



EVERETT
WASHINGTON

City of Everett **2020 Benefit Highlights**

Welcome!

The benefits in this summary are effective
January 1, 2020 to December 31, 2020.

This overview is a summary of your benefits. For more detailed information, please refer to your summary plan descriptions (SPDs). The plan SPDs determine how all benefits are paid.

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Eligibility

All active City of Everett Appointive employees who work a minimum of 30 hours per week are eligible for the benefits outlined in this guide on the 1st of the month following date of hire.

In order to comply with the Affordable Care Act (ACA), the City of Everett determines full-time eligibility for benefits based on the Look Back Measurement Method. Refer to the Look Back Measurement Method section of this guide for additional information on how full-time eligibility is determined.

MAKING CHANGES

Your benefit elections remain in effect until the end of the Plan Year (January 1 through December 31). Only the occurrence of a qualifying life event (birth, marriage, adoption, etc.) will allow you to make changes to your benefit elections. Please contact the Benefits Coordinator within 30 days to report a family status change or life event or if you have questions on what qualifies as a family status change. If you are not enrolled at the time you experience a change in family status or life event and you gain a new dependent, you may be able to enroll within 60 calendar days under HIPAA rules.

DEPENDENTS

Some plan benefits offer coverage for your dependents. Eligible dependents include:

- Your dependent children up to age 26
- Your disabled children of any age
- Your spouse
- Your qualified domestic partner
(of same or opposite gender)

If you have a domestic partner (of same or opposite gender), he or she is eligible to enroll as a dependent on your benefits plan. You must live together and meet all criteria outlined in the domestic partner definition in the affidavit. Employee premium contributions for domestic partners must be deducted on a post-tax basis. Premium contributions paid by the City of Everett on behalf of the domestic partner will be treated as imputed income for the employee. Please contact the Benefits Coordinator for more information on the application process.

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Legal Notices are located in the back of the booklet for reference.

Enrollment

BENXCEL INITIAL LOG IN

1. To log into BenXcel, go to **benxcel.net**
2. Enter your user information
 - USER ID: First 4 characters of last name (lowercase) + Last 4 digits of SSN
 - Password: First 4 characters of last name (lowercase) + Last 4 digits of SSN
 - Your Company Name: City of Everett
3. Click the 'Sign In' button to enter the system

ENROLLMENT INSTRUCTIONS

1. Review Usage and Legal Agreements and Welcome Screen and click Continue to proceed. You may not continue to your dashboard until your entire enrollment is complete.
2. A change password screen will appear for you to change your initial password.
3. Complete Emergency Contact Page
4. Review Demographics page.
5. Add Spouse/Domestic Partner and Children when prompted. *Please note: You must provide supporting verification documentation (marriage certificate, birth certificate, etc.) when adding a new Spouse/Domestic Partner or child.*
6. Complete Enrollment Information. Follow the prompts.
7. Click the "Enroll Now" button to select a plan. If you are already enrolled in a benefit and do not want to make any changes, select the 'Keep Plan' button.
8. An Election Summary will continue to update with elections and costs as you go through your enrollment.
9. A beneficiary screen will appear if you've elected any coverages requiring you to designate a beneficiary.
10. A Confirmation Statement will appear when your enrollment is complete. You can print or download it as a PDF.
11. Click the 'Finish' button to submit your enrollment. A pop-up box will appear when your enrollment has processed. You will be automatically routed to your dashboard.
12. Make sure to upload all required dependent verification documentation from the 'Upload Documents' link on your dashboard. Choose the enrollment type from the Enrollment Mode dropdown box, and then upload the documentation as one of the supported formats listed. Click 'save' when complete.
13. A yellow countdown box will appear at the top right corner of your dashboard notifying you of the amount of time remaining to make benefit selections.

If you log out of the system at any time without finishing your enrollment, the system will save all elections made prior to you logging out.

Medical Coverage

Nothing is more important than the health of you and your family. Our benefit plans promote coverages to help you live a healthier life. As an eligible employee, you may choose to enroll in one of the three medical plans offered. Compare the options carefully and choose the one that is the best for you and your family.

NEW! HMA CDHP

The City of Everett offers a CDHP plan. This plan is administered by Healthcare Management Administrators (HMA), and pays 80% in-network and 60% out-of-network up to the allowable amounts for most covered services after the deductible has been met. The plan also includes 100% coverage for preventive care to which no deductible applies.

The CDHP plan features a \$1,500 individual (\$3,000 family) in-network deductible and an in-network out-of-pocket maximum of \$2,500 for individual coverage (\$5,000 family).

Certain out-of-network charges in excess of the plan allowable amounts do not count toward these limits and you may be responsible for additional out of pocket expenses.

If you participate in the City of Everett CDHP plan, you will receive an HRA/VEBA account. The money in your HRA/VEBA may be used to pay (or reimburse yourself) for qualified healthcare expenses. Any remaining funds in your HRA/VEBA roll over from year to year. More information on the HRA/VEBA can be found on page 9.

HMA PPO

The City of Everett PPO Plan, administered by Healthcare Management Administrators (HMA), pays 90% in-network and 60% out-of-network for most covered services after the \$300 individual (\$600 per family) deductible has been met. It also includes 100% coverage for preventive care to which no deductible applies. Your out-of-pocket maximum is \$750 individual (\$1,500 per family) for in-network coverage.

