City of Redmond

Council Members Benefits Guide

JANUARY

2024

Redmond
WASHINGTON

WELCOME TO YOUR BENEFITS!

City of Redmond is proud to offer a comprehensive benefits package to our council members and their families. This package is designed to provide choice, flexibility and value.

To learn about the available plans and choose which ones are right for your lifestyle and budget, take a look at this Benefits Guide. Highlights of all the plans and some additional decision-making tools are available online too. If you have general questions on your benefits or how to enroll, reach out to Human Resources or a Gallagher Benefit Advocate—their contact info is toward the back of this Guide under "Your Benefits Contacts."

In addition, a Summary of Benefits and Coverage (SBC) is available using Connect2MyBenefits at https://c2mb.ajg.com/cityofredmond (no login required) to help you make your healthcare coverage choices. The SBC summarizes information about your medical plan options and is in a standard format required by the Affordable Care Act. A paper copy is also available, free of charge. Please contact Human Resources to request a copy.

Each year when Open Enrollment is finalized, we'll make detailed carrier booklets available to you. But for now, please refer to this guide and online resources.

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 page 28 for more details.

WHAT'S INSIDE

NEW COUNCIL MEMBER BENEFITS ENROLLMENT OVERVIEW

For newly eligible council members. **Please follow the steps below to choose your benefits and enroll.**

THE BENEFIT PLANS OFFERED ARE:

- Choice of two medical insurance plans:
    - RedMed through Premera
    - Kaiser Permanente
- Prescription drug insurance included with each medical plan
- Dental insurance
- Vision insurance
- Long Term Disability and Survivor Life
- Flexible spending accounts for tax savings on healthcare and dependent care expenses
- Employee assistance program (EAP)
- Retirement Plans
    - Department of Retirement Systems (DRS)
    - Municipal Employees Benefit Trust (MEBT)
    - MetLife 457 Plan

IMPORTANT

Enrollment timeline may vary in certain situations. See “Special Enrollment Rights” on pages 18 and 20.

1. PREPARE EVERYTHING YOU WILL NEED

- Social Security numbers for you and your family members whom you want to enroll in your benefits or list as beneficiaries
- Dates of birth for your family members
- Documents supporting dependent status. Examples include:
    - Marriage Certificate
    - Birth Certificate
    - Notification from dependent’s new employer

2. CHOOSE YOUR BENEFITS

Take the time to review the benefit outlines provided in this Guide and the Summary of Benefits and Coverage available on Connect2MyBenefits (https://c2mb.ajg.com/cityofredmond). This will help you understand the plans that are offered and how they will fit your lifestyle and budget. To make sure your family doctor and dentist are covered by the plans you have chosen, check the Provider Directory online or call customer service (see “Your Benefits Contacts” in the back of this Guide).

3. ENROLL - YOU HAVE 30 DAYS TO ENROLL IN MOST PLANS

- Log in to workterra and complete your healthcare, life, and disability enrollments.
- Complete and return the necessary enrollment and beneficiary forms to enroll in retirement plans.

Note: These forms are required to be returned even if you are declining coverage.

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QUESTIONS

Contact a Benefit Advocate (a service provided by Gallagher). You can reach a Benefit Advocate at: BAC.CityofRedmondWA@ajg.com or by phone: 425.201.8419, 6:00 a.m. - 6:00 p.m. PT Monday - Friday

OPEN ENROLLMENT OVERVIEW

For council members already enrolled.

Open Enrollment is in the month of November. You are able to change your elections during the Open Enrollment period and the changes become effective January 1st of the following year. Only under certain circumstances may you make changes outside of Open Enrollment, which are referred to as qualified changes in status. Unless you experience a qualified change in status, you will not be able to change your enrollment election until the next Open Enrollment period. Examples of qualified changes in status include:

- Birth or adoption of a child
- You or a dependent loses coverage under another plan
- Change in marital status
- Relocation out of the service area
- You, your spouse, or dependent become eligible for other group coverage including loss of eligibility for Medicaid, become eligible for Medicaid or a child reaches age 26
- Open Enrollment through your spouse's employer
- Change in hours or employment status impacting eligibility

IMPORTANT

Enrollment timeline may vary in certain situations. See "Special Enrollment Rights" on pages 18 and 20.

BENEFIT PLAN CHANGES

- **RedMed Plan:**
  - Benefits team has gone green! You can now manage your benefits online through Workterra. To change your benefits from a work device, you'll have single sign on: https://workterra.net/Platform/login/SSO?TPA=nUPcY1TZbENgVLkIw977OQ==&source=wbJJKtS48bg=
- **Medical Plans:**
  - Your Premera (RedMed) Plan and Kaiser HMO plan will include a few new benefits beginning in 2024:
  - Hearing Hardware with benefits of $3,000 per ear every 36 months
  - Supplemental and Diagnostic Breast Examinations: Plans will now waive cost shares for this service.
  - Pregnancy Termination
- **Dental:**
  - Increased Annual Maximum from $2,500 per covered member to $3,000 per covered member per year
- **Vision:**
  - Increased annual allowance from $300 year to $400 per year
- **Flexible Spending Account:**
  - Healthcare FSA maximum is $3,200 Annual carryover amount is $640.
  - Dependent Care FSA maximums will remain at $5,000 per household.
  - Please remember that you must complete enrollment in Workterra to re-enroll in your Flex Plans each year!

You must complete enrollment (workterra) to participate in the 2024 FSA plan year – even if you were previously enrolled. Healthcare and Dependent Care FSAs require you to make a new election each you that you wish to participate.

MEDICAL/DENTAL/VISION PLANS

Unless you are making Open Enrollment changes (i.e. changing from one medical plan to another, adding/removing a spouse/ domestic partner or child), you will not be required to go online and change your elections. Complete online enrollment only if you are making open enrollment election changes. If we do not receive any enrollment changes online, your current elections will continue for the 2024 plan year, with the exception of your Flexible Spending Account election.

FLEXIBLE SPENDING ACCOUNT (FSA/SECTION 125)

You must complete Flexible Spending Account (FSA) enrollment online (**workterra**) to participate in the 2024 FSA plan year - even if you were previously enrolled. Use the resources online to help determine how much money to contribute to your FSA. Participating in an FSA plan allows you to save on taxes when paying for eligible healthcare and dependent care expenses. Please see the Flexible Spending Account section in this Guide for more details.

RETIREMENT

The normal contribution limit for elective deferrals to a qualified retirement plan (401(k) or 457(b)) is $23,000 in 2024. Members age 50 or older may contribute up to an additional $7,500, for a total of $30,500. Members taking advantage of the special pre-retirement catch-up may be eligible to contribute up to double the normal limit, for a total of $46,000. The maximum defined contribution limit for all deferred contributions in 2024 is $69,000.

