2024 BENEFITS

IAFF

Navigating To a Healthier Kirkland

CONTENTS

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to Kirknet/Human Resources/Healthcare Corner. The plan benefit booklets determine how all benefits are paid.

GETTING STARTED

2024 BENEFITS

January 1, 2024 through December 31, 2024

At The City of Kirkland, we believe that you, our employees, are our most important asset, and helping you and your families achieve and maintain good physical, emotional, and financial health is a top priority for us. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided on the following pages.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to Kirknet/Human Resources/Healthcare Corner.

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.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are a regular employee working 20 or more hours per week.

Refer to "Determining Eligibility" later in this guide for details.

Eligible dependents

- Legally married spouse, including same-sex spouse
- Same or opposite sex domestic partners *(you must complete a LEOFF Domestic Partner Affidavit which can be requested from HR, as well as a Domestic Partner Affidavit*[1] *which can be found on Kirknet/Healthcare Corner)*
- Natural, adopted, or stepchildren up to age 26 regardless of marital employment status *(they also do not have to live with you or be enrolled in school)*
- 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 coverage information, please refer to the benefit booklets for each benefit.

Dependents must meet eligibility requirements. Please see "Determining Eligibility" for important information on termination of coverage for ineligible dependents.

When you can enroll

Coverage for new employees begins on the 1st of Month following or coinciding with date of hire. Open enrollment for current employees is generally held in November. 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.

[1] Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner.

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 your or a dependent'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).

Please contact Human Resources when you experience a qualifying event. You must submit any changes within 30 days (60 days for birth or adoption) after the event.

HOW TO ENROLL

1. Log in to **Employee Self-Serve** ESS using your network credentials.
2. From the column on the left, click on 'Benefits'.
3. **New Hire**: You have 30 days from date of hire to complete your online enrollment selections. Your deadline will be listed in the banner at the top of the benefit page.
   Open Enrollment: The Benefits page will show your current elections. To begin the open enrollment process, click on 'Open Enrollment'; either from the link at the top or from the column on the left.
4. The online enrollment process requires you to make a selection for each benefit.
   a. To decline a benefit, you will select **Decline Benefit**, next to the benefit plan. Keep in mind, if you decline medical coverage, you must complete the Waiver of Health Insurance form located on Kirknet/Human Resources/Healthcare Corner and return that to the HR Analyst – Benefits in Human Resources prior to the end of the enrollment period.
   b. To select your plans, click on **Make New Election**.
   c. If you have no changes to current elections, select **No Changes**.
5. If you select **Make New Election** you will need to select from the list of plans, the plan option you would like to enroll in for the calendar year. Once the plan is selected, scroll to the bottom of the page for next steps.
   a. If you select a plan that you are adding a dependent, you need to be sure to provide the proper documentation to the HR Analyst-Benefits in Human Resources prior to the end of the enrollment period, such as birth certificate for children, marriage license for spouses, etc.
   b. **NOTE:** For **LEOFF Trust** and **Teamsters Dental** paper enrollment forms are still required and are located at the top right of the page. You can print directly from **ESS** if you are connected to a printer.
6. To add a dependent click on Add New Dependent. A pop-up box will appear on the screen. Make sure you completed all sections, as well as social security number. **Note:** While not all sections are starred, they are required for us to send to our carriers for the insurance. After all sections are complete, click save.
7. Once you have added all dependents, click 'Continue'.
8. This will bring you back to the **Open Enrollment** page where you can complete the remaining health and flexible spending benefit elections. **Note: For Flexible Spending Accounts, please enter the per pay period amount, not the annual amount.**
9. Once all benefit elections are completed and you've verified the Current Elections and your New Elections on the **Enrollment** page, click 'Continue'.
10. The **Review Your Enrollment** page is a complete view of your benefit elections, covered dependents, and cost. If all is complete and correct, click 'Submit Choices'. If not, click 'Modify' and make changes.
11. Once your choices are submitted, print your confirmation statement as proof of your enrollment elections for the calendar year.

BENEFITS HELP

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 you're not sure how or when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HRA and an FSA? A Benefit Advocate can help answer these questions and more.