Certain out-of-network charges in excess of the plan allowable amounts do not count toward these limits and you may be responsible for additional out of pocket expenses.

ABOUT NETWORK PROVIDERS

In-network care: When you seek medical services from a network provider, you receive a higher level of benefit. This means when you use network providers, you

substantially reduce the amount both you and the City of Everett pay for medical services. One of the advantages of an in-network provider is that you usually do not need to file claim forms. Show your ID card to a preferred provider, and the provider will use the information on the card to submit the claim on your behalf.

Out-of-Network Care: You may choose to receive care from a provider that is not a part of the network, that is, an out-of-network provider, but you receive a lower level of coverage. Your benefit coverage is based on an allowable amount determined by the plan to be reasonable for services provided. You are responsible for any amounts above the allowed amount and they will not be credited toward the deductible and out of pocket limits. You may also be required to file your own claims. You should confirm coverage with out-of-network providers prior to receiving services as you may find you have no coverage at all.

KAISER CORE HMO

The City of Everett CORE HMO Plan, administered by Kaiser Permanente pays 100% after a copay for most in-network covered services. This plan has no deductible and your out-of-pocket maximum is \$1,000 individual (\$2,000 per family). Your care must be managed from the list of Kaiser Permanente Network Providers. There is no coverage for providers outside of the Kaiser Permanente Network.

CHOOSE THE COVERAGE THAT IS BEST FOR YOU AND YOUR FAMILY.

All of these plans have an annual out-of-pocket maximum for qualified expenses. If you should reach this maximum, your costs will be capped. Certain expenses, such as an out-of-network charge that exceeds the plan's allowable amount do not count toward the deductible or out-of-pocket maximum and you will continue to be responsible for those expenses.

Medical Benefit Plans

	HMA CDHP		HMA PPO		Kaiser CORE HMO
Vera Near-site Clinic Physician and Preventive Care	Covered in full		Covered in full		Not Applicable
Clinic Incentive Contribution	\$200 per employee \$400/family (spouse/domestic partner only)		\$100 per employee		Not Applicable
Annual HRA/VEBA Contribution	\$1,200/individual \$2,400/family		Not Applicable		Not Applicable
	In-Network	PAR ¹ / Out-of-Network	In-Network	PAR ¹ / Out-of-Network	In-Network Only
Lifetime Plan Maximum	Unlimited		Unlimited		Unlimited
Annual Plan Maximum	Unlimited		Unlimited		Unlimited
Calendar Year Deductible (unless otherwise noted, the deductible applies to all services)	\$1,500/individual \$3,000/family		\$300/individual \$600/family	\$300/individual \$600/family	\$0
Out-of-Pocket Maximum (includes deductible and in-network medical copays)	\$2,500/individual \$5,000/family		\$750/individual \$1,500/family	\$1,500/individual \$3,000/family	\$1,000/individual \$2,000/family
Physician Office Visit	80% after deductible	60% after deductible	\$20 copay then paid at 100%	\$20 copay then paid at 60%	\$10 copay then paid at 100%
Other Services (X-Ray and Lab)	80% after deductible	60% after deductible	90% after deductible	90% after deductible	Paid at 100%
Preventive Care (adult and child)	Paid at 100%	Not covered	Paid at 100%	Not covered	Paid at 100%
Emergency Room (copay waived if admitted)	80% after deductible		\$100 copay then paid at 90% after deductible		\$75 copay then paid at 100%
Hospital Inpatient	80% after deductible	60% after deductible	\$100 copay per admission then paid at 90% after deductible	\$200 copay per admission then paid at 80% after deductible	\$100 copay per admittance then paid at 100%
Outpatient	80% after deductible	60% after deductible	\$100 copay then paid at 90% after deductible	\$100 copay then paid at 60% after deductible	\$10 copay then paid at 100%

Medical Benefit Plans

	HMA CDHP		HMA PPO		Kaiser CORE HMO
	In-Network	PAR ¹ / Out-of-Network	In-Network	PAR ¹ / Out-of-Network	In-Network Only
Rehabilitation					
Inpatient	80% after deductible	60% after deductible	\$100 copay per admission then paid at 90% after deductible	\$200 copay per admission then paid at 60% after deductible	\$100 copay per admittance then paid at 100%
Outpatient	80% after deductible (up to 36 visits per calendar year)	60% after deductible	90% after deductible (up to 36 visits per calendar year)	60% after deductible	\$10 copay then paid at 100% (up to 60 visits per calendar year)
Mental Health and Chemical Dependency					
Inpatient	80% after deductible	60% after deductible	\$100 copay per admission then paid at 90% after deductible	\$200 copay per admission then paid at 80% after deductible	\$100 copay per admittance then paid at 100%
Outpatient	80% after deductible	60% after deductible	\$20 copay then paid at 100%	\$20 copay then paid at 60%	\$10 copay then paid at 100%
Chiropractic Services	80% after deductible (up to 24 visits per calendar year)	Not covered	\$20 copay then paid at 80% (up to 24 visits per calendar year)	Not covered	\$10 copay then paid at 100% (up to 10 visits per calendar year)

¹Participating (PAR) Network Out-of-Pocket max is \$750/\$1,500 and Preventive Care is covered at 100%

This benefit summary is for illustrative purposes only. In case of discrepancy, please refer to the plan booklet for coverage information as the plan booklet will prevail.

