

Western States Health & Welfare Trust Fund of the OPEIU

Open Enrollment Notice

**Enclosed is your 2027 Open Enrollment Booklet
Read Carefully! DEADLINE IS NOVEMBER 25, 2026**

IMPORTANT THINGS FOR YOU TO KNOW FIRST

The enclosed book details plan changes effective January 1, 2027. *If you do not wish to change your retiree medical plan selection or add or remove dependents, no action is required.*

NW Natural retirees eligible for coverage under the Western States Health & Welfare Trust will not be required to opt out of coverage but may elect to opt out. In this case, the retiree will be covered under the voluntary provisions of Section 16.1.3. Please refer to page 69 of the NW Natural Joint Accord for more information.

Northwest Natural Retiree Premium Rate: The 2027 monthly retiree premium is \$498.28.

If you (and/or your dependents) 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 pages 11-12 of the enclosed Open Enrollment packet for more details.

If you wish to make 2027 Plan changes or add/remove dependents, you must submit your completed enrollment form to the Western States Trust office by November 25, 2026.

Online Enrollment is Available

If you wish to add or delete a dependent, or change benefit plans, you can do this online! Simply go to www.westernstatesbenefits.org. Log in and click on Member Benefits and Open Enrollment. You can also upload any required marriage or birth certificates securely using the "Documents to Submit" button.

Important: If you don't have an account yet, you can easily register and create an account on the Trust website. Instructions on self-registration is included.

You can also return your enrollment form by mail, fax, or email:

Mail: Western States Trust Office PMB #116
5331 S Macadam Ave, Suite 258, Portland, OR 97239
Fax: 503-228-0149
Email: westernstates@benesys.com

Need Help?



Email: westernstates@benesys.com
Call Local: 503-224-0048, ext 1678
Call Toll-Free: 1-800-547-4457, ext 1678

Western States Health & Welfare Trust Fund of the OPEIU

Enhanced Member Benefit Website

www.westernstatesbenefits.org

Dear Member:

The Trustees of the Western States Trust Fund of the OPEIU are pleased to offer an enhanced member benefit website, www.westernstatesbenefits.org. This website provides you with a more effective way to access and manage your benefits.

The website enables you to obtain basic benefit information about the Plan, review answers to frequently asked questions, access your personal benefit information, and communicate with the Benefit Office via e-mail. You can also find helpful links regarding benefits provided by the Plan.

To access your personal benefit information, such as your benefit elections, work history detail, forms, and Plan documents, you need to register as a new user by clicking the *Create an Account* link at the top right hand corner in the Login box. More detailed instructions are shown on the back of this letter. Once you are registered, you can access your personal benefit information by entering your *User Name* and *Password*, so please keep these confidential. **Please note, only one user name and password is permitted per email address. If more than one person in your family requires website access, each must use a different email address.**

Every member, spouse, and dependent over the age of 18 will need to create their own login that will give them access to their own Protected Health Information (PHI). Each person that creates their own username and password will not have their PHI available for viewing by any other user.

Please contact the Benefit Office at (800) 547-4457 if you encounter any difficulty logging in, or if you have any questions regarding the Member Benefit website. You can also email the Benefit Office directly by using the "Contact Us" section of the website.

Please visit the enhanced Member Benefit website soon and see all that it has to offer!

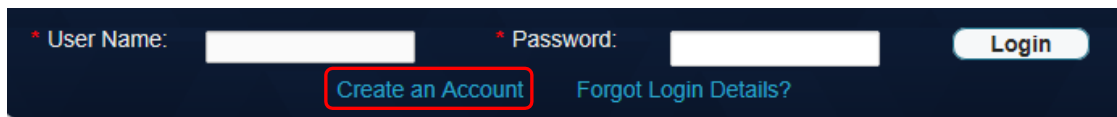
Board of Trustees,

Western States Trust Fund of the OPEIU

HOW TO REGISTER ON THE WEBSITE

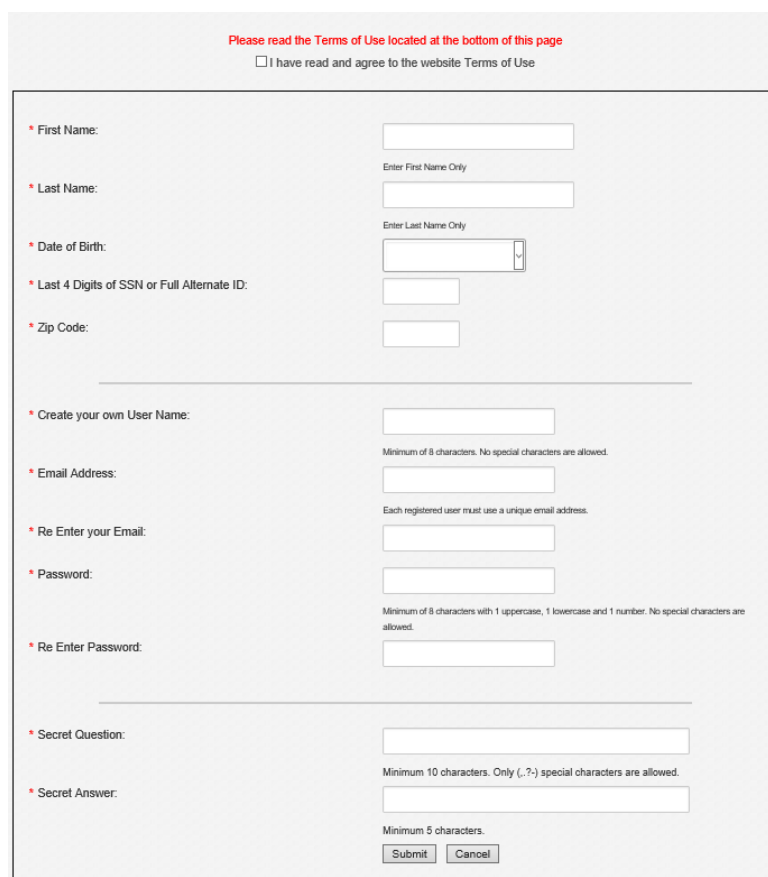
When registering for the first time, please follow these instructions:

