# GET TO KNOW YOUR BENEFITS




MARYSVILLE

# CONTENTS



**This guide is an overview** and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

# GETTING STARTED

## City of Marysville 2024 BENEFITS

Jan. 1, 2024 through Dec. 31, 2024

## 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. Please see the *Important Notices* section for more details.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, the City of Marysville supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, disability, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

# WHO'S ELIGIBLE FOR BENEFITS?

## Employees

You are eligible if you are a full-time employee working 30+ hours per week.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

## Eligible dependents

- Legally married spouse (including same-sex spouse) or same or opposite sex registered domestic partner
- Natural, adopted or step children up to age 26.
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

For additional information, please refer to the benefit booklets for each benefit.

## When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the 1st of the month following date of hire.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

# CHANGING YOUR BENEFITS

*Click to play video*


## LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

# ENROLLING FOR BENEFITS

## BenXcel (aka BCC)

The City of Marysville uses an online enrollment system, called BenXcel. BenXcel is an online system that enables you to make all your benefit elections in one place. If you don't have access to a computer, you can access BenXcel from a tablet or smartphone. Here are some tips to help you get started.

## Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

## Getting started

- LOG IN to BenXcel

https://benxcel.net

- Enter your username: The first 2 letters of your first name, the first 2 letters of your last name and the last 4 digits of your SSN (ex: Mickey Mouse with SSN: 123456789 would be mimo6789)
- Enter your initial password: The last 4 digits of your SSN and your full date of birth (mmddyyyy). You will be prompted to change this password upon login. Your password has been reset to this initial password.
- Enter the Company Name: **City of Marysville**
- Click the SIGN IN button to enter the system

## If you need help

- If you need help, contact BenXcel by phone or email

800-685-6100 or customersupport@benxcel.com

MON – THURS: 5:00am – 5:00pm PT

FRI: 5:00am – 3:00pm PT

# COST OF COVERAGE

The City of Marysville pays for the full cost of employee only coverage on the Premera 250 PPO and Kaiser 200 HMO medical plans, as well as the vision and LTD (Police Command Staff and MPOA only) plans. You share in the cost of coverage for other plans and coverage levels.

In general, you pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes. Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax.

| Costs shown are monthly. | **Your Cost** |
|---|---|
| **Medical – Premera PPO** | |
| **Employee Only** | $0.00 |
| **Employee + Spouse** | $90.09 |
| **Employee + Spouse + Child** | $134.47 |
| **Employee + Spouse + 2 or more Children** | $171.16 |
| **Employee + 1 Child** | $44.38 |
| **Employee + 2 or more Children** | $81.07 |
| **Medical – Kaiser HMO** | |
| **Employee Only** | $0.00 |
| **Employee + Spouse** | $79.14 |
| **Employee + Spouse + Child** | $119.53 |
| **Employee + Spouse + 2 or more Children** | $159.91 |
| **Employee + 1 Child** | $40.38 |
| **Employee + 2 or more Children** | $80.77 |
| **Dental – Delta Dental of WA (DDWA)** | |
| **Employee Only** | $2.01 |
| **Employee + 1 Dependent** | $3.42 |
| **Employee + 2 Dependent** | $3.93 |
| **Orthodontia – MPOA ONLY** | |
| **Employee Only / Employee + 1 or more Dependents** | $0 (100% paid by the City of Marysville) |
| **Vision – Vision Service Plan (VSP)** | |
| **Employee Only / Employee + 1 or more Dependents** | $0 (100% paid by the City of Marysville) |

# MEDICAL

## OUR PLANS

Premera 250 PPO Plan

Kaiser 200 HMO Plan

## PPO, HMO… WHAT?

Not all medical plans work the same way. Read these short descriptions to learn a little about the main differences between your two options

- **PPO:** PPO stands for Preferred Provider Organization. Your health plan has contracted with a network of providers, facilities, and pharmacies to discount their cost of services for you. By obtaining care in-network you receive the highest benefit possible. You can still obtain care from non-network providers or facilities, you just may need to pay more for those services. You might consider a PPO if:
    - You want to be able to see any provider, even a specialist, without a referral
- **HMO:** HMO stands for Health Maintenance Organization. When enrolling in this type of plan, all care must be obtained by care providers that are a part of the HMO. Care received outside of that group of healthcare providers is generally not covered. Consider an HMO if
    - You like having one doctor to manage your care
    - You are happy with the selection of network providers

# Medical PPO

As an employee of the City of Marysville, you have access to two medical plans: the Premera 250 PPO and Kaiser 200 HMO.