HOW TO FIND HMA PROVIDERS

1. Go to accesshma.com
2. Click 'Menu' at the top of the page, then click 'Member'
3. Click 'Find a Provider' at bottom of the page
4. Click on your region
5. Enter search criteria
6. Click 'Search'
7. A list of providers will appear along with contact information.

HOW TO FIND KAISER PERMANENTE PROVIDERS*

1. Go to kp.org/wa
2. Click 'Find Doctors' at the top of the page
3. Select our network 'Core'
4. Select search criteria
5. A list of providers will appear along with contact information

*Kaiser will be expanding their network 4/1/2020.

Prescription Drug Benefit Plans

We know that prescription drug coverage is important to you and your family. If you are enrolled in a medical plan, you will automatically receive prescription coverage. Using an in-network pharmacy will save you money. When you use an out-of-network pharmacy, you may be charged amounts over the allowed charges. The mail order option allows you to buy qualified prescriptions in larger 90-day quantities.

	HMA CDHP CVS/Caremark		HMA PPO CVS/Caremark		Kaiser CORE HMO
	In-Network	PAR/ Out-of-Network	In-Network	PAR/ Out-of-Network	In-Network Only
Annual Out-of-Pocket Maximum	Combined with Medical		\$1,000/individual \$2,000/family		Combined with Medical
Retail Pharmacy					
Generic	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Brand Name	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$20 copay
Non-Formulary Brand	20% up to \$50	20% up to \$50	20% up to \$50	20% up to \$50	*
Supply Limit	34 days or 100 units	34 days or 100 units	34 days or 100 units	34 days or 100 units	30 days
Mail Order					
Generic	\$20 copay		\$20 copay		\$20 copay
Brand Name	\$50 copay	Not covered	\$50 copay	Not covered	\$40 copay
Non-Formulary Brand	\$50 copay		\$50 copay		Not Covered
Supply Limit	90 days		90 days		90 days

**If you opt for a brand-named drug, and it's not medically necessary, you pay copay plus cost difference between generic and brand-name drug*

Note: Certain prescriptions may require preauthorization, step therapy (where the plan requires that certain prescriptions are tried before others), or have dispensing limits. Specialty prescriptions (e.g., injectibles) may need to be purchased from a specific provider. Confirm that your pharmacy is in-network before making your purchase.

MORE WAYS TO SAVE ON PRESCRIPTION DRUGS ON YOUR HMA PLAN

FREE PRESCRIPTIONS

Did you know that some of your prescriptions are covered for free? Under the Affordable Care Act, some preventive prescriptions, may be covered in full. In addition, any generic prescription dispensed at the Vera clinic is free.

MAINTENANCE PRESCRIPTIONS

If you take long-term, maintenance medications, you can now get a 90-day supply at any CVS pharmacy (i.e. Target pharmacy) instead of filling your prescriptions every 30 days.

No Cost Access to Care (HMA PARTICIPANTS ONLY)

ASSERTA HEALTH

PLANNING SURGERY? HAVING A BABY? LOOKING TO SAVE MONEY AND ELIMINATE BILLS?

Asserta can help with understanding your benefits and facilitate the selection of a high-value, high-quality provider. Asserta also offers assistance with appointment scheduling and pre-certification. Already have a provider selected? No problem! Asserta can still work to negotiate a reduced cost share for the procedure on your behalf. **Best of all, members who participate in the Asserta program will pay no out-of-pocket costs. Procedures include orthopedics (including spinal procedures), general surgery and high cost diagnostic procedures, among others.**

LOWER YOUR COSTS

The City of Everett has partnered with Asserta to help you and the health plan save money. Your personal health assistant will help you understand how your plan works and how you can lower your costs by choosing a high-value provider who consistently delivers good outcomes at an affordable price. Your personal health assistant can help you navigate complex procedures and save money at the same time.

To learn more call: (888)720-2260.

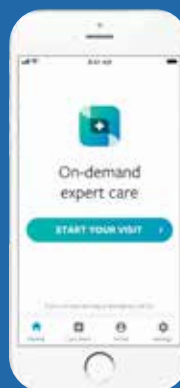
HOW DOES IT WORK?

Your personal health assistant will ask questions to understand the procedure you need and attempt to negotiate a cash price for your procedure that is less than your medical plan's cost. When you, the provider, and the plan agree to a cash rate, your personal health assistant will walk you through the steps on how to get the procedure scheduled. They will make sure that any required pre-certification is completed and prepare to pay the full cash price when you receive care.

98POINT6

ON-DEMAND PRIMARY CARE

98point6 is a new kind of on-demand, text-based primary care delivered through a private and 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. They can also help you better understand any primary care conditions. Unlimited primary care through 98point6 is available to benefit-enrolled HMA participants. Cost per visit is \$0. Download the 98point6 app from the App Store or Google Play to get started.