- 1) From your computer or mobile device, connect to the website listed on the front page of this letter.
- 2) Locate the Login box in the upper right-hand corner of the screen.
- 3) Click on “Create an Account” to get started.

A dark blue header bar containing login and registration options. It includes fields for 'User Name' and 'Password', a 'Login' button, a 'Create an Account' button (highlighted with a red box), and a 'Forgot Login Details?' link.

* User Name: * Password:
[Create an Account](#) [Forgot Login Details?](#)

- 4) The Registration Screen will display next. Please enter all information, as all fields are required. Once all information has been entered, please click “Submit” on the bottom of the screen.

A registration form with a light gray background. At the top, it says 'Please read the Terms of Use located at the bottom of this page' and has a checkbox 'I have read and agree to the website Terms of Use'. The form fields are: 'First Name' (with a hint 'Enter First Name Only'), 'Last Name' (with a hint 'Enter Last Name Only'), 'Date of Birth' (a date picker), 'Last 4 Digits of SSN or Full Alternate ID', 'Zip Code', 'Create your own User Name' (with a hint 'Minimum of 8 characters. No special characters are allowed.'), 'Email Address' (with a hint 'Each registered user must use a unique email address.'), 'Re Enter your Email', 'Password' (with a hint 'Minimum of 8 characters with 1 uppercase, 1 lowercase and 1 number. No special characters are allowed.'), 'Re Enter Password', 'Secret Question' (with a hint 'Minimum 10 characters. Only (.?-) special characters are allowed.'), and 'Secret Answer' (with a hint 'Minimum 5 characters.'). At the bottom are 'Submit' and 'Cancel' buttons.

Please read the Terms of Use located at the bottom of this page
☐ I have read and agree to the website Terms of Use

* First Name:
Enter First Name Only

* Last Name:
Enter Last Name Only

* Date of Birth:

* Last 4 Digits of SSN or Full Alternate ID:

* Zip Code:

* Create your own User Name:
Minimum of 8 characters. No special characters are allowed.

* Email Address:
Each registered user must use a unique email address.

* Re Enter your Email:

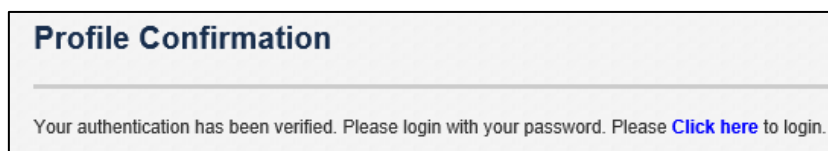
* Password:
Minimum of 8 characters with 1 uppercase, 1 lowercase and 1 number. No special characters are allowed.

* Re Enter Password:

* Secret Question:
Minimum 10 characters. Only (.?-) special characters are allowed.

* Secret Answer:
Minimum 5 characters.

- 5) After registering you will receive an email notification with a link to confirm your registration. Your email address will also be used in the event you forget your user name and password.

A box titled 'Profile Confirmation' with a light gray background. It contains the text: 'Your authentication has been verified. Please login with your password. Please [Click here](#) to login.'

Profile Confirmation

Your authentication has been verified. Please login with your password. Please [Click here](#) to login.



RETIREE BENEFITS GUIDE

2027 PLAN YEAR OPEN ENROLLMENT



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WELCOME TO YOUR 2027 BENEFITS

The Trustees have successfully negotiated another year of benefit plan renewals with the Trust's insurance carriers and administrators. As always, in 2027 we will continue to provide a comprehensive benefit package, helping you and your family stay healthy as well as provide valuable coverage in the event of illness or injury.

There are usually legislatively mandated or administratively imposed changes to health insurance plans each year. Most of the changes being implemented in 2027 are described on page 5 of this handbook.

Due to increases in healthcare costs overall, Trustees have opted to continue subsidizing premiums, reducing the financial impact on you to a level below what other employers in the region are experiencing.

Welcome to your 2027 Benefits. May the upcoming year be filled with good health for you!