## PREMERA BLUE CROSS 250 PPO PLAN
Network: Premera Heritage & Heritage Plus 1

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible** *(aggregate)* | $250 per individual<br>$750 family limit | $250 per individual<br>$750 family limit |
| **Annual Out-of-Pocket Maximum** | $3,000 per individual<br>$6,000 family limit | $3,000 per individual<br>$6,000 family limit |
| **OFFICE VISIT** | | |
| Primary Provider | First 4 visits: Plan pays 100%; thereafter plan pays 90% after deductible | Plan pays 70% after deductible |
| Specialist | First 4 visits: Plan pays 100%; thereafter Plan pays 90% after deductible (combined with Primary Provider office visits) | Plan pays 70% after deductible |
| **Preventive Services** | Plan pays 100% | Participating: Plan pays 100%;<br>Other: Plan pays 70% after deductible, |
| **Chiropractic** | Plan pays 90% after deductible<br>(up to 15 visits per calendar year) | Plan pays 70% after deductible<br>(in-network limitations apply) |
| **Hearing Instruments** | Up to $3,000 per ear with hearing loss every 36 months | Up to $3,000 per ear with hearing loss every 36 months |
| **Lab and X-ray** | Plan pays 90% after deductible | Plan pays 70% after deductible |
| **Urgent Care** | Plan pays 90% after deductible | $70 after deductible |
| **Emergency Room** | $75 copay then plan pays 90% after deductible<br>(copay waived if admitted) | $75 copay then plan pays 90% after deductible<br>(copay waived if admitted) |
| **Inpatient Hospitalization** | Plan pays 90% after deductible | Plan pays 70% after deductible |
| **Outpatient Surgery** | Plan pays 90% after deductible | Plan pays 70% after deductible |
| **PRESCRIPTION DRUGS** | | |
| Generic | **Pharmacy:** $5 copay then plan pays 100%; **Mail order:** $10 copay then plan pays 100% | **Pharmacy:** Not covered;<br>**Mail order:** Not covered |
| Brand Name | **Pharmacy:** $25 copay then plan pays 100%; **Mail order:** $50 copay then plan pays 100% | **Pharmacy:** Not covered;<br>**Mail order:** Not covered |
| Non-preferred Brand | **Pharmacy:** $50 copay then plan pays 100%; **Mail order:** $100 copay then plan pays 100% | **Pharmacy:** Not covered;<br>**Mail order:** Not covered |
| All others | $100 copay then plan pays 40% | **Pharmacy:** Not covered;<br>**Mail order:** Not covered |
| Supply Limit | **Pharmacy:** 30 days;<br>**Mail order:** 90 days | **Pharmacy:** Not applicable;<br>**Mail order:** Not applicable |

# Medical HMO

KAISER PERMANENTE 200 HMO PLAN
All care must be received at a Kaiser facility, from a Kaiser provider

| | IN-NETWORK ONLY |
|---|---|
| **Annual Deductible** *(aggregate)* | $200 per individual<br>$400 per family |
| **Annual Out-of-Pocket Maximum** | $2,500 per individual<br>$5,000 per family |
| **OFFICE VISIT** | |
| Primary Provider | 1st 4 outpatient visits: $20 copay then plan pays 100%; thereafter: $20 copay then plan pays 90% after deductible. |
| Specialist | $20 copay then plan pays 90% after deductible |
| **Preventive Services** | Plan pays 100% |
| **Chiropractic** | $20 copay then plan pays 90% after deductible<br>(up to 10 visits per calendar year) |
| **Hearing Instruments** | $1,500 limit per 36 months |
| **Lab and X-ray** | 1st $500, plan pays 100%; thereafter<br>plan pays 90% after deductible |
| **Urgent Care** | $20 copay then plan pays 90% after deductible |
| **Emergency Room** | $75 copay then plan pays 90% after deductible<br>(copay waived if admitted) |
| **Inpatient Hospitalization** | Plan pays 90% after deductible |
| **Outpatient Surgery** | Plan pays 90% after deductible |
| **PRESCRIPTION DRUGS** | |
| Generic | **Pharmacy:** $10 copay then plan pays 100%;<br>**Mail order:** $20 copay then plan pays 100% |
| Brand Name | **Pharmacy:** $20 copay then plan pays 100%;<br>**Mail order:** $40 copay then plan pays 100% |
| Non-preferred Brand | **Pharmacy:** $40 copay then plan pays 100%;<br>**Mail order:** $80 copay then plan pays 100% |
| Supply Limit | **Pharmacy:** 30 days;<br>**Mail order:** 90 days |

