NORTHWEST
Kidney Centers

2025

Benefit Summary

Live. Learn. Hope.

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If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 25 for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Benefits Overview

Northwest Kidney Centers is proud to offer a comprehensive benefits package to eligible, full-time employees who work 24 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical, dental and vision), and Northwest Kidney Centers provides other benefits at no cost to you (life, accidental death & dismemberment). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

Benefits Offered

- Medical
- Dental
- Vision
- Flexible Spending Account (FSA)
- Health Savings Account (HSA)
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short Term Disability
- Long Term Disability
- Employee Assistance Program

Eligibility

You and your dependents are eligible for Northwest Kidney Centers benefits on the first of the month following date of hire, or the first day of the month after you enter the eligible class of employment.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or Northwest Kidney Centers eligible dependents.

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.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 31 days.

Medical Benefits—HDHP & HMO Plans

Administered by Kaiser Permanente

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Northwest Kidney Centers.

Northwest Kidney Centers offers you a choice of one (1) HDHP, one (1) HMO and one (1) PPO medical plans. Your medical election includes vision coverage through VSP. See page 11 for more information.

	Kaiser HDHP PPO Plan & HSA		Kaiser HMO Plan
	In-Network	Out-of-Network	In-Network
Lifetime Benefit Maximum	Unlimited		Unlimited
Calendar Year Deductible	$2,000 single / $4,000 family (Aggregate)	$4,000 single / $8,000 family (Aggregate)	$1,000 per individual / $3,000 family
Calendar Year Out-of-Pocket Maximum	$3,500 single / $7,000 family (Aggregate)	Unlimited	$2,200 per individual / $6,600 family
Coinsurance	20%	50%	20%
Doctor's Office			
Primary Care Office Visit	20% after deductible	50% after deductible	$30 copay per visit
Specialist Office Visit	20% after deductible	50% after deductible	$30 copay per visit
Preventive Care/Screening/ Immunization	Covered in full	Not covered	Covered in full
Diagnostic Test (x-ray, blood work)	20% after deductible	50% after deductible	Covered in full
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	Covered in Full
Prescription Drugs			
Retail—Preferred Generic Drugs (30-day supply)	20% after deductible; At Kaiser: 10% after deductible	Not Covered	$20 copay
Retail—Preferred Brand Drugs (30-day supply)	20% after deductible; At Kaiser: 10% after deductible	Not Covered	$40 copay
Retail—Non-preferred Drugs (30-day supply)	20% after deductible; At Kaiser: 10% after deductible	Not Covered	$60 copay
Specialty Drugs	Applicable Preferred generic, Preferred brand or Non-Preferred cost shares apply	Not Covered	Applicable Preferred generic, Preferred brand or Non-Preferred cost shares apply
Mail Order—Preferred Generic Drugs (90-day supply)	2x retail cost share	Not Covered	2x retail cost share
Mail Order—Preferred Brand Drugs (90-day supply)	2x retail cost share	Not Covered	2x retail cost share
Mail Order—Non-preferred Drugs (90-day supply)	2x retail cost share	Not Covered	2x retail cost share
Hospital Services			
Emergency Room*	20% after deductible	20% after deductible	$150 copay per visit then** 20% after deductible
Inpatient	20% after deductible	50% after deductible	20% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	$30 copay per visit
Ambulance Service	20% after deductible	20% after deductible	20%

*You must notify Kaiser Permanente within 24 hours if admitted to an out-of-network provider; limited to initial emergency only.
** Copayment waived if admitted directly to the hospital as an inpatient.
Aggregate: If enrolled with any other family member on the medical plan, the limits refer to family regardless of who is accessing care.

