your Kaiser PCP.	You pay 40% of allowed amount for most services after plan deductible.
VSP vision benefits are included with all medical plans. See next page.			

SUMMARY OF VISION BENEFITS

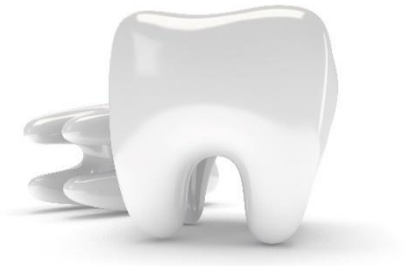
This is a summary only and does not include all benefits and exclusions. Visit https://workforcenow.adp.com or the KNet for additional information.

Automatic enrollment with all medical plans	Vision Service Plan (VSP)	
	VSP Provider	**Non-VSP Provider**
Exam 1 every 12 months	You pay $25 copay then covered in full.	Covered in full up to $45
Lenses 1 pair every 12 months	You pay $25 copay then covered in full for standard lenses. Copay applies to exam, lenses and frame combined.	Single vision: Covered up to $30 Lined bifocal: Covered up to $50 Lined trifocal: Coveredup to $65
Frames 1 pair every 12 months	Covered up to $180 allowance ($100 at Costco). Discount of 20% on any cost above allowance. One $25 copay applies if you are buying exam, lenses & frames at the same time.	Covered up to $70
Contacts Once every 12 months in lieu of frames/lenses	Covered in full up to $180. Fitting and evaluation exam will not exceed $60 copay after 15% discount	Elective: Covered up to $105 Necessary: Covered up to $210

- You can use Costco Optical for your exam and hardware; however, please note not all Costco optometrists are VSP Providers**.** Costco's published prices already include discounts. Costco frame allowance of $100 is equivalent to higher frame allowance at other VSP preferred providers. You can take your prescription from any vision provider to a Costco Optical Shop and take advantage of their frame and lens discounts. You do not have to be a Costco member to use their Optical Shop, as long as you are a VSP enrollee.

- If you use a non-VSP provider, you will pay your provider first and submit a claim to VSP for reimbursement. Claim forms can be found at **www.vsp.com**.

SUMMARY OF DENTAL PLANS



This is a summary only and does not include all benefits and exclusions. Visit https://workforcenow.adp.com or the KNet for additional information.

PREFERRED PROVIDERS	Base Plan Dental Dental Delta PPO Providers	Buy Up Plan Delta Dental Delta PPO Providers
Calendar Year Deductible	None	None
Calendar Year Maximum Benefit	$1,500 per person	$2,500 per person
Class 1 Preventive Services Including exams, X-Rays, cleanings	Covered in full	Covered in full
Class 2 Basic Services Including fillings & root canals	You pay 20%	You pay 20%
Class 3 Major Services Including crowns & bridges	You pay 50%	You pay 50%
Class 4 Orthodontic Services for Adults and Children up to age 26	Not Covered	You pay 50%; plan pays up to $2,000 per person lifetime maximum benefit

Notes apply to both plans:

- **If you use a Delta Premier dentist instead of a Delta PPO dentist**: the coinsurance percentage will be the same as shown above, but you pay $25 per person/$75 per family deductible for Class 2 and 3 services, and your coinsurance costs will be higher. Example: 20% of a Premier dentist's charge is higher than 20% of a PPO dentist's charge.
- **If you use a dentist that is not contracted with Delta at all**: the coinsurance will be the same as shown above, but you pay $25 per person/$75 per family deductible for Class 2 and 3 services. Your coinsurance costs are very likely to be higher because the dentist will likely charge more than a PPO dentist. In addition, a non-contracted dentist can balance bill you for any amounts that are not paid by our dental plans.
- **Pre-Treatment Estimate:** If your dental work will be extensive, your dentist can send the proposed pla of care n to Delta before you begin treatment. Delta will provide an estimate of your out-of-pocket expenses to both you and your dentist.

SUMMARY OF DISABILITY & LIFE BENEFITS

This is a summary only and does not include all benefits and exclusions. Visit https://workforcenow.adp.com or the KNet for additional information.