# EMPLOYEE ASSISTANCE PROGRAM (EAP)

## CONTACT THE EAP

### Phone

**(800) 777-4114**

### Website

**www.FirstChoiceEAP.com**

**username: marysville**

## Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through First Choice EAP can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

## No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 3 sessions face-to-face or telehealth
- Unlimited web access to helpful articles, resources, and self-assessment tools.

### SERVICES INCLUDE SUPPORT FOR

- Anxiety and Depression
- Couples/Relationship
- Parenting
- Crisis Support
- Alcohol/Drug Problems
- Grief and Loss
- Work Conflict
- Compulsive Behaviors
- Domestic Violence
- Legal and Financial
- Childcare and Eldercare
- Home Ownership
- ID Theft
- Health Living Tips

# DENTAL AND VISION

## OUR DENTAL PLANS

Delta Dental Incentive PPO

Delta Dental Incentive PPO (MPOA)

### About Dental Coverage

It's important to go to the dentist regularly.  Regular exams catch dental issues early before they become more expensive and difficult to treat. Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures

Marysville Police Officer Association (MPOA) members have access to orthodontia benefits for adults and children

## OUR VISION PLAN

VSP Vision

### About Vision Coverage

Vision coverage helps with the cost of eyeglasses or contacts. Even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues.

# Dental

As an employee of the City of Marysville, you have access to comprehensive coverage through Delta Dental of Washington via the Delta Dental PPO and Delta Dental Premier networks.

When you first enroll in the plan, your "incentive level" (or benefit level) will be 100%. Each calendar year that you use any of your dental benefits, your "incentive level" maintains the 100% benefit level. If you do not use your dental plan for a year, your incentive level will decrease by 10% but it will never go below 70%.

| | INCENTIVE DENTAL PPO ALL ACTIVE EES (EXCEPT MPOA) | | INCENTIVE DENTAL PPO MPOA ONLY | |
|---|---|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK |
| **Annual Deductible** | $0 per individual<br>$0 per family | | $0 per individual<br>$0 per family | |
| **Annual Plan Maximum** | $1,500 | | $1,500 | |
| **Diagnostic & Preventive** | Plan pays 100% - 70% | | Plan pays 100% - 70% | |
| **BASIC SERVICES** | | | | |
| Fillings | Plan pays 100% - 70% | | Plan pays 100% - 70% | |
| Root Canals | Plan pays 100% - 70% | | Plan pays 100% - 70% | |
| Periodontics | Plan pays 100% - 70% | | Plan pays 100% - 70% | |
| **Major Services** | Plan pays 50% | | Plan pays 50% | |
| **ORTHODONTIC SERVICES** | Covered for adults and children | | | |
| Orthodontia | Not covered | | Plan pays 50% | |
| Lifetime Maximum | N/A | | $2,000 | |

## Choose an in-network dentist

Your plan gives you access to the Delta Dental PPO℠ and Delta Dental Premier® networks.

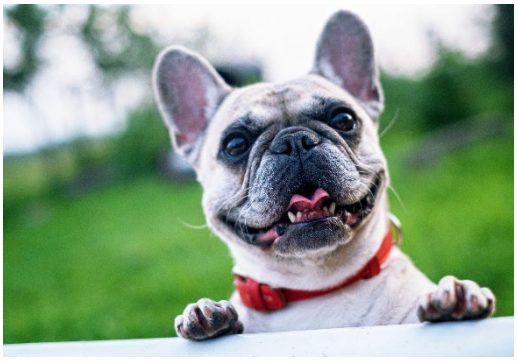
| | Delta Dental PPO | Delta Dental Premier | Non-Delta Dental |
|---|---|---|---|
| Your plan's network | ✓ | ✓ | |
| Benefits go farthest which means least out-of-pocket costs | ✓ | ✓ | |
| Files claims forms for you | ✓ | ✓ | |
| Comes with our quality management and cost protection | ✓ | ✓ | |
| No cost protection which means greatest out-of-pocket costs | | | ✓ |