TRUSTEE NAME	TITLE	EMPLOYER	CONTACT INFORMATION
Howard Bell	Co-Chair, Labor	OPEIU	hb@opeiu11.org (360) 719-1860
Joseph Karney	Co-Chair, Employer	NW Natural	joseph.karney@nwnatural.com (503) 610-7550
Karyn Morrison	Labor Trustee	OPEIU	km@opeiu11.org (360) 719-1796
Kate Wyllie	Employer Trustee	NW Natural	kate.wyllie@nwnatural.com (971) 225-3799
Cheyenne Russell	Labor Trustee	OPEIU	cr@opeiu11.org (360) 719-1814
Sara Slack	Employer Trustee	Skamania County	sslack@co.skamania.wa.us (509) 427-3976



2027 PLAN YEAR

Open Enrollment November 1-25, 2026.

WHAT YOU NEED TO DO...

REVIEW THE 2027 BENEFITS IN THIS BOOKLET

- The Summary of Material Modification (SMM)
Important Plan Changes
- The Medical Benefit Comparison

DECIDE IF YOU WANT TO MAKE A CHANGE FOR 2027 – THIS IS YOUR CHANCE!

- To change your medical plan elections
- If you do not wish to make any changes to your coverage, **no action is required.**
- **The DEADLINE** to submit your enrollment form is **November 25!**

SEND YOUR COMPLETED ENROLLMENT FORM TO WESTERN STATES TRUST:

- **Mail:** PMB#116, 5331 S Macadam Ave., Suite 258,
Portland, OR 97239
- **Fax:** (503) 228-0149
- **Email:** westernstates@benesys.com
- **Enrollment forms can be found online at:**
www.westernstatesbenefits.org

CONTACT US:

- **Local:** (503) 224-0048
- **Toll Free:** (800) 547-4457 ext. 1678
- **Email:** westernstates@benesys.com

KEEPING YOUR COSTS DOWN

- The OPEIU Health and Welfare Trustees work diligently with the health plans to minimize rate increases in order to provide you and your family with a comprehensive **benefits package.**

DID YOU KNOW?

- If you and or your dependents will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see compliance notices for more details.

SUMMARY OF MATERIAL MODIFICATIONS (SMM)

Important benefit changes to your health plan effective Jan. 1, 2027

This plan is not Grandfathered under the Patient Protection and Affordable Care Act.

REGENCE BLUECROSS BLUESHIELD OF OREGON

MEDICAL

- Routine physical exams, well-women's care includes screening for cervical cancer.
- Members are no longer required to select a primary care physician or practitioner. OR HB4040

PHARMACY

- MedsYourWay-Retail discount prescription card built in benefit. Compares plan covered benefit pricing to available discount card prices and applies the lowest price option at the pharmacy.
- Amazon Home Delivery is the exclusive mail order pharmacy replacing Express Scripts.

KAISER PERMANENTE

MEDICAL

- No benefit changes.

MEDICAL & PHARMACY COMPARISON

REGENCE BLUECROSS BLUESHIELD OF OREGON				KAISER PERMANENTE
PROVIDERS / FACILITIES	PREFERRED PROVIDERS (PPO)	PARTICIPATING PROVIDERS	NON-PARTICIPATING NON-PPO PROVIDER ¹	KAISER PERMANENTE PROVIDERS & CONTRACTED FACILITIES
Calendar Year (CY) Maximum	None			None
Calendar Year (CY) Deductible	\$300 per individual - \$600 per family			None
Medical Calendar Year (CY) Out-of-Pocket Maximum (OOPM)	\$3,000 per individual \$6,000 per family		\$6,000 per individual \$12,000 per family	\$3,500 per individual \$7,000 per family
Provider Office / Clinic Visit	MEMBER PAYS after deductible (unless otherwise noted with * = deductible waived):			MEMBER PAYS:
- Primary care (injury or illness) - Virtual Care / Telehealth - Specialist - Other practitioner (Acupuncture, Chiro)	\$20 copay / visit*² \$10 copay / visit* \$20 copay / visit* 20%*⁵	\$20 copay / visit* \$20 copay / visit* \$20 copay / visit* 20%*⁵	40% 40% 40% 20%*⁵	\$15 copay / visit ^{3,4} - No cost share \$15 copay / visit \$10 copay / visit ⁶
Preventive Care	No cost share*	No cost share*	40%⁷	No cost share
Outpatient Testing - Diagnostic tests (x-ray, blood work) - Imaging (CT/PET scans, MRIs)	20%* 20%*	40% 40%	40% 40%	\$20 copay/visit \$20 copay / visit
Prescription Drugs RX Calendar Year Out-of-Pocket Maximum Value medications - Generic medications - Preferred brand medications - Non-preferred brand medications - Specialty medications	\$4,300 per individual - Retail and Mail Order: \$0 copay (Optimum Value medications) - Retail: \$10 or 20% (whichever is greater) - Mail Order: \$20 or 20% (whichever is greater) - Retail: \$20 or 20% (whichever is greater) - Mail Order: \$40 or 20% (whichever is greater) - Retail & Mail Order: 50% - Paid according to their formulary designation			- None - Specific list of medications apply - Retail: \$15 copay - Mail Order: \$30 copay - Retail: \$30 copay - Mail Order: \$60 copay - Retail: \$50 copay - Mail Order: \$100 copay - Paid according to their formulary designation
Outpatient surgery - Facility fee - Physician / surgeon fees	20%⁸ 20%	40% 40%	40% 40%	- No cost share \$15 copay / procedure
Emergency Care - Emergency Room - Emergency medical transportation - Urgent care	\$75 copay/visit, then 20% 20% \$20 copay / visit ⁹	\$75 copay/visit, then 20% 20% \$20 copay / visit⁹	\$75 copay/visit, then 20% 20% 40%	\$75 copay / visit \$75 copay / transport \$15 copay / visit
Hospital - Facility fee - Physician / Surgeon Fees	20% 20%	40% 40%	40% 40%	\$100 copay / day (\$500 max/CY) - No cost share
- Mental Health / Substance Abuse Inpatient services - Outpatient services	20% \$20 copay / visit*²	20% \$20 copay / visit*²	40% 40%	\$100 copay / day (\$500 max/CY) \$15 copay / visit
- Maternity - Prenatal and postnatal care - Delivery and all inpatient services	20% 20%	40% 40%	40% 40%	\$15 copay / office visit¹⁰ \$100 copay / day (\$500 max/CY)
- Recovery or special health needs Home health care¹¹ - Rehabilitation services (OT, PT, ST) - Skilled nursing care - Durable medical equipment	20% 20%¹² 20% 20%	40% 40%¹² 40% 40%	40% 40%¹² 40% 40%	- No cost share \$15 copay / visit (20 visits/CY) - No cost share 20%