Employee Disability Benefits provided at no cost to you:

Our disability benefits pay a percentage of your Northwest Kidney Centers wages if you are unable to work due to illness or injury that prevents you from completing some or all of your job duties. These benefits are not payable for on-the-job injuries which are covered by Workers Compensation.

Insurer	**New York Life**
For disabilities lasting up to 26 weeks:	
Maximum Weekly Benefit	60% of pre-disability earnings up to $2,308/week
Benefits Begin on	8th day of a disability
Duration of Benefits	up to 26 weeks (includes 1 week waiting period)
For disabilities lasting longer than 26 weeks:	
Maximum Monthly Benefit	60% of pre-disability earnings up to $10,000/month
Benefits Begin on	181st day of a disability
Duration of Benefits	Up to age 65 or Social Security Normal Retirement Age

During the first 7 days of a disability, you may receive your full wages if you have accrued vacation or sick leave time. The disability benefits shown here are offset by Washington (or other state) disability plans, other income such as Social Security, pension or retirement benefits, but not by income that you contribute to your 401k savings.

Employee Life and AD&D Insurance provided at no cost to you:

Insurer	**New York Life**
Life and AD&D Benefit	1 times Annual Earnings up to $300,000
Benefit Reductions	Age 65: 65% of original amount. Age 70: 45% of original amount. Age 75: 30% of original amount. Age 80: 20% of original amount. Age 85: 15% of original amount. Benefits terminate at retirement.

You may convert this benefit to an individual insurance policy when you retire or terminate employment. Contact HR or the insurance company for assistance.

Additional Life Insurance available through payroll deduction:

Insurer **New York Life**

You have the opportunity to purchase additional life insurance for yourself and family members through payroll deduction.

If you take advantage of this option when first hired, you can purchase a guaranteed amount of life insurance without providing any medical history or having a medical exam.

EMPLOYEE ASSISTANCE PLAN

This is a summary only and does not include all benefits and exclusions. Visit the Knet or https://workforcenow.adp.com for additional information.

Our Employee Assistance Program (EAP) is provided to you at no cost. All employees and household members are eligible for 3 free face-to-face or telehealth visits.

You can speak confidentially to a qualified clinical expert 24/7 by phone for assistance with a wide variety of issues. There is also an extensive library of information and resources online at **www.FirstChoiceEAP.com.**

Administrator: First Choice Employee Assistance Plan

Consultation Services and Online Tools and Resources

- Alcohol and Drug Dependency
- Anxiety and Depression
- Child and Elder Care Resources
- Compulsive Behaviors
- Crisis Support
- Grief and Loss
- Healthy Living Tips
- ID Theft
- Legal and Financial
- Relationships and Parent
- Terminal Illness
- Work Conflicts

Call 800.777.4114 or visit www.FirstChoiceEAP.com

User Name: NWKIDNEY Password: employee

FLEXIBLE SPENDING ACCOUNTS

This benefit allows you to use pre-tax compensation for certain expenses. **This benefit does not require enrollment on a medical/vision plan.** Please review the Navia Flex Plan brochure before enrolling by visiting https://workforcenow.adp.com or the KNet. This is a summary only and does not include all benefits and exclusions.

Health Care Flex Spending Account

For Plan 2 Kaiser HMO and Plan 3 Kaiser Traditional PPO enrollees.
Not for Plan 1 Kaiser HDHP PPO enrollees unless you are not eligible for a Health Savings Account, or you waive Health Savings Account participation.

- Reimbursement for qualified health expenses that are not paid by your insurance plan.
- Over-the-counter medicines and drugs are allowable expenses without a prescription. Menstrual products are also allowable expenses.
- **Maximum election for 2023 is $3,050.**
- If you have funds remaining on December 31, 2023, you can roll over up to **$610 into your 2024 Flex Health Care Account**, as long as you also elect to contribute for the 2024 plan year. (Rollover maximum from 2022 to 2023 is $570.)

Dependent Care Flex Spending Account

Available to all benefit-eligible employees.