# Vision

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **COPAYS** | | |
| Exam | Plan pays 100% | Plan pays 100%<br>*(up to $45)* |
| Materials | Plan pays 100% | Plan pays 100%<br>*(see schedule below)* |
| **EYEGLASS LENSES** | | |
| Single Vision Lens | Plan pays 100% of basic lens | Up to $30 |
| Bifocal Lens | Plan pays 100% of basic lens | Up to $50 |
| Trifocal Lens | Plan pays 100% of basic lens | Up to $65 |
| **Frames** | Reimbursed up to $200 | Reimbursed up to $70 |
| **Contacts (Elective)** | Up to $200 (instead of eye glasses) | Up to $105 (instead of eye glasses) |
| **FREQUENCY** | | |
| Exam | Once every 12 months | Once every 12 months |
| Lenses | Once every 12 months | Once every 12 months |
| Frames | Once every 24 months | Once every 24 months |
| Contacts (Elective) | Once every 12 months | Once every 12 months |

# Pet Insurance to Cover All Members of Your Family



## Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. Rates will depend on the age and breed of your pet. MetLife provides coverage for this program. You can enroll in this program at any time. Payments will be set up on a direct bill basis to employees.

## Enrolling with MetLife

MetLife Pet Insurance offers an employee benefit discount of 5%, plus a multi-pet discount and a family plan option if you enroll more than one pet. Employees can choose the level of coverage that best fits their needs and can also include a routine wellness care rider with their coverage for an additional cost.

## CONTACT INFORMATION

To enroll you can call 1-800-GET-MET8 and mention you are an employee of City of Marysville or go to metlife.com/getpetquote and find your employer name.

| Category | Options |
|---|---|
| **Benefit Limits** | $500 - $10,000 or unlimited |
| **Deductibles** | $50 - $2,500 |
| **Reimbursements** | 50%, 60%, 70%, 80%, 90%, 100% |
| **Preventive Care** | Optional coverage |
| **Sample Rates:** | |
| $250 Deductible / $7,000 Annual Limit / 70% Reimbursement<br><br>1-year-old Mixed Breed dog - $30.77/month<br>4-year-old Australian Shepherd - $28.23/month<br>2-year old Domestic Medium Hair cat - $22.58/month | $250 Deductible / $25,000 Annual Limit / 90% Reimbursement<br><br>1-year-old Mixed Breed dog - $47.70/month<br>4-year-old Australian Shepherd - $42.73/month<br>2-year old Domestic Medium Hair cat - $31.59/month |

*Sample rates are based on age/breed /location and will vary.*
*Plan options will vary by age/breed/location and may not all be available.*

# TAX SAVINGS

## PLANS TO HELP YOU SAVE

- Healthcare Flexible Spending Account
- Dependent Care Flexible Spending Account

## Save taxes on qualified expenses

Flexible Spending Accounts (FSAs) are pre-tax benefits. Funds set aside into these plans avoid Federal Income Tax, helping you save up to 40% on health and dependent care expenses.

- A Healthcare Flexible Spending Account (HCFSA) is a personal expense account that allows employees to set aside a portion of their salary pre-tax to pay for qualified medical expenses.
- A Dependent Care FSA (DCFSA) is a pre-tax benefit account that enables you to set aside money to pay for out-of-pocket daycare or dependent care expenses

Both accounts are Use-It or Lose-It so consider your needs carefully.

# HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

*Click to play video*


## You can spend your FSA dollars on:

- Deductibles, copays, coinsurance
- Medically necessary expenses not covered by your health plan
- Prescription drugs
- Over-the-counter (OTC) drugs prescribed by your doctor
- Some drugstore items such as diabetic supplies and first aid
- Dental and vision care services
- Certain types of medical equipment

## Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered by Navia Benefit Solutions.

## How the healthcare FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- **You can contribute up to $3,200, the annual limit set by the IRS for 2024**. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

## Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $640 to use the following year. Any additional remaining balance will be forfeited.

**FSA TAX SAVINGS EXAMPLE**

**$60,000 Annual Pay, with $1,500 FSA Contribution**

| | | |
|---|---|---|
| **$330**<br>22% Federal income tax | **$115**<br>7.65% FICA tax | **$445**<br>Annual FSA tax savings |

**$120,000 Annual Pay, with $2,750 FSA Contribution**

| | | |
|---|---|---|
| **$660**<br>24% Federal income tax | **$210**<br>7.65% FICA tax | **$870**<br>Annual FSA tax savings |

*Your tax savings may vary depending on tax filing status and other variables*

# PAYING FOR DAYCARE? MAKE IT TAX-FREE!

*Click to play video*


## EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

## Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Navia Benefit Solutions.

## Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only child care, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

**You can set aside up to $5,000 per household per year.** You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

**Estimate carefully!** You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. **Unspent funds will be forfeited**.

# ENGAGE

## Get Help to Understand Your Benefits

We provide access to resources to further your knowledge and understanding of your benefit plan. Alliant offers a team of experts to help research questions you may have about how your claims have been processed or paid.

- **Alliant Benefit Advocates** – Advocates can help answer questions about how your benefits work. They can also help answer questions about a healthcare claim or research a billing issue

## Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

# HAVE QUESTIONS ABOUT YOUR BENEFITS?

*Click to play video*


## CONTACT YOUR ALLIANT BENEFIT ADVOCATE

### Email

**benefitsupport@alliant.com**

### Phone

**(800) 489-1390**

### Hours

**Monday – Friday**
**5 a.m. to 5 p.m. PT**

## Get help from a Benefit Advocate

Are you getting married and not sure how and when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? A Benefit Advocate can help answer these questions and more.

Benefit Advocates are trained benefits experts who can help you understand and use your healthcare insurance and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Health care claim or billing issues, when warranted
- Coverage changes due to life events (marriage, new child, divorce, etc.).

## Claims assistance

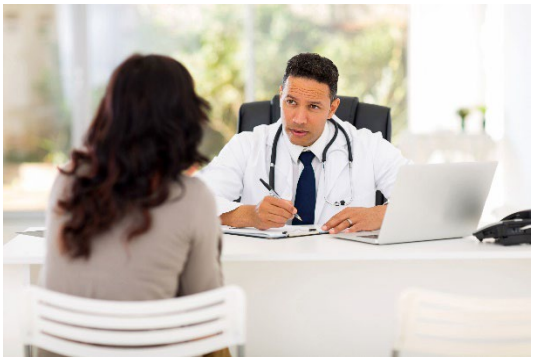
If you need claims assistance, you'll need to complete a HIPAA Authorization Form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed.

# KNOW WHERE TO GO

*Where* you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

| Type | Appropriate for | Examples | Access | Cost |
|---|---|---|---|---|
| **Nurseline**  | Quick answers from a trained nurse | • Identifying symptoms<br>• Decide if immediate care is needed<br>• Home treatment options and advice | 24/7 | **$0** |
| **Online visit**  | Many non-emergency health conditions | • Cold, flu, allergies<br>• Headache, migraine<br>• Skin conditions, rashes<br>• Minor injuries<br>• Mental health concerns | 24/7 | **$** |
| **Office visit**  | Routine medical care and overall health management | • Preventive care<br>• Illnesses, injuries<br>• Managing existing conditions | Office Hours | **$$** |
| **Urgent care, walk-in clinic**  | Non-life-threatening conditions requiring prompt attention | • Stitches<br>• Sprains<br>• Animal bites<br>• Ear-nose-throat infections | Office Hours, or up to 24/7 | **$$$** |
| **Emergency room**  | Life-threatening conditions requiring immediate medical expertise | • Suspected heart attack or<br>• stroke<br>• Major bone breaks<br>• Excessive bleeding<br>• Severe pain<br>• Difficulty breathing | 24/7 | **$$$$$** |

# PREVENTIVE CARE SCREENING BENEFITS



## TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

## You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

## What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

**Preventive care is covered in full only when obtained from an IN-NETWORK provider.**

## Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

# PRESCRIPTIONS BREAKING YOUR BUDGET?

*Click to play video*


## THE FORMULARY DRUG TIERS DETERMINE YOUR COST

| | |
|---|---|
| $ | Generic Drug |
| $$ | Brand Name Drug |
| $$$ | Specialty Drug |

## Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

## What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

## Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

**To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.**

# DISABILITY INSURANCE

(Police Command Staff & MPOA only)

## 3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

## LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you can't work for a longer time, long-term disability (LTD) coverage replaces part of your monthly income. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

### Standard LTD

| | |
|---|---|
| **Monthly benefit amount** | 67% of first $17,910 of Pre-disability Earnings up to a maximum of $12,000 before reduction by Deductible Income |
| **Benefits begin** | After 90 days of disability |
| **Maximum payment period** | Determined by your age when disability begins (The age at which disability begins may affect duration of benefits) |

# IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

# PLAN CONTACTS

## HELPFUL RESOURCES

**Benefits Portal/App**
MyBenefits.Life®
Cityofmarysville.mybenefits.life

**Benefit Advocate**
benefitsupport@alliant.com
(800) 489-1390

## MEDICAL, DENTAL & VISION

**Premera Blue Cross**
Policy #4018895
Premera.com
Member Services
(800) 722-1471
24 Hr Nurse Line
(800) 841-8343

**Kaiser Permanente Insurance Company**
Policy #0983900
kp.org
Member Services
(888) 901-4636

**Delta Dental of WA**
Policy #09640 (All Others)
#09641 (Police)
deltadentalWA.com
Member Services
(800) 554-1907

**Vision Service Plan (VSP)**
Policy #30095155
vsp.com
Member Services
(800) 877-7195

## LONG TERM DISABILITY (LTD)

**Standard Insurance Group**
Policy #610516-A
Standard.com
Member Services
(503) 321-70000

## FLEXIBLE SPENDING ACCOUNTS

**Navia Benefit Solutions**
Group #MYV
Naviabenefits.com
Member Services
(425) 452-3500

## BENEFITS ADMINISTRATION

**Benefit Coordinators Corporation**
Group #CTYOM
Benxcel.net
Member Services
(800) 685-6100

# GLOSSARY

## -A-

**Allowed Amount**
The maximum amount your plan will pay for a covered healthcare service.

**Ambulatory Surgery Center (ASC)**
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

**Annual Limit**
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

## -B-

**Balance Billing**
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

**Brand Name Drug**
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

## -C-

**COBRA**
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

**Claim**
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

**Coinsurance**
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

**Copayment**
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

## -D-

**Deductible**
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage has an ***embedded*** deductible. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

**Dental Basic Services**
Services such as fillings, routine extractions and some oral surgery procedures.

**Dental Diagnostic & Preventive**
Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

**Dental Major Services**
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

**Dependent Care Flexible Spending Account (FSA)**
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age
13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

## -E-

**Eligible Expense**
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

**Excluded Service**
A service that your health plan doesn't pay for or cover.

## -F-

**Formulary**
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

## -G-

**Generic Drug**
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

**Grandfathered**
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

## -H-

**Healthcare Flexible Spending Account (FSA)**
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

# GLOSSARY

## -I-

**In-Network**
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

## -L-

**Long Term Disability Insurance**
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

## -M-

**Mail Order**
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

## -O-

**Open Enrollment**
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

**Out-of-Network**
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

**Out-of-Pocket Cost**
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

**Out-of-Pocket Maximum**
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

**Outpatient Care**
Care from a hospital that doesn't require you to stay overnight.

## -P-

**Participating Pharmacy**
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

**Plan Year**
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

**Preferred Drug**
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non- preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

**Preventive Care Services**
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

**Primary Care Provider (PCP)**
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

## -T-

**Telehealth / Telemedicine / Teledoc**
A virtual visit to a doctor using video chat on a computer, tablet or smartphone.
Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

## -U-

**UCR (Usual, Customary, and Reasonable)**
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

**Urgent Care**
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

## -V-

**Vaccinations**
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

# IMPORTANT PLAN INFORMATION

## HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the accompanying Annual Notices document.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **Availability of Privacy Practices Notice:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

## COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

# PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available accompanying Annual Notices document. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

## SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

## SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

- [AWC] Kaiser Permanente HMO Plan - All Employees
- [AWC] Kaiser Permanente HMO Plan - Pre-65 Retirees
- Premera Blue Cross PPO Plan - All eligible employees
- Premera Blue Cross PPO Plan - Pre-65 Retirees

## STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the City of Marysville Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

# DETERMINING ELIGIBILITY

The information below explains in detail how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

## ANNUAL MEASUREMENT METHOD

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. The City of Marysville uses the annual measurement method to determine whether an employee meets this eligibility threshold.

# 2024

# Annual Notices

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MARYSVILLE

# Medicare Part D Notice

## Important Notice from City of Marysville 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 Marysville 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 Marysville has determined that the prescription drug coverage offered by the City of Marysville Health and Welfare 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.

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## 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 Marysville 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 Marysville 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 Marysville 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.