Medical Benefits—HDHP & HMO Plans (Continued)

Administered by Kaiser Permanente

	Kaiser HDHP PPO Plan & HSA		Kaiser HMO Plan
	In-Network	Out-of-Network	In-Network
Mental Health Services			
Inpatient Services	20% after deductible	50% after deductible	20% after deductible
Outpatient Services	20% after deductible	50% after deductible	$30 copay per visit
Substance Abuse Services			
Inpatient Services	20% after deductible	50% after deductible	20% after deductible
Outpatient Services	20% after deductible	50% after deductible	$30 copay per visit
Other Services			
Maternity Services (inpatient)	20% after deductible	50% after deductible	20% after deductible
All other maternity hospital/ physician services	20% after deductible	50% after deductible	20% after deductible
Manipulative Therapy Services	20% after deductible (15 visits per calendar year)	50% after deductible (15 visits per calendar year)	$30 copay per visit (10 visits per calendar year)
Physical, Occupational and Speech Therapy Services	20% after deductible (60 visits / 60 inpatient days combined per calendar year)	50% after deductible (60 visits / 60 inpatient days combined per calendar year)	Outpatient: $30 copay per visit (60 visits combined per calendar year) Inpatient: 20% after deductible (60 days combined per calendar year)
Skilled Nursing 60-day calendar year maximum	20% after deductible	50% after deductible	20% after deductible

Note: Pre-authorization is required for high end outpatient radiology such as CT, MRI and PET unless associated with emergency care.

Medical Benefits—PPO Plan

Administered by Kaiser Permanente

	Kaiser Traditional PPO Plan	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited	
Calendar Year Deductible	$1,000 per individual / $3,000 family	$2,000 per individual / $6,000 family
Calendar Year Out-of-Pocket Maximum	$2,500 per individual / $7,500 family	Unlimited
Coinsurance	20%	40%
Doctor's Office		
Primary Care Office Visit	$30 copay per visit	40% after deductible
Specialist Office Visit	$30 copay per visit	40% after deductible
Preventive Care/Screening/ Immunization	Covered in full	40% after deductible
Diagnostic Test (x-ray, blood work)	20% after deductible	40% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible
Prescription Drugs		
Retail—Preferred Generic Drugs (30-day supply)	$20 copay	Not Covered
Retail—Preferred Brand Drugs (30-day supply)	$45 copay; At Kaiser: $40 copay	Not Covered
Retail—Non-preferred Drugs (30-day supply)	$65 copay; At Kaiser: $60 copay	Not Covered
Specialty Drugs	Applicable Preferred generic, Preferred brand or Non-Preferred cost shares apply	Not Covered
Mail Order—Preferred Generic Drugs (90-day supply)	2x retail cost share	Not Covered
Mail Order—Preferred Brand Drugs (90-day supply)	2x retail cost share	Not Covered
Mail Order—Non-preferred Dugs (90-day supply)	2x retail cost share	Not Covered
Hospital Services		
Emergency Room*	$150 copay per visit then 20% after deductible	$150 copay per visit then 20% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Ambulance Service	20% after deductible	20% after deductible

*You must notify Kaiser Permanente within 24 hours if admitted to an out-of-network provider; limited to initial emergency only. Copayment waived if admitted directly to the hospital as an inpatient.

Medical Benefits—PPO Plan (Continued)

Administered by Kaiser Permanente

	Kaiser Traditional PPO Plan	
	In-Network	Out-of-Network
Mental Health Services		
Inpatient Services	20% after deductible	40% after deductible
Outpatient Services	$30 copay per visit	40% after deductible
Substance Abuse Services		
Inpatient Services	20% after deductible	40% after deductible
Outpatient Services	$30 copay per visit	40% after deductible
Other Services		
Maternity Services (inpatient)	20% after deductible	40% after deductible
All other maternity hospital/ physician services	20% after deductible	40% after deductible
Manipulative Therapy Services (8 visits per calendar year)	$30 copay per visit	40% after deductible
Physical, Occupational and Speech Therapy Services (Outpatient: 45 visits combined per calendar year; Inpatient: 30 days combined per calendar year)	Outpatient: $30 copay per visit; Inpatient: 20% after deductible	40% after deductible
Skilled Nursing 60-day calendar year maximum	20% after deductible	40% after deductible

Note: Pre-authorization is required for high end outpatient radiology such as CT, MRI and PET unless associated with emergency care.

VSP vision benefits are included with all medical plans.

Kaiser Provider Networks

PPO/HDHP – Access PPO Network

This Preferred Provider Organization (PPO) plans offer a wide choice of providers. You can elect to use an Access PPO provider or any other provider for your healthcare services. If you choose a network provider, your cost will be less. You do not need a referral for specialist care. You can locate Access PPO providers by visiting the provider directory at www.kp.org/wa.