- The day care expense must be to allow you (and spouse if applicable) to work, actively look for work or be a full-time student.
- Your dependent must live with you and must be 12 years old or younger.
- The care provider cannot be a dependent on your tax return or your child under age 19.
- A Day Care FSA works like a bank account. You cannot be reimbursed more than you have contributed to the account year to date.
- **Maximum election for 2023 is $5,000.**

HEALTH SAVINGS ACCOUNT (HSA)

Please review the Optum Health Savings account brochure before enrolling by visiting https://workforcenow.adp.com or the KNet. This is a summary only and does not include all benefits and exclusions.

HSA Eligibility

For Plan 1 Kaiser HDHP Access PPO enrollees only.
Please review the Optum HSA brochure before enrolling.

To deposit funds into a Health Savings Account, you must be an adult who meets the following qualifications:

- Be enrolled on an HSA-qualified, high deductible medical plan.
  YES Plan 1 Kaiser HDHP PPO is a qualified plan.
  NO Plan 2 Kaiser HMO is not a qualified plan.
  NO Plan 3 Kaiser Traditional PPO is not a qualified plan.
- Have no other medical insurance plan; however you can have other types of insurance such as dental, vision, disability and long term care coverage.
- Are not enrolled on Medicare or Medicaid.
- Cannot be claimed as a dependent on someone else's tax return.

Calendar Year Contribution Maximum for 2023 from all sources:

- **Single employee enrolled on qualified medical plan (Plan 1 only)** **$3,850**
- **Family enrolled on qualified medical plan (Plan 1 only)** **$7,750**
- **Accountholders age 55 and older can contribute an extra $1,000 per year.**

Who can Contribute?

Deposits to your HSA can be made by anyone including you, your employer or a family member. The combined deposits cannot exceed the HSA maximum calendar year limits shown above.

ADDITIONAL BENEFITS

Please visit https://workforcenow.adp.com or the KNet for additional information.

Paid Time Off (PTO)

We support your need to rest and recharge by offering Paid Time Off. This benefit is pro-rated for employees who work less than 40 hours per week. PTO can be used for any reason such as appointments, sick/personal days and leisure.

Family Medical Leave Administration

New York Life administers our Family Medical Leave (FMLA) benefit. If FMLA is due to an employee's illness or injury, New York Life will streamline the transition process from FMLA to our disability benefits if needed. There is more information available on the KNet or contact Human Resources.

Transit Subsidy

Northwest Kidney Centers subsidizes the ORCA pass and participation in Van Pools.

NKC pays 55% and employees pay 45% of the monthly pass cost for employees who can use public transportation at least 50% of their work time. Passes are purchased by payroll deduction.

Educational Assistance/Tuition Reimbursement

Eligibility: Following one year of service of 500 hours or more.

Northwest Kidney Centers offers up to $4,000 per year for advanced education related to work at NKC.

This may be for an Associate's, BA, BS or Master's Degree.

Full details are available on the KNet: "Tuition Reimbursement Policy".

401K Retirement Savings Plan

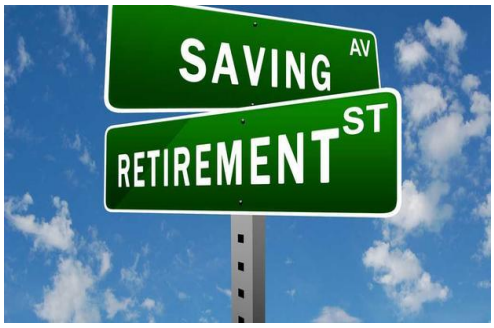
Please visit https://workforcenow.adp.com or the KNet for additional information.

Employees can save for retirement through automatic enrollment in our 401K plan. Employees are eligible for enrollment on the first day of the month following 60 days of continuous employment.

Contributions are made through payroll deductions.
You can self-direct your contributions into a number of investment funds.

Features of the plan include:

- **Employee Pre-tax Contributions**
- **Employer Match Contributions**
- **Employer Discretionary Contributions**



Employer matching contributions begin at the next 401K enrollment period following completion of one year of service of at least 1000 hours.

We will match 100% of your contribution up to 4% of your compensation.

Maximum contribution for 2023 is $22,500 from all sources. If you are age 55 or over the additional catch-up contribution is $7,500.

A discretionary contribution between 1% and 3% may be given to employees who are eligible for our matching contribution. This is not guaranteed to be distributed every year.

STILL HAVE QUESTIONS?