## 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 Marysville 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 Marysville 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:** | 01/01/2024 |
| **Name of Entity/Sender:** | City of Marysville |
| **Contact-Position/Office:** | Chief Administrative Officer |
| **Address:** | 501 Delta Avenue Marysville, WA 98270-4234 |
| **Phone Number:** | (360) 363-8000 |

# 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. If you would like more information on WHCRA benefits, call your plan administrator (360) 363-8000.

# 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 (360) 363-8000.

# HIPAA Notice of Special Enrollment Rights

If you decline enrollment in City of Marysville'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 Marysville'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 Marysville'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 right, you may add the dependent to your current coverage or change to another health plan.

# Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for City of Marysville describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting (360) 363-8000.

# Notice of Choice of Providers

The Kaiser 200 PPO Plan generally requires 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 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 Kaiser member services (800) 901-4636.

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

You do not need prior authorization from Kaiser 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 member services at (800) 901-4636.

# 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)**.

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

| |
|---|
| **ALABAMA – Medicaid** |
| Website: http://myalhipp.com/ \| Phone: 1-855-692-5447 |
| **ALASKA – Medicaid** |
| The AK Health Insurance Premium Payment Program \| Website: http://myakhipp.com/<br>Phone: 1-866-251-4861 \| Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx |
| **ARKANSAS – Medicaid** |
| Website: http://myarhipp.com/ \| Phone: 1-855-MyARHIPP (855-692-7447) |
| **CALIFORNIA – Medicaid** |
| Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322 \| Fax: 916-440-5676 \| Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** |
| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center: 1-800-221-3943 \| State Relay 711<br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991 \| State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program<br>HIBI Customer Service: 1-855-692-6442 |
| **FLORIDA – Medicaid** |
| Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |

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|---|
| **GEORGIA – Medicaid** |
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra \| Phone: 678-564-1162, press 2 |
| **INDIANA – Medicaid** |
| Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ \| Phone: 1-877-438-4479<br>All other Medicaid Website: https://www.in.gov/medicaid/ \| Phone 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** |
| Medicaid Website: https://dhs.iowa.gov/ime/members \| Medicaid Phone: 1-800-338-8366<br>Hawki Website: http://dhs.iowa.gov/Hawki \| Hawki Phone: 1-800-257-8563<br>HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp \| HIPP Phone: 1-888-346-9562 |
| **KANSAS – Medicaid** |
| Website: https://www.kancare.ks.gov/ \| Phone: 1-800-792-4884 |
| **KENTUCKY – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)<br>Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx \| Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov \| KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718 \| Kentucky Medicaid Website: https://chfs.ky.gov |
| **LOUISIANA – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** |
| Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-442-6003 \| TTY: Maine relay 711<br>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 800-977-6740 \| TTY: Maine relay 711 |
| **MASSACHUSETTS – Medicaid and CHIP** |
| Website: https://www.mass.gov/masshealth/pa \| Phone: 1-800-862-4840 \| TTY: 617-886-8102 |
| **MINNESOTA – Medicaid** |
| Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp \| Phone: 1-800-657-3739 |
| **MISSOURI – Medicaid** |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm \| Phone: 573-751-2005 |
| **MONTANA – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 \| email: HHSHIPPProgram@mt.gov |
| **NEBRASKA – Medicaid** |
| Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633 \| Lincoln: 402-473-7000 \| Omaha: 402-595-1178 |
| **NEVADA – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov \| Medicaid Phone: 1-800-992-0900 |
| **NEW HAMPSHIRE – Medicaid** |
| Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program |

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| Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** |
| Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710 |
| **NEW YORK – Medicaid** |
| Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100 |
| **NORTH DAKOTA – Medicaid** |
| Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742 |
| **OREGON – Medicaid** |
| Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid** |
| Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462 |
| **RHODE ISLAND – Medicaid and CHIP** |
| Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** |
| Website: https://www.scdhhs.gov | Phone: 1-888-549-0820 |
| **SOUTH DAKOTA – Medicaid** |
| Website: http://dss.sd.gov | Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** |
| Website: http://gethipptexas.com/ | Phone: 1-800-440-0493 |
| **UTAH – Medicaid and CHIP** |
| Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT – Medicaid** |
| Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427 |
| **VIRGINIA – Medicaid and CHIP** |
| Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp<br>Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** |
| Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022 |
| **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002 |
| **WYOMING – Medicaid** |
| Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269 |

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

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

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

# ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

# The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

MARYSVILLE

Rev. 10/23/2023