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

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Problems with health care claims or billing, when warranted
- Coverage changes due to life events (such as marriage, a new child, or divorce)

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-duration basis, and only to the individuals listed on the form. You can end the permissions granted by the form at any time. Your Benefit Advocate will provide the form to you when needed.

MEDICAL

OUR PLANS

- Premera HDHP
- Kaiser HMO Plan

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Think about these factors when choosing your medical plan:

Do you like your doctors?

Check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more, consider the Premera HDHP, which includes out-of-network coverage. Keep in mind, if you select the Kaiser HMO Plan, you must stay in the Kaiser network of doctors.

What are your healthcare needs?

Compare how each plan covers the services you need most often, such as office visits, specialists, or prescriptions.

What's your budget?

What will you pay for coverage? Is there a deductible? What is your share of the cost for office visits and prescriptions? All of these factors together affect your total cost for healthcare.

WHICH PLAN IS RIGHT FOR YOU?

Click to play video

HMO, PPO, HDHP—what's the difference?

Not all medical plans work the same. This video will help you understand how each type of plan works.

HMO (Health Maintenance Organization)

Consider the HMO plan, if:

- You want lower, predictable out-of-pocket costs.
- You like having one doctor to manage your care.
- You are happy with the selection of network providers.
- You don't see any doctors that are out-of-network.
- You have convenient access to Kaiser facilities.

Plan To Consider

- Kaiser Permanente HMO Plan

HDHP (High Deductible Health Plan)

Consider the HDHP, if:

- You want to be able to see any provider, even a specialist, without a referral.
- You want access to both in- and out-of-network providers.
- You want coverage for out-of-network providers and are willing to pay more to see these providers.

Plan To Consider

- Premera HDHP

HELPFUL DEFINITIONS

Click to play video

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Deductible

The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.

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 eligible expenses for the rest of the plan year.

Coinsurance

After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.

Copay

A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.

In-network / Out-of-network

In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

LEOFF TRUST PREMERA HDHP

Heritage Plus Network

You always pay the deductible and copayments ($). The coinsurance (%) shows what the plan pays after the deductible.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$1,500 per individual $3,000 family limit *(offset by HRA contributions)*	
Annual Out-of-Pocket Maximum	$2,000 per individual $4,000 family limit	Unlimited
Preventive Services	Plan pays 100% *(see contract for limitations)*	Not covered
Office Visit		
Primary visit	$35 copay then plan pays 100%	Plan pays 50% after deductible
Specialist visit	$35 copay then plan pays 100%	Plan pays 50% after deductible
Virtual visit	$20 copay then plan pays 100%	Plan pays 50% after deductible
Chiropractic	$35 copay then plan pays 100% *(up to 24 visits per calendar year)*	Plan pays 50% after deductible
Lab and X-ray	First $500 plan pays 100% then plan pays 80% after deductible	Plan pays 50% after deductible
Urgent Care	$35 copay then plan pays 100%	Plan pays 50% after deductible
Emergency Room	$200 copay then plan pays 80% after deductible *(copay waived if admitted)*	
Hospitalization	Plan pays 80% after deductible	Plan pays 50% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 50% after deductible
PRESCRIPTION DRUGS		
Generic	$15 copay then plan pays 100%	$15 copay then plan pays 60%
Brand Name	$35 copay then plan pays 100%	$35 copay then plan pays 60%
Non-preferred Brand	$35 copay then plan pays 100%	$35 copay then plan pays 60%
Supply Limit	30 days	30 days
Mail Order		
Generic	$30 copay then plan pays 100%	Not covered
Brand Name	$70 copay then plan pays 100%	
Non-preferred Brand	$70 copay then plan pays 100%	
Supply Limit	90 days	

KAISER PERMANENTE HMO PLAN

Core Network

You always pay the deductible and copayments ($). The coinsurance (%) shows what the plan pays after the deductible.