Benefit	Vendor	Contact Information	
Medical **Plan 1 Kaiser HDHP** **Plan 3 Kaiser PPO**	Kaiser Permanente	Customer Service: Network: Website:	888.901.4636 Access PPO www.kp.org/wa
Medical **Plan 2 Kaiser HMO**	Kaiser Permanente	Customer Service: Network: Website:	888.901.4636 Kaiser HMO www.kp.org/wa
Vision	Vision Service Plan	Customer Service: Network: Website:	800.877.7195 VSP Choice www.vsp.com
Dental	Delta Dental	Customer Service: Network: Website:	800.554.1907 Delta PPO www.deltadentalwa.com
FMLA Reporting & Filing **Life, AD/D & Disability** **Voluntary AD/D Life**	New York Life	Customer Service: Website:	888.842.4462. www.mynylgbs.com
Employee Assistance Plan	First Choice	Helpline: Website: User Name: Password:	800.777.4114 www.firstchoiceeap.com NWKidney employee
Flex Plan	Navia Health Solutions	Customer Service: Website:	800.669.3539 www.naviabenefits.com
Health Savings Account	Optum Bank	Customer Service: Website:	866.234.8913 www.optumbank.com
401K Investment Advisor	RBC Wealth Management Retirement Plan Advisors	Customer Service: Email:	866.416.9716 retirementplanadvisors.info@rbc.com
401k Account Access	Prudential Retirement Plan Account Services	NKC Group #: Customer Service: Website:	107105 877.778.2100 www.retirement.prudential.com

Northwest Kidney Centers	**Human Resources**	**206.720.3745**	**HR@nwkidney.org**
Broker Claim Support	**Stephanie Stone**	**206.336.2993**	**stephanie.stone@ahtins.com**

Preventive Services Covered under the Affordable Care Act

The Affordable Care Act (ACA) requires private health insurers to cover recommended preventive services without cost-sharing such as copays and deductibles when receiving these services from a Preferred Provider only. The ACA requires coverage of services with an A or B recommendation from the Preventive Services Task Force. **Visit www.uspreventiveservicestaskforce.org for the most up to date list.**

Covered Preventive Services for Adults

1. Abdominal Aortic Aneurysm one-time screening for men of specific ages who have smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use for men and women of specific ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of specific ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Type 2 Diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. Immunication vaccines for adults, doses and specific ages vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (flu)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diptheria, Pertussis
    - Varicella
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) counseling for adults at higher risk
14. Tobacco Use screening for adults and cessation interventors for tobacco users
15. Syphilis screening for all adults at higher risk

Covered Preventive Services for Women

1. Well-women visits for recommended preventive services
2. Anemia screening on a rouine basis for pregnant women
3. Bacteriuria urinary tract or other infection screening for pregnant women
4. BRCA counseling about genetic testing for women at higher risk
5. Breast Cancer Mammography screenings every 1-2 years for women over 40
6. Breast Cancer Chemoprevention counseling for women at higher risk
7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women
8. Cervical Cancer screening for sexually active women
9. Chlamydia Infection screening for younger women and women at higher risk
10. Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
11. Domestic and interpersonal violence screening and counseling for all women
12. Folic Acid supplements for women who may become pregnant
13. Gestational diabetes screening for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes
14. Gonorrhea screening for all women at higher risk
15. Hepatitis B screening for pregnant women at their first prenatal visit
16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are age 30 or older
18. Osteoporosis screening for women over age 60, depending on risk factors
19. RH Incompatibility screening for pregnant women and follow up testing if higher risk
20. Sexually Transmitted Infections (STI) counseling for sexually active women
21. Syphilis screening for pregnant women or other women at higher risk
22. Tobacco use screening and interventions for all women; expanded counseling for pregnant tobacco users