ELIGIBILITY

Council members are eligible for benefits. Coverage will begin on the first day of your term. IYou may enroll your eligible dependents for medical, dental, and vision. They are also eligible to receive Employee Assistance Program (EAP) services. Your eligible dependents include:

- Your legal spouse or state-registered domestic partner
- Your children up to age 26
- Any dependent child who is incapable of self-support because of a physical or mental disability

The City of Redmond extends health benefits to council members' state-registered domestic partners. Costs for coverage of domestic partners and their children might not be deducted on a pre-tax basis. If your domestic partner is not an eligible tax dependent as defined in Section 152 of the Internal Revenue Code, then a portion of your contribution will be deducted after-tax and the City's contribution for domestic partner coverage will be taxable income to you and reported as imputed income on your paycheck. If your domestic partner or child of a domestic partner qualifies as a dependent under Section 152 of the Internal Revenue Code, you may file the proper documentation with the IRS and seek a refund for taxes withheld. For more information, please contact Human Resources.

MAKING CHANGES TO YOUR BENEFITS

You may make changes to your healthcare and insurance benefit choices once a year during the Open Enrollment period. All benefits you select will be effective for a full calendar year, unless you have a "qualified change in status" or lose eligibility under the plan (e.g. leave office). Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

If you have a qualified change in status, you can make changes to your benefits by contacting Human Resources within 31 days of the change (Kaiser) or 60 days of the change (RedMed) (see pages 18-21 for additional information). You will need to provide Human Resources with documentation showing the change in status. The change to your benefits must be consistent with the change in family status. For example, if you have a new baby, you can enroll the child as a dependent under your current health plan, but you may not remove another dependent who is already covered. To determine if a life event qualifies, please contact Human Resources or a Gallagher Benefit Advocate.

QUALIFIED CHANGE IN STATUS EXAMPLES

- Birth or adoption of a child
- Loss of your or a dependent's coverage under another plan
- Change in marital status
- Relocation out of the service area
- You, your spouse or dependent become eligible for other group coverage including loss of eligibility for Medicaid, become eligible for Medicaid or a child reaches age 26
- Open Enrollment through your spouse's employer
- Change in hours or employment status impacting eligibility

Event	Medical, Dental, & Vision	Sample Document
Marriage, death of spouse, divorce, annulment, or legal separation	• Enroll newly eligible spouse or you may drop coverage if enrolling in spouse's plan. • Drop election only for spouse. • Elect for self or dependents who lose eligibility under spouse's plan.	• Marriage Certificate
Birth, adoption or death of a dependent child	• Enroll newly-eligible dependent. • Drop election for dependent who died.	• Birth Certificate
Employment status change of Dependent *(Gain/Loss of employment, and any involuntary loss of coverage)*	• Drop coverage for those who enroll under dependent's new plan. • Enroll self, spouse or dependents who lose eligibility under spouse's prior plan.	• Notification from dependent's new employer (additional documentation required if dropping plans)

2024 COUNCIL MEMBER (CM) MONTHLY CONTRIBUTIONS

MEDICAL

	RedMed - Your Monthly Cost	RedMed - City Monthly Cost	Kaiser - Your Monthly Cost	Kaiser - City Monthly Cost
CM only	$0.00	$955.10	$0.00	$836.98
CM plus Spouse	$648.40	$1,233.00	$570.36	$1,081.42
CM plus Child	$280.76	$1,075.44	$248.66	$943.56
CM plus Children	$659.82	$1,237.90	$582.78	$1,086.74
CM, Spouse, Child	$929.20	$1,353.34	$819.00	$1,187.98
CM, Spouse, Children	$1,308.30	$1,515.80	$1,153.12	$1,331.18

DENTAL & VISION

	Dental - Your Monthly Cost	Dental - City Monthly Cost	Vision - Your Monthly Cost	Vision - City Monthly Cost
CM only	$0.00	$69.34	$0.00	$17.20
CM plus Spouse	$37.84	$85.56	$9.62	$21.32
CM plus Child	$38.78	$85.96	$5.38	$19.50
CM plus Children	$91.16	$108.42	$12.70	$22.64
CM, Spouse, Child	$76.60	$102.18	$15.00	$23.64
CM, Spouse, Children	$129.00	$124.64	$22.34	$26.78

MEDICAL BENEFITS OVERVIEW

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. City of Redmond offers you the choice of RedMed (through Premera Blue Cross) or Kaiser Permanente. These plans provide excellent coverage of preventive services, such as routine physical exams and immunizations, that are very important to you and your family's health. Prescription drug coverage is included with each medical plan.

REDMED PLAN THROUGH PREMERA BLUE CROSS

This PPO (Preferred Provider Organization) plan offers a wide choice of providers. You can elect to use a provider in the Heritage and Heritage Plus 1 PPO network or any other provider for your healthcare services. If you choose an in-network provider, your cost will be less (please see the plan highlights on the following pages for the difference in coverage between in-network and out-of-network). You do not need a referral for specialist care. You can find PPO providers online at **premera.com** or by phone - please see the information in "Your Benefits Contacts" at the end of this Guide.

THE BLUECARD® PROGRAM - WORLDWIDE COVERAGE

The BlueCard® Program offers you access to a network of contracted Blue Cross Blue Shield providers across the world if you're traveling or living outside of Washington or Alaska. Just like at home, these networks can save you time and money. For covered benefits that are available to you outside of Washington or Alaska, please refer to your Benefit Booklet or call Premera Blue Cross.

Note: For emergency care outside of Washington or Alaska, go to the nearest hospital and contact BlueCard® if admitted. For assistance finding a PPO provider or questions, contact BlueCard®:

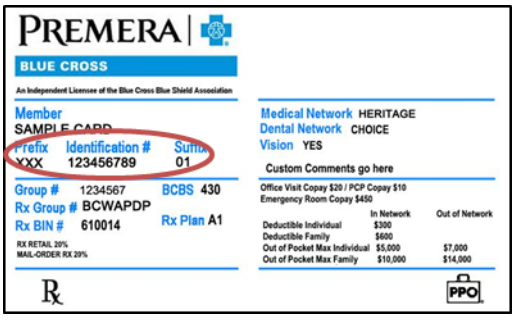
Inside the U.S. call 800.810.BLUE (2583)

Outside the U.S. (call collect): 804.673.1177

MANAGE YOUR HEALTHCARE INFORMATION ONLINE

Once you register online at **premera.com** with your member identification number and suffix number from your ID card, you can log in at any time for secure access to your personal healthcare information. Members can also use the last 4 digits of their SSN to register.

Once logged in, you can view your claims history, review your benefits and eligibility, order ID cards, and more.



KAISER PERMANENTE HMO PLAN

With this plan, out-of-pocket expenses are low but you must seek services from Kaiser Permanente Network Providers. You select a Primary Care Physician (PCP) who will coordinate care with your other providers. Please note that non-network services will not be covered without a referral. You can find Kaiser Permanente providers online or by phone – please see the information in "Your Benefits Contacts" at the end of this Guide.

PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

KAISER PERMANENTE®

CALENDAR YEAR DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses. The family deductible applies if you have family members enrolled in your plan along with you. However, each member is only responsible for the individual deductible, until the cumulative family deductible is met. Calendar year refers to January 1 through December 31.

COPAY & COINSURANCE

A copay is a flat dollar amount you pay for a medical service. Coinsurance is when you pay a percentage of the cost.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you pay in a calendar year for covered medical services. Once the out-of-pocket maximum is met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for covered services. The family out-of-pocket maximum applies if you have family members enrolled in your plan along with you. However, each member is only responsible for the individual out-of-pocket maximum, until the cumulative family out-of-pocket maximum is met. The out-of-pocket maximum starts over each January 1.

OUT-OF-NETWORK PROVIDERS

When you use out-of-network providers, RedMed will pay for services based upon usual customary and reasonable charges (UCR). You will be responsible for the remaining costs.

MEDICAL BENEFITS - PLAN HIGHLIGHTS

BELOW IS AN OVERVIEW OF THE MOST COMMONLY USED BENEFITS. THIS SUMMARY IS NOT AN EXHAUSTIVE LIST OF BENEFITS COVERED UNDER THE PLAN. PLEASE REFER TO THE SPD FOR ADDITIONAL INFORMATION OR TO REVIEW A BENEFIT NOT ILLUSTRATED BELOW.

	RedMed – Premera Blue Cross		HMO - Kaiser Permanente
PCY = Per Calendar Year (January 1-December 31)	**Network Benefits**	**Non-Network Benefits**	**In-Network Benefits**
Annual Deductible (individual/family)	$100/$300		None
Annual Out-of-Pocket Maximum (individual/family)	$600/$1,200		$2,000/$4,000
Preventive Care	No charge		$10 per visit
Outpatient Services			
Office Visit includes primary care services, outpatient mental health and chemical dependency services	20% after deductible		$10 per visit
Diagnostic Lab & X-Ray	20% after deductible		No charge[1]
Surgery	20% after deductible		$10 copay
Rehabilitation	20% after deductible		$10 per visit up to 60 days PCY
Massage Therapy	20% after deductible up to 12 PCY		Covered Under Rehabilitation
Other Services			
Chiropractic Care	20% after deductible up to 20 visits PCY		$10 per visit up to 10 visits PCY
Acupuncture	20% after deductible up to 8 visits PCY		$10 per visit up to 8 visits PCY[2]
Emergency Room (copay waived if admitted)	$50 copay + 20% after deductible		$75 copay at a designated facility $125 copay at a non-designated facility
Inpatient Hospitalization includes inpatient mental health, chemical dependency and maternity services	20% after deductible		No charge

[1]High end radiology imaging services must be determined Medically Necessary and require prior authorization.

[2]Per medical diagnosis without prior authorization; additional visits are permitted when approved by the plan.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

PRESCRIPTION DRUG PROGRAM

Your medical insurance includes a comprehensive prescription drug program. Generally, your out-of-pocket cost is lowest when you buy generic drugs, and highest when you buy brand drugs that are not on the formulary.

REDMED

Express Scripts/Premera through RedMed covers a broad formulary of drugs. To determine whether your drug is on the formulary, please check the online list at www.premera.com (Formulary: Preferred A2). A list of in-network pharmacies is also available on the website. The drug list is updated periodically to ensure that newer, more effective drugs are listed. You will also be able to obtain a list of in-network pharmacies by visiting Premera's website.

REDMED MAIL ORDER PRESCRIPTION DRUGS – EXPRESS SCRIPTS

If you take prescription drugs on an ongoing, maintenance basis, you can save money by using the Mail Order program and ordering a 90-day supply at a time.

To take advantage of this money-saving program, download all required Mail Order forms online at www.premera.com. Send your prescription(s), Mail Order Service Form, and payment for each prescription to the address on the order form. You will receive your prescriptions by mail in about two weeks, delivered in sealed, insulated (when necessary), and tamper-evident packaging.

KAISER PERMANENTE

Kaiser Permanente covers a broad formulary of drugs. To determine whether your drug is on the formulary, please check the online list at www.kp.org/wa. The drug list is updated periodically to ensure that newer, more effective drugs are listed.

KAISER PERMANENTE MAIL ORDER PRESCRIPTION DRUGS

If you take prescription drugs on an ongoing, maintenance basis, you can save money by using the Mail Order program and ordering a 90-day supply at a time.

To take advantage of this money-saving program, work with your Kaiser Permanente provider or pharmacist to setup the service. You will receive your prescriptions by mail in about 2-3 days, delivered in sealed, insulated (when necessary), and tamper-evident packaging.

	RedMed	Kaiser Permanente
Retail Pharmacy *Deductible*	*At participating pharmacies only* up to 34-day supply *Medical deductible applies*	*At participating pharmacies only* up to 30-day supply
Generic/Preferred Generic	20% after deductible	$10 copay
Non-Preferred Generic	N/A	Applicable preferred generic/brand cost applies
Brand/Preferred Brand	20% after deductible	$10 copay
Non-Preferred Brand	N/A	Applicable preferred generic/brand cost applies
Mail Order - up to 90-day supply	$5/$10/$10 applicable copay	2 x applicable retail copay

Prescription costs accumulate towards medical out-of-pocket maximums.

PREMERA HEALTHCARE RESOURCES

LIVONGO – FREE HYPERTENSION AND DIABETES SUPPORT

Livongo offers chronic condition support for managing diabetes & hypertension for you and your family members that are covered under your Premera health plan.

Diabetes: You'll get unlimited test strips, ordered online or directly through your meter and shipped right to your door. Members are provided with an advanced cellular-chip meter that automatically uploads readings, provides real-time tips, eliminates logbooks by sharing data directly with doctors and notifies your family if a reading is out of range.

Hypertension: Monitoring your blood pressure is easy with unlimited, live, one-on-one coaching. Members are provided a cellular-connected blood pressure monitor. Through the connected app, members can get high-blood-pressure alerts and access real-time insights and interpret trends.

For members who may qualify for this program, you may receive notification from Livongo/Premera's preferred vendor to enroll. Otherwise, you may Text "GO PBCPROGRAMSWA" to 85240 to learn more and join. You can also join by visiting https://hello.livongo.com/GEN?regcode=PREMERAWAREGISTER or call 800.945.4355 and use registration code: PBCPROGRAMSWA.

SAVEONSP – SPECIALTY PHARMACY DRUG PROGRAM

SaveonSP is a mandatory specialty drug program working with Premera's preferred vendor, Accredo for qualifying medications. When applicable, SaveonSP will walk the member through enrollment in the manufacturer-funded coinsurance assistance program and the member will owe a reduced cost.

Members **must enroll** if they are taking a medication that qualifies. If they do not enroll, they will be charged 30% coinsurance and the coinsurance will not count toward any out-of-pocket maximums The out-of-pocket maximum is the most you'll pay in a calendar year for covered medical and prescription drug expenses.

Please call 800.683.1074 to enroll. You must contact SaveonSP prior to filling your prescription. The program cannot be retroactively applied to a previously filled prescription.

**SaveonSP does not apply if the drug is administered under the medical benefit. Drugs may be covered under the medical benefit when administered and billed through a provider as part of the medical service.*

DESIGNATED CENTERS OF EXCELLENCE

Designated Centers of Excellence facilities are recognized for higher efficiency, lower costs and better patient outcomes for delivering specialty care. When seeking care from Premera's designated providers for specific services, the plan will waive member deductible and coinsurance. Covered areas for centers of excellence include: Cancer care, Cardiac care, Maternity care, Knee and hip replacement, Spine surgery, Transplant surgery, Gene therapy, Cellular immunotherapy – CAR-T, and Substance use treatment and recovery. To get started and find a facility that's right for you, call Premera at 800.722.1471.

KAISER HEALTHCARE RESOURCES

Experience integrated, convenient, quality care with the Kaiser plan. Out-of-pocket expenses are low but you must seek services from a Kaiser Permanente Provider or contracted network provider. When using Kaiser Providers, know that your provider is accessible to help navigate care needed. Kaiser also knows that information, education, and support can help you better manage chronic conditions like diabetes and hypertension. Take advantage of the classes and resources that Kaiser Permanente offers by visiting wa.kaiserpermanente.org.

Care Chat: No cost resource, to get 24/7 care from Kaiser clinician via secure chat. www.kp.com/wa/onlinecare
MyStrength: No cost, self-care resource which can help you navigate challenges, improve sleep/mood, and more! www.kp.org/wa/mhw
ClassPass: Unlimited on-demand video workouts, you can get access to ClassPass at www.kp.org/exercise

VIRTUAL CARE WITH PREMERA

Premera has a virtual health network providing easy access to board certified, quality care that saves you money and time. Once enrolled, register at Premera.com to learn more about the virtual care resources available to you and your enrolled family members.

Download the Premera MyCare app to find options available to you in one mobile application!

DOCTOR ON DEMAND PRIMARY AND BEHAVIORAL HEALTH CARE

https://www.doctorondemand.com/premera **Availability**: 24/7 Access or by appointment

What it is: A video or phone-based consultation with a board-certified doctor or licensed psychologist. It's easiest to set up your account by downloading the Doctor on Demand mobile app, so it's ready before you need care. You can also reach Doctor on Demand on the web: www.doctorondemand.com/premera.

What it's for: Diagnosing and treating common illnesses, such as sinus problems, urinary tract infection, pink eye, bronchitis, upper respiratory infection, nasal congestion, allergies, flu, skin infections and rash as well as behavioral health visits. They can even prescribe certain drugs if necessary.

98POINT6 TEXT-BASED VIRTUAL CARE

https://www.98point6.com/premera **Availability**: 24/7 Access

What it is: 98point6 is a new kind of on-demand primary care delivered through a highly secure in-app messaging experience on your mobile phone. With 98point6, U.S-based, board-certified physicians answer questions, diagnose and treat acute and chronic illnesses, outline care options and order any necessary prescriptions or lab tests. 98point6 can also help you better understand any primary care conditions.

BOULDER CARE FOR SUBSTANCE ABUSE DISORDER

boulder.care/getstarted **Availability**: M-F, 8:00 am to 7:00 pm PT; Sat, 9:00 am to 2:00 pm PT

What it is: Boulder Care provides treatment for opioid use disorder and alcohol use disorder. With this program, members can have video visits and text messaging with a therapist.

TALKSPACE VIRTUAL THERAPY FOR BEHAVIORAL HEALTH

talkspace.com/premera **Availability**: 24/7 Access

What it is: easily connect to therapists and psychiatrists by video and text. Start by signing up at talkspace.com/premera using Chrome, Firefox, Safari or Edge, get matched with the best therapist for you and start messaging your therapist right away. You can also visit the Premera behavioral health digital resource center at blue.premera.com/BHsupport to find useful resources, information on starting conversations, and more.

OMADA HEALTH VIRTUAL CARE PROGRAM

www.omadahealth.com/premera

What is it: Omada Health is a virtual physical therapy provider that is accessed by the member through a mobile app. With Omada Health, you will receive an individualized care plan built around your schedule with continuous support from a physical therapist. During an initial video consultation, members will be evaluated if the Omada Health recovery program is appropriate for their care. Members will be sent the equipment needed to complete their treatment program.

VIRTUAL CARE WITH KAISER

As a Kaiser member, you are able to connect with providers online at www.kp.org/wa/onlinevisit. Through this tool, you can receive care for common conditions such as cold and flu symptoms, cough, sore throat, and other common non-life threatening life conditions. Through Kaiser, you will receive a response and any prescription made available within 2 hours (9:00 AM to 9:00 PM).

DENTAL BENEFITS

Going to the dentist isn't on anyone's list of favorite things to do, but City of Redmond's dental benefits make it as painless as possible with comprehensive coverage through RedMed administered by Premera. You can access services from any licensed dentist you wish. However, your costs will typically be lower if you choose a Preferred Provider (PPO) dentist in the Choice network. You can find PPO dentists online. Please see the information in "Your Benefits Contacts" at the back of this Guide.

To find a dental provider, go to www.premera.com and use the provider search engine.

USUAL, CUSTOMARY & REASONABLE

Benefits are paid at the negotiated fee level for in-network providers. Benefits for services from out-of-network providers will be paid at the 90th percentile of the amount charged by the majority of dentists in the area.

	Any Licensed Dentist
Annual Deductible Per Person Per Family	None
Annual Benefit Maximum	$3,000 per person
Services	
Diagnostic and Preventive includes exams, x-rays, cleanings, topical fluoride application, space maintainers, sealants, fillings	No charge
Basic Services Includes extractions, oral surgery, periodontics, endodontics	20%
Major Services includes crowns, bridges, dentures, implants	20%
Orthodontia (6 month waiting period for new enrollees) for Adults and Dependent Children	20%

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

VISION BENEFITS

To help you take care of your eyesight, City of Redmond provides vision benefits through RedMed administered by Premera Blue Cross. You may choose to obtain your vision care services from any provider you wish.

	Any Licensed Provider
Basic Examination	Once Per Calendar Year Covered in Full
Hardware	$400 Allowance Per Calendar Year Lenses, Frames & Contact Lenses

Members can be balance billed if they receive dental and/or vision care from a non-contracted provider.

LONG TERM DISABILITY AND SURVIVOR LIFE INSURANCE

LONG TERM DISABILITY (LTD) COVERAGE

A long term, serious illness or injury can come out of nowhere. When an member cannot work for an extended period of time, an LTD plan can help cover a portion of the employee's pre-disability earnings.

	Long Term Disability
Monthly Benefit Amount	60% of base monthly earnings
Maximum Monthly Benefit	$7,800
Elimination Period	180 days
Benefit Duration	To age 65 or SSNRA
Definition of Disability	Own occupation for 24 months

IMPORTANT

Restrictions and limitations apply to these benefits. Please review the insurance booklet or certificate for complete details.

SURVIVOR LIFE INSURANCE

City of Redmond provides a survivor life insurance policy to financially protect your loved ones. Survivor life insurance is a monthly survivor income benefit that becomes payable after your death provided that at least one eligible spouse, eligible parent, or eligible child survives you.

	Survivor Life
Insured Earnings	The first $13,000 of your monthly rate of earnings from your Employer.
Percentage of Insured Earnings	The percentage of earnings used to determine the monthly Survivor Income Benefit payable for an Eligible Spouse, Eligible Child or Eligible Parent, (prior to reduction for any Deductible Income)
Eligible Spouse with no Eligible Children or Eligible Parents	30% for the Eligible Spouse
Eligible Spouse with one or more Eligible Children and/or Eligible Parents	30% for the Eligible Spouse and an additional 30% divided equally among the Eligible Children and Eligible Parents
One or more Eligible Children and/or Eligible Parents with no Eligible Spouse:	(a) If there are Eligible Children with no Eligible Parent: 60% divided equally among the Eligible Children (b) If there are Eligible Child(ren) with Eligible Parent(s): 30% divided equally among the Eligible Child(ren) and an additional 30% divided equally among the Eligible Child(ren) and Eligible Parent(s)
Eligible Parent with no Eligible Children or Eligible Spouse	30% divided equally among the Eligible Parents
Family Maximum	$7,800 per month (60% of Insured Earnings)

FLEXIBLE SPENDING ACCOUNTS (FSA)

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

HOW DOES AN FSA WORK?

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

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

QUALIFYING EVENTS:

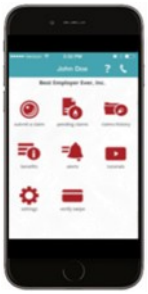
- Marriage
- Divorce
- Birth of a child

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

DECIDE HOW MUCH TO CONTRIBUTE TO FLEXIBLE SPENDING ACCOUNTS

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

MYNAVIA MOBILE APP



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

REIMBURSEMENTS

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

NAVIA BENEFITS CARD

The Navia Benefits Card is a debit card to be used in conjunction with your FSA elections. This card will pay for expenses at any merchant who accepts MasterCard® and is an allowable provider. The Navia Benefits card enables you to pay for eligible expenses directly from your FSA so you do not have to wait for reimbursement. Please keep your Navia Benefits Card. Your annual election amount will be loaded onto your existing card for use.

Keep your receipts! In the event Navia Benefit Solutions requires documentation for a purchase made with the Navia Benefits card, it is your responsibility to provide the detailed copy of your store receipt (not just a credit slip stating dollar amount).

Your Navia Benefits card will be activated upon your first transaction. If your card is lost or stolen, you may report your card and request a replacement through the online portal or by contacting Navia Benefit Solutions immediately at 800.669.3539.

CARRY OVER

For 2024, you can carry over unused healthcare FSA money from the 2023 plan year. The IRS limits this amount from year to year and for 2024 the amount is $640. Unused amounts in your Dependent Care FSA cannot be carried over and will be forfeited. To help you plan, use the online calculator at www.naviabenefits.com.

FLEXIBLE SPENDING ACCOUNTS
(CONTINUED)

HEALTHCARE FSA

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

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

MAXIMUM HEALTHCARE CONTRIBUTION

$3,200

Examples of eligible healthcare expenses

- Copays for doctor visits and prescription drugs
- Co-insurance for your medical, dental and vision plans
- Deductible amounts for your medical, dental and vision plans
- Over-the-counter medicines, except insulin, require a prescription in order to be eligible for reimbursement

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

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

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

DEPENDENT CARE FSA

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

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

Examples of qualified daycare providers

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

MAXIMUM DEPENDENT CARE CONTRIBUTION

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

$2,500 for married members filing separately

Does my daycare provider need to be licensed?

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

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City of Redmond provides an Employee Assistance Program (EAP) through Wellspring. The EAP offers free and confidential counseling and assistance in resolving situations that may impact your personal or professional life. All City of Redmond council members are automatically covered by the EAP.

The EAP provides short term counseling and referrals to help you deal with a variety of issues that can affect you at work or at home, such as:

- Managing stress and anxiety
- Depression
- Parenting
- Alcohol or drug problems
- Coping with grief and loss
- Legal assistance
- Debt management and budgeting
- Elder care options
- Work/Life balance

EAP professionals are available to assist you 24 hours a day, seven days a week by calling 800.553.7798. When you or a family member contacts the EAP, your call will be answered by a trained professional who will discuss your personal concerns with you and make sure you have access to appropriate resources.

Following your initial call, you may receive coaching over the telephone with an EAP professional, or you may be referred to an appropriate counselor in your area, depending on your situation and your preference. In addition to the EAP services described above, you can also receive personalized preventive health and wellness information and referrals through the EAP. Work/life resources and referrals are available for:

- Marriage and family concerns
- Child care (including summer care)
- Wellness and nutrition
- Senior care (facilities, services and support groups)
- Prenatal care (classes and hospitals)
- Legal assistance
- Financial information (budgets, debts, planning)
- Specialty health providers (information and referral)

FIND TIPS ON STRESS MANAGEMENT, WELLNESS AND MORE ONLINE!

Wellspring offers a wealth of educational resources on their website. Please see the access information under “Your Benefits Contacts” in the back of this Guide.

IF YOU VISIT A COUNSELOR

Up to 8 sessions per unrelated situation are provided at no charge to you. If more sessions are needed, the EAP professionals can work with your health plan to determine further coverage.

RETIREMENT PLANNING

The City of Redmond opted out of participating in Social Security for our regular employees and City Council Members have that choice as well. In order to opt out of Social Security, City Council Members must make the choice to enroll in a DRS Plan or MEBT. If enrollment in one of these plans is not chosen then you will be defaulted into Social Security. The 457 Plan is an additional option but does not qualify as a Social Security replacement plan.

FIND TIPS ON RETIREMENT AND ALL IT HAS TO OFFER

https://c2mb.ajg.com/cityofredmond/retirement-planning/

DRS

The Washington State Department of Retirement Systems (DRS) administers all retirement systems for public employees, including Police Officers and Fire Fighters, and City Council Members. City of Redmond Council Members may be eligible to participate and request membership in PERS 2 or PERS 3. Whether you are enrolling or opting out of membership, you must go to the Elected Official page on the DRS website (under the Plans tab) to read about the requirements for becoming a member and to complete the required Application for Membership as an Elected or Appointed Official form and send it to the Department of Retirement Systems (DRS). DRS will then notify the City if you will be participating in their plan.
Current handbooks outlining the details of each plan, as well as forms and other helpful information, are available on the DRS website: www.drs.wa.gov (to log into your personal account, contact DRS directly).

MEBT

The City of Redmond formed the Municipal Employees' Benefit Trust (MEBT) under federal law that allowed governmental organizations to opt out of the Social Security program. MEBT is similar to Social Security because, like Social Security, it also provides retirement and disability benefits for you and, in case of death, benefits for your beneficiaries. Unlike Social Security, your individual vested account balance increases based on contributions and fluctuates based on market performance, and the account belongs to your beneficiary upon your death.

As an eligible council member, you can make contributions to your MEBT account subject to Internal Revenue Code Deferral Limits and Annual Addition Limits, with a minimum contribution of 6.2%. Within MEBT there are council member contributions and an employer account for the City's contribution. They City matches your first 6.2% contribution at 80%. Council member contributions may be made pre -tax (you defer income tax on these contributions until you take a distribution) or after-tax (you pay income tax now prior to making the contribution).

Current information on the details of the plan, as well as forms and other helpful information, are available on the MEBT website: www.mebt.org (to login to your personal account contact Northwest Plan Services directly).

SECTION 457 DEFERRED COMPENSATION PLAN

Participation in the 457 Deferred Compensation Plan provides you with a great way to either start or continue saving for retirement.

- IT'S EASY. Your contributions are automatically deducted from your paycheck on a pre-tax basis. You don't have to pay taxes on your account until you take money out of your Plan, so your savings can potentially benefit from years of tax-free compounding.
- IT'S SMART. The money you put into your Plan reduces your current taxable income dollar for dollar. As a result, you'll pay less in taxes each pay period.
- IT'S FLEXIBLE. No matter what type of investor you are or where you are in your career, you can choose from a wide variety of funding options to suit your needs.

Current information on the details of the plan, as well as forms and other helpful information, are available on the MetLife website: www.metlife.com.

INSURANCE TERMS DEFINED

COPAY

A copay is a flat dollar amount you pay for a medical service. Copays may apply to office visits, prescription drugs, or emergency room visits (varies by plan).

DEDUCTIBLE

A deductible is the amount you need to pay up front before the plan begins paying expenses. Not all services are subject to the deductible. Please see the plan highlights in this guide or the Summary Plan Description (SPD) for specific information.

The family deductible applies if you have family members enrolled in your plan along with you. The family deductible is the most you have to pay for deductibles if you have dependents enrolled. Each person has their own deductible, but once the family deductible is met, no one else in your family has to pay toward their deductible.

COINSURANCE

Coinsurance is the portion of the cost you pay after you meet your annual deductible. Coinsurance is a percentage of the allowable amount, or the contracted rate. The plan pays a percentage of the allowable amount and you pay a percentage. The RedMed Plan pays 80% after you meet your annual deductible and you pay 20% for covered services.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the maximum amount you'll have to pay in a calendar year for covered medical expenses. You pay toward the out-of-pocket maximum when you pay your coinsurance amount. Anything above the out-of-pocket maximum will generally be covered by the plan at 100%. Your deductibles, medical copays, and prescription drug charges apply also toward the medical out-of-pocket maximum on the RedMed Plan.

ALLOWABLE AMOUNT

When you use non-network providers on the RedMed Plan, the plan will pay a percentage of the allowable amount. This amount is usually the same as what the plan would pay for similar in-network services. The amount the plan pays and the amount you pay is based on the allowable amount. However, if your provider charges more than the allowable amount, your will be responsible for the cost difference. This is called "balance billing." In-network providers cannot balance bill. Note: non-network services are not covered on the Kaiser Permanente plan.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN - REDMED

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

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

RedMed – Premera Blue Cross (Individual: 20% coinsurance and $100 deductible; Family: 20% coinsurance and $300 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 425.556.2124 or nbruce@redmond.gov.

OUT-OF-AREA BENEFITS

If you are traveling or living outside of Washington 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 co-insurance.

HIPAA SPECIAL ENROLLMENT RIGHTS

City of Redmond Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

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

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN - REDMED (CONTINUED)

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Nicole Bruce - Benefits Program Manager at 425.556.2124 or nbruce@redmond.gov.

Important Warning

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

PREVENTIVE CARE

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed under "Your Benefits Contacts" in the back of this Guide.

COBRA

Federal COBRA is a U.S. law that applies to employers who employ 20 or more individuals and sponsor a group health plan. Under Federal COBRA you may be eligible to continue your same group health insurance for up to 18 months if your job ends or your hours are reduced. You are responsible for COBRA premium payments.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN – KAISER PERMANENTE

ORGAN TRANSPLANT

There is no waiting period for organ transplants.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

HMO - Kaiser Permanente (Individual: 0% coinsurance and $2,000 deductible; Family: 0% coinsurance and $4,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 425.556.2124 or nbruce@redmond.gov.

OUT-OF-AREA BENEFITS

Kaiser Permanente provides worldwide emergency and urgent care. If you experience an emergency medical condition, you should call 911 or go to the nearest medical facility. The emergency room copay will apply. If you are admitted to a hospital, you need to contact your health plan immediately or as soon as reasonably possible (Hospital Notification Line at 1-888-457-9516). If you need urgent care when you are outside of the service area, you can call Member Services at 1-888-901-4636. If possible, Kaiser Permanente will help you arrange care at a Kaiser Permanente facility.

HIPAA SPECIAL ENROLLMENT RIGHTS

City of Redmond Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the City of Redmond Health Plan (to actually participate, you must complete online election form and pay part of the premium through payroll deduction).

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, or 60 days after birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Nicole Bruce - Benefits Program Manager at 425.556.2124 or nbruce@redmond.gov.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN *(CONTINUED)*

Important Warning

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

GRANDFATHERED PLAN DISCLOSURE

This disclosure is applicable to the following plan:

- HMO - Kaiser Permanente

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 425.556.2124. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans..

PATIENT PROTECTIONS DISCLOSURE

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

For children, you may designate a pediatrician as the primary care provider.

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

COBRA

Federal COBRA is a U.S. law that applies to employers who employ 20 or more individuals and sponsor a group health plan. Under Federal COBRA you may be eligible to continue your same group health insurance for up to 18 months if your job ends or your hours are reduced. You are responsible for COBRA premium payments.

HEALTHCARE REFORM & YOUR BENEFITS

City of Redmond offers a medical plan option that provides 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.

NOTICE OF PRIVACY PRACTICES

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

SAFEGUARDING YOUR PROTECTED HEALTH INFORMATION

The ***City of Redmond Employee Health Benefit Plan*** (the "Plan," "we," or "us") is committed to protecting the privacy of your personal health information. We are required by applicable federal and state laws to maintain the privacy of your Protected Health Information ("PHI"), to provide you with notice of our legal duties and privacy practices with respect to PHI, to abide by the terms of the notice currently in effect, and to notify affected individuals following a breach of unsecured PHI. This notice explains our privacy practices, our legal duties, and your rights concerning your Protected Health Information (referred to in this notice as "PHI"). The term "PHI" includes any information that is personally identifiable to you and that is transmitted or maintained by the Plan, regardless of form (oral, written, electronic). This includes information regarding your health care and treatment, and identifiable factors such as your name, age, and address. The Plan will follow the privacy practices described in this notice while it is in effect.

WHY DOES THE PLAN COLLECT YOUR PROTECTED HEALTH INFORMATION?

We collect PHI from you for a number of reasons, including determining the appropriate benefits to offer you, to pay claims, to provide case management services, and to provide quality improvement services.

HOW DOES THE PLAN COLLECT YOUR PROTECTED HEALTH INFORMATION?

We collect PHI through you, your health care providers, and our Business Associates. For example, Premera Blue Cross, a Business Associate, receives PHI from you on your health care enrollment application and from your health care providers, such as through the submission of a claim for reimbursement of covered benefits.

HOW DOES THE PLAN SAFEGUARD YOUR PROTECTED HEALTH INFORMATION?

We protect your PHI by:

- Treating all of your PHI that is collected as confidential;
- Stating confidentiality policies and practices in our group health plan administrative procedure manual, as well as disciplinary measures for privacy violations;
- Restricting access to your PHI to those employees who need to know your personal information in order to provide services to you, such as paying a claim for a covered benefit;
- Only disclosing your PHI that is necessary for a service company to perform its function on our behalf, and the company agrees to protect and maintain the confidentiality of your PHI; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your PHI.

HOW DOES THE PLAN USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION?

We will not disclose your PHI unless we are allowed or required by law to make the disclosure, or if you (or your authorized representative) give us permission. Uses and disclosures, other than those listed below, require your authorization. If there are other legal requirements under applicable state laws that further restrict our use or disclosure of your PHI, we will comply with those legal requirements as well. Following are the types of disclosure we may make as allowed or required by law:

- **Treatment**: We may use and disclose your PHI for the treatment activities of a health care provider. It also includes consultations and referrals between one or more of your providers. Treatment activities include disclosing your PHI to a provider in order for that provider to treat you.
- **Payment:** We may use and disclose your medical information for our payment activities, including the payment of claims from physicians, hospitals and other providers for services delivered to you. Payment also includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, utilization review and preauthorization). For example, we may tell a physician whether you are eligible for benefits or what percentage of the bill will be paid by the Plan.
- **Health Care Operations:** We may use and disclose your medical information for our internal operations, including our customer service activities. Health care operations include but are not limited to quality assessment and improvement, disease and case management, medical review, auditing functions including fraud and abuse compliance programs and general administrative activities.
- **Treatment Alternatives and Health-Related Benefits and Services:** We may use and disclose PHI to tell you about possible treatment options or alternatives and health-related benefits that may be of interest to you.
- **Business Associates:** We may also share PHI with third party "business associates" who perform certain activities for us. We require these business associates to afford your PHI the same protections afforded by us.

- **Plan Sponsor:** Since you are enrolled in a self-insured group health plan, we may disclose your PHI to the Plan's sponsor to permit it to perform administrative activities in accordance with 45 CFR § 164.504(f).
- **To you or your Authorized Representative**: Upon your request, we will disclose your PHI to you or your authorized representative. If you authorize us to do so, we may use your PHI or disclose it to the person or entity you name on your signed authorization. After you provide us with an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. In certain situations when disclosure of your information could be harmful to you or another person, we may limit the information available to you, or use an alternative means of meeting your request.
- **To your Parents, if you are a Minor:** Some state laws concerning minors permit or require disclosure of PHI to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of the state where the treatment is provided, and will make disclosures consistent with such laws.
- **Your Family and Friends:** If you are unable to consent to the disclosure of your PHI, such as in a medical emergency, we may disclose your PHI to a family member or friend to the extent necessary to help with your health care or with payment for your health care. We will only do so if we determine that the disclosure is in your best interest.
- **Research; Death; Organ Donation:** We may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes; for example, to identify a deceased person or to determine the cause of death.
- **Public Health and Safety:** We may disclose your PHI if we believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may also disclose PHI for public health activities, such as preventing or controlling disease, injury or disability; reporting births and deaths; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- **Victims of Abuse, Neglect, or Domestic Violence:** We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Health Oversight Activities:** We may disclose your health information to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- **Required by Law:** We must disclose your PHI when we are required to do so by law.
- **Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, warrant, discovery request, or other lawful process.
- **Law Enforcement:** We may disclose limited information to law enforcement officials; for example, to identify or locate a suspect, material witness, or missing persons.
- **Correctional Institutions:** We may disclose PHI to correctional institutions or law enforcement officials if you are in custody.
- **Military and National Security:** We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances as deemed necessary by military command authorities. We may disclose to authorized federal officials PHI: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- **Workers' Compensation:** We may disclose your PHI to the extent necessary to comply with workers' compensation laws and other similar programs.
- **De-identified Health Information:** We may disclose health information if it has been de-identified so that it does not identify an individual.
- **Limited Data Sets:** We may disclose your PHI as part of a limited data set for research, public health and health care operations activities.
- **Incidental Disclosures:** We may disclose your PHI incidental to otherwise-permitted disclosures.
- **Other Uses and Disclosures:** Other uses and disclosures will be made only with your written authorization. Generally, if you authorize us to use or disclose your PHI, you may revoke the authorization, in writing, at any time, except to the extent that we have already relied on your authorization. Also, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. We are required to obtain your authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, to sell PHI, or to use or disclose PHI for any purpose not described in the notice.

WHAT RIGHTS DO YOU HAVE AS AN INDIVIDUAL REGARDING OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION?

You have the right to request all of the following:

- **Access to your PHI:** You have the right to review and receive a copy of your PHI as provided in 45 CFR § 154.524. We may charge you a nominal fee for providing you with copies of your PHI. This right does not include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to other state or federal laws that prohibit us from releasing such information. We may also limit your access to your PHI if we determine that providing the information could possibly harm you or another person, you have the right to request a review of that decision.
- **Amendment:** You have the right to request that we amend your PHI. Your request must be in writing, and it must identify the information that you think is incorrect and explain why the information should be amended. We may decline your request for certain reasons, including if you ask us to change information that we did not create. If we decline your request to amend your records, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in any future disclosures of that information.
- **Accounting of Disclosures:** You have the right to receive a report of instances in which we or our business associates disclosed your PHI for purposes other than for treatment, payment, health care operations, and certain other activities. You are entitled to such an accounting for the 6 years prior to your request, though not for disclosure made prior to April 14, 2004. We will provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for creating and sending these additional reports.
- **Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your PHI for treatment, payment, health care operations or to persons you identify. We are not required to agree to your request except in case of a disclosure restricted under 45 CFR § 164.522(a)(1)(vi). If we do agree, we will abide by our agreement (except in an emergency).
- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. If you advise us that disclosure of all or any part of your PHI could endanger you, we will comply with any reasonable request provided you specify an alternative means of communication.
- **Electronic Notice:** You have the right to a paper copy of this notice upon request even if you agreed to receive this notice electronically**.** Please contact us using the information listed at the end of this notice to obtain this notice in written form.
- **Genetic Information:** Plans other than long-term health care plans are prohibited from using PHI that is genetic information for underwriting purposes.

CAN I "OPT OUT" OF CERTAIN DISCLOSURES?

You may have received notices from other organizations that allow you to "opt out" of certain disclosures. The most common type of disclosure that applies to "opt outs" is the disclosure of personal information to a non-affiliated company so that company can market its products or services to you. As a self-insured group health plan, we must follow many federal and state laws that prohibit us from making these types of disclosures. Because we do not make disclosures that apply to "opt outs," it is not necessary for you to complete an "opt out" form or take any action to restrict such disclosures.

WHEN IS THIS NOTICE EFFECTIVE?

This notice takes effect April 14, 2004 and was revised effective September 23, 2013. It will remain in effect until we revise it.

WHAT IF THE PLAN CHANGES ITS NOTICE OF PRIVACY PRACTICES?

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your individual rights, our duties or other privacy practices stated in this notice. For your convenience, a copy of our current notice of privacy practices is always available on our Web site at *http://redweb* in accordance with paragraph 45 § CFR 164.520(c)(3)(i) and you may request a copy at any time by contacting us at the number listed below. In the event of a change or revision to the notice, we will prominently post the change or the revised notice on our Web site by the effective date of the material change to the notice, and we will provide the revised notice, or information about the material change and how to obtain the revised notice, in our next annual mailing to individuals then covered by the plan. If we do not post our notice on our web site pursuant to paragraph 45 § CFR 164.520 (c)(3)(i), then we will provide the revised notice, or information about the material change and how to obtain the revised notice, to individuals then covered by the plan within 60 days of the material revision to the notice.

NOTICE OF PRIVACY PRACTICES *(CONTINUED)*

CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations Parts* 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

HOW CAN YOU REACH US?

If you want additional information regarding our Privacy Practices, or if you believe we have violated any of your rights listed in this notice, please contact our Privacy Officer at ***City of Redmond, Attn: Nicole Bruce, PO Box 97010, MS: 3NHR, Redmond, WA 98073-9710.*** If you have a complaint, you also may submit a written complaint to the Region X, Office for Civil Rights, U.S. Department of Health and Human Services, 2201 Sixth Avenue-Suite 900, Seattle, Washington 98121-1831; phone (206) 615-2287, fax (206) 615-2297, TDD (206) 615-2296. For all complaints filed by e-mail send to: OCRComplaint@hhs.gov. Your privacy is one of our greatest concerns and there is never any penalty to you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

CHIP (CONTINUED)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health-_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: 6 https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

NOTICE OF CREDITABLE COVERAGE

Important Notice from City of Redmond, WA

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Redmond, WA 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. **City of Redmond, WA has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current 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 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 company coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company 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 City of Redmond and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE *(CONTINUED)*

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**January 1, 2024**
Name of Entity/Sender:	**City of Redmond**
Contact—Position/Office:	**Nicole Bruce - Benefits Program Manager**
Office Address:	**15670 Ne 85th St, PO BOX 97010**
	Redmond, Washington - 98073-9710
	United States
Phone Number:	**425.556.2124**

YOUR BENEFITS CONTACTS

GALLAGHER BENEFIT ADVOCATES

If you do not receive satisfactory service from your insurance companies, a Benefit Advocate (a service provided by Gallagher), is available to help with issues pertaining to your benefits.

Please do not include any confidential or sensitive information, such as Social Security numbers or health information, via email. Once you are connected to a Benefit Advocate, more sensitive information can be shared.

You can reach a Benefit Advocate at:
BAC.CityofRedmondWA@ajg.com
or by phone: 425.201.8419,
Toll Free: 833.627.1567

6:00 a.m. - 6:00 p.m. PT
Monday - Friday

Benefit	Administrator	Group #	Contact Information		Website
Medical, Dental, & Vision	Premera Blue Cross	4018525	Customer Service Monday – Friday 24-Hour NurseLine BlueCard Access	800.722.1471 5am-8pm 800.841.8343 800.810.2583	www.premera.com www.bcbs.com
Medical	Kaiser Permanente	0446300	Customer Service Monday – Friday 24-Hour Nurseline Mail Order Pharmacy	888.901.4636 8am-8pm 800.297.6877 800.245.7979	www.kp.org/wa
Survivor Life, LTD	Standard Insurance	639955	Customer Service Monday - Friday	800.368.2859 6am-5pm	www.standard.com
Flexible Spending Accounts	Navia Benefit Solutions	CRD	Customer Service Monday-Friday	800.669.3539 5am-5pm	www.naviabenefits.com
Employee Assistance Program	Wellspring Family Services		24/7	800.553.7798	www.wellspringeap.org Code: City of Redmond
Retirement	Department of Retirement Services (DRS)	PERS: 50-57 LEOFF: B110	Customer Service Monday – Friday	800.547.6657 8am-5pm	www.drs.wa.gov
Retirement	MetLife 457	1009624-01	Customer Service Monday – Friday Saturday	800.543.2520 5am-7pm 6am-2:30pm	www.metlife.com
Retirement	Municipal Employees Benefit Trust (MEBT)	C20050	Customer Service Monday-Friday	877.690.5410 5am-5pm	www.mebt.org
Enrollment	Workterra		Customer Service Monday-Friday	888.604.4511 9am-5pm	www.workterra.net

THIS BENEFIT SUMMARY PREPARED BY:

Gallagher

Insurance | Risk Management | Consulting

PLEASE NOTE:

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.