Please note: This is a summary of benefits only, for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this comparison and the plan document, the information in the plan document shall prevail.

1. Members may be balanced billed for balances beyond any deductible and coinsurance amounts.

2. The first three mandated primary care/behavioral health (Preferred providers only) office visit or psychotherapy visits are covered after a \$5 copay. Regular plan cost shares apply for subsequent visits.

3. First preventive care visits each year, either virtually or in-person covered at no member cost share.

4. First three visits each year for primary care or primary care related services are covered after a \$5 copay per visit.

5. Chiropractic spinal manipulations are limited to 30 visits, and are combined with osteopathic spinal manipulation visits for a combined 30 visits per calendar year. Acupuncture visits are limited to 30 visits per calendar year.

6. Chiropractic care is limited to 20 visits per calendar year. Self-referred acupuncture is limited to 12 visits per calendar year. Copays do not apply to the out-of-pocket maximum (OOPM).

7. Immunizations for children up to age 18 are covered in full.

8. Coinsurance is reduced to 10% when in-network Preferred Provider Ambulatory Surgery Centers are used.

9. Members are responsible for their portion of any ancillary charges, e.g. x-rays, lab work, and outpatient surgery.

10. Prenatal care is considered preventive, therefore there is no cost share and the copay does not apply.

11. Up to 130 visits per year

12. Inpatient: 60 day limit/CY; Outpatient: 45 visit limit/CY (combined limit includes occupational therapy (OT), physical therapy (PT), and speech therapy (ST)).

HEALTH PLAN CONTACT INFORMATION

BENEFIT	PROVIDER	CUSTOMER SERVICE INFORMATION	WEB INFORMATION
Medical and Prescription Drug	Regence BCBSO Group # 10010748	1.888.370.6157	www.regence.com
	Regence BCBSO Group # 10010748	1.844.765.2894	www.regence.com/pharmacy
	Mail order Prescription Drugs - Express Scripts Pharmacy	1.833.599.0451	www.expressscripts.com
	Kaiser Permanente Group # 1616	1.800.813.2000	www.kp.org
	Kaiser Permanente Group # 1616 Mail order Prescription Drugs	1.800.548.9809	www.kp.org/refill

If you have specific questions about treatment or how benefits apply to your situation, call the insurance provider directly.

24 HOUR PHONE NUMBERS FOR URGENT HELP

Regence BCBSO nurse advice line: 1.800.267.6729, Press 1
Kaiser Permanente nurse advice line: 1.800.813.2000

REQUIRED ANNUAL COMPLIANCE NOTICES

Dependent Audit

As part of our ongoing commitment to benefit plan compliance and responsible administration, the **Western States Health & Welfare Trust Fund of the OPEIU, Local 11** is conducting a dependent eligibility verification through iVerifyPro.

If you have enrolled dependents, your participation is required to maintain their coverage. iVerifyPro will assist you throughout the process.

On **February 1, 2027**, iVerifyPro will mail instructions for submitting the required documentation through its secure online portal. Please submit your documents by **March 4, 2027**, to avoid any interruption in coverage.



Note: *Termination of benefits due to failure to respond or dependent ineligibility is **NOT** a COBRA-qualifying event.*

2027 Plan Year Annual Compliance Notice

Women's Health and 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 this plan.

If you would like more information on WHCRA benefits, contact Regence BlueCross BlueShield of Oregon or Kaiser Permanente.