Covered Preventive Services for Children

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children up to age 18
4. Blood Pressure screening for children up to age 18
5. Cervical Dysplasia screening for sexually active females
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents
8. Developmental screening for children under 3, surveillance through childhood
9. Dyslipidemia screening for children of all ages at higher risk of lipid disorders
10. Fluoride Chemoprevention supplements for nonfluoridated water
11. Gonorrhea preventive medications for all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children up to age 18
14. Hematocrit or Hemoglobin screening
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk
17. Immunization vaccines for children from birth to age 18, doses and ages vary:
    - Tetanus, Diptheria and Pertussis
    - Haemophilus Influenzae Type B
    - Hepatitis A and B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza (Flu Shot)
    - Measles, Mumps and Rubella
    - Meningococcal and Pneumococcal
    - Rotavirus
    - Varicella
18. Iron Supplements for children ages 6 to 12 months at risk for anemia
19. Lead screening for children at risk of exposure
20. Medical History for all children throughout development
21. Obesity screening and counseling
22. Oral Health Risk assessment for children up to age 10
23. Phenylketonuria (PKU) screening for newborns
24. Sexually Transmitted Infection screening/counseling for adolescents at higher risk
25. Tuberculin testing for children at higher risk up to age 18
26. Vision screening for all children

Legal Notices

Women's Health and Cancer Rights Act

Enrollment Notice

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

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

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

Newborns' and Mother's Health Protection Act

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

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 31 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after marriage, birth, or placement for adoption. Example: When hired, you were single and did not elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 31 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What Is "Balance Billing" (Sometimes Called "Surprise Billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You Are Protected From Balance Billing For:
Emergency Services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain Services at an In-network Hospital or Ambulatory Surgical Center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When Balance Billing Isn't Allowed, You Also Have the Following Protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Visit https://www.federalregister.gov/ for more information about your rights under federal law.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	A HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2
ALASKA – Medicaid	**INDIANA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861; Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/; Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
ARKANSAS – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki; Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
CALIFORNIA – Medicaid	**KANSAS – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322; Email: hipp@dhcs.ca.gov	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KENTUCKY – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program. HIBI Customer Service: 1-855-692-6442	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
FLORIDA – Medicaid	**LOUISIANA – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html. Phone: 1-877-357-3268	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Children's Health Insurance Program

MAINE – Medicaid	OREGON – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003; TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740; TTY: Maine relay 711	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MASSACHUSETTS – Medicaid and CHIP	PENNSYLVANIA – Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462
MINNESOTA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/children-and families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
MISSOURI – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
MONTANA – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEBRASKA – Medicaid	TEXAS – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEVADA – Medicaid	UTAH – Medicaid and CHIP
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW HAMPSHIRE – Medicaid	VERMONT– Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW JERSEY – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
NEW YORK – Medicaid	WASHINGTON – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
NORTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100	Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
NORTH DAKOTA – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
OKLAHOMA – Medicaid and CHIP	WYOMING – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

OMB Control Number 1210-0137 (expires 1/31/2023). To see if any other states have added a premium assistance program since January 31, 2022, 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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on My Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about coverage offered by your employer, check your summary plan description or contact **Human Resources.**

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)	
NORTHWEST KIDNEY CENTERS	91-6057438	
5. Employer address	6. Employer phone number	
12901 20th Avenue South	206.292.2771	
7. City	8. State	9. ZIP code
Seatac	WA	98168
10. Who can we contact about employee health coverage at this job?		
Human Resources		
11. Phone number (if different from above)	12. Email address	
206.720.3745	HR@nwkidney.com	

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

- As your employer, we offer a health plan to:

  ☑ All employees. Eligible employees are:

  employees who regularly work at least 24 hours a week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Legal spouse, domestic partner, and children.

  ☐ We do not offer coverage.

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

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

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

Creditable Coverage Disclosure Notice

Important Notice from Northwest Kidney Centers About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Northwest Kidney Centers has determined that the prescription drug coverage offered by the Northwest Kidney Centers Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Northwest Kidney Centers coverage will not be affected. The prescription benefit you have on your current Northwest Kidney Centers plan will not change or terminate. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that you may have available when you become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Northwest Kidney Centers coverage, be aware that you and your dependents will be able to get this coverage back, normally at the next Northwest Kidney Centers open enrollment.

CMS Form 10182-CC Updated April 1, 2011

Creditable Coverage Disclosure Notice

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	Most recent distribution date is approximately November 1, 2022 as part of this guide for Open Enrollment
Name of Entity/Sender:	Northwest Kidney Centers
Contact-Position/Office:	Human Resources
Address:	12901 20th Avenue South
Phone Number:	206.720.3745

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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www.ahtins.com