Employee Benefits

Effective January 1, 2025

General Plan

Employees who are:

Non-Represented &
Represented

Dated: October 28, 2024

Welcome to Your Benefits!

The City of Bellevue is proud to offer a comprehensive benefits package to our valued employees and their families. This package is designed to provide choice, flexibility and value.

This Benefits Guide will help you learn more about your benefits, review highlights of the available plans and make selections that best fit your lifestyle and budget. This information, along with other decision-making tools, is also available online. In addition, you can contact Human Resources or call the team of Benefit Advocates at Gallagher Benefit Services for help understanding your benefits and completing your enrollment. You may visit c2mb.ajg.com/cityofbellevue for additional benefit information and resources.

Due to Healthcare Reform, in addition to the benefits guide, an additional summary of coverage is available to help you make an informed choice. The Summary of Benefits and Coverage (SBC) summarizes important information about any health option in a standard format, to help you compare options. The SBCs are available at c2mb.ajg.com/cityofbellevue. A paper copy is also available at no charge upon request. Please contact Human Resources to request a copy.

For alternative formats, translations, interpreters, or reasonable accommodation requests, please phone at least 48 hours in advance 425-452-6838 or BellevueHR@bellevuewa.gov. If you are deaf or hard of hearing, dial 711.

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 36 for more details.

Table of Contents

Your Benefits Contacts

Connect2MyBenefits

Your online library for everything benefits! Information when you need it.
Contains plan descriptions, SBC's, forms, links to provider directories, drug lists, and other valuable online resources.

c2mb.ajg.com/cityofbellevue

Gallagher Benefit Advocates

If you do not receive satisfactory service from your insurance companies, a Benefit Advocate (a free 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.CityofBellevue@ajg.com or
by phone: 425-201-8417
Toll free: 833-207-4373
6:00 a.m. - 6:00 p.m. PT
Monday - Friday

The City of Bellevue Health Benefits

Michelle Robinson — 425-452-4585 | mrobinson@bellevuewa.gov
Lori Duringer — 425-452-7866 | lduringer@bellevuewa.gov

Medical Coverage – Premera Blue Cross (Group #1016431)		
Customer Service	800-722-1471	www.premera.com
24-hour Nurseline	800-841-8343	
Doctor on Demand Virtual Care		www.doctorondemand.com/premera
98Point6 Text-Based Care		www.98point6.com/premera/
TalkSpace Virtual Behavioral Healthcare		talkspace.com/premera
Omada Virtual Physical Therapy		go.omadahealth.com/premera
Teladoc Weight Management, Hypertension & Diabetes Resource	800-945-4355	
Medical Coverage – Kaiser Permanente (Group #0072700)		
Customer Service	888-901-4636	www.kp.org/wa
24-hour Nurseline	800-297-6877	
24-hour Emergency Line	888-457-9516	
Care Chat	888-901-4636	www.kp.org/wa
Dental Coverage – Delta Dental of Washington PPO Plan (Group #396)		
Customer Service	800-554-1907	www.deltadentalwa.com
Dental Coverage – Willamette Dental of Washington, Inc. (Group #Z146/WA38)		
Customer Service	855-433-6825	www.willamettedental.com
Appointment Center	855-433-6825	
Vision Coverage – Vision Service Plan (VSP) (Group #12012021)		
Customer Service	800-877-7195	www.vsp.com
Life/AD&D & Long Term Disability Insurance – Standard (Life/AD&D Group #641875, LTD Group #313017)		
Customer Service	800-368-1135	www.standard.com
Flexible Spending Accounts – Navia Benefit Solutions (Company Code: CFB)		
Customer Service	800-669-3539 phone 866-831-6222 fax	www.naviabenefits.com Company Code: CFB
Employee Assistance Program – Wellspring		
Customer Service	800-553-7798	www.wellspringeap.org Username: City of Bellevue

Carrier Apps

Go Online with Benefits

When you register online with your carriers, you'll have more access at your fingertips – cost estimates of procedures (this can allow for smart consumer shopping), ID cards on the go, and benefit/claim details.
Perks available through your carriers:

- With Premera: no cost Experian Credit Monitoring, and virtual resources for behavioral, physical therapy, and primary care through the MyCare App.
- With Kaiser: correspond with providers as well as access emotional/behavioral support at no cost with *Calm* and *Ginger* apps .

Premera Blue Cross

Anytime you need it, the answer is right in your pocket! From your smart phone, with the touch of a button, look up contracted providers, view your benefits, manage your prescriptions, and provide mobile proof of coverage.

Find a Doctor
Find in-network doctors, dentists, pharmacies, urgent care facilities, and hospitals.

Benefits
About to make an appointment? Check to see if it's covered.

Claims
Paying a provider? Check your current deductible and claims status.

Proof of Coverage
Show your coverage on your phone, or email it to your provider.

NurseLine
Not sure whether to see a doctor? Get advice in one touch with the 24-hour Nurseline.

Premera Virtual Care App: MyCare

Your virtual healthcare options are available via one mobile resource, **MyCare**. Premera has a virtual health network providing easy access to board certified, quality care that can save 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.

Kaiser Permanente

Download the free app to schedule an appointment with your Kaiser Permanente care team, contact the Consulting Nurse, manage your prescriptions, locate and find wait times for clinics, pharmacies, and labs – and more!

Delta Dental

It's easy to get the most out of your dental benefits with the free mobile app for Apple iOS and Android users. If you're not already registered, you can set up your account from the app's login page.

Find a Dentist
Quickly search to find out if there's an in-network dentist near you by using the app.

Claims
Recently have dental work? Find out if your claim was paid by viewing your claim status in the app.

Coverage Details
Unfortunately, you need a filling. Sign in to see what percentage is covered by your benefits.

Proof of Coverage
Show your coverage on your phone, or email it to your provider.

Navia

The MyNavia mobile app is a mobile platform that allows you to manage your benefits from the palm of your hand. The app includes access to real-time account balances, tutorial videos, account alerts and claim submissions.

Benefit Plans Offered

Three medical plans including a prescription drug benefit:

- Kaiser Permanente HMO
- Premera Blue Cross Choice PPO
- Premera Blue Cross Core PPO

Two dental plans:

- Delta Dental of Washington PPO Plan
- Willamette Dental of Washington, Inc. EPO Plan

Two vision plans:

- VSP exam only benefit
- VSP exam and hardware benefit

In addition, the following benefits are also offered:

- Life and Accidental Death and Dismemberment (AD&D) insurance
- Long-Term Disability insurance
- Additional Voluntary Life insurance options
- Flexible Spending Accounts (FSA) for tax savings on health and daycare expenses
- Employee Assistance Program (EAP)

Questions:

Contact a Benefit Advocate
(a free service provided by Gallagher).
You can reach a Benefit Advocate at:
BAC.CityofBellevue@ajg.com or by phone:
Local: 425-201-8417
Toll free: 833-207-4373
6:00 a.m. - 6:00 p.m. PT
Monday - Friday

2025 Benefit Changes

Premera Updates:

New: Behavioral Matchmaker

Premera has added support to align you with your behavioral health needs. Behavioral Health Matchmakers offer the extra support needed on your care journey by providing a list of in-network, outpatient providers who are accepting new patients. Copays or deductibles apply when you see a provider. Call customer service at the number on the back of your ID card to request help finding a provider.

Update: Chronic Condition Support is now Teladoc Health

The chronic condition support for diabetes, hypertension and weight loss through Teladoc (previously known as Livongo) has expanded service. There are new "Plus" designations where members can qualify for more than one program. Mental Health support will now be included in the updated program.

Delta Dental of Washington

Update: ID Cards

The plan will no longer issue paper ID cards. For quick access to a virtual card, visit: DeltaDentalWA.com/idcard/validation. Delta Dental also provides a mobile app and an easy resource on their web through MySmile (deltadentalwa.com/mysmile).

New: Virtual Dentistry

Effective January 1, 2025, Delta Dental of Washington is offering virtual services through Dentistry.One. Whether you face a dental emergency, require after-hours care, or simply have general concerns about your oral health, get the answers you need 24/7.

Healthcare Flexible Spending Account (FSA)

Assumed Increase to maximum annual election from $3,050 to $3,300. Healthcare and daycare FSA's must be elected each calendar year in accordance with Internal Revenue Service (IRS) requirements.

Enrollment Checklist

Please follow these steps to choose your benefits and enroll.

1. Assess your household coverage needs

- Review "Who is Eligible?", which follows this section.

2. Prepare everything you will need:

- Social security numbers for you and your family members whom you want to enroll in benefits
- Dates of birth for your family members

3. Review materials, explore your options, evaluate plans and choose your health & life benefits

- Take time to review the benefit outlines provided in this Guide and on Connect2MyBenefits at c2mb.ajg.com/cityofbellevue. This will help you understand the plans offered and how they will fit your lifestyle and budget. To make sure your family doctor and dentist are covered by the plans you select or have selected, check the Provider Directory online or call customer service (see Your Benefits Contacts at the beginning of this Guide).

4. Determine if you will participate in a FSA and how much you will contribute

- Determine how much money you should put into your Flexible Spending Accounts (FSA) to save on taxes when paying for healthcare and daycare expenses. Please see the Flexible Spending Accounts section in this Guide for more details.
- Your FSA election does not roll over to the new plan year. You must make a new election each year you want to participate in the plan.

5. Complete your enrollment online using Bellevue Benefits

Use Bellevue Benefits to complete your enrollment, view your current healthcare benefits or request a change to your benefits. Access Bellevue Benefits at https://cityofbellevuehr.workterra.net

- Logon with your user name and password
- Your user name is your full last name **(lower case)** and first four digits of your birth date (MM/DD)
- Your password is initially set to your full last name **(lower case)** and last four digits of your Social Security number.
    - *For open enrollment, passwords are being reset to your full last name (lower case) and last four digits on your Social Security number.*
- You will be prompted to change your password once you have logged into the system

6. Carefully review your confirmation statement in Bellevue Benefits, then hit "Done"

- It is recommended that you print or save the confirmation statement for your records and check your pay stub to ensure your payroll deductions are accurate. Remember to report any discrepancies to Human Resources within 30 days of your coverage effective date.

Who is Eligible?

Medical:

- All active fully benefited employees assigned to work at least 30 hours per week (including regular, limited term, training pool and transitional employment status positions or such other fully-benefited positions as council designates)
- Elected Officials
- All active partially benefited employees who qualify as full-time under the law
- All active regular part-time fully benefited employees working at least 20 hours per week, but less than 30 hours per week as of March 31, 2014 (a grandfathered employment status)

Dental, Vision, and Flexible Spending Accounts:

- All active fully benefited employees assigned to work at least 30 hours per week (including regular, limited term, training pool and transitional employment status positions or such other fully-benefited positions as council designates)
- Elected Officials
- All active regular part-time fully benefited employees working at least 20 hours per week, but less than 30 hours per week as of March 31, 2014 (a grandfathered employment status)

Coverage will begin on the first of the month following date of employment. You may enroll your eligible dependents for medical, dental, vision and voluntary life/AD&D. They are also eligible to receive Employee Assistance Program (EAP) services. Your eligible dependents include:

- Spouse: the lawful spouse of the employee (Note: a spouse is no longer eligible upon divorce or legal separation)
- Domestic partner new domestic partnerships must be state registered
- Dependent child who is under 26 years of age. An eligible child is one of the following:
    - The natural offspring of either or both the employee or spouse.
    - A legally adopted child of either or both the employee or spouse or a child placed with the employee for the purpose of legal adoption in accordance with state law.
    - A legal ward of the employee or spouse. There must be a court order signed by a judge, which grants guardianship of the child to the employee or spouse as of a specific date. When the court order expires, the child is no longer an eligible child.
    - Foster children are not eligible for coverage.
- Continuing coverage for a child who became disabled prior to reaching age 26 is allowed provided the employee submits a request and provides proof of the child's disability within 30 days of reaching age 26 and the request is approved. Please contact Human Resources for more information.

Married employees and domestic partners who both work at the City of Bellevue may enroll as an employee or dependent but not both. If enrolled as an employee or dependent, no double coverage or waiver incentives (if available to you) are permitted. Children may be enrolled under one parent's coverage but not both.

The City of Bellevue extends health benefits to employees' domestic partners. However, the value of these benefits is included in employee's gross income, subject to federal income tax. In general, the value of the coverage is the same as adding a spouse to an employee's medical/vision and/or dental plan, minus any amount the employee pays through payroll deduction. 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. If you would like specific information on the taxation of domestic partner benefits, you may contact Human Resources.

Making Changes to Your Benefits

Life Events

You may make changes to your healthcare and insurance benefit choices once a year during the open enrollment period. Unless you experience a qualified status change during the year or leave employment, you will not be able to change your enrollment election until the next open enrollment period.

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. Examples of status changes include:

- Birth or adoption of a child
- New dependents and spouse as a result of marriage
- Divorce
- If you were covered under your spouse's health insurance plan and lost coverage as a result of their termination of employment or reduction in hours

You **must** request a change to your benefits through Bellevue Benefits within 30 days of:

- Divorce, legal separation or annulment
- Termination of domestic partnership
- Dependent child no longer eligible due to age
- Death of a dependent child or spouse

These life events require you to make changes to your benefits because the dependents are no longer eligible for coverage under the health plans. Note: You certify in Bellevue Benefits that the family members you enroll in health benefits are eligible for coverage and failure to update changes to that information in a timely manner subjects you to repayment of any claims or premiums paid by the city and/or health plan as well as possible disciplinary action up to and including termination.

You **may** request a change to your benefits through Bellevue Benefits:

- Within 60 days of birth, adoption or placement for adoption
- Within 30 days of marriage
- Within 30 days of declaration of state registered domestic partnership
- Within 30 days of a gain or loss other coverage for you or your dependents

To make this change, logon to Bellevue Benefits at https://cityofbellevuehr.workterra.net. In the bottom left corner under ***Favorite Actions***, or the bottom right under ***Quick Links***, select **Initiate Qualifying Event**. Select the Qualifying Event and enter the Life Event Date. Click **Save** and an enrollment window will open that will step you through the benefits that you are allowed to change specific to your life event. You will know that you have completed your changes in Bellevue Benefits when you click the **Finish** button at the bottom of the Confirmation Statement.

Insurance Terms Defined

Co-pay

A co-pay is a flat dollar amount you pay for a medical service. Co-pays may apply to office visits, prescription drugs, emergency room visits and hospital admissions.

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 following pages for benefit 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 individual 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. For the Premera Blue Cross Choice Plan, the plan pays 90% after you meet your annual deductible and you pay 10% for in-network 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%. On the Premera plans, your deductibles and co-pays also apply toward the out-of-pocket maximum.

Allowable Amount

When you use non-network providers (also called "out-of-network"), 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, you will be responsible for the cost difference. This is called "balance billing." This cost difference or balance billing does not count toward your out-of-pocket maximums. In-network providers cannot balance bill. Note: non-network services are not covered on the Kaiser Permanente or Willamette Dental of Washington, Inc. plans.

Comparing In-Network to Non-Network Providers

When you see non-network providers, the plan pays a lower coinsurance of the allowable amount. This means your out-of-pocket costs will be greater than if you see in-network providers. The below examples assume the deductible (if any) has been met and no co-pays apply.
Below is an example, assuming you are enrolled in a Premera Plan, which uses the Heritage network.

Type of Provider	Amount Charged by Your Provider	Allowed Amount	Amount Plan Pays in Coinsurance	Amount You Pay in Coinsurance	Balance Billing Amount	Your Total Out-of-Pocket Cost
Heritage	$1,000	$800	$800 (100% x $800)	$0	$0	$0
Non-Network	$1,000	$800	$480 (60% x $800)	$320 (40% x $800)	$200*	$520 ($320 + $200)

*Note: This amount does not count toward the out-of-pocket maximum.

Which Plan Best Meets the Needs of Me & My Family?

Why Kaiser HMO?

- Integrated care - because Kaiser is both a care provider and a health plan, you can get the care and coverage you need in one convenient package.
- Kaiser Permanente health plans are rated among the nation's best for overall treatment, prevention, and patient experience by the National Committee for Quality Assurance. KP Washington was also recognized as the highest-ranked medical group in the 2023 Community Checkup from Washington Health Alliance
- At most care facilities, you can see your doctor, get a lab test or X-ray, and pick up your medications — all without leaving the building.
- As a plan member, you can receive a variety of covered health services at Kaiser Permanente facilities in California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, the Longview/Vancouver area of Washington State, and the District of Columbia. Just call Member Services about getting a visiting member identification number. Your specific benefits will vary depending on your plan.

Why Premera Blue Cross PPO?

- Access medical care services from any provider.
- Choose providers in the Heritage network so the plan benefits are higher, and your expenses are lower.
- Look for the Blue Distinction Total Care when selecting a provider, with a focus on providing preventive services and wellness coaching, as well as working with patients with chronic conditions to better meet their care needs.

Exploring My Options

- When deciding which medical plan is the best fit for you and your family, it is important to consider the total cost of coverage.
- This includes the amount deducted from your paycheck plus what you pay providers when accessing care.
- Use this chart to help you compare which plan may be the best fit for you.

	KAISER PERMANENTE HMO	PREMERA CHOICE PPO	PREMERA CORE PPO
Want to pay the lowest employee contributions from your paycheck?	✓	✓	
Want the integrated, convenient, high-quality care of a health maintenance organization (HMO)?	✓		
Want the flexibility to see any providers? Your cost will be less by using the Heritage preferred provider network (PPO).		✓	✓
Want preventive care covered at 100% in network?	✓	✓	✓
Want unlimited behavioral health?	✓	✓	
Want access to more massage therapy visits?	✓	✓	
Want vision exams and hardware integrated with your medical plan?	✓		
Want only a co-pay for office visits?	✓	✓	✓
Want a lower deductible?	✓		✓
Want an app that allows you to view ID Cards and provide multiple ways to access care?	✓	✓	✓

Make the Most of Your Health Benefits

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1

Take advantage of your free preventive care and screenings

Your medical plan covers preventive services, including immunization shots and screenings, at no cost to you. These services are free when delivered by an in-network provider and if billed as preventive care by the provider.

2

Shop around for medications

- Ask your doctor if generic medications are available for your prescriptions.
- For maintenance drugs, see if the mail-order service can save you time and money.
- Compare prices at pharmacies online such as Express Scripts or Good Rx mobile apps.

3

Stay in network

- Premera is able to negotiate discounts with in-network providers so it always costs less. Locate a provider on premera.com, and confirm provider is still in-network when scheduling an appointment.
- Kaiser coverage is available through KP locations nation-wide. Notify Kaiser's Hospital Notification Line in case of emergency care admissions at 888-457-9516.

4

Compare prices for services (Premera plans only)

Prices for services, such as an MRI, or for a medical procedure can vary. We know many things are important when selecting a provider or facility and cost should be one of those factors being evaluated. When you log-in to Premera.com, use the "Procedure Cost" option under "Find a Doctor" section. You will be able to search by actual procedure or billing code to help compare options.

5

Budget and save for the deductible and out-of-pocket healthcare costs

In addition to your monthly premiums taken from your paycheck, there are other out-of-pocket healthcare costs - be aware of your annual deductible and plan benefits and ensure you are saving or setting aside money to cover all your medical, dental and vision costs.

Consider contributing to a Healthcare Flexible Spending Account (FSA) – see page 30 to learn more. A Healthcare FSA allows you to save pre-tax dollars for eligible healthcare expenses. However, the full amount you contribute must be used in the plan year.

Where to Get the Care You Need

TIPS

6

Prices for the same service varies depending on where you seek the care. It's important to know when to visit your primary care doctor, urgent care or the emergency room and what other options you have.

Minor
Routine
Urgent
Emergency

24/7 Nurseline

When enrolling through a Kaiser or Premera plan, you have free access to the nurseline.

Nurseline Resources:

Premera: 800-841-8343
Kaiser: 800-297-6877

For **non-emergency conditions**. Nurseline can help provide home treatment tips and direction of care.

Virtual Care ($0 - $)

Availability: **Premera**: 24/7;
Kaiser: 24/7 phone advice
Care Chat (6 am to 9 pm M-F). Mental Health Advice, Pharmacy and Member Services (8a.m. - 5p.m.M-F)

For conditions like flu symptoms, allergies, and ear infections, talk to a doctor by phone or video.

Doctor's Office/Retail Health Clinic ($)

Availability: Office hours vary

Best for **routine care** check-ups, physicals, preventive screenings, and other non-urgent conditions.

Urgent Care ($$)

Availability: Typically includes evenings and weekends

For **not life threatening conditions**, but requiring timely care. Use for illnesses, minor fractures, and diagnostic services.

Emergency Room ($$$)

Availability: 24/7

Life threatening conditions:
- Difficulty breathing
- Heart attack or stroke
- High fever
- Loss of consciousness
- Poisoning, severe burns or wounds that need stitches

These examples are not meant to be used as medical advice. Please call the 24/7 Nurseline about your specific issue to get advice on where to go for care.

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 Healthcare

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.

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.

Talkspace Virtual Therapy for Behavioral Healthcare

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

What it is: easily connect to therapists and psychiatrists by video and text. Start by signing up, 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 – Virtual Physical Therapy Provider

https://go.omadahealth.com/premera

What it is: Omada is a virtual physical therapy provider that is accessed by the member through a mobile app. With Omada, 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 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. 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).

Kaiser Permanente offers virtual behavioral health solutions and mindfulness apps! Access and care options vary from virtual patient appointments, care chat, and self-care apps. Members can visit www.kp.org/wa/mhw to get connected to care.

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. The City of Bellevue offers you a choice of medical plans through Premera Blue Cross and Kaiser Permanente. The plans cover most of the same benefits, but your out-of-pocket expenses and network physicians vary. All plans provide excellent coverage of preventive services, such as routine physical exams and immunizations, that are very important to your and your family's health. Prescription drug coverage is also included with each medical plan option.

Please read the description of the plans below; then review the highlights of what each plan covers on the following pages.

Premera Blue Cross Preferred Provider Organization (PPO) Plans

These PPO (Preferred Provider Organization) plans offer a wide choice of providers. You can elect to use a Premera network provider or any other provider for your healthcare services. If you choose a network provider, your cost will be less (please see the plan highlights on the next page for the difference in coverage between in-network and non-network). The Premera Plans utilize the Heritage network.

You do not need a referral for specialist care. You can find Premera providers online or by phone – please see the information in Your Benefits Contacts at the beginning of this Guide. Be sure to check with your provider at the time of service to verify network status as this may change.

Kaiser Permanente Health Maintenance Organization (HMO) plan

Experience integrated, convenient, quality care with this plan. Out-of-pocket expenses are low but you must seek services from a Kaiser Permanente Provider or contracted network provider. You are encouraged to select a Primary Care Physician (PCP) who will coordinate care with your other providers. In addition to medical and prescription drug coverage, vision exam and hardware coverage are also exclusively included with Kaiser Permanente. Please note that non-network services will not be covered unless authorized in advance. You can find Kaiser Permanente providers online or by phone – please see the information in "Your Benefits Contacts" at the beginning of this Guide.

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

KAISER PERMANENTE®

Kaiser Perks:

For help with managing your healthcare conditions and want information for Discounts and Fitness Programs, access Kaiser Permanente at:

wa.kaiserpermanente.org/html/public/member-guide/perks

wa.kaiserpermanente.org/html/public/services/fitness

Premera Behavioral Health Support

Need help finding a behavioral health specialist? Call customer service at the number on the back of your ID card to request help finding a provider.

Mobile App Access

Access apps from Google Play or the Apple Store to help you better use your benefits.

Premera Blue Cross

Kaiser Permanente

Kaiser Permanente HMO Plan Highlights

PCY = Per Calendar Year	Kaiser Permanente Provider
Calendar Year Deductible	$0 per individual / $0 per family
Calendar Year Out-of-Pocket Maximum	$2,000 per individual / $4,000 per family
Lifetime Benefit Maximum	Unlimited
Your cost shares will be as follows:	
Physician and Diagnostic Services	
Physician's Office Visits	$10 co-pay
Outpatient Surgery	$10 co-pay
Preventive Services, including: well care physicals, immunizations, pap smear exams, mammograms	Covered in Full
Vision Exam (one exam every 12 months)	$10 co-pay
Frames and Contacts (Members 19 and over)*	$200 hardware allowance every 12 months
Obstetrical Care (Dependent children are covered)	Covered in Full (Inpatient) $10 co-pay(Outpatient)
Diagnostic Lab & X-ray	Covered in Full
Acupuncture (up to 8 visits per medical diagnosis PCY) Additional visits must be approved	$10 co-pay
Chiropractic (up to 10 visits PCY)	$10 co-pay
Physical Therapy • Inpatient (up to 60 days PCY) • Outpatient (up to 60 visits PCY)	 Covered in Full $10 co-pay
Massage Therapy • Inpatient • Outpatient	 See Physical Therapy See Physical Therapy
Hospital Services	
Inpatient Hospital Services	Covered in Full
Emergency Room	$75 co-pay, (for Designated Facilities) $75 co-pay, (for Non-Designated Facilities) (co-pay waived if admitted)
Mental Health	
Outpatient (unlimited visits PCY)	$10 co-pay
Inpatient (unlimited days PCY)	Covered in Full
Chemical Dependency	
Outpatient (unlimited visits PCY)	$10 co-pay
Inpatient (unlimited days PCY)	Covered in Full

***Members under 19: 1 pair of frames and lenses per year or contact lenses covered in full. Members age 19 and over: $200 per 12 months, benefit includes lenses, including contact lenses, and frames.

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.

Kaiser Permanente Prescription Drug Benefits

KAISER PERMANENTE®

Your plan includes a comprehensive prescription drug program.

	Kaiser Permanente Pharmacy
Rx Retail Pharmacy (30-day supply)	Covered in Full after listed co-pays (no deductible): $10 co-pay for generic and/or brand
Mail Order Pharmacy (90-day supply)	Covered in Full after listed co-pays (no deductible): $30 co-pay for generic and/or brand

Important Information Regarding Your Medical Benefit Plan – Kaiser Permanente

Organ Transplant

There is no waiting period for Organ Transplants.

Women's Health and Cancer Rights Act

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

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

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

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, or 60 days after birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

Patient Protection Disclosure Notice

The Health Plan generally requires/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.

Healthcare Reform & your Benefits

The City offers coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. It's unlikely that you are eligible for premium assistance for insurance purchased through a Marketplace due to access to an employer plan

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.

Premera Choice Plan Highlights

PREMERA BLUE CROSS

PCY = Per Calendar Year	In-Network (Heritage)	Out-of-Network
Calendar Year Deductible	$750 per individual $1,500 per family	
Calendar Year Out-of-Pocket Maximum	$1,500 per individual $3,000 per family	
Lifetime Benefit Maximum	Unlimited	

After the deductible is satisfied, your cost shares will be as follows:

Physician and Diagnostic Services		
Physician's Office Visits	$30 co-pay, deductible waived	40% of allowable*
Outpatient Surgery	10%	40% of allowable*
Preventive Services, including: well care physicals, immunizations, pap smear exams, mammograms	Covered in Full (deductible waived)	Not Covered Pap smear, mammograms: 40% of allowable*
Vision Exam	Not Covered	Not Covered
Obstetrical Care (Dependent children are covered)	10%	40% of allowable*
Diagnostic Lab & X-ray	10%	40% of allowable*
Acupuncture (up to 12 visits PCY)	$30 co-pay, deductible waived	40% of allowable*
Chiropractic (up to 12 visits PCY)	$30 co-pay, deductible waived	40% of allowable*
Physical Therapy (up to 45 visits PCY – shared with Massage)	$30 co-pay, deductible waived	40% of allowable*
Massage Therapy (up to 45 visits PCY – shared with Physical Therapy)	$30 co-pay, deductible waived	40% of allowable*
Hospital Services		
Inpatient Hospital Services	10%	40% of allowable*
Emergency Room	10%	10%*
Mental Health		
Outpatient (unlimited visits PCY)	$30 co-pay, deductible waived	40% of allowable*
Inpatient (unlimited visits PCY)	10%	40% of allowable*
Chemical Dependency		
Outpatient (unlimited visits PCY)	$30 co-pay, deductible waived	40% of allowable*
Inpatient (unlimited days PCY)	10%	40% of allowable*

Deductible applies unless otherwise noted

* You are responsible for the coinsurance amount plus any amount over allowable after the annual deductible is satisfied. The City of Bellevue plan covers the difference up to the allowable amount.

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.

Important! Premera Blue Cross requires prior authorization to receive coverage for certain planned services. If prior authorization is not obtained for a required service, you may be subject to additional cost shares not outlined here. A complete list of services requiring prior authorization is available at www.premera.com.

Premera Core Plan Highlights

Note: This plan is closed for non-represented employees hired on or after December 1, 2018, Fire Prevention Officers, IBEW and Teamsters Utilities, Parks, Finance & Asset Management, and Transportation employees hired on or after December 1, 2019, and Teamsters Development Services and Bellevue Police Support Guild employees hired on or after December 1, 2020.

PCY = Per Calendar Year	In-Network (Heritage)	Out-of-Network
Calendar Year Deductible	$0 per individual $0 per family	$250 per individual $500 per family
Calendar Year Out-of-Pocket Maximum	$1,500 per individual $3,000 per family	
Lifetime Benefit Maximum	Unlimited	
After the deductible is satisfied, your cost shares will be as follows:		
Physician and Diagnostic Services		
Physician's Office Visits	$15 co-pay	40% of allowable*
Outpatient Surgery	Covered in Full	40% of allowable*
Preventive Services, including: well care physicals, immunizations, pap smear exams, mammograms	Covered in Full	Not Covered
Vision Exam	Not Covered	Not Covered
Obstetrical Care (Dependent children are covered)	Covered in Full	40% of allowable*
Diagnostic Lab & X-ray	Covered in Full	40% of allowable*
Acupuncture (up to 12 visits PCY)	$15 co-pay	Not Covered
Chiropractic (up to 30 visits PCY – shared with Physical Therapy)	$15 co-pay	40% of allowable*
Physical Therapy (up to 30 visits PCY – shared with Chiropractic)	$15 co-pay	40% of allowable*
Massage Therapy (up to 4 visits PCY)	$15 co-pay	Not Covered
Hospital Services		
Inpatient Hospital Services	$250 co-pay per admission	40% of allowable* after you pay $250 co-pay per admission
Emergency Room	$100 co-pay (co-pay waived if admitted)	$100 co-pay*, deductible waived (co-pay waived if admitted)
Mental Health		
Outpatient (up to 15 visits PCY)	$15 co-pay	40% of allowable*
Inpatient (up to 20 days PCY)	$250 co-pay per admission	40% of allowable* after you pay $250 co-pay per admission
Chemical Dependency		
Outpatient (unlimited visits PCY)	$15 co-pay	40% of allowable*
Inpatient (unlimited days PCY)	$250 co-pay per admission	40% of allowable* after you pay $250 co-pay per admission

Deductible applies unless otherwise noted

* You are responsible for the coinsurance amount plus any amount over allowable after the annual deductible is satisfied. The City of Bellevue plan covers the difference up to the allowable amount.

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.

IMPORTANT! Premera Blue Cross requires prior authorization to receive coverage for certain planned services. If prior authorization is not obtained for a required service, you may be subject to additional cost shares not outlined here. A complete list of services requiring prior authorization is available at www.premera.com.

Premera Prescription Drug Benefits

Your plans include a comprehensive prescription drug program. The level of coverage depends on whether the drug is generic or brand, and whether it is on the Premera formulary, or preferred drug list. 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.

Premera covers a broad formulary of drugs. To determine whether your drug is on the formulary, please check the online list at www.premera.com. There, you can also find a list of in-network pharmacies. The drug list is updated periodically to ensure that newer, more effective drugs are listed. Drugs are automatically removed from the formulary when generic alternatives become available.

When filling a prescription, present your Premera member ID card to any participating pharmacy. If using an out-of-network pharmacy, you will need to pay the drug cost out-of-pocket and then submit a claim form to Premera for reimbursement of the covered amount.

NOTE *All prescription drug co-pays will accumulate toward the medical out-of-pocket maximum for the Core and Choice plans.*

	Core Plan In-Network	Choice Plan In-Network
Rx Retail Pharmacy (30-day supply)	Covered after listed co-pays, no deductible: $10 co-pay for generic (Tier 1) $20 co-pay for preferred brands (Tier 2) 50% for non-preferred brands (Tier 3)	Covered after listed co-pays, no deductible: $10 co-pay for generic (Tier 1) $25 co-pay for preferred brands (Tier 2)* $45 co-pay for non-preferred brands (Tier 3)*

*The Choice plan requires generic drugs to be dispensed in place of a brand name drug. If a brand name drug is dispensed when a generic equivalent is available, the cost will be the difference in cost between the brand name drug and the generic equivalent in addition to the brand name co-pay amount.

Premera Blue Cross Mail Order Prescription Drugs – Express Scripts by Mail

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 mail order program, ask your doctor to write you a prescription for a 90 day supply. Send it in along with the form you can download online at www.premera.com, select Pharmacy, then the "Mail Order Prescriptions" tab. You can then conveniently refill the prescription online or over the phone.

	Core Plan In-Network	Choice Plan In-Network
Mail Order Pharmacy (90-day supply)	Covered after listed co-pays, no deductible: $20 co-pay for generic (Tier 1) $40 co-pay for preferred brands (Tier 2) 50% for non-preferred brands (Tier 3)	Covered after listed co-pays, no deductible $25 co-pay for generic (Tier 1) $62 co-pay for preferred brands (Tier 2)* $112 co-pay for non-preferred brands (Tier 3)*

Resources

Premera provides tools on www.premera.com and the Express Scripts®* mobile app, which let you manage your pharmacy care anytime, anywhere.

- View current medications, set dosing time, and refill reminders
- Look up potential lower-cost options available under your plan and discuss them with your doctor – while you're still in the doctor's office!
- Request, manage, and track home delivery of ongoing maintenance medications
- Use your phone to show your virtual ID card at the pharmacy
- Receive personalized alerts of possible health risks related to medications
- Locate in-network retail pharmacies

IMPORTANT! Some drugs require prior authorization or step therapy. To see if your prescription requires prior authorization, visit the Pharmacy section at www.premera.com.

If you take Specialty drugs, you must fill your prescription through Accredo Health Group or SaveonSP. The Accredo Specialty Pharmacy provides additional services and clinical support. SaveonSP is defined on page 23. Newly prescribed Specialty medications may also be subject to SplitFill which splits the initial fill into two smaller fills, allowing the member to assess the medication and reduce waste. Contact Customer Service at 800-722-1471 for more information. You may also view a complete list of specialty drugs at www.premera.com.

**Express Scripts® is an independent company that provides pharmacy benefit services on behalf of Premera Blue Cross.*

Premera - Additional Programs

Teladoc Health – Free Hypertension and Diabetes Support

Teladoc Health 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 and lancets, 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.

Weight Management: This program provides expertise, support and technology with a focus on weight loss and weight management. The emphasis is on nutrition, exercise, sleep, and stress management. This is an app-based program where members receive a personalized experience through group chats, progress tracking, challenges, and more.

You can join by registering by calling Livongo by Teladoc Health at 800-945-4355.

Experian Credit Monitoring

Employees and their dependents enrolled in one of the Premera Blue Cross medical plans have access to a free credit report monitoring plus ID theft and fraud resolution services from Experian®. There are two programs to choose from: one for adults over the age 18 with a credit history and one for dependents under 18 years of age.

*Identity theft insurance is underwritten by insurance company subsidiaries or affiliates of American International Group, Inc. (AIG). The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

How to Enroll

Sign in to your Premera account at www.premera.com.
Click "My Account"
Click "Account Settings"
Click "Sign Up Today"

You may also call the customer service number on the back of your Premera ID card. A Premera representative will connect you to Experian to complete your enrollment.

IdentityWorks Credit 1-Bureau

- Available to employees and their dependents 18 years of age and older (who have credit history)
- Credit monitoring
- Experian credit reports
- Identity restoration
- Experian IdentityWorks ExtendCARE™
- Up to $1 Million Identity Theft Insurance*

IdentityWorks Minor Plus

- Available for your dependents under 18 years of age.
- Internet surveillance to identify trading or selling of your minor's personal information on the dark web
- Identity restoration
- Experian IdentityWorks ExtendCARE™
- Up to $1 Million Identity Theft Insurance*

Important Information Regarding Your Medical Benefit Plan – Premera Blue Cross

Organ Transplant

There is no waiting period for organ transplants. Organ and bone marrow transplants have a $2,000 ($7,500 on Choice Plan) travel and lodging maximum. Please see your plan booklet for further details.

Women's Health and Cancer Rights Act

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

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

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

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, co-pays and coinsurance.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after marriage and 60 days after birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

Healthcare Reform & your Benefits

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

Important Information Regarding Your Medical Benefit Plan – Premera Blue Cross

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" at the beginning 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.

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 a high copay and the copays 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 on Knee & Hip Replacement – Choice Plan Only

Designated Centers of Excellence facilities are recognized for higher efficiency, lower costs and better patient outcomes for delivering specialty care. When seeking care for knee and hip replacements from Premera's designated providers, the plan will waive member deductible and coinsurance. To get started and find a facility that's right for you, call Premera at 800-722-1471.

Dental Benefits

Oral care is very important to your health and general well-being. The City of Bellevue provides comprehensive dental coverage through either Delta Dental of Washington or Willamette Dental of Washington, Inc.

Delta Dental of Washington plan

Under the Delta Dental plan, you may access dental care services from any dentist you wish. However, if you obtain services from a Delta Dental PPO dentist, your benefits will likely be paid at a higher level and your out-of-pocket expenses will be lower. Delta Dental of Washington offers a comprehensive provider network both locally and across the nation. All participating Delta Dental dentists agree to provide services to you at discounted, negotiated fees. If you use non-network dental providers, your charges will be based on the maximum allowable fee for your area, as determined by Delta Dental of Washington.

Willamette Dental of Washington, Inc. plan

The Willamette Dental of Washington, Inc. plan offers access to the exclusive providers in the Willamette Dental Group dental practice. All group dentists are employed by Willamette Dental Group and provide services in their 50+ locations to you at predictable, low co-pays. If you use non-Willamette Dental Group dental providers, you will not have coverage.

DELTA DENTAL

Delta Dental of Washington

Willamette Dental Group

Maximum Allowable Fee – Delta Dental

When you use out-of-network services, your plan will pay a percentage of the maximum allowable fee. If your dentist charges more than the maximum allowable fee, you will be responsible for the difference.

Dental Benefits, continued

You can find Delta Dental or Willamette Dental Group providers online – please see the information in Your Benefits Contacts at the beginning of this Guide.

Before Treatment Begins

You should have your dentist's office contact Delta Dental in writing for a predetermination if you expect the charges to be more than $300. You and your dentist will receive a predetermination stating how much of the cost will be covered under the plan, and how much will be your responsibility.

	Delta Dental of Washington		Willamette Dental of Washington, Inc.
	PPO Provider	Premier / Non-Network Provider	Willamette Dental Group Dentist
Calendar Year Deductible	$0 per individual $0 per family		$0 per individual $0 per family
Calendar Year Maximum Benefit	$2,000 per individual		No Annual Maximum*
General Office Visit & Orthodontic Copay	N/A		$5 per visit
Specialist Office Visit Copay	N/A		$30 per visit
Preventive and Diagnostic Services, includes: exams, cleanings, x-rays, sealants and topical fluoride treatments	Covered in Full		Covered in Full after office visit copay
Basic Services, includes: fillings, extractions, and endodontics	Covered in Full		Covered in Full after office visit copay
Major Services, includes: • crowns and bridges • implants	 50% 50%		 $100 co-pay Covered in Full to $1,500 annual max
Orthodontia	Not Covered		$1,200 co-pay (no lifetime maximum)
TMJ Benefit	50% to $1,000 annual max ($5,000 lifetime maximum)		Covered in Full to $1,000 annual max ($5,000 lifetime maximum)

*TMJ, orthognathic surgery, & dental implant surgery have benefit maximums.

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.

Virtual Dentistry with Delta Dental of WA

Effective January 1, 2025, Delta Dental of Washington is offering virtual services through Dentistry.One. Whether you're facing a dental emergency, require after-hours care, or simply have general concerns about your oral health, get the answers you need 24/7.

1. Visit Dentistry.one/delta-dental-wa and create an account
2. Speak with a live dentist now and schedule an appointment, or send pictures for review
3. Receive personalized Oral Health Report with recommended next steps
4. Dentistry.One can help schedule a visit with an in-network provider nearby

Vision Benefits

Kaiser members are covered for vision hardware and exam through Kaiser, bundled with Medical coverage.

To help you take care of your eyesight, the City of Bellevue provides you the option of two vision care plans through VSP Vision Care:

- Exam which covers an exam only*, or
- Exam & Hardware which covers both an exam and vision hardware.

*You can receive 20% savings on a complete pair of prescription glasses. Within 12 months of exam: 20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses from any VSP doctor (does not apply to participating retail chains). Contact lens exam (fitting and evaluation): Member receives 15% off of contact lens exam service.

VSP offers you access to a large network of doctors nationwide. You may choose to obtain your vision care services from any provider you wish. When you access care from VSP network providers, your benefits are greater, and your out-of-pocket costs are less. You may call VSP direct to find a VSP doctor and a retail chain provider and view special offers by visiting their website at www.vsp.com or calling 800-877-7195. Click “create an account” under “Members” to register and login to their website.

Please refer to the table on the following page to find out how often you are eligible for services.

Your VSP Member ID is not your social security number. The VSP Member ID is 9 digits in length. Please use the appropriate number of leading zeroes and then your 5-digit or 6-digit employee ID number. Look for your employee ID number on your paycheck stub.

Note:

For the Exam & Hardware Plan standard progressive lenses and tints are covered in full if obtained from a VSP doctor.

All other lens options are not covered; however, you will receive an average of 35-40% savings on all non-covered lens options like anti-reflective coatings or scratch resistant coatings from a VSP doctor. Be sure to ask your provider for details or call VSP.

Vision Benefits, continued

	Exam Plan		Exam & Hardware Plan	
	VSP Signature	Non-Participating*	VSP Signature	Non-Participating*
Co-pay for all Services				
• Exams	$20 co-pay	$20 co-pay	$20 co-pay	$20 co-pay
• Prescription Glasses	Not Covered*	Not Covered	$20 co-pay	$20 co-pay
After the co-pays have been satisfied, your cost shares will be as follows:				
Eye Exam (once every calendar year)	Covered in Full	Up to $50	Covered in Full	Up to $50
Basic Lenses (once every calendar year)				Reimbursed/Plan Pays…
• Single	Not Covered	Not Covered	Covered in Full	Up to $50
• Lined Bifocals	Not Covered	Not Covered	Covered in Full	Up to $75
• Lined Trifocals	Not Covered	Not Covered	Covered in Full	Up to $100
Frames (once every calendar year)	Not Covered	Not Covered	Covered in Full up to $175	Up to $70
• Costco/Walmart/Sam's Club Allowance	Not Covered	Not Covered	Covered in Full up to $95	Not Covered
Contact Lenses (once every calendar year in lieu of lenses and frames)			(up to $60 co-pay for fitting & evaluation)	
• Elective	Not Covered	Not Covered	Covered in Full up to $175	Up to $160
• Medically Necessary	Not Covered	Not Covered	Covered in Full after $20 co-pay	Up to $210

*20% discount on complete pairs of prescription glasses and lens enhancements when using a VSP doctor (Costco and Walmart/Sam's Club not included)

Note: When you use non-participating providers, you will be required to pay upfront for your services and submit your claim to VSP for reimbursement up to the amount shown in the table above.

VSP has contracted with retail chain providers in addition to a VSP doctor. To locate all providers in your area, please login to your account on vsp.com. Participating Retail Chains provide members the same covered-in-full benefit experience they receive from a VSP Doctor, with minor exceptions like the frame allowance at Costco and Walmart/Sam's Club. Participating Retail Chains can check eligibility online and submit claims to VSP. As a note, not all Costco and Walmart/Sam's Club doctors are on VSP's network, please verify their participation in the VSP network. Additional information can be found at https://c2mb.ajg.com/cityofbellevue.

Life & Disability Benefits

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

In the event of your death, this plan pays your beneficiary a benefit of $50,000.

In the event of your accidental death, this plan pays your beneficiary a benefit of $50,000. If you are seriously injured as the result of an accident (e.g., lose your eyesight, paralysis), this plan will pay a partial benefit to you.

You are automatically enrolled in this coverage upon becoming eligible for benefits. The City of Bellevue pays the full cost of this coverage.

	Life/AD&D
Benefit Amount	
• Life Insurance	$50,000
• Accidental Death & Dismemberment	$50,000
Benefits Begin to Reduce at Age:	70

When you first enroll...

When you first enroll in life insurance benefits, you will need to designate a beneficiary who would receive the benefits in the event of your death. You may change or update your beneficiary at any time.

Long-Term Disability (LTD) Coverage

The City of Bellevue provides a valuable benefit that helps protect your income if you become ill or injured and are unable to work. This benefit has been designed to protect your income for a longer period of disability.

LTD coverage through The Standard provides monthly benefits if you are not able to return to work after 180 days of disability due to illness or injury. LTD benefits can replace up to 60% of your salary, to a maximum benefit of $5,000 per month. Benefits are offset by income from other sources including Social Security or Workers' Compensation, sick pay, annual or personal leave pay, retirement plan or other salary continuation. Benefits begin after you have been continuously disabled for 180 days, and may continue until Social Security Normal Retirement Age, or the date you are no longer disabled.

You are automatically enrolled in this coverage upon becoming eligible for benefits. The City of Bellevue pays the full cost of this coverage.

	Long-Term Disability
Monthly Benefit Amount	60% of base monthly earnings
Maximum Monthly Benefit	$5,000
Elimination Period	180 days
Benefit Duration	To age 65/Social Security Normal Retirement Age
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.

Note: If you are located in an area that offers disability coverage or has a paid leave program, it may impact the benefit you receive under our coverage. For specific benefit coverage information, please contact The Standard.

Voluntary Life/AD&D Benefits

Not everyone's personal situation is the same; your family needs may be different from your co-workers. In recognition of these differences, the City of Bellevue offers voluntary life insurance benefits, which you can purchase at group rates. The coverage you purchase is in addition to the life insurance provided to you by the City of Bellevue.

- **Employee**— Elect amounts in $10,000 increments up to $500,000 maximum.
- **Spouse**—$10,000 increments up to 100% of the amount you elect for yourself, including your basic life insurance, up to $250,000.
- **Children**— benefit of $2,000, $5,000 or $10,000

If you enroll when you are initially eligible you are guaranteed coverage up to $200,000 but no more than four times your annual salary for yourself, up to $20,000 for your spouse and up to $10,000 for your children without answering medical questions. Complete the Evidence of Insurability Form if you (or your spouse) wish to enroll for more than the Guarantee Issue amount during your initial eligibility period.

Complete the Evidence of Insurability Form if you (or your spouse) wish to enroll more than 31 days after you become eligible.

Children of domestic partners are not eligible unless the children are adopted by the employee.

Voluntary AD&D insurance is also available in amounts equal to voluntary life insurance.

Voluntary Life/AD&D – Benefit Outline	
Benefit Options	
Employee	$10,000 Increments
Spouse	$10,000 Increments
Children	$2,000, $5,000 or $10,000
Benefit Maximums	
Employee	$500,000
Spouse	Lesser of the Employee Benefit or $250,000
Children	$2,000, $5,000 or $10,000
Guarantee Issue	
Employee	Lesser of 4x Annual Salary or $200,000
Spouse	$20,000
Children	$10,000
Benefits Begin to Reduce at Age:	70
Waiver of Premium	Included
Portability	Included

Flexible Spending Accounts (FSA)

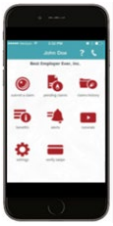
Looking for a way to save money on healthcare and/or dependent day care? Flexible Spending Accounts (FSAs) save you money by reducing the taxes you pay. Your FSA contributions are deducted from each paycheck before federal taxes are calculated. So you do not pay taxes on your eligible FSA expenses.

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 daycare expense, you can pay for it with tax-free money. The accounts are not connected: you pay for healthcare expenses and daycare expenses with separate accounts.
- You may use money in your FSA to pay for eligible expenses incurred by you, your spouse and your eligible tax dependents. You and/or your dependents do not have to be enrolled in the city's 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 daycare expenses. Create an election for each year you wish to participate.



MyNavia Mobile Application

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 for any Navia participant with an active FSA. The app includes access to real-time account balances, tutorial videos, account alerts, and claim submissions.

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 electronic 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 year to year. 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 or provider Explanation of Benefits (not just a credit slip stating dollar amount).

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.

Flexible Spending Accounts (FSA), 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.

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

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

Maximum Healthcare Contribution

$3,300

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

No. You and/or your dependents do not have to be enrolled in a City of Bellevue medical plan to participate in the Healthcare FSA.

Use it or lose it

You must use up the entire amount you pay into your Flexible Spending Accounts by March 15 of the following calendar year. For claims incurred by March 15, you have 90 days (until June 15) to submit for reimbursement.

If you do not, you will lose the unspent money.

To help you plan, use the online calculator: www.naviabenefits.com.

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 employees or married employee filing jointly

$2,500 for married employees 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.

Employee Assistance Program (EAP)

The City of Bellevue 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 the City of Bellevue employees and their eligible family 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:

- Aging / Elder Care and Care-Giving Issues
- Communicating Effectively
- Alcohol and Drug Dependency
- Gambling Problems
- Anxiety and Depression
- Career Path
- Divorce
- Domestic Violence Assessment
- Work-Related Problems
- Financial or Legal Concerns
- Grief and Loss
- Parenting Support
- Relationships
- Stress Management
- Terminal Illness
- Troubled Teens
- Emotional Concerns

Wellspring FAMILY SERVICES

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" at the beginning of this Guide.

If you visit a counselor

Up to 6 sessions per situation are provided at no charge to you. Counseling options are available: face-to-face, video, chat, and text-based. If more sessions are needed, the EAP professionals can work with your health plan to determine further coverage.

EAP counselors 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. If you visit a counselor, up to 6 sessions per 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.

Free and Confidential

All EAP counseling and assistance is free and confidential.

Call 800-553-7798 for assistance.

Gallagher Marketplace Voluntary Coverages

The Marketplace options are being provided as a convenience for employees and do not constitute an endorsement, approval, or sponsorship by the City of Bellevue of any of the products or services offered.

Benefits With Gallagher Marketplace

Giving you year-round access to additional benefits that could save you money.

Gallagher Marketplace is your gateway for discovering and accessing unique benefits that best fit your lifestyle. Our program offers significant savings on things you are already buying—like home and auto, pre-paid legal services, identity theft protection, pet insurance, renters insurance, boat or RV insurance, employee discount perks as well as extended vehicle warranties. Gallagher Marketplace also offers access to individual medical, dental and vision coverage as well as Medicare supplemental programs.

With a centralized hub, you can explore an array of benefit options, available not only to Gallagher clients but also to their friends and families.

Discover what benefits your organization offers through Gallagher Marketplace.

The Value

- Whether full-time, part-time or contract workers, all employees and their families are eligible
- Benefit access and potential savings through bundling with the ability to choose from multiple carriers
- Potential costs savings compared to shopping on your own
- Licensed insurance advisors to help find the policy that meets your needs

The Convenience

- Enroll any time of the year, not just during open enrollment
- Simple sign-up with payment options
- Easily compare rates from multiple carriers
- Schedule a callback from licensed insurance advisors for a time that's most convenient
- All programs are portable so you can keep the coverage no matter where life takes you

How It Works

1. Visit Gallagher Marketplace to see your available benefits.
2. Select a product to view more details.
3. Click on the partner link to learn more, get a free no obligation quote or apply for coverage.

To learn more, scan the QR code or visit c2mb.ajg.com/cityofbellevue/gallagher-marketplace/

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: 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

GEORGIA – Medicaid
GA HIPP Website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

CALIFORNIA – Medicaid
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

FLORIDA – Medicaid
Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

MAINE – Medicaid
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

CHIP, continued

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462 CHIP Phone: 1-800-986-KIDS (5437)
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health care/medicaid/
Phone: 1-800-541-2831

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/upp/
Email:upp@utah.gov Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VIRGINIA – Medicaid and CHIP
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

WEST VIRGINIA – Medicaid and CHIP
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)

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since of July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov **877.267.2323** (Menu Option 4, Ext. 61565)

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa **866.444.EBSA (3272)**

Notices of Creditable Coverage

Important notice from the City of Bellevue
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 the City of Bellevue 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.

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).

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

When can you join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two 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 the City of Bellevue coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may not still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current the City of Bellevue coverage, be aware that you and your dependents may not be able to get this coverage back by enrolling back into the City of Bellevue benefit plan during the open enrollment period under the City of Bellevue 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 the City of Bellevue 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 the City of Bellevue changes. You also may request a copy of this notice at any time.

Certificate of Creditable Prescription Drug Coverage, continued

For more information about your options under Medicare Prescription Drug Coverage…

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

For more information about Medicare Prescription Drug Coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

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

Date:	January 1, 2025
Name of Entity/Sender:	The City of Bellevue
Contact--Position/Office:	Michelle Robinson - Benefits Program Administrator
Address:	450 110th Ave Ne Bellevue, Washington 98004-5514 United States
Phone Number:	425-452-4585

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.

This notice is effective September 1, 2020. If you have any questions about this notice, please contact Michelle Robinson, Privacy Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009, 425-452-4071 (facsimile), 425-452-4585 (phone).

Who will follow this notice

This notice describes the medical information practices of the City of Bellevue Health Plan providing medical, dental, vision, prescription drug, health flexible spending account, and employee assistance program benefits (the "Plan") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and describes how the Plan will use or disclose your Protected Health Information to carry out treatment, payment, or healthcare operations, or for any other purpose permitted or required by law.

We are required by law to maintain the privacy of your protected health information, to provide you with a notice of our legal duties and privacy practices with respect to your protected health information, and to follow the terms of the notice that is currently in effect. We are also required to notify affected individuals in the case of a breach of unsecured protected health information.

Our pledge regarding Protected Health Information

We understand that your protected health information and your health is personal and are committed to safeguarding your protected health information. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records, including claims records, the Plan maintains. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your protected health information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose your protected health information. It also describes our obligations and your rights regarding the use and disclosure of protected health information.

We reserve the right to change the terms of this Notice and to make new provisions about your protected health information that we maintain, as allowed or required by law. If we make any material change, we will provide you with a copy of our revised Notice of Privacy Practices by direct mail or hand delivery. A copy of the revised Notice of Privacy Practices will also be posted on our website: https://c2mb.ajg.com/cityofbellevue.

HIPAA only protects certain medical information known as "protected health information." Generally, protected health information is information created or received by a health care provider, a health care clearing house, a health plan, or your employer on behalf of your health plan, from which it is possible to identify you and which relates to: (1) your past, present, or future physical or mental health condition; (2) the provision of health care to you; or (3) the past, present, or future payment of health care claims on your behalf. Note: The individually identifiable health information of a person who has been deceased for more than 50 years is not protected health information under the Privacy Rule.

How we may use and disclose your Protected Health Information ("PHI")

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For treatment (as described in applicable regulations). We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose protected health information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might use your PHI information for case management.

For payment (as described in applicable regulations). We may use and disclose your protected health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may use your PHI to adjudicate a claim for a specialist office visit. We may also share medical information with a utilization review or precertification service provider, to assist with the adjudication or subrogation of health claims, or to another health plan to coordinate benefit payments.

Notice of Privacy Practices, continued

For health care operations (as described in applicable regulations). We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use your PHI for underwriting, premium rating, and other activities relating to determining plan coverage.

As required by law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding, such as a malpractice action, or a divorce proceeding.

To avert a serious threat to health or safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your, another person's, or the public's health and safety. But disclosure would only be to someone able to help prevent the serious threat. For example, we may disclose your protected health information in case of exposure to a highly infectious disease.

To Plan Sponsors. For plan administration purposes, your protected health information may be disclosed to specifically designated employees. Those employees will only use or disclose that protected health information necessary to perform plan administration functions or as otherwise required or permitted by HIPAA. Your employer may not use protected health information for employment purposes without your express authorization. Information may be disclosed to another health plan (as described by HIPAA) maintained by the City of Bellevue for purposes of facilitating claims payable under that plan or for other purposes permitted by HIPAA.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on behalf of the Plan or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate such as a third-party administrator to process your claims for Plan benefits.

Prohibition on use or disclosure of genetic information. The plan (other than the long term care plan, if applicable,) is prohibited from using or disclosing your genetic information for underwriting purposes.

Treatment alternatives or health-related benefits and services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services.

Special situations. The following are categories of other circumstances in which we may use or disclose your protected health information. While this is not an exhaustive list of the specific ways that we may use or disclose your PHI, each way that we may use or disclose your PHI would fall into one of these categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary

Military and Veterans. If you are a current member of the armed forces, we may release protected health information as deemed necessary by military command authorities to ensure the proper execution of their military mission. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information to the extent necessary to comply with laws relating workers' compensation or similar programs, that provide benefits for work-related injuries or illness without regard to fault.

Public Health Risks. We may disclose your protected health information to public health authorities. Reportable activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To conduct public health surveillance, investigation, or intervention;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence, but only if you agree to the disclosure, or the disclosure is required or authorized by law.

Health oversight activities. We may disclose your protected health information to a health oversight agency for reasons authorized by law. For example, a health oversight agency may conduct audits, investigations, inspections, and licensure (e.g., reporting the results of a TB test to the Center for Disease Control).

Notice of Privacy Practices, continued

Lawsuits and disputes. If you are involved in a lawsuit or a legal dispute, we may disclose your protected health information in response to a court or administrative order, a subpoena, discovery request, or other lawful process by someone else involved in

The dispute. Prior to responding, we will attempt to inform you of the request or obtain an order protecting the health information requested.

Law enforcement. We may release medical information if asked to do so by a law enforcement official:

- To report certain types of wounds or other physical injuries as required by law;
- In response to a court order, subpoena, court-ordered warrant, summons or similar process issued by a judicial officer;
- In response to a grand jury subpoena; or
- As otherwise permitted by HIPAA.

Coroners, medical examiners and funeral directors. We may release your protected health information to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death, or other duties authorized by law. We may also release protected health information to funeral directors as necessary to carry out their duties.

National security and intelligence activities. We may release your protected health information to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities authorized by the National Security Act and implementing regulations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official with lawful custody over you, we may release your protected health information to the correctional institution or law enforcement official, if that information is necessary for one of the following:

- To provide you with health care;
- To protect your health and safety or the health and safety of other individuals; or
- For the safety and security of officers or employees of the correctional institution.

Uses and disclosures for which your written authorization is required. We may use or disclose your personal health information in the following circumstances only with your written authorization: Disclosure to your spouse, another family member such as a parent for an adult child, or a close personal friend designated by you to receive your protected health information, including an individual involved in your care prior to your death, unless you object.

All other uses and disclosures of your PHI not described in this Notice of Privacy Practices will be made only with your written authorization. You have the right to revoke your written authorization at any time, but you must do so in writing, and we are required to comply with your request, except to the extent that we took prior action relying upon your authorization.

Your rights regarding your Protected Health Information

You have the following rights regarding protected health information we maintain about you:

Right to inspect and copy. You have the right to inspect and copy protected health information maintained by the Plan in a designated record set. To inspect and copy your designated record set, you must submit your request in writing to: Lori Duringer, Privacy Contact Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009, 425-452-4071 (facsimile), 425-452-7866 (phone). If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to amend. If you feel that protected health information we have about you is inaccurate or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan in a designated record set. To request an amendment, your request must be made in writing and submitted to: Lori Duringer, Privacy Contact Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009, 425-452-4071 (facsimile), 425-452-7866 (phone). In addition, you must provide a reason that supports your request.

Notice of Privacy Practices, continued

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the designated record set kept by or for the Plan;
- Was not created by us, unless you provide us with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an accounting of disclosures. You have the right to request an "accounting of disclosures" (i.e., a list) of your protected health information where such disclosures were made other than: (1) for treatment, payment, or health care operations; (2) to you; (3) pursuant

to your authorization; (4) to friends or family in your presence or due to an emergency; (5) for national security purposes; or (6) incidental to an otherwise permissible use or disclosure.

To request this accounting of disclosures, you must submit your request in writing to: Lori Duringer, Privacy Contact Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009, 425-452-4071 (facsimile), 425-452-7866 (phone). Your request must state a time period which may not be longer than six years from the date of the request. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12 month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred to comply with the original request.

Right to request restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limitation on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a treatment for Hepatitis C you had.

We are not required to agree to a requested restriction or limitation, unless your request is made to restrict disclosure to an insurance carrier for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the protected health information pertains solely to a health care item or service for which you have paid the healthcare provider out-of-pocket in full. If we do agree to a restriction or limitation, we must abide by it unless you revoke it in writing.

To request restrictions, you must make your request in writing to: Lori Duringer, Privacy Contact Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009, 425-452-4071 (facsimile), 425-452-7866 (phone). In your request, you must tell us:

- What information you want to limit or restrict;
- Whether you want to limit our use, disclosure or both; and
- To whom you want the limits to apply, for example, disclosures to another family member.

Right to request confidential communications. You have the right to request that we communicate with you about medical matters in an alternative way or at an alternative location. For example, you can ask that we only contact you at work or by cell phone. To request confidential communications, you must make your request in writing to: Lori Duringer, Privacy Contact Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009, 425-452-4071 (facsimile), 425-452-7866 (phone). We will not ask you the reason for your request. And we will accommodate all reasonable requests.

A note about personal representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- Verification of identity as an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Notice of Privacy Practices, continued

However, we are not required to disclose your protected health information to a personal representative if we have a reasonable belief that: (1) you are or may have been subject to domestic violence, abuse or neglect by the designated personal representative; (2) treating the designated individual as your personal representative would endanger you; or (3) it is not in your best interest, using professional judgment, to allow the designated individual to act as your personal representative.

Right to request electronic copy of PHI maintained electronically in one or more designated record sets. If the plan maintains an "electronic health record" or maintains your PHI electronically in a "designated record set," you have the right to: (1) obtain a copy of the information in electronic format and/or (2) ask the Plan to send the copy to a third party. The Plan requires you to make the request for electronic copies of your PHI in writing, and the Plan may charge you a reasonable fee for labor costs for sending the electronic copy of your health information. To request an account of electronic health records, you must make the request in writing to: Lori Duringer, Privacy Contact Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009, 425-452-4071 (facsimile), 425-452-7866 (phone). The Plan will send the information to a third party at your request only if you provide complete information including the name and address of the third party.

Right to be notified of a breach. You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of your unsecured protected health information. Business Associates include the Business Associates themselves and their subcontractors.

Right to a paper copy of this notice. You have the right to receive a paper copy of this notice. You may ask us to provide you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website: https://c2mb.ajg.com/cityofbellevue. To obtain a paper copy of this notice via mail, contact: Lori Duringer, Privacy Contact Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009,
425-452-4071 (facsimile), 425-452-7866 (phone).

Changes to this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the employer website or Intranet. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan. To file a complaint with the Plan, contact: Lori Duringer, Privacy Contact Officer for the City of Bellevue Health Plan, 450 110th Ave NE, P.O. Box 90012, Bellevue, WA 98009,
425-452-4071 (facsimile), 425-452-7866 (phone). All complaints must be submitted in writing. In addition to filing a complaint with the Plan you may file a complaint with the Secretary of the Department of Health and Human Services: Pacific Region, Office for Civil Rights, U.S. Department of Health and Human Services, 90 7th Street, Suite 4-100, San Francisco, CA 94103. Voice Phone (800) 368-1019. FAX (202) 619-3818. TDD (800) 537-7697.

For all complaints filed by e-mail send to: ocrmail@hhs.gov. You will not be penalized or retaliated against for filing a complaint.

Other uses of medical information

All other uses and disclosures of your medical information not described in this Notice of Privacy Practices or HIPAA and its implementing regulations will be made only with your written authorization. You have the right to revoke your written authorization at any time, but you must do so in writing, and we are required to comply with your request, except to the extent that we took prior action relying upon your authorization.

Notice to Enrollees

The City of Bellevue's self-insured Core Plan administered by Premera Blue Cross

The City of Bellevue is required to provide the following information to employees electing coverage under the City of Bellevue's self-insured plans, administered by Premera.

The notice is to let you know that the coverage for mental health benefits are remaining at the same levels as they are in 2024 for the Premera Core plan.

Typically, mental health parity requirements related to employer health plans have been expanded and made permanent; however, to help contain healthcare costs, the City of Bellevue is choosing to not expand coverage in this area at this time for the Premera Core plan.

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirement listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy.

The City of Bellevue has elected to exempt the City of Bellevue Health Plans (Core) from the following requirement:

Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from this Federal requirement will be in effect for the 2025 plan year beginning January 1, 2025 and ending December 31, 2025.

Please call Human Resources at 425-452-4585 if you have any questions about this notice.

Notes

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Gallagher

Insurance | Risk Management | Consulting

Please note:

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