In addition to the providers you can access locally through Kaiser locations and the Access PPO Network, the PPO plan utilizes First Choice Health and First Health to extend coverage nationwide. Access PPO members are able to use Kaiser Permanente providers in other regions, please call ahead to Kaiser's member services for arrangements (888.901.4636).

- **Access PPO Network**

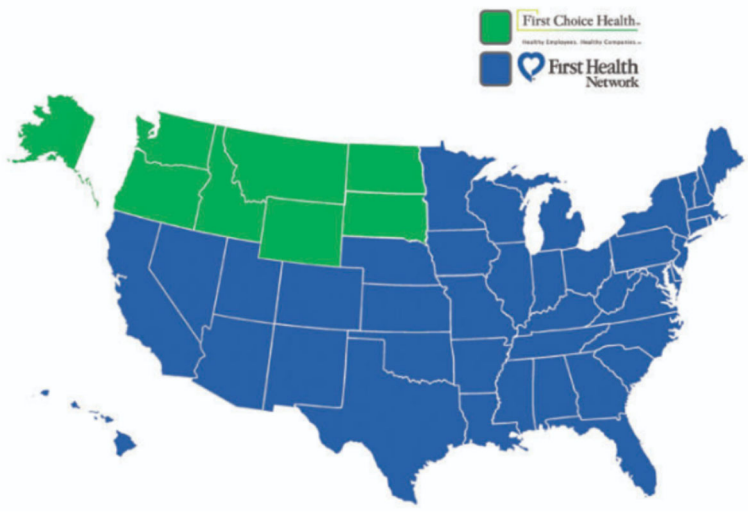
  Extensive network of Washington state providers including Kaiser Washington Permanente Medical Group and over 29,000 providers. www.kp.org/wa *(indicate Access PPO for network)*

- **First Choice Health Network**

  You can access in-network care from an additional 50,000 doctors in Washington, Oregon, Idaho, Alaska, and Montana through this regional network. Find providers on the First Choice Health website.

- **First Health Network**

  You can access in-network care from more than 1.5 million providers in all states nationwide (except for Washington, Oregon, Idaho, Alaska, and Montana) from this national network. Find providers on the First Health Network website.



For additional information and resources on Access PPO Plans, please review Kaiser's Access PPO Member Guide.

HMO Plan – Core Network

With this plan, you select a Kaiser Permanente of Washington provider to designate as your Primary Care Physician (PCP). A provider directory can be found at www.kp.org/wa. You must utilize Kaiser Permanente providers for all services. When traveling and temporarily in another Kaiser Permanente region and you need services, you may visit another Kaiser facility. Kaiser facilities are located in California, Colorado, District of Columbia, Hawaii, Georgia, Maryland, Virginia, Oregon and Washington. **When accessing care at another Kaiser facility in another region, be sure to contact Kaiser to arrange for a visiting member services ID number.**

Services performed by a provider outside the Kaiser network in Washington or outside another Kaiser region when traveling will only be covered if associated with an emergency.

For additional information and resources on the HMO Plan, please review Kaiser's Core Network Member Guide.

How the Plans Work

Three plans use the Kaiser Permanente network and cover 100% of the cost for preventive care services like calendar year physicals and routine immunizations. The way you pay for care is different with each plan.

With the HDHP, you pay the full negotiated cost for medical services and prescription drugs until you meet your calendar year deductible. If you meet the deductible, you and the plan share the costs (coinsurance) until you reach the calendar year out-of-pocket maximum. After that, the plan pays for 100% of your claims for the rest of the year. Your paycheck deductions for this plan are lower than the PPO plan.

The PPO plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your calendar year out-of-pocket maximum. This plan has higher paycheck deductions than the HDHP.

