

Legal Notices – Effective January 1, 2023

The following notices are important information regarding your health benefits we are required to share with you

- Important Information Regarding your Medical Plans
- Notice regarding your wellness benefits
- Certificate of Creditable Coverage
- Statement of ERISA Rights
- Notice of Privacy Practices

Important Information About Your Medical Plans

Healthcare Reform & Your Benefits

We offer medical plan options that provide valuable comprehensive coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. Also note, it's unlikely that you are eligible for financial help from the government to help you pay for insurance purchased through a Marketplace because you have access to an employer plan that complies with the affordability standard.

Organ Transplant

Transplant procedures must meet the plan's criteria for coverage. The medical indications of the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives are all reviewed. The transplant must be furnished in an approved transplant center. See contract for additional details.

Out-of-Area Benefits

If you are traveling or living outside of Washington or Alaska and need medical care, you may use a Blue Cross or BlueShield PPO provider to receive the same benefits as the preferred level of your plan. When you are outside of the service area and need medical care, call the BlueCard Access Line at 800.810.BLUE (2583) for information on the nearest PPO doctors and hospitals. The doctor or hospital will verify your membership and coverage information after you present your identification/membership card. The doctor or hospital will electronically route your claim to your Blue Cross plan for processing. Because all PPO providers are paid by the plan directly, you are not required to pay for the care at time of service and then wait for reimbursement. You will only need to pay for out-of-pocket expenses, such as non-covered services, deductible, copays and coinsurance.

IMPORTANT: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see the "Certificate of Creditable Prescription Drug Coverage" section on page 3 for more details.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

- All stages of reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or co-pays and co-insurance amounts.

Non-Network Costs

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. Please note the maximum allowed amount for an eligible procedure may not be equal to 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.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Benefits Department. Refer to your benefit booklet for details.

Notice Regarding Wellness Program

Our wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. You will be asked to complete a preventive physical screening. The screening is a brief exam that measures things such as your height, weight, body-mass, blood pressure, cholesterol and similar health indicators. You are not required to complete to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive towards medical premiums for completing the screening. Although you are not required to participate in the wellness program, only employees who do so will receive the premium incentive.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Saltchuk may use aggregate information it collects to design a program based on identified health risks in the workplace, our wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is Vivacity in order to provide you with services under the wellness program. Your individually identifiable medical information will not be shared with your employer.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

Certificate of Creditable Prescription Drug Coverage

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).

IMPORTANT NOTICE FROM SALTCHUK ABOUT YOUR PRESCRIPTION DRUG COVERAGE & 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 Saltchuk Resources 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. Saltchuk Resources has determined that the prescription drug coverage offered by Premera 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 through 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 Saltchuk coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may not still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current Saltchuk coverage, be aware that you and your dependents may not be able to get this coverage back by enrolling back into the Saltchuk benefit plan during the open enrollment period under the Saltchuk benefit plan.

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 Saltchuk 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

See contact information 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 Saltchuk changes. You also may request a copy of this notice at any time. 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 socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	January 1, 2023
Name of Entity/Sender:	Saltchuk Resources, Inc.
Contact:	Human Resources Department
Address:	450 Alaskan Way South Suite 708 Seattle, WA 98104
Phone Number:	206.652.1105

Premium Assistance under Medicaid & 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](tel: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 \(3272\)](tel:1-866-444-EBSA).

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1.855.692.5447

ALASKA – Medicaid

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

Website: <http://myarhipp.com/>
Phone: 1.855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
<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+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1.800.221.3943/ State Relay 711

CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1.800.359.1991/ State Relay 711
Health Insurance Buy-up Program (HIBI):
<https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 1.855.692.6442

FLORIDA – Medicaid

Website:
<https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1.877.357.3268

GEORGIA – 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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1.877.438.4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone 1.800.457.4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884

KENTUCKY – 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: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618.5488 (LaHIPP)

CHIP (CONTINUED)

MAINE – Medicaid

Enrollment Website: <http://www.maine.gov/dhhs/ofi/application-forms>
Phone: 1.800.442.6003/ TTY: Maine relay 711
Private Health Insurance Premium Webpage:
<http://www.maine.gov/dhhs/ofi/application-forms>
Phone: 1.800.977.6740/ TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 1.800.657.3739