For more information regarding your rights after a mastectomy, visit:

<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf>

Newborns and Mothers' Health Protection Act

Special Rights on Childbirth

Group health plans and health insurance issuers offering group insurance coverage 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 normal 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 the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

HIPAA Notice of Privacy Practices Availability Notice

The Western States Health & Welfare Trust Fund of the OPEIU maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan.

You have the right to request a copy of the Plan's Notice of Privacy Practices from the Trust Office by submitting a written request to:

PMB #116 S Macadam Ave, Suite 258
Portland, OR 97239

You may also obtain a copy of this notice on the Plan's website: www.westernstatesbenefits.org.

2027 Plan Year Annual Compliance Notice

TO: Western States Health & Welfare Trust Fund of the OPEIU Participants and Their Eligible, Covered Dependents

REGARDING: Prescription Drug Coverage and Medicare

We are sending this notice to all employees, early retirees and COBRA participants currently covered under the Western States Trust medical plans. This notice is intended for participants who are eligible for Medicare. **If you are NOT and NO ONE in your immediate family is eligible for Medicare you may disregard this notice.**

If you or a covered dependent is eligible for Medicare, please read this notice carefully and keep it where you can find it. This notice has information about Western States Trust pharmacy plan and about your options under a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost 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.

Following are some important points about Medicare Prescription Drug (Medicare Part D) 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. Regence BlueCross BlueShield of Oregon and Kaiser Permanente have determined that the prescription drug coverage offered by Western States Trust is, on average for all plan participants, expected in 2027 to pay out as much or more than what the standard Medicare prescription drug coverage would be expected to pay on average 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 prescription drug plan.
3. **Read this notice carefully** – it explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 enroll in a Medicare prescription drug plan and drop your coverage under the Western States Trust pharmacy plan you and your covered dependents will automatically lose coverage under the Trust medical plan as well. You may not be able to get this coverage back at a future date. In addition, Western States Trust is not permitted to contribute to your premiums should you elect to drop the Trust's sponsored coverage.

2027 Plan Year Annual Compliance Notice

Remember, your current coverage pays for other health expenses, in addition to prescription drugs. You will still be eligible to receive all your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. However, you may not exclude prescription drug coverage from your Regence BlueCross BlueShield of Oregon or Kaiser Permanente plan.

If your coverage is a result of active employment, under Regence BlueCross BlueShield of Oregon, your prescription drug coverage would be primary. Regence BlueCross BlueShield of Oregon does not coordinate with Medicare, but Medicare would be secondary. While enrolled under Kaiser, if a secondary Medicare Prescription drug plan was purchased outside of Kaiser, Kaiser is not capable of coordinating with Medicare if drugs are purchased outside of the Kaiser system.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose coverage under Western States Trust's pharmacy plan and don't enroll in Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug coverage later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium will go up 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 19 months without coverage, your premium will always 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 next October to enroll.

Information regarding your pharmacy benefits has been provided to you in your benefit comparison and Summary Plan Description (SPD). NOTE: You may receive this notice at other times in the future, such as before the next period you may enroll in Medicare prescription drug coverage, and if Western States Trust's coverage changes. You also may request another 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 available in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also get more information about Medicare prescription drug plans from the following:

- Centers for Medicare, Medicaid Services (CMS/Medicare): www.medicare.gov , or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Senior Health Insurance Benefits Assistance program (SHIBA - their telephone number is noted in the Medicare & You handbook).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online 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 prescription 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:	October 2026
Name of Entity:	Western States Health & Welfare Trust Fund of the OPEIU
Contact:	BeneSys, Inc.
Address:	PMB #116 5331 S Macadam Ave., Suite 258, Portland, OR 97239
Phone:	503-224-0048