	HDHP	PPO Plan
Per-paycheck Cost for Coverage	$	$$
Calendar Year Deductible	$$	$
Calendar Year Out-of-pocket Maximum	$$	$
Using the Plan	Pay less with each paycheck and more when you need care	Pay more with each paycheck and less when you need care
Spending Account Options	Health savings account (HSA) Dependent care FSA	Health care FSA Dependent care FSA

Paying For Health Care

Northwest Kidney Centers offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

	HSA	FSA
What medical plan can I choose?	HDHP	PPO plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)
When can I use the funds?	Funds are available as you contribute to the account	All of the funds you elect for the year are available on January 1
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	For 2025, only $660 can roll over into the next plan year. Anything over this amount will be forfeited.
How do I pay for eligible expenses?	With your Optum debit card (You can also submit claims for reimbursement online at www.optumbank.com)	With your Navia Health Solutions debit card (You can also submit claims for reimbursement online at www.naviabenefits.com)
How much can I contribute each year?	$4,300 for individual coverage or $8,550 for family coverage (this total includes company funding) and additional $1,000 for catch up contributions in 2025	You can contribute $3,300 in 2025
Can I change my contributions throughout the year?	Yes, you can log on to https://workforcenow.adp.com to change your HSA contributions at any time	No, unless you have a qualifying life event

Dental Benefits

Administered by Delta Dental

Oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Northwest Kidney Centers dental benefit plan.

Services	Delta Dental Base Plan		Delta Dental Buy Up Plan	
	Delta Dental PPO Dentist	Delta Dental Premier / Non-Participating Dentist	Delta Dental PPO Dentist	Delta Dental Premier / Non-Participating Dentist
Calendar Year Deductible *(does not apply to Preventive Services)*	$0	$25 Individual $75 Family	$0	$25 Individual $75 Family
Calendar Year Benefit Maximum	$1,500		$2,500	
Preventive Dental Services (cleanings, exams, x-rays)	Covered in Full		Covered in Full	
Basic Dental Services (fillings, root canal therapy, oral surgery)	20%		20%	
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%		50%	
Orthodontia Services *(adults & children)*	Not Covered		50% to $2,000 per person lifetime maximum	

Notes apply to both plans:

- **If you use a dentist that is not contracted with Delta:** 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: I**f your dental work will be extensive, your dentist can send the proposed plan of care to Delta before you begin treatment. Delta will provide an estimate of your out-of-pocket expenses to both you and your dentist.

Vision Benefits

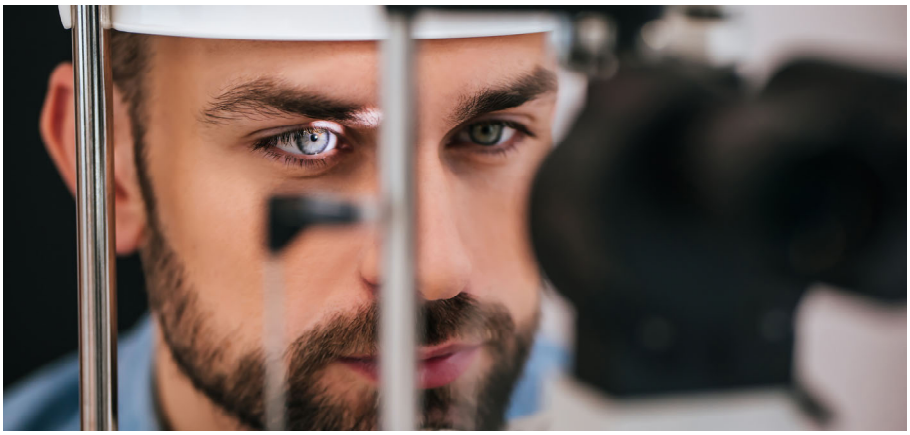
Administered by Vision Service Plan

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Service		In-Network VSP Choice Provider	Out-of-Network Non-VSP Provider
Eye Exam — Once every 12 months		$25 copay	Up to $45
Lenses — One pair every 12 months	Single Vision Lenses	$25 copay Copay applies to exam, lenses and frame combined.	Up to $30
	Lined Bifocal Lenses		Up to $50
	Lined Trifocal Lenses		Up to $65
Frames — One pair every 12 months		Covered up to $225 allowance (up to $245 allowance for featured brands) (up to $125 allowance 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.	Up to $70
Contact Lenses — Once every 12 months in lieu of frames/lenses		Covered in full up to $225. Fitting and evaluation exam will not exceed $60 copay after 15% discount	Elective: Up to $105 Necessary: 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 $125 is equivalent to a 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.