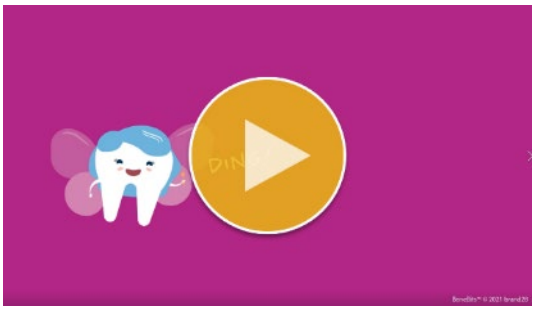
	IN-NETWORK ONLY
Annual Deductible	$0 per individual $0 family limit
Annual Out-of-Pocket Maximum	$2,000 per individual $4,000 family limit
Preventive Services	Plan pays 100% *(see contract for limitations)*
Office Visit	
Primary visit	$10 copay then plan pays 100%
Specialist visit	$10 copay then plan pays 100%
Virtual visit	Plan pays 100%
Chiropractic	$10 copay then plan pays 100% *(up to 10 visits per calendar year)*
Lab and X-ray	Plan pays 100%
Urgent Care	$10 copay then plan pays 100%
Emergency Room	$50 copay then plan pays 100% *(copay waived if admitted)*
Hospitalization	$100 copay per day, up to 4 days, then plan pays 100%
Outpatient Surgery	$10 copay then plan pays 100%
PRESCRIPTION DRUGS	
Generic	$10 copay then plan pays 100%
Brand Name	$10 copay then plan pays 100%
Non-preferred Brand	Not covered
Supply Limit	30 days
Mail Order	
Generic	$10 copay then plan pays 100% *($5 discount per 30-day supply)*
Brand Name	$10 copay then plan pays 100% *($5 discount per 30-day supply)*
Non-preferred Brand	Not covered
Supply Limit	90 days

DENTAL

OUR PLANS

- Premera PPO Dental Plan
- Willamette Dental DMO Plan

Click to play video



Why sign up for dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

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.

What's the difference?

Preferred Provider Organization (PPO)

Provides flexibility to see any licensed dentist, but you will receive savings of significant fee reductions for going to dentist that is part of the PPO network, or in-network.

Dental Maintenance Organization (DMO)

The provider you see and the treatment you receive, must be at a specific facility. Often has lower dental premiums, lower, set copays for dental treatment.

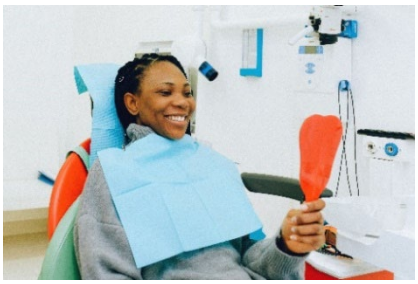
LEOFF TRUST PREMERA DENTAL PPO PLAN

Heritage Plus Network

You always pay the deductible and copayments ($). The coinsurance (%) shows what the plan pays after the deductible.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$25 per individual $75 family limit	
Annual Plan Maximum[2]	$2,500 per individual	
Diagnostic and Preventive Services	Plan pays 100%	
Basic Services Fillings Root canals Periodontics	Plan pays 100% after deductible	
Major Services	Plan pays 50% after deductible	
ORTHODONTIC SERVICES		
Orthodontia **Lifetime Maximum** Adults Children	Not covered	

What you need to know about this plan



Type of Plan:	Preferred Provider Organization (PPO)
Features:	See any provider, but you'll pay more out of network[3]
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my HRA or FSA?	If you participate in a healthcare FSA or HRA, you can use your account to pay for dental expenses.

[2] Annual Plan Maximum applies to basic and major services only.

[3] When utilizing a Premera PPO Network dentist, services are covered at a lower negotiated fee schedule, making out-of-pocket cost at the dentist less. When going to a nonparticipating dentist, services are covered, but the member has the responsibility to cover the cost difference in service charges if that provider charges more.

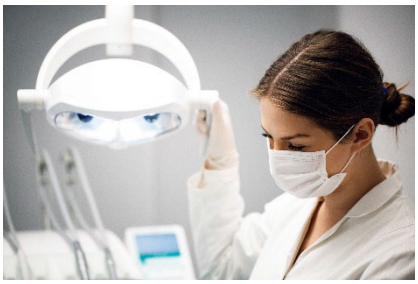
WILLAMETTE DENTAL DMO PLAN

Willamette Dental Group

You always pay the deductible and copayments ($). The coinsurance (%) shows what the plan pays after the deductible.