GET STARTED TODAY

1. **INSTALL THE APP:** Download 98point6 from the App Store or Google Play
2. **CREATE YOUR ACCOUNT:** No password to remember; just enter your mobile number and you'll receive a unique pin.
3. **START YOUR VISIT:** Get a personalized care plan, labs ordered, and necessary prescriptions sent to your pharmacy.

No Cost Access to Care (HMA PARTICIPANTS ONLY)

VERA WHOLE HEALTH CLINIC

HEALTHCARE REIMAGINED

Your health is our only focus. That's why we've designed the entire clinic experience with you at the center.

It's available to you, your spouse, dependents and coworkers. You'll have all the time you need with a provider and you won't be rushed out the door. Use the clinic for screenings, chronic disease management, that nagging cough, or that annoying pain in your knee that you've been ignoring. **Did we mention that preventive visits are always free? It's true.**

Monday–Tuesday: 7:00am–4:00pm; Wednesday–Thursday: 8:00am–6:00pm; Friday: 8:00am–3:00pm
Clinic Phone: 425-903-3070; Clinic Fax: 425-953-5768

SERVICES



PREVENTIVE CARE

Annual Whole Health Evaluation; immunizations; screenings; well women exams; family planning



CHRONIC DISEASE MANAGEMENT

Diabetes; hypertension; depression



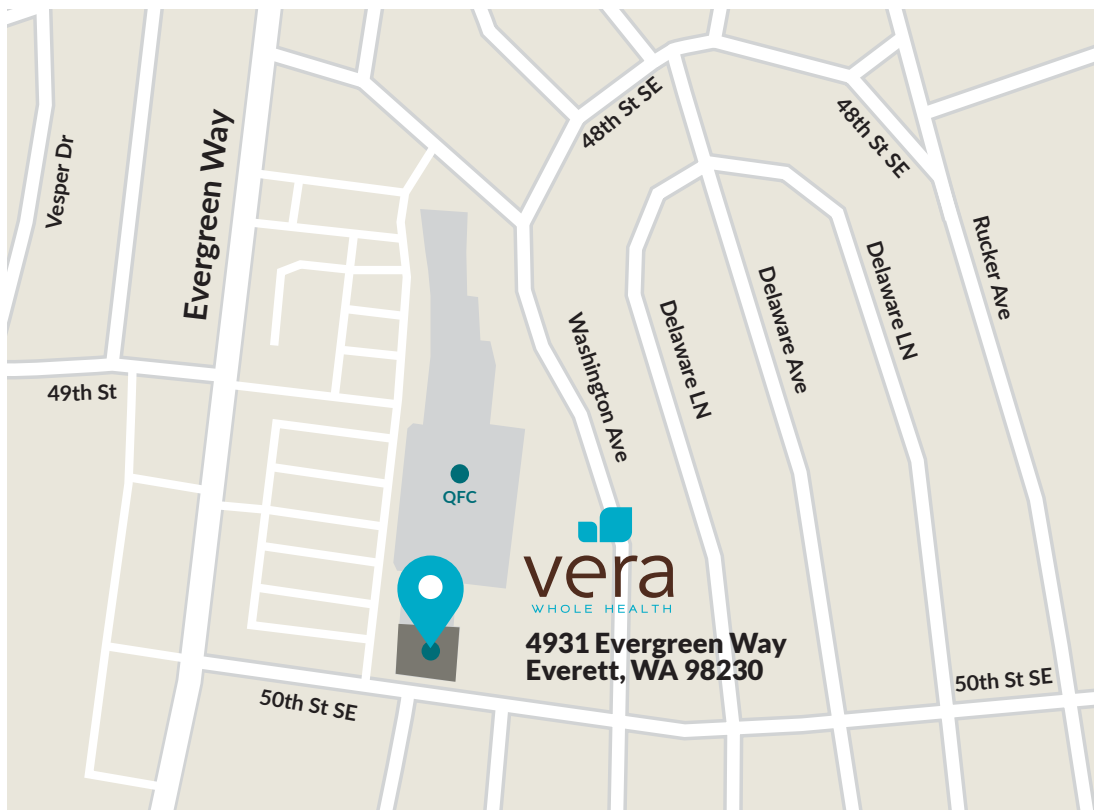
ACUTE CARE

Coughs/colds; wound care; sprains and strains; rashes; urinary tract infections; back pain



BONUS SUPPORT SERVICES

Health coaching; on-site labs; provider-dispensed medications; specialty care coordination and advocacy



HRA/VEBA

Employees electing to enroll in the CDHP Health plan will receive \$1,200 per individual and \$2,400 per family into a VEBA account funded by the City of Everett. This VEBA account is paired with a Health Reimbursement Arrangement (HRA) which allows you to use the VEBA funds for current or future out-of-pocket health-related expenses. Dollars contributed that are not used in the current plan year, carry over and can be used in subsequent plan years for reimbursement of qualifying, out-of-pocket healthcare expenses. During retirement, these contributions can also be used to reimburse for healthcare insurance premiums. If you were hired after the first month of the plan year, these contributions will be pro-rated. The HRA/VEBA doesn't replace your group health insurance plan; it works with your plan to provide additional coverage options. To find out more visit bpas.com.