Spending Accounts

Flexible Spending Account

Administered by Navia Health Solutions

Looking for a way to save money on healthcare and/or dependent day care? Flexible Spending Accounts (FSAs) save you money by reducing the taxes you pay. Your FSA contributions are deducted from each paycheck before federal taxes are calculated. So you do not pay taxes on your eligible FSA expenses.

**Those electing an HSA (Healthcare Savings Account) are ineligible for a Healthcare FSA.

How Does an FSA work?

FSA contributions are taken from your paycheck on a pre-tax basis according to your annual elections. Once you have elected your annual deductions, you cannot change your elections under most circumstances.

When you have an eligible healthcare or dependent day care expense, you can pay for it with tax-free money. The accounts are not connected: you pay for healthcare expenses and dependent day care expenses with separate accounts.

You may use money in your FSA to pay for eligible expenses incurred by you, your spouse and your dependents. You and/or your dependents do not have to be enrolled in the medical plan to participate in the healthcare FSA.

Decide How Much to Contribute to Your FSAs

Use the online calculator at www.NaviaBenefits.com to determine how much money you should put into your Flexible Spending Accounts (FSA) to save on taxes when paying for healthcare and dependent care expenses. Login to the Paychex system to enroll.

MyNavia Mobile App

The MyNavia mobile app is a mobile platform that allows you to manage your benefits from the palm of your hand. Available for iPhone and Android devices, the app is free to download and free to use tool for any Navia participant with an active FSA. The app includes access to real-time account balances, tutorial videos, account alerts, and claim submissions. Simply search for "MyNavia" on Google Play or Apple Store and follow the directions.

Reimbursements

Receiving a reimbursement is simple; all you need is a claim form and proper documentation. The documentation needs to show the date of service(s), cost, and the type(s) of expense you are claiming. The date of service for your expense must be within the current plan year. Your welcome packet from Navia Benefit Solutions will contain claim reimbursement details.

Navia Benefits Card

The Navia Benefits Card is a debit card to be used in conjunction with the FSA. The Navia Benefits card enables you to pay for eligible expenses directly from your FSA so you do not have to wait for reimbursement at allowed providers. Please keep your Navia Benefits Card. Your annual election amount will be loaded onto your existing card for use. Your Navia Benefits card will be activated upon your first transaction. If your card is lost or stolen, you may report your card and request a replacement through the online portal or by contacting Navia Benefit Solutions immediately at 800.669.3539. **Keep your receipts!** In the event Navia Benefit Solutions requires documentation for a purchase made with the Navia Benefits card, it is your responsibility to provide the detailed copy of your store receipt (not just a credit slip stating dollar amount).

Spending Accounts (continued)

Healthcare FSA

Administered by Navia Health Solutions

This plan allows you to pay for eligible medical, dental, and vision out-of-pocket expenses with non-taxed dollars.

The amount you designate will be deducted from your paycheck in equal amounts throughout the plan year. Once you incur an eligible expense, you can request reimbursement from your account. Note: You may request reimbursement of up to your entire annual election, even though the money has not yet been placed into your account.

Examples of eligible healthcare expenses:

- Copays for doctor visits and prescription drugs
- Coinsurance for your medical, dental, and vision plans
- Deductible amounts for your medical, dental, and vision plans
- Over-the-counter medicines
- Feminine care products
- COVID tests, face masks, hand sanitizer, at home test kids, and more

2025 Maximum Healthcare Contribution

$3,300

For a complete and updated list, you can visit **www.NaviaBenefits.com**.

Is enrollment in the Healthcare FSA tied to the medical plan?

No. You and/or your dependents do not have to be enrolled in the medical plan to participate in the healthcare FSA.

HDHP plan participants cannot participate in the Healthcare FSA; however, they can put pre-tax money aside in the HSA bank account.

Dependent Care FSA

Administered by Navia Health Solutions

This plan allows you to pay for daycare expenses on a pre-tax basis so you and your spouse can go to work or school. You can use this account for children up to the age of 13 (other individuals may qualify if they are incapable of self-care and are considered taxable dependents).