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, go to <https://regence.com> or call 1-888-367-2116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-888-367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$300 individual / \$600 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> , <u>prescription drug coverage</u> and those services listed below as "deductible does not apply." "No charge" means \$0 <u>copayment</u> or 0% <u>coinsurance</u> , regardless of <u>deductible</u> applicability.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Preferred provider</u> and <u>participating provider</u> : \$3,000 individual / \$6,000 family per calendar year. <u>Non-participating provider</u> : \$6,000 individual / \$12,000 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>prescription drug out-of-pocket limit</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See https://regence.com/go/OR/Preferred or call 1-888-367-2116 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the preferred <u>network</u> . You pay more if you use a <u>provider</u> in the participating <u>network</u> . You will pay the most if you use a <u>non-participating provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use a <u>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Preferred Provider (You pay the least)	What You Will Pay Participating Provider (You pay more)	Non-participating Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$5 <u>copay</u> / upfront office visits, <u>deductible</u> does not apply; \$20 <u>copay</u> / additional office visits, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for other services	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 40% <u>coinsurance</u> for other services	40% <u>coinsurance</u>	First 3 upfront office visits / year. Limit is for primary care and behavioral health visits combined.
	<u>Specialist</u> visit	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for other services	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 40% <u>coinsurance</u> for other services	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Coinsurance and deductible do not apply for childhood immunizations from <u>non-participating providers</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	40% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	Preferred Provider (You pay the least)	What You Will Pay		Limitations, Exceptions, & Other Important Information
			Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://regence.com/go/2027/OR/3tierStd	Tier 1 (Typically, generic drugs with highest overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	\$10 <u>copay</u> or 20% <u>coinsurance</u>,* <u>deductible</u> does not apply / retail prescription; \$20 <u>copay</u> or 20% <u>coinsurance</u>,* <u>deductible</u> does not apply / home delivery prescription; *whichever is greater \$10 <u>copay</u>, <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription	\$10 <u>copay</u> or 20% <u>coinsurance</u>,* <u>deductible</u> does not apply / retail prescription; \$20 <u>copay</u> or 20% <u>coinsurance</u>,* <u>deductible</u> does not apply / home delivery prescription; *whichever is greater \$10 <u>copay</u>, <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription	<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. No charge, <u>deductible</u> does not apply for drugs specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. Medications for the treatment of anorexia and weight loss medications limited to \$500 combined retail prescription and home delivery prescription per individual / lifetime. <u>Out-of-pocket limit</u>: \$4,300 individual per calendar year. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / home delivery prescription 30-day supply / <u>specialty drug</u> prescription <u>Specialty drugs</u> are not available through home delivery. Coverage includes compound medications at 50% <u>coinsurance</u>, <u>deductible</u> does not apply. <u>Cost shares</u> for insulin will not exceed \$35 / 30-day supply or \$105 / 90-day supply. No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u>. The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Tier 2 (Typically, brand drugs with moderate overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	\$20 <u>copay</u> or 20% <u>coinsurance</u>,* <u>deductible</u> does not apply / retail prescription; \$40 <u>copay</u> or 20% <u>coinsurance</u>,* <u>deductible</u> does not apply / home delivery prescription;	\$20 <u>copay</u> or 20% <u>coinsurance</u>,* <u>deductible</u> does not apply / retail prescription; \$40 <u>copay</u> or 20% <u>coinsurance</u>,* <u>deductible</u> does not apply / home delivery prescription;	

Common Medical Event	Services You May Need	Preferred Provider (You pay the least)	What You Will Pay Participating Provider (You pay more)	Non-participating Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
			*whichever is greater \$50 <u>copay</u> , <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription	*whichever is greater \$50 <u>copay</u> , <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription	
	Tier 3 (Typically, brand drugs with lower overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	50% <u>coinsurance</u> , <u>deductible</u> does not apply / retail prescription; 50% <u>coinsurance</u> , <u>deductible</u> does not apply / home delivery prescription; \$100 <u>copay</u> , <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription	50% <u>coinsurance</u> , <u>deductible</u> does not apply / retail prescription; 50% <u>coinsurance</u> , <u>deductible</u> does not apply / home delivery prescription; \$100 <u>copay</u> , <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription	
	<u>Specialty drugs</u>	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	Refer to tier 1, 2 and 3 drugs above.	Refer to tier 1, 2 and 3 drugs above.	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> for ambulatory surgery center physicians; 20% <u>coinsurance</u> for all other physicians	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$75 <u>copay</u> / visit	20% <u>coinsurance</u> after \$75 <u>copay</u> / visit	20% <u>coinsurance</u> after \$75 <u>copay</u> / visit	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$20 <u>copay</u> / visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for other services	\$20 <u>copay</u> / visit, <u>deductible</u> does not apply; 40% <u>coinsurance</u> for other services	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 <u>copay</u> / upfront office or psychotherapy visits, <u>deductible</u> does not apply; \$20 <u>copay</u> /	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; No charge for other services, <u>deductible</u> does not apply	40% <u>coinsurance</u>	First 3 upfront visits / year. Limit is for primary care and behavioral health visits combined.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
		additional office or psychotherapy visits, <u>deductible</u> does not apply; No charge for other services, <u>deductible</u> does not apply			
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	130 visits / year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	60 inpatient days / year 45 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	25 neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	100 inpatient days / year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|---|------------------------|---|
| • Cosmetic surgery, except congenital anomalies | • Long-term care | • Routine foot care, except for diabetic patients |
| • Dental care | • Private-duty nursing | • Weight loss programs |
| • Infertility treatment | • Routine eye care | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---------------------------------|---|--|
| • Abortion | • Chiropractic care, 30 spinal manipulation visits / year | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture, 30 visits / year | • Hearing aids, 1 per ear / year | |
| • Bariatric surgery | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1-888-367-2116. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-888-367-2116 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling 1-503-947-7984 or the toll-free message line at 1-888-877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.gov.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-367-2116.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of preferred provider pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,770

Managing Joe's Type 2 Diabetes

(a year of routine preferred provider care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,100

Mia's Simple Fracture

(preferred provider emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

The plan would be responsible for the other costs of these EXAMPLE covered services.