CLINIC INCENTIVE FOR HMA PARTICIPANTS ONLY

If you complete your Annual Whole Health Evaluation (AWHE), which includes a wellness exam, biometric screening and a coaching introduction, between January and December of 2020, you can earn up to \$200 depending on your health plan.

For employees on the PPO health plan, you will earn \$100 for completing your AWHE.

For employees and spouses/domestic partners on the CHDP health plan, you will each earn \$200 for completing your AWHE – maximum \$400 per family.

The AWHE can be completed in one visit.

TAX ADVANTAGES

VEBA is a tax-advantaged account so you aren't taxed on your employer's contributions to it. Plus, your VEBA accrues interest that grows on a tax-free basis. Since VEBAs have to be used for eligible medical expenses, your distributions are tax-free too. **Money goes in tax free, is invested tax free, and comes out tax free.**

ACTIVE EMPLOYEES

Use money in your HRA/VEBA to pay health plan deductibles, co-pays and coinsurance as well as prescription drugs and certain insurance premiums. Don't worry, if you don't spend all of the funds in your HRA/VEBA by the end of the year, your balance will simply roll into the next year. You'll accumulate funds over time which means you'll have money to pay for health expenses when you retire.

POST-RETIREMENT

Your employer can contribute funds to help you, your spouse and eligible dependents pay for medical expenses even after your retirement. That's pretty generous! Use your post-retirement VEBA funds to pay for certain medical premiums and long-term care premiums. Your employer can choose to make contributions throughout your working life or convert accumulated unused sick time, vacation, severance money, or other longevity-based benefits.

FULL COVERAGE

All medical expenses defined under IRS Code Section 213(d) are eligible under your HRA/VEBA including;

- Co-pays, prescriptions, and deductibles
- Dental, medical, and vision services
- Medicare Part B and D
- Medical supplies and equipment

Dental Benefit Plan

Regular visits to your dentists can help more than protect your smile, they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes and heart disease. City of Everett provides you with a comprehensive coverage through Delta Dental of Washington.

	Delta Dental PPO Plan	
	In-Network	Out-of-Network
Calendar Year Deductible	\$0/individual \$0/family	\$0/individual \$0/family
Annual Plan Maximum	\$2,000/individual	\$2,000/individual (combined with in-network)
Waiting Period	None	None
Diagnostic and Preventive	Plan pays 100%	Plan pays 100%
Basic Services Fillings, Root Canals, Periodontitis Treatment	Plan pays 100%	Plan pays 100%
Major Services	Plan pays 50%	Plan pays 50%
Orthodontic Services	Not covered	Not covered

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Provider Choice: You may seek care from any licensed provider. If you visit a PPO or Premier dentist, you will have access to the lowest out-of-pocket costs. If you visit an out-of-network dentist, you may be responsible for additional costs if the provider's charges exceed the plan's usual and customary levels.

Pre-Treatment Estimate: If your dental work will be extensive, you should have your dentist submit the proposed treatment plan to the insurance company before you begin treatment. The insurance company will provide you with a summary of the plan's coverage and your estimated out-of-pocket costs.

DELTA DENTAL IS MOBILE!

It's easy to get the most out of your dental benefits with our free mobile app for Apple iOS and Android users. Here's what you can do when you're on the go:

FIND A DENTIST.

You're on vacation, need care and aren't sure if there's an in-network dentist near you. Open the Delta Dental app and easily search.

VIEW COVERAGE DETAILS.

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

CHECK YOUR CLAIM STATUS.

You had some dental work and want to know if your claim was paid. Sign in to the app and view your claim status.

DISPLAY YOUR ID CARD.

Need your ID card? No problem! Sign in and e-mail your ID card to your dentist or show the office staff your digital ID card from your phone.

DOWNLOAD AND GET ON.

Visit the App Store (Apple) or Google Play (Android) and search for Delta Dental, download, and install. The app uses the same information and password as your MySmile personal benefits center. If you're not already registered, you can set up your account from the app's login page.

Vision Benefits

Vision coverage for Appointive members is through HMA. A routine eye exam is important, not only for correcting vision, but because it can lead to detecting other serious health conditions. Please note that the vision eyewear benefit may not cover all costs including lens coatings, contact lens fitting, and taxes.

		HMA and Kaiser Participants	
		In-Network	Out-of-Network
Eye Exam (once per calendar year)		Plan pays 100%	
Eyeglass Lenses (per pair)			
Single Vision		Up to \$50	
Bifocal		Up to \$80	
Trifocal		Up to \$100	
Lenticular Insight		Up to \$180	
Eyeglass Frame (once every two calendar years)		Up to \$150	
Elective Contact Lenses (in lieu of frames)		Up to \$125	

Provider Choice: The HMA vision plan allows you to seek care from any licensed provider. When you visit an in-network provider, you will experience lower out-of-pocket expenses. If you visit an out-of-network provider, you may be required to pay the provider up front and submit a claim to the insurance company for reimbursement. In addition, you will be responsible for additional costs if the out-of-network provider charges exceed the plan’s maximum reimbursement levels. For more information, go to accesshma.com.