The amount you designate will be deducted from your paycheck in equal amounts throughout the plan year. You are eligible to be reimbursed as the account is funded. Reimbursements cannot exceed the account balance. The IRS will not allow you to claim a dependent care credit on your Federal Tax Return for reimbursed expenses from the dependent care reimbursement account. Consult your professional tax advisor to determine whether you should enroll in this plan.

Examples of qualified daycare providers:

- Daycare centers
- Before and after school providers
- In-home daycare providers
- Day camp (not overnight)

2025 Maximum Dependent Care Contribution

$5,000 for single employees or married employees filing jointly

$2,500 for married employees filing separately

For a complete and updated list, you can visit **www.NaviaBenefits.com**.

Does my daycare provider need to be licensed?

No. Your provider must be over the age of 18 and cannot be a qualified dependent living in your household. Your provider's Social Security number must be provided at the time of claim. The amount you pay this provider will be reported on your Federal Tax Return and the amount paid should be claimed as income on your provider's Federal Tax Return.

For additional information on FSA plans, including a full list of eligible expenses, please refer to www.NaviaBenefits.com.

2025 Carry Over

You may carry over up to $660 in unused healthcare FSA money from one year to the next. Unused amounts in your Dependent Care FSA cannot be carried over and will be forfeited. To help you plan, use the online calculator at www.NaviaBenefits.com.

Spending Accounts (continued)

Health Savings Account (HSA)

Administered by Optum

Please review the ADP 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.

What is an HSA?

If you enroll in the HDHP, then you may be eligible to open an HSA. An HSA is a bank account where you can set aside money to pay for eligible healthcare expenses that you would be paying for out-of-pocket. The money in your HSA is not considered income, so it is not subject to taxes.

How does an HSA work?

You can use the money in your HSA at any time to pay for eligible medical, dental and vision expenses.

When you visit a provider, no copay is required at the time of service. The provider will submit a claim to your health plan for the services you received.

Your health plan will then send you an Explanation of Benefits (EOB) outlining the negotiated/ allowed charges. The provider will then send you an invoice reflecting the allowed charges. Make sure the amount matches the EOB sent to you by your health plan.

You can then pay the invoice with money from your HSA (either your HSA debit card or as a reimbursement to you). Remember to keep your receipts, in case the IRS requests them.

Who can open an HSA?

You are eligible to open and contribute to an HSA if you meet the following requirements:

- You must be covered by a qualified high deductible health plan.
- You must **not** be enrolled in or covered by Medicare or Tricare.
- You must **not** be covered by your own or a spouse's general Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or any other non HSA-qualified health plan.
- You must **not** be claimed as a tax dependent on another person's taxes.
- You have **not** received any Veteran's Administration health benefits for a non-service connected in the last three months. You have **not** used Indian Health Services coverage in the last three months.

2025 Contributions

IRS Limits:
Employee Only: $4,300
Family: $8,550

Northwest Kidney Center Contribution:
$500

Since your contributions plus your employer's contributions cannot exceed the IRS limit, **your contribution limits** are:

Employee Only: $3,800
Family: $8,050

For individuals 55 or older, an additional $1,000 in "catch-up" contributions are allowed.

Your money rolls over every year. There is no "use it or lose it" rule"

HSAs and Domestic Partners

Domestic partners are eligible to be enrolled in an HDHP plan, however, distributions from the HSA are only allowed if your domestic partner is an IRS qualified tax dependent. Consult your tax advisor for details.

Qualified Medical Expenses (QMEs)

Designated by the IRS and include medical, dental, vision and prescription expenses. This list can be used as a reference to help determine whether an expense is qualified. QMEs are subject to change by the IRS at any time. It is the member's responsibility to verify that expenses incurred are designated by the IRS as a QME. Please visit the IRS website for more information.

Life and AD&D Insurance

Administered by New York Life Insurance

Northwest Kidney Centers provides basic life and accidental death and dismemberment (AD&D) insurance through New York Life Insurance at no cost to eligible employees. If you want additional coverage for yourself, your spouse, or your children, you can purchase voluntary coverage at our group rates.