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-800-813-2000 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-813-2000 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$3,500 Individual / \$7,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-800-813-2000 (TTY: 711) for a list of Participating Providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes, but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 / visit	Not covered	\$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Specialist visit	\$15 / visit	Not covered	None
	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Xray: \$20 / visit. Lab tests: \$20 / visit.	Not covered	None
	Imaging (CT/PET scans, MRI's)	\$20 / visit	Not covered	Some services may require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	\$15 (retail) & \$30 (mail order) / prescription .	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	\$30 (retail) & \$60 (mail order) / prescription .	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	\$50 (retail) & \$100 (mail order) / prescription .	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through exception process.
	Specialty drugs	\$50 (retail) / prescription	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through exception process.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$15 / visit	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need immediate medical attention	Emergency room care	\$75 / visit	\$75 / visit	Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	\$75 / trip	\$75 / trip	None
	Urgent care	\$15 / visit	Not covered	Non-participating providers covered when temporarily outside the service area. \$15 / visit
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 / day up to \$500 / year.	Not covered	Prior authorization required.
	Physician/surgeon fee	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit	Not covered	\$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Inpatient services	\$100 / day up to \$500 / year.	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	Professional services are included in the facility fee.
	Childbirth/delivery facility services	\$100 / day up to \$500 / year.	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	130 visit limit / year. Prior authorization required.
	Rehabilitation services	Outpatient: \$15 / visit Inpatient: \$100 / day up to \$500 / year.	Not covered	Outpatient: 20 visit limit / therapy / year. Prior authorization required. Inpatient: Prior authorization required.
	Habilitation services	\$15 / visit	Not covered	20 visit limit / therapy / year. Prior authorization required.
	Skilled nursing care	No charge	Not covered	100 day limit / year. Prior authorization required.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Prior authorization required.
	Hospice service	No charge	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	\$15 / visit for refractive exam	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
- Children's glasses - Cosmetic surgery - Dental care (Adult & Child)	- Long-term care - Non-emergency care when traveling outside the U.S. - Private-duty nursing	- Routine foot care - Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
- Acupuncture (12 visit limit / year) - Bariatric surgery	- Chiropractic care (20 visit limit / year) - Hearing aids (Under age 26: 1 aid / ear / 36 months)	- Infertility treatment - Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-813-2000 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Oregon Department of Insurance	1-888-877-4894 or https://dfr.oregon.gov/
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-813-2000 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-813-2000 (TTY: 711) uff

NAVAJO (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-813-2000 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-813-2000 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-800-813-2000 (TTY: 711)

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$15	■ Specialist copayment	\$15	■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$100	■ Hospital (facility) copayment	\$100	■ Hospital (facility) copayment	\$100
■ Other (blood work) copayment	\$20	■ Other (blood work) copayment	\$20	■ Other (x-ray) copayment	\$20
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$200	Copayments	\$700	Copayments	\$300
Coinsurance	\$0	Coinsurance	\$10	Coinsurance	\$50
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$260	The total Joe would pay is	\$710	The total Mia would pay is	\$350

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

This notice is available at <https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice>.

For Washington Members:

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 1-800-562-6900, or 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/online-services/cc/pub/complaintinformation.aspx>.

Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-813-2000**(TTY: 711).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆኑ ተገቢ የሆኑ ረዳት መርሻዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: 711)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-813-2000** (TTY: 711).

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-813-2000** (TTY: 711)。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است. با **1-800-813-2000** تماس بگیرید (TTY تلفن متنی): **(711)**.

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-813-2000** an (TTY: 711).

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。
1-800-813-2000 までお電話ください (TTY: 711)。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់: បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសមស្រប ដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: 711)។

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다.
1-800-813-2000로 전화해 주세요(TTY: 711).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: 711).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-813-2000** irratti bilbilaa (TTY:- **711**)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**)।

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la **1-800-813-2000** (TTY: 711).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).

WESTERN STATES HEALTH & WELFARE TRUST OF THE OPEIU

PMB #116,5331 S Macadam Ave Ste 258, Portland, OR 97239

Phone (503) 224-0048 or (800) 547-4457, ext. 1678 Fax (503) 228-0149 email westernstates@benesys.com☐ **OPT OUT FROM MEDICAL/ DENTAL, AND VISION PLANS. (MUST COMPLETE "OTHER CURRENT COVERAGE" SECTION BELOW)** **NWN****MEDICAL PLAN DESIRED**

- ☐ REGENCE BCBS PPO PLAN
☐ KAISER PERMANENTE

**Note: Choice of coverage is offered
to new employees or during Open
Enrollment**

I am applying:**For open enrollment**

- ☐ To add Spouse (**Also reverse side of form is required**)
☐ To add Domestic Partner (**Also reverse side of form and
Autopay form are required**)
☐ To add child(ren)
☐ To remove family member(s)

☐ When completing this form, if you
require additional space, please attach an
additional page. Please check this box if
additional pages are attached.

EMPLOYEE INFORMATION (This section must always be completed when enrolling for the first time or making changes)

Employee Last Name		First Name	MI	Sex F ☐ M ☐	Date of Birth		Local Union #
Social Security #		Email Address		Employer			Hire Date
Mailing Address			City	STATE	ZIP	Phone ()	☐ Mobile ☐ Home
Marital Status: ☐ Married ☐ Never Married ☐ Domestic Partner ☐ Divorced ☐ Widowed		Date of Marriage: _____ Date of Divorce or Death of Spouse/Partner: _____				Work Phone ()	

DEPENDENT INFORMATION (All information requested must be completed. If any item is not applicable, write "N/A")

Requirements when enrolling dependents: If enrolling a spouse or domestic partner, completion of the reverse side of this form is **required**, along with a marriage certificate photocopy for spouse, autopay form for domestic partner, and birth-certificate photocopies for children.