This benefit summary is for illustrative purposes only. In case of discrepancy, please refer to the plan booklet for coverage information as the plan booklet will prevail.

HOW TO FIND DELTA DENTAL PROVIDERS

1. Go to deltadentalwa.com.
2. Click "Resources" on the top of the screen
3. Click "Find a Dentist"
4. Enter your search criteria and select the network ("Delta Dental PPO (In-Network)" or "Delta Dental Premier (Out-of-Network)")
5. Click "Search"
6. A list of providers will appear along with contact information

HOW TO FIND HMA VISION PROVIDERS

1. Go to accesshma.com
2. Click on 'Menu' at the top of the page and click 'Member'
3. Click 'Find a Provider' at the bottom of the page
4. Click on your region
5. Enter search criteria
6. Click 'Search'
7. A list of providers will appear along with contact information.

Cost of Coverage

Who is covered?	Single Employee			Employee + 1 dependent			Employee + 2 or more dependents		
	Plan cost per month	COE pays per month	Employee pays per month	Plan cost per month	COE pays per month	Employee pays per month	Plan cost per month	COE pays per month	Employee pays per month
Medical Plan									
HMA PPO	\$712.42	\$641.18	\$71.24	\$1,424.87	\$1,282.40	\$142.48	\$1,994.81	\$1,795.34	\$199.48
HMA CDHP	\$591.44	\$561.86	\$29.58	\$1,182.91	\$1,123.78	\$59.14	\$1,656.07	\$1,573.28	\$82.80
Kaiser HMO	\$818.05	\$736.26	\$81.80	\$1,627.92	\$1,465.12	\$162.80	\$2,413.24	\$2,171.92	\$241.32
Dental Plan	\$55.00	\$55.00	\$0.00	\$137.00	\$137.00	\$0.00	\$137.00	\$137.00	\$0.00
HMA (Vision)	\$21.00	\$21.00	\$0.00	\$21.00	\$21.00	\$0.00	\$21.00	\$21.00	\$0.00



Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

BASIC LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the City of Everett. Coverage is provided by The Standard.

	Schedule of Benefits
Basic Life Amount	One times covered annual earnings up to a maximum of \$250,000
Basic AD&D Amount	One times covered annual earnings up to a maximum of \$250,000

Taxes: Due to IRS regulations, a life insurance benefit of \$50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by The Standard.

	Schedule of Benefits
Employee Voluntary Life Amount	Up to a maximum of lesser of six times covered annual earnings or \$300,000
Spouse Voluntary Life Amount	Up to a maximum of \$300,000
Child(ren) Voluntary Life Amount	Up to a maximum of \$10,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Evidence of Insurability (EOI): Depending on the amount of coverage you select, you may need to submit EOI, which involves providing the insurance company with additional information about your health. Find form online at standard.com/mhs.

Long-Term Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

The cost of coverage is paid in full by the City of Everett. Coverage is provided by The Standard.

	Schedule of Benefits
Monthly Benefit Amount	Plan pays 66 2/3% of covered monthly earnings
Maximum Monthly Benefit	\$7,500
Benefits Begin	After 90 days
Maximum Payment Period*	ADEA schedule

**The age at which the disability begins may affect the duration of the benefits.*

Employee Assistance Program (EAP)

Life is unpredictable. To help you and your household members cope with everyday life, work challenges, stress, family problems, and other personal issues, an Employee Assistance Program (EAP) is available 24 hours a day, seven days a week through Wellspring. This service is completely confidential and is available to all employees and their household members. Enrollment is automatic, and City of Everett pays the full cost for coverage. Benefits include confidential access to the following:

- Trained counselors via telephone for assistance with issues including the following:
 - depression, stress, or grief
 - marital and parenting problems
 - alcohol and substance abuse
 - conflicts
- Online self-assessment and self-help programs
- Referrals for up to three face-to-face visits per incident with a nearby counselor for free!
- Dependent care referral (includes qualification of facilities)
- Financial assistance
- Legal consultation for common legal problems

WELLSPRING

Phone: 800 553 7798 | Website: wfseap.com
Group #: City of Everett

Deferred Compensation Plan

Saving for the future is more important than ever. We're living longer these days – which could mean spending 20 or more years in retirement. Our deferred compensation plans offer you the opportunity to save and invest today which may give you the best chance to achieve a more comfortable tomorrow.

HOW MUCH CAN I CONTRIBUTE?

- \$19,500 all eligible participants
- \$25,000 if age 50 or over
- \$38,000 if you qualify for pre-retirement catch-up contributions*

**Contact a Retirement Plan Specialist for more information.*

GET HELP ONLINE

MANAGE YOUR ACCOUNT

- For ICMA-RC participants - icmarc.org/login
- For Mass Mutual participants - massmutual.com/serve

TIPS & TOOLS

- For ICMA-RC participants - icmarc.org/realize
- For Mass Mutual participants - massmutual.com/serve

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. The catch is that you have to use the money in your account by our plan year's end. Otherwise, that money is lost, so plan carefully. You must re-enroll in this program each year. BPAS administers this program.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 01/01/20 and 03/15/21 and submitted for reimbursement no later than 03/31/21.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the City of Everett health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- For more information, please visit bpas.com.