	How it Works	Basic Life and AD&D (company paid benefit)	Voluntary Life and AD&D (Employee paid benefit)
Life	Your beneficiaries receive this benefit if you pass away	Lesser of 1x annual earnings up to $300,000	**You**: Increments of $10,000; lesser of 5x annual earnings up to $500,000; **Your spouse**: Increments of $5,000 up to $250,000 (not to exceed 50% off EE's amount); **Your child(ren)**: Birth to 14 days: $500; 14 days to 6 months: $1,000; 6 months up to 26 years: $10,000 (not to exceed 100% of EE's amount)
AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	Lesser of 1x annual earnings up to $300,000	An amount mirroring your voluntary life election amount.
Benefits Reduce To:	Benefits begin to reduce at age 65 and terminate at retirement		

When newly eligible, you can elect up to the guarantee issue amounts without medical underwriting (Employee: lesser of 5x earnings or $200,000/Spouse: $40,000). When you apply for coverage as a late entrant, any amount for which you apply will require underwriting.

Keep Your Beneficiaries Up to Date

It is important to designate a beneficiary (the person who will receive the benefit) for your life and AD&D insurance. Please make sure to keep the person's information updated so your benefit is paid according to your wishes. This information is held in ADP

Disability Insurance

Northwest Kidney Centers also provides disability insurance through New York Life Insurance. This benefit replaces a portion of your income if you become disabled and are unable to work.

	How it Works	Who Pays for the Benefit
Short-term Disability	You receive 60% of your income up to $2,308 per week. Benefits begin after 7 calendar days of absence from work and continue for up to 26 weeks.	Company
Long-term Disability	You receive 60% of your income up to $10,000 per month. Benefits begin after 180 calendar days when short-term disability benefits end and continue until you reach the Social Security Normal Retirement Age or to age 65.	Company

Employee Assistance Plan

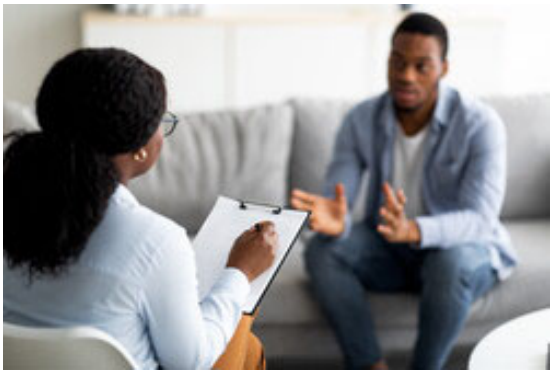
Administered by First Choice Health

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, your spouse or domestic partner and children to age 26 are eligible for 3 free sessions with an EAP provider, either face-to-face or by telehealth visits through Talkspace.

Additional Work Life resources include: Elder and Childcare resources and consultations, Legal and Financial consultations, ID Theft and Fraud consultations, Home Ownership Assistance Program and BenefitHub Discount Program.

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.



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

Contact Information

24/7 Phone Support: 800.777.4114
Website: www.FirstChoiceEAP.com
User Name: nwkidney

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 100% of the monthly pass cost for employees who can use public transportation at least 50% of their work time.

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 2025 is $23,500 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.

Employee Contributions for Benefits

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	$312.06	$24.77	$339.06	$96.64	$313.51
Employee & Spouse	$136.66	$528.04	$310.16	$464.82	$355.91	$518.35
Employee & Child	$102.69	$396.72	$116.49	$465.58	$133.63	$522.80
Employee & Children	$153.74	$593.98	$174.47	$697.41	$200.23	$783.41
Employee & Spouse & Child	$175.49	$678.17	$398.17	$596.80	$456.79	$665.35
Employee & Spouse & Children	$226.54	$875.30	$514.13	$770.53	$589.99	$859.24

*Plan 1: NKC will contribute $500 to your HSA in 2025— $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	$25.18	$3.83	$25.45
Employee & Spouse	$22.56	$26.76	$30.09	$27.29
Employee & Children	$32.07	$27.42	$47.24	$28.49
Employee & Family	$54.62	$29.01	$73.50	$30.33