Add	Remove	Relationship (Spouse, Domestic Partner, Son, Daughter)	Last Name	First Name	MI	Gender (M or F)	Social Security#	Date of Birth MM/DD/YY

OTHER CURRENT COVERAGE

Do you or any family members currently have other group (employer) coverage?	☐ Yes ☐ No
Are any dependents eligible (whether or not they are enrolled) for other group (employer) coverage through either their own or a spouse's employment?	☐ Yes ☐ No
If yes, dependent name and date dependent was first eligible for such coverage: _____	
Are you or any family members covered by Medicare?	☐ Yes ☐ No
Are you or any family member covered by Medicare disability?	☐ Yes ☐ No

If the answer to any of the above questions is "Yes," please complete the section below.
(If you have more than one additional policy, provide information on a separate sheet.)

Name of Policy holder with other coverage			Relationship	
Policy holder's birth date		Name of other group insurance plan		
Address of other coverage		City	State	Zip
This coverage is for: ☐ Medical ☐ RX ☐ Dental ☐ Vision		Plan covers: ☐ Self ☐ Spouse ☐ Child(ren) ☐ Stepchild(ren)	Numbers that identify you to other group plan (group, ID, etc.):	
Name of Employer:		☐ Continuation ☐ Retiree ☐ Active	Effective Date	Termination Date

NOTE: If you or your dependents become eligible for and/or enrolled in other coverage, you are required to notify the plan in writing within 30 days. Failure to notify the plan of other coverage and/or any false statements or misrepresentation on this form is considered fraudulent and may result in retroactively terminating plan coverage, in which event you will be responsible for reimbursement for all amounts paid in connection with that coverage, including claims incurred.

COVERAGE OF CHILDREN: An employee's child will be considered a dependent until the end of the month that the child attains age 26. The term "child" may include children related to the employee by blood or marriage, such as siblings and grandchildren. In the case of siblings and other relatives who are not natural children, the employee must produce a court order showing legal guardianship to obtain coverage. In the case of grandchildren, the employee must show either legal guardianship or that the grandchild's natural parent is an eligible dependent enrolled in this plan. Coverage for the child can continue beyond age 26 if the child meets the definition of incapacitated child as defined in the benefit booklet.

Note: If enrolling a spouse or domestic partner, it is also required that you and your spouse or domestic partner complete and sign the reverse side of this form.

I certify that I have read the instructions and that the above information is complete and accurate. I also certify that all claims submitted will be only for myself or for my dependents who are eligible for benefits under the plan. I understand that I will be responsible to reimburse the Trust fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any claim form, or if I conceal any information pertaining to any such claims. I agree to provide the Trust Fund, upon request, with verification of any information.

PLEASE SIGN X**Date Signed**

WESTERN STATES HEALTH & WELFARE TRUST FUND OF THE OPEIU

DECLARATION OF MARRIAGE OR DOMESTIC PARTNERSHIP

_____ and I are spouses or domestic partners and meet
(Spouse or Domestic Partner's name)
the requirements set forth below in all respects. For purposes of this declaration, a "*Domestic Partnership*" is one consisting of two persons of the same or opposite gender.

1. We are each 18 years of age or older and are legally married or share a close personal relationship.
2. We are responsible for each other's common welfare and neither of us is married to or in a registered domestic partnership with anyone else.
3. We share a common residence.
4. We are jointly, financially responsible for basic living expenses including, but not limited to, food, shelter, and medical expenses.
5. We are not related by blood closer than would bar legal marriage in any state where we have a common residence and are domiciled.
6. We were mentally competent to consent to contract when our marriage or domestic partnership began and remain mentally competent.
7. We agree that we are bound by and subject to all the provisions of the health plan and any additional provisions of the Domestic Partnership Endorsement if applicable.
8. We understand that willful falsification of information contained in this affidavit may result in the termination of our enrollment in the health plan and could result in a claim for damages for losses sustained by the health plan because of such willful falsification.
9. We agree to notify the Trust Office in writing within 30 days of any change that would cause us to fail to meet any requirement of this declaration, the underlying health plan, or the Domestic Partnership Endorsement if applicable.
10. We certify under penalty of perjury under the laws of the State of _____, where this declaration is executed,
(State of residence)
that the foregoing is true and accurate to the best of our knowledge.

This declaration terminates upon the death of the signing employee's spouse or domestic partner, or by a change in circumstances attested to in this declaration. The signing employee must notify the Trust Office in writing within thirty (30) days after such death or change.

Notice: Signing this declaration may or may not have legal implications affecting relations between married or domestic partners beyond the extension of medical or dental insurance coverage for which it is intended. If you desire further information concerning the possible legal consequences of signing this form, please consult an attorney. There may also be tax consequences that you should review with your tax advisor.

I attest that the certification I have provided herein is true and correct to the best of my knowledge.

Employee's signature

Spouse or Domestic Partner's signature

Date and Place

Date and Place