HEALTHCARE FSA

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to \$2,750.

DEPENDENT CARE FSA

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to \$5,000 per household for eligible dependent care expenses for the year.

BPAS

Phone: 866 401 5272

Website: bpas.com

Look-Back Measurement

City of Everett uses the look-back measurement method to determine medical plan eligibility.

NEW EMPLOYEES

New employees hired to work a variable hour or seasonal schedule. If you are hired into a position where your hours vary and City of Everett is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee, eligible for coverage under the terms of the plan.

Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 30 or more hours a week over that 12 month period, you will be offered coverage by the first of the second month after your IMP ends. Your coverage will remain in effect during an associated stability period that will last 12 months from the date coverage is offered. If your employment is terminated during that stability period, you will be offered continued coverage under COBRA.

ONGOING EMPLOYEES

An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which City of Everett counts employee hours to determine which employees work full-time. An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be offered coverage as of the first day of the stability period associated with the standard measurement period. Coverage will be in effect for a 12-month stability period. If your employment is terminated during a stability period, you will be offered continued coverage under COBRA.



For Assistance

BENEFIT ADVOCATES

Should you or your covered family members have a benefit or claims question, you should contact the highly trained Benefit Advocate team.* The advocate is able to contact the insurance providers on your behalf to obtain information related to the following:


- Incorrect payment of insurance claims
- Appeal of denied claims, if warranted
- Benefit questions and clarifications
- Enrollment questions

Benefit Advocates are available Monday through Friday 8:00 a.m. to 5:00 p.m. PT. Please have your insurance identification card available when you call.

City of Everett HR Manager, Marcy Hammer: 425 257 7035 (or 425 257 8767), mhammer@everettwa.gov
 Alliant Benefit Advocate: 833 252 8055, mybenefits@alliant.com

**Due to HIPAA Privacy regulations, we may need to obtain your written authorization in order to assist with certain issues. The Benefit Advocate or Coordinator will provide you with an authorization form, if needed.*

INSURANCE CARRIERS

	Provider	Phone	Web / Email	Group Number
Medical/Vision	HMA	800 668 6004	accesshma.com	020188
Telehealth (HMA participants only)	98point6	N/A	98point6.com	N/A
Asserta (HMA Plan only)	Asserta	888 720 2260	assertahealth.com	N/A
HRA/VEBA	BPAS	866 401 5272	bpas.com	CITEVE1807
RX (HMA Plan only)	CVS/Caremark	866 260 4646	caremark.com	N/A
Medical/RX	Kaiser Permanente	888 901 4636	kp.org	1479300
Medical Near-site Clinic (HMA participants only)	Vera Clinic	425 903 3070	TBD	N/A
Dental	Delta Dental of WA	800 554 1907	deltadentalwa.com	00389 
Flexible Spending Account	BPAS	866 401 5272	bpas.com	N/A
Employee Assistance Program	Wellspring	800 553 7798	wfseap.com	City of Everett
Deferred Compensation MassMutual ICMA-RC	William Cook David Goren	206 254 1000 202 607 6149	bill.cook@valic.com dgoren@icmarc.org	107672 301333

2020 Annual Legal Notices

MEDICARE PART D NOTICE

Important Notice from City of Everett 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 Everett 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 Everett has determined that the prescription drug coverage offered by the City of Everett Employee Health Benefit 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 City of Everett coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under City of Everett Employee Health Benefit Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Everett prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 Everett 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 Everett 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.

For more information about Medicare prescription drug coverage:

- Visit 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 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 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: 11/1/19
Name of Entity/Sender: City of Everett
Contact-Position/Office: Marcy Hammer/HR Manager
Address: 2930 Wetmore Avenue, 5th Floor, Everett, WA 98201
Phone Number: (425) 257-7035

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: \$300 deductible; 90% coinsurance (in-network). If you would like more information on WHCRA benefits, call your plan administrator (425) 257-7035.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (425) 257-7035

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in City of Everett's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in City of Everett's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in City of Everett's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

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 Everett (the "Plan") is committed to protecting the privacy of your health information. We are required by applicable federal and state laws to maintain the privacy of your Protected Health Information. 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 and revised September 12, 2013 until replaced.

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, Healthcare Management Administrators, 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 set forth below, including most uses and disclosures of psychotherapy notes, 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 preauthorizations).

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.
- **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.
- **To You:** Upon your request, subject only to a few limitations, we will disclose your PHI to you. If you authorize us to do so, we may use your PHI or disclose it to anyone for any purpose. 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.
- **Your Family and Friends:** If you are unavailable to consent to the use or disclosure of 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, 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.
- **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 disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- **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, discovery request, or other lawful process.
- **Law Enforcement:** We may disclose limited information to law enforcement officials.
- **Military and National Security:** We may disclose to Military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities.

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 look at and get a paper or electronic copy of your PHI, except in certain limited circumstances, within 30 days of your request with a 30 day allowable extension. We may charge you a nominal fee for providing you with copies of your PHI.
- **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 deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, 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 name, of the amendment and to include the changes in any future disclosures of that information.

*Breach Notification: You have the right to receive notice of a breach of your unsecured PHI no later than 60 days after the incident.

- **Accounting of Disclosures:** You have the right to receive a list 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 September 12, 2013. 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 medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for responding to these additional requests. We will act on your request no later than 30 days after receipt. We may extend the time for providing an accounting by no more than 30 days but we must provide you a written explanation for the delay.
- **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 these additional restrictions, but if we do, we will abide by our agreement (except in an emergency or as required by law).
- **Confidential Communication:** You have the right to request in writing 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 must comply with any reasonable request provided it specifies an alternative means or location of communication.
- **Electronic Notice:** If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

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.

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. 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. You may request a copy at any time by contacting us at the number set forth below.

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 c/o the Human Resources Department at 2930 Wetmore Ave, Everett, WA 98201, (425) 257-8767. 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. Voice 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 we will not penalize or retaliate against you in any way if you choose to file a complaint.

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 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 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 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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: myakhipp.com/
Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: 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: healthfirstcolorado.com/

Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711

CHP+: colorado.gov/pacific/hcpf/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid

Website: flmedicaidprecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: in.gov/fssa/hip/

Phone: 1-877-438-4479

All other Medicaid

Website: indianamedicaid.com

Phone 1-800-403-0864

IOWA – Medicaid

Website: dhs.iowa.gov/hawki

Phone: 1-800-257-8563

KANSAS – Medicaid

Website: kdheks.gov/hcf/

Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: chfs.ky.gov

Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 1-888-695-2447

MAINE – Medicaid

Website: maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-442-6003

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: mass.gov/eohhs/gov/departments/masshealth/

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEW HAMPSHIRE – Medicaid

Website: dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: healthcare.oregon.gov/Pages/index.aspx
oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311
(Direct Rite Share Line)

NEVADA – Medicaid

Medicaid Website: dhcnp.nv.gov
Medicaid Phone: 1-800-992-0900

TEXAS – Medicaid

Website: gethipptexas.com/
Phone: 1-800-440-0493

SOUTH DAKOTA - Medicaid

Website: dss.sd.gov
Phone: 1-888-828-0059

UTAH – Medicaid and CHIP

Medicaid Website: medicaid.utah.gov/
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

UTAH – Medicaid and CHIP

Medicaid Website: medicaid.utah.gov/
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

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Website: greenmountaincare.org/
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CHIP Website: coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

SOUTH CAROLINA – Medicaid

Website: scdhhs.gov
Phone: 1-888-549-0820

WEST VIRGINIA – Medicaid

Website: mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP
(1-855-699-8447)

WASHINGTON – Medicaid

Website: hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WISCONSIN – Medicaid and CHIP

Website: dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531

WEST VIRGINIA – Medicaid

Website: mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP
(1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS NOTICE

City of Everett complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. City of Everett does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

City of Everett:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Marcy Hammer.

If you believe that City of Everett has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Marcy Hammer, Benefits Coordinator, 2930 Wetmore Avenue, Everett, WA 98201, 425-257-7035, mhammer@everettwa.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Marcy Hammer, Benefits Coordinator is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-425-257-7035.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 – 425-257-7035

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-425-257-7035.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-425-257-7035번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-425-257-7035.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-425-257-7035.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-425-257-7035.

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-425-257-7035។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-425-257-7035 まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-425-257-7035.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-425-257-7035.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-425-257-7035 (رقم)

هاتف الصم والبكم: 1-425-257-7035.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-425-257-7035 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-425-257-7035.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-425-257-7035.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy private individual health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage we offer to you. Please note that this notice is informational only.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private individual health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES THE EMPLOYMENT-BASED HEALTH COVERAGE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered you health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and you may wish to enroll in our health plan, if you are eligible. (Just because you received this Marketplace notice does not mean you are eligible.) However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if we do not offer coverage to you at all or do not offer coverage that meets certain standards. If the cost of self-only coverage under our health plan is more than 9.5% of your household income for the year, or if our health plan does not meet the "minimum value"¹ standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution—as well as your employee contribution—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION ABOUT THE HEALTH INSURANCE MARKETPLACE?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT EMPLOYER-PROVIDED HEALTH PLAN COVERAGE

If you decide to complete an application for coverage in the Marketplace, you will be asked for information about our health plan coverage. The information below can help you complete your application for coverage in the Marketplace.

1. General Employer Information.

Employer name:	City of Everett
Employer Identification Number (EIN):	91- 6001248
Employer street address:	2930 Wetmore Ave, 5th Floor
Employer phone number:	425-257-7035
Employer city:	Everett
Employer state:	WA
Employer ZIP code:	98201
Who can we contact about employee health coverage at this job?	Human Resources
Phone number (if different from above):	Same
Email address:	Mhammer@everettwa.gov

2. **Eligibility.** You may be asked whether or not you are currently eligible for our health plan coverage or whether you will become eligible for coverage within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting Marcy Hammer at 425-257-7035.

3. **Minimum Value.** If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.
4. **Premium Cost.** If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact Marcy Hammer at 425-257-7035.

5. **Future Changes.** You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, you will be provided with information about any changes to our health plan coverage before the next City of Everett open enrollment period in the fall of each year during open enrollment. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