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Contact Information	
Medical Plan 1 Kaiser HDHP Plan 3 Kaiser PPO	Kaiser Permanente	Phone: Website: Network:	888.901.4636 www.kp.org/wa Access PPO
		Group #:	HDHP Individual: 8154200 HDHP Family: 8154300 PPO: 8496400
Medical Plan 2 Kaiser HMO	Kaiser Permanente	Phone: Website: Network: Group #	888.901.4636 www.kp.org/wa Core HMO 1652100
Dental	Delta Dental	Phone: Website: Network: Group #:	800.554.1907 www.deltadentalwa.com Delta PPO 00835
Vision	Vision Service Plan	Phone: Website: Network: Group #:	800.877.7195 www.vsp.com VSP Choice 30044148
Flexible Spending Account	Navia Health Solutions	Phone: Website: Group #:	800.669.3539 www.naviabenefits.com NKC
Health Savings Account	Optum Bank	Phone: Website: Group #:	866.234.8913 www.optumbank.com HB5432
Employee Assistance Program	First Choice Health	Phone (24/7): Website: User Name:	800.777-4114 www.firstchoiceeap.com nwkidney
FMLA Reporting & Filing Life and AD&D Short Term/Long Term Disability Voluntary Life and AD&D	New York Life	Phone: Website:	888.842.4462 www.mynylgbs.com
401K Investment Advisor	RBC Wealth Management Retirement Plan Advisors	Phone: Email:	866.416.9716 retirementplanadvisors.info@rbc.com
401k Account Access	Empower	Phone: Website:	855.739.7154 participant.empower-retirement.com/
Northwest Kidney Centers	People Team	Phone: Email:	206.720.3745 people@nwkidney.org.
Benefit Advocate Center (BAC)	Gallagher Benefit Services	Phone: Email:	833.817.2952 bac.nwkidney@ajg.com

Legal Notices

Patient Protections Disclosure

The Northwest Kidney Centers Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser Permanente at 888.901.4636 or www.kp.org/wa.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Kaiser Permanente at 888.901.4636 or www.kp.org/wa.

Women's Health & Cancer Rights Act

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 the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Kaiser HDHP PPO Plan & HSA (Individual: 20% coinsurance and $2,000 deductible; Family: 20% coinsurance and $4,000 deductible)
Plan 2: Kaiser HMO Plan (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $3,000 deductible; Individual within a family: 20% coinsurance and $2,000 deductible)
Plan 3: Kaiser Traditional PPO Plan (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $3,000 deductible; Individual within a family: 20% coinsurance and $2,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 206.720.3745 or people@nwkidney.org.

Newborns' and Mothers' Health Protection Act

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

Non-Network Costs (PPO/HDHP Only)

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

Preventive Care

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed under "Your Benefits Contacts" in the back of this guide. Additional information on preventive benefits can be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Legal Notices

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

Legal Notices

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Northwest Kidney Centers is committed to the privacy of your health information. The administrators of the Northwest Kidney Centers Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting People Team at 206.720.3745 or people@nwkidney.org.

HIPAA Special Enrollment Rights

Northwest Kidney Centers Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Northwest Kidney Centers Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact People Team at 206.720.3745 or people@nwkidney.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Legal Notices

Notice of Creditable Coverage

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 prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug 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 join 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 medical 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.

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.

Legal Notices

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:	**January 01, 2025**
Name of Entity/Sender:	**Northwest Kidney Centers**
Contact—Position/Office:	**People Team**
Office Address:	**12901 20th Avenue South** **SeaTac, Washington 98168** **United States**
Phone Number:	**206.720.3745**

Legal Notices

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Northwest Kidney Centers, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: People Team.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov/.

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Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Northwest Kidney Centers
People Team
12901 20th Avenue South
SeaTac, Washington 98168
United States
206.720.3745
people@nwkidney.org

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Legal Notices

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income. [1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact People Team.

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.

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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 Northwest Kidney Centers		4. Employer Identification Number (EIN) 91-6057438
5. Employer address 12901 20th Avenue South		6. Employer phone number 206.720.3745
7. City SeaTac	8. State Washington	9. ZIP code 98168
10. Who can we contact about employee health coverage at this job? People Team		
11. Phone number (if different from above)	12. Email address people@nwkidney.org	

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

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

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

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

Notes

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting