



City of Redmond COBRA Benefits Guide

JANUARY
2025



Redmond
WASHINGTON

YOUR BENEFITS CONTACTS

GALLAGHER BENEFIT ADVOCATES

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

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

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

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

Benefit	Administrator	Group #	Contact Information		Website
Medical, Dental, & Vision	Premera Blue Cross	4018525	Customer Service Monday - Friday 24-Hour NurseLine BlueCard Access	800.722.1471 5am-8pm 800.841.8343 800.810.2583	www.premera.com www.bcbs.com
Medical	Kaiser Permanente	0446300	Customer Service Monday - Friday 24-Hour Nurseline Mail Order Pharmacy	888.901.4636 8am-8pm 800.297.6877 800.245.7979	www.kp.org/wa
Employee Assistance Program	SupportLinc	City of Redmond	24/7	800.553.7798	www.supportlinc.com Code: cityofredmond
COBRA Administration	Flexible Benefit Services		Customer Service Monday - Friday	855.846.1209 8am-5pm	https://portal.myflexcobra.com

2025 COBRA MEMBER MONTHLY CONTRIBUTIONS

	RedMed - Medical	Kaiser - Medical	RedMed - Dental	RedMed - Vision
Employee only	\$1,013.76	\$761.19	\$70.73	\$17.54
Employee plus Spouse	\$1,996.94	\$1,502.20	\$125.87	\$31.56
Employee plus Child	\$1,439.49	\$1,084.24	\$127.23	\$25.38
Employee plus Children	\$2,014.26	\$1,518.33	\$203.57	\$36.05
Employee, Spouse, Children	\$2,997.54	\$2,259.32	\$258.71	\$50.10
Spouse only	\$1,013.76	\$761.19	\$70.73	\$17.54
Spouse plus Child	\$1,439.49	\$1,084.24	\$127.23	\$25.38
Spouse plus Children	\$2,014.26	\$1,518.33	\$203.57	\$36.05
Child only	\$1,013.76	\$761.19	\$70.73	\$17.54
Employee, Spouse, Child	\$2,422.72	\$1,825.23	\$182.36	\$39.41

EAP continuation can be purchased at a rate of \$3.21 per month.

MEDICAL BENEFITS OVERVIEW

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

REDMED PLAN THROUGH PREMERA BLUE CROSS

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

THE BLUECARD® PROGRAM - WORLDWIDE COVERAGE

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

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

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

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

MANAGE YOUR HEALTHCARE INFORMATION ONLINE

Once you register online at premera.com with your member identification number and suffix number from your ID card, you can log in at any time for secure access to your personal healthcare information.

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

KAISER PERMANENTE HMO PLAN

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

PREMERA |

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

Member
SAMPLE CARD
Prefix Identification # Suffix
XX 123456789 01

Group # 1234567 BCBS 430
Rx Group # BCWAPDP Rx Plan A1
Rx BIN # 610014

Medical Network HERITAGE
Dental Network CHOICE
Vision YES
Custom Comments go here

Office Visit Copay \$30 / PCP Copay \$10 Emergency Room Copay \$450	In Network	Out of Network
	Deductible Individual \$300	
	Deductible Family \$600	
	Out of Pocket Max Individual \$5,000	\$7,000
	Out of Pocket Max Family \$10,000	\$14,000

Rx

PREMERA |

BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association



CALENDAR YEAR DEDUCTIBLE

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

COPAY & COINSURANCE

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

OUT-OF-POCKET MAXIMUM

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

OUT-OF-NETWORK PROVIDERS

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

MEDICAL BENEFITS - PLAN HIGHLIGHTS

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



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

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

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

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

PRESCRIPTION DRUG PROGRAM

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

REDMED

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

REDMED MAIL ORDER PRESCRIPTION DRUGS – EXPRESS SCRIPTS

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

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

KAISER PERMANENTE

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

KAISER PERMANENTE MAIL ORDER PRESCRIPTION DRUGS

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

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



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

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

PREMERA HEALTHCARE RESOURCES

TELADOC – FREE HYPERTENSION AND DIABETES SUPPORT

Teladoc (previously known as Livongo) offers chronic condition support for managing diabetes & hypertension for you and your family members that are covered under your Premera health plan.

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

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

For members who may qualify for this program, you may receive notification Premera's preferred vendor to enroll. Otherwise, you may call 800.945.4355 to learn more.

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 copay assistance program and the member will owe a reduced cost.

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

Please call 800-683-1074 to enroll. You must contact SaveonSP prior to filling your prescription. The program cannot be retroactively applied to a previously filled prescription.

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

DESIGNATED CENTERS OF EXCELLENCE

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

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. You'll receive a custom list of mental health providers based on your unique preferences:

- Two or more recommended in-network providers who are accepting new patients
- Detailed profile of each provider

You'll receive your list within four days, at no cost to you.

KAISER HEALTHCARE RESOURCES

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

Care Chat: No cost resource, to get 24/7 care from Kaiser clinician via secure chat. www.kp.com/wa/onlinecare

ClassPass: Unlimited on-demand video workouts, you can get access to ClassPass at www.kp.org/exercise

VIRTUAL CARE WITH PREMERA

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

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

DOCTOR ON DEMAND PRIMARY AND BEHAVIORAL HEALTH CARE



<https://www.doctorondemand.com/premera>

Availability: 24/7 Access or by appointment

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

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

98POINT6 TEXT-BASED VIRTUAL CARE



<https://www.98point6.com/premera>

Availability: 24/7 Access

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

BOULDER & WORKIT VIRTUAL TREATMENT FOR SUBSTANCE ABUSE DISORDER



[boulder.care/getstarted](https://www.boulder.care/getstarted)

Availability: 24/7 Access

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

[workithealth.com/premera](https://www.workithealth.com/premera)

Availability: 24/7 Access

What it is: WorkIt Health provides treatment for opioid use disorder and alcohol use disorder. With this program, members can live chat and video with a therapist.



TALKSPACE VIRTUAL THERAPY FOR BEHAVIORAL HEALTH



[talkspace.com/premera](https://www.talkspace.com/premera)

Availability: 24/7 Access

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

OMADA HEALTH - VIRTUAL CARE PROGRAM

www.omadahealth.com/premera



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

VIRTUAL CARE WITH KAISER



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

DENTAL BENEFITS

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

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

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

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

VISION BENEFITS

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

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

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



USUAL, CUSTOMARY & REASONABLE

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



EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

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

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

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

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

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



FIND TIPS ON STRESS MANAGEMENT, WELLNESS AND MORE ONLINE!

SupportLinc offers a wealth of educational resources on their website. Please see the access information under "Your Benefits Contacts" in the front of this Guide.

IF YOU VISIT A COUNSELOR

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



**Download
the mobile
app today!**



800-553-7798



supportlinc.com

INSURANCE TERMS DEFINED

COPAY

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

DEDUCTIBLE

A deductible is the amount you need to pay up front before the plan begins paying expenses. Not all services are subject to the deductible. Please see the plan highlights in this guide or the Summary Plan Description (SPD) for specific information. The family deductible applies if you have family members enrolled in your plan along with you. The family deductible is the most you have to pay for deductibles if you have dependents enrolled. Each person has their own deductible, but once the family deductible is met, no one else in your family has to pay toward their deductible.

COINSURANCE

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

OUT-OF-POCKET MAXIMUM

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

ALLOWABLE AMOUNT

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

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN - REDMED

NON-NETWORK COSTS

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

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

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

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

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

OUT-OF-AREA BENEFITS

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

HIPAA SPECIAL ENROLLMENT RIGHTS

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

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

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

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

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

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

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN (CONTINUED)

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

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

Important Warning

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

PREVENTIVE CARE

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

COBRA

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

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN - KAISER PERMANENTE

ORGAN TRANSPLANT

There is no waiting period for organ transplants.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

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

HMO - Kaiser Permanente (Individual: 0% coinsurance and None deductible; Family: 0% coinsurance and None deductible)

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

OUT-OF-AREA BENEFITS

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

HIPAA SPECIAL ENROLLMENT RIGHTS

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

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

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

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

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

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

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

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

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN (CONTINUED)

Important Warning

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

GRANDFATHERED PLAN DISCLOSURE

This disclosure is applicable to the following plan(s):

- HMO - Kaiser Permanente

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

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

PATIENT PROTECTIONS DISCLOSURE

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

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

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

COBRA

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

HEALTHCARE REFORM & YOUR BENEFITS

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

NOTICE OF PRIVACY PRACTICES

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

SAFEGUARDING YOUR PROTECTED HEALTH INFORMATION

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

WHY DOES THE PLAN COLLECT YOUR PROTECTED HEALTH INFORMATION?

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

HOW DOES THE PLAN COLLECT YOUR PROTECTED HEALTH INFORMATION?

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

HOW DOES THE PLAN SAFEGUARD YOUR PROTECTED HEALTH INFORMATION?

We protect your PHI by:

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

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

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

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

NOTICE OF PRIVACY PRACTICES (CONTINUED)

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

NOTICE OF PRIVACY PRACTICES (CONTINUED)

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

You have the right to request all of the following:

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

CAN I "OPT OUT" OF CERTAIN DISCLOSURES?

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

WHEN IS THIS NOTICE EFFECTIVE?

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

WHAT IF THE PLAN CHANGES ITS NOTICE OF PRIVACY PRACTICES?

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your individual rights, our duties or other privacy practices stated in this notice. For your convenience, a copy of our current notice of privacy practices is always available on our Web site at c2mb.ajg.com/cityofredmond in accordance with paragraph 45 § CFR 164.520(c)(3)(i) and you may request a copy at any time by contacting us at the number listed below. In the event of a change or revision to the notice.

NOTICE OF PRIVACY PRACTICES (CONTINUED)

CONCLUSION

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

HOW CAN YOU REACH US?

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

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

CHIP (CONTINUED)

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

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

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

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

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

NOTICE OF CREDITABLE COVERAGE

Important Notice from City of Redmond

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Redmond and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Redmond has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

If you decide to join a Medicare drug plan, your current coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current company coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company benefit plan.

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

You should also know that if you drop or lose your current coverage with City of Redmond and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

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

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

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE (CONTINUED)

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2025
Name of Entity/Sender: City of Redmond
Contact—Position/Office: Nicole Bruce - Benefits Program Manager
Office Address: 15670 Ne 85th St, PO BOX 97010
Redmond, Washington 98073-9710
United States
Phone Number: 425.556.2124



THIS BENEFIT SUMMARY PREPARED BY



Insurance | Risk Management | Consulting

PLEASE NOTE:

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