MISSOURI – Medicaid

Website: <http://dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573.751.2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HSHIPPPprogram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <https://dhcfp.nv.gov>
Medicaid Phone: 1.800.992.0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/oii/hipp.htm>
Phone: 603.271.5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609.631.2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1.800.701.0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1.800.541.2831

NORTH CAROLINA – Medicaid

Website: <https://dma.ncdhhs.gov/>
Phone: 919.855.4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1.844.854.4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1.888.365.3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1.800.699.9075

PENNSYLVANIA – Medicaid

Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 855.697.4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1.888.549.0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 1.888.828.0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
Phone: 1.800.440.0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 1.877.543.7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1.800.250.8427

VIRGINIA – Medicaid and CHIP

Website: <http://www.coverva.org/hipp/> <http://www.coverva.org/en/hipp/>
Medicaid Phone: 1.800.432.5924
CHIP Phone: 1.855.242.8282

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1.800.562.3022

WEST VIRGINIA – Medicaid

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

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1.800.362.3002

WYOMING – Medicaid

Website: <https://healthy.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, 2022, OR FOR MORE INFORMATION ON SPECIAL ENROLLMENT RIGHTS, CONTACT EITHER:

U.S. Department of Labor

Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services
cms.hhs.gov
877.267.2323
(Menu Option 4, Ext. 61565)

Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the documents governing the plan, including the insurance contract and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

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

You have rights regarding reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For

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

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

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires that all medical records and other

individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your health information only for each of the following purposes: treatment, payment, health care operations and certain special situations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- Payment means such activities as obtaining reimbursement for

Saltchuk Resources Benefit Package consists of the following health plans sponsored by Saltchuk

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| • Premera Blue Cross HDHP w/ an HSA | • Delta Dental of Washington |
| • Premera Blue Cross PPO Base Plan | • VSP |
| • Premera Blue Cross PPO Buy-Up Plan | • Symetra Financial |
| | • AIG (Chartis) Travel Insurance |

services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.

- Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, health plan budgeting, carrier bidding, and customer service. An example would be an internal quality assessment review or to a business associate of the health plan.
- Special Situations include disclosures for your safety or for the safety of the general public; to individuals involved in your care or payment for your care (unless you specifically object to such disclosures); for instances of national security; for worker's compensation; for organ donation programs (if you are an organ donor); to military command (if you are a member of the armed services); to coroners, medical examiners or funeral directors; or as otherwise required by law.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- We may communicate with you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you, however, if we are receiving compensation for these communications, we must first obtain written authorization from you.
- We may not use or disclose your genetic information for underwriting purposes. We may also not sell your health information without your express written authorization, unless the sale is part of a merger, transfer, sale or consolidation of the health plan to another health plan.
- We will not use your protected health information for employment purposes or another benefits plan without your written authorization.
- Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
- You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
 - The right to inspect and copy your protected health information, either electronically or on paper, and obtain this copy within 30 days or within 60 days if we are unable to provide the information within 30 days and notify you of the delay within the first 30 days.
 - The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
 - The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction, unless the request is made to restrict disclosure to an insurer or health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the protected health information pertains solely to a health care item or service for

which you have paid out of pocket in full. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request an amendment of your protected health information. We are not required to agree to the requested amendment of your information, but will consider your request.
- The right to receive an accounting of certain non-routine disclosures of protected health information that were not disclosed for treatment, payment or health care operations.
- We have the obligation to provide and you have the right to obtain notice from us in the event that the privacy or security of your protected health information has been breached.
- You have the right to opt out of any communications that may be construed as fundraising or marketing for the health plan.
- We have the obligation to let you know about the availability of this notice every three years. You have the right to receive a paper copy of this notice from us upon request.
- We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a copy of the revised notice within 60 days of the change.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information on HIPAA or to file a claim:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington D.C., 20201
Toll Free: 877.696.6775 or 202.619.0257

Contact Information

If you have questions about this notice contact the Health Plan Privacy Official at:
Saltchuk Resources Inc.
Benefits Team
450 Alaskan Way suite 708
Seattle, WA 98104
206.652.1103

Highlights of the Hawaii Prepaid Health Care Law

Address all inquiries to:

Department of Labor and Industrial Relations – Disability Compensation Division

Oahu: 830 Punchbowl Street, Room 209
Po Box 3769
Honolulu, Hawaii 96812-3769
Phone: (808) 586-9188

Hawaii: State Office Building
75 Aupuni Street, Room 108
Hilo, Hawaii 96720
Phone: (808) 974-6464

West Hawaii: PO Box 49
Kealahou, Hawaii 96750
Phone: (808) 322-4808

Maui: State Office Building. #2
2264 Aupuni Street
Wailuku, Hawaii 96793
Phone: (808) 243-5322

Kauai: State Office Building
3060 Ewa Street, Room 202
Lihue, Hawaii 96766-1887
Phone: (808) 274-3351

For more information, please visit our website at:
<http://labor.hawaii.gov/dcd>

Auxiliary aids and services are available upon request. Please call the above listed telephone numbers, or dial 711 and ask for the phone number listed above for the office near you. A request for a reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s). It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected to discrimination, excluded from participation in, or denied the benefits of the department's services, programs, activities, or employment

The information herein is intended to provide employers and employees with general understanding of the Prepaid Health Care Act. For comprehensive details, please refer to the law (Chapter 393, HRS)

Prepaid Health Care Act

Originally enacted in 1974, the Hawaii Prepaid Health Care Act

was the first in the nation to set minimum standards of health care coverage for workers. Preempted in October of 1981 by the Federal Employee Retirement Income Security Act of 1974 (ERISA), the Prepaid Health Care Act was reinstated effective March 1, 1983

The Prepaid Health Care Act requires Hawaii employers to provide health care coverage for eligible employees to insure protection against the high cost of medical and hospital care for nonwork-related illness or injury.

Excluded Employment

Services excluded from health care coverage include, but are not limited to: 1) individuals who work less than twenty hours per week; 2) Federal, State, and County workers; 3) agricultural seasonal workers; 4) insurance or real estate salespersons paid solely by commission; 5) individuals working for son, daughter, or spouse; and 6) children under age 21 working for father or mother. (For a complete listing, refer to Section 393-5 of the law.)

Securing Coverage

Employers may obtain health coverage by: 1) purchasing an approved health care plan from a health care contractor or a Hawaii licensed insurance carrier; 2) adopting an approved self-insured health care plan; or 3) negotiating a collective bargaining agreement.

Employees may form associations for the purpose of providing health care coverage as long as such health care protection is obtained from an authorized health care contractor.

Eligibility For Enrollment

Employees who work twenty hours or more per week and earn a monthly wage of at least 86.67 times the Hawaii minimum hourly wage are deemed eligible after four consecutive weeks of employment. Health care coverage must then be provided to such eligible employees at the earliest enrollment date of the employer's health care contractor.

Exemptions From Coverage

Exempt Employees

The following categories of employees can claim an exemption from coverage: 1) those covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents; 2) those covered as dependents under a qualified health care plan; 3) those who are recipients of public assistance or covered by a State-legislated health care plan governing medical assistance; and 4) those who are followers of religious groups who depend upon prayer or other spiritual means for healing.

“Employee Notification to Employer” (Form HC-5)

To claim an exemption or individual waiver, an employee must complete and submit Form HC-5 to the employer. The employer is prohibited from coercing or attempting to coerce the employee to waive coverage. The employer retains the original Form HC-5 and gives a copy to the employee. The employer sends a copy to the Department of Labor and Industrial Relations only when the employee selects waiver #4 or upon request by the Director. The exemption/waiver notification is binding for one year and must be renewed every December 31.

Concurrent Employment

An employee who works concurrently for two or more employers is required to designate the principal and secondary employer and file notification (Form HC-5) with the employers for subsequent filing with the Department of Labor and Industrial Relations. The principal employer shall be the employer who pays the employee the most wages; only in cases where the employer who does not pay the most wages employs the employee for at least 35 hours per week does the employee determine which of the employers shall be the principal employer. The designated principal employer is required to provide coverage pursuant to the law.

Continuation of Coverage Provision

In the event an employee is disabled and unable to work, the employer is obligated to enable the employee to continue health care coverage by continuing the employer's share of the premium costs for three months following the month during which the employee became disabled, or for the period for which the employer has undertaken payment of employee's regular wages, whichever is longer. The employee must maintain the employee's portion of the premium payments.

Health Care Contractor

Type

A prepaid health care contractor may fall in one of three groups: 1) any medical group or organization which provides health care benefits under a prepaid health care plan; 2) any nonprofit organization which defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan; or 3) any insurer who defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan.

Selection

The employer selects the health care contractor and the plan type.

Health Care Plans

Type

There are two types of health care plans: 1) a plan by which a prepaid health care contractor would furnish health care, and 2) a plan by which the health care contractor would defray or reimburse, in whole or in part, the expenses of health care.

Benefits

To meet standards as prescribed by law, prepaid health care plans must include at least the following benefits: 1) hospital (including inpatient care for at least 120 days of confinement in each calendar year), 2) surgical, 3) medical, 4) diagnostic, and 5) maternity. (For further details, refer to Section 393-7 of the law.)

An employee's determination of principal employer is binding for one year or until change of employment occurs. Whenever an employee elects to make a change with respect to the status of each, notification (Form HC-5) must be filed. (For complete details, refer to Section 393-6 of the law.)

The employer is prohibited from coercing, interfering, or influencing an employee in making a determination of principal employer.

Premium Payments

The employer may elect to pay the entire premium amount or share the cost with the employee. The employer must pay at least one-half the premium cost; however, the employee's contribution cannot exceed 1.5% of the employee's monthly wages. In the event the employee's allowable share constitutes less than one-half of the premium, the employer is liable for the entire remaining portion. The employer is permitted to withhold the employee's contribution from the employee's wages.

An employee cannot agree to pay a greater share from wages, except for the purpose of paying for the added cost of providing prepaid health care benefits for the employee's dependents under the same plan.

Plan Approval

All health care plans must be approved as meeting prescribed minimum standards by the State Department of Labor and Industrial Relations. Such determination is made by the director under the advisement of a seven-member prepaid health care advisory council consisting of representatives from the medical and public health professions, from consumer interest, and from people experienced in prepaid health care protection.

Penalties

An employer who fails to comply with the coverage provisions of the law shall be subject to a penalty of not less than \$25, or \$1 for each employee for every day during which such failure continues, whichever sum is greater. If such default extends for 30 days, the employer's business may be closed for as long as the default continues.

An employer, employee, or health care contractor, who willfully fails to comply with any other provision or any rule or regulation, may be fined not more than \$200 for each violation.

Furthermore, any person who, after twenty-one days written notice and the opportunity to be heard by the director, is found to have violated any provision of Chapter 393 or rule adopted thereunder for which no penalty is otherwise provided, shall be fined not more than \$250 for each offense.

Appeal

When health care benefits are denied a worker, the employer or the prepaid health care contractor must promptly mail a notice of denial to the worker who then has twenty days in which to request a review by the Department of Labor and Industrial Relations. If the parties are not satisfied by the department's findings, the case will be referred to the Prepaid Health Care Appeals Referee. The decision of the referee shall be final and binding, unless the aggrieved party appeals the decision.

Special Fund

The Prepaid Health Care Premium Supplementation Fund is established by general fund appropriation and used to defray the cost of providing health care benefits for employers with less than eight workers entitled to and covered under the Prepaid Health Care Act. To qualify for premium supplementation, the employer must meet the criteria outlined in Section 393-45 of the law.

The Fund may also reimburse health care expenses to workers of bankrupt employers and non-complaint employers. Benefits paid from the Fund shall be recovered from those defaulting employers.

Administering Agency

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the Hawaii Prepaid Health Care Law. For further information, please contact the offices listed on the back of this brochure.

Notes



Insurance | Risk Management | Consulting

Please note:

This overview has been prepared to briefly highlight key features of your plan and is not to replace your insurance contract or booklet. We have compiled information into summary form to answer questions we most commonly receive. Please refer to the insurance carriers' contracts and booklets for more detailed information and plan limitations. Actual claims paid are subject to the terms and conditions of the individual carriers' contracts.