	IN-NETWORK ONLY
Annual Deductible	$0 per individual $0 family limit
Annual Plan Maximum	Unlimited
Diagnostic and Preventive Services	$10 copay then plan pays 100%[4]
Basic Services Fillings Root canals Periodontics	$10 copay then plan pays 100%[4]
Major Services	$10 copay then plan pays 100%[4]
ORTHODONTIC SERVICES	
Orthodontia	$1,000 copay then plan pays 100%
Lifetime Maximum	Unlimited
Adults	Covered
Children	Covered

What you need to know about this plan



Type of Plan:	Dental Maintenance Organization (DMO)
Features:	Unlimited plan maximum and set copayments for services.
Am I restricted to in-network providers?	Yes
Do I have to select a primary dentist?	Yes
Can I use my HRA or FSA?	If you participate in a healthcare FSA or HRA, you can use your account to pay for dental expenses.

[4] Certain services may require a different copay amount. Please review the contract for the full fee schedule.

VISION

OUR PLAN

- Premera Vision with Medical
- VSP Vision Plan

Click to play video

Why sign up for vision coverage?

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.

Visit vsp.com/offers for exclusive VSP member savings on services like LASIK and PRK, additional savings on eyeglasses, and rebates on contact lenses.

LEOFF TRUST PREMERA VISION

Premera participants only

Heritage Plus Network

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	IN-NETWORK	OUT-OF-NETWORK
Examination		
Under Age 19	$35 copay then plan pays 100%	
Age 19+	Covered in full	
Frequency	1x every calendar year	
Hardware	Frames, lenses, and contacts	
Under Age 19	Plan pays 100% for one pair glasses/frames or contacts	
Age 19+	Plan pays 100% up to $300 allowance	
Frequency	1x every calendar year	

What you need to know about this plan

Am I restricted to in-network providers?

No, see any licensed vision provider, but you'll pay more out of network

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in the healthcare FSA or HRA, you can use your account to pay for vision care and eyewear with tax-free dollars.

VSP VISION PLAN

Kaiser participants only

VSP Signature Network

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	IN-NETWORK	OUT-OF-NETWORK
Examination	$10 copay then plan pays 100%	$10 copay then plan pays 100% up to $50
Frequency	1x every 12 months from last date of service	
Materials	Plan pays 100%	Plan pays 100% up to amount based on schedule below
Frames	$120 allowance, plus additional 20% discount on additional amounts	Reimbursed up to $70
Frequency	1x every 24 months for the last date of service	
Lenses		
Single vision	Plan pays 100% of basic lens	Reimbursed up to $50
Bifocal	Plan pays 100% of basic lens	Reimbursed up to $75
Trifocal	Plan pays 100% of basic lens	Reimbursed up to $100
Frequency	1x every 12 months for the last date of service	
Elective Contacts	$150 allowance *(copay waived; instead of eyeglasses)*	Reimbursed up to $105
Frequency	1x every 12 months for the last date of service	

What you need to know about this plan

Features:	The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.
Am I restricted to in-network providers?	No, see any licensed vision provider, but you'll pay more out of network
Eyeglasses are expensive. Will I still be able to afford them, even with insurance?	Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in the healthcare FSA or HRA, you can use your account to pay for vision care and eyewear with tax-free dollars.

HRA VEBA

ARE YOU ELIGIBLE?

You are eligible for the HRA if you are enrolled in either medical plan.

CAN I HAVE BOTH AN HRA AND AN FSA?

Yes! You can have both an HRA and a healthcare Flexible Spending Account (FSA) at the same time, but you can't be reimbursed from both accounts for the same expense. Generally, the FSA is used first until the account is depleted.

Your "allowance" for healthcare expenses

Healthcare can be expensive. That's why City of Kirkland provides individuals enrolled in a medical plan with an HRA (Health Reimbursement Arrangement) to help pay for medical expenses in the form of a VEBA[5]. A VEBA account allows the City of Kirkland to deposit funds into a tax-exempt irrevocable trust arrangement on your behalf. The VEBA is paired with a (HRA) which allows you to use the VEBA funds for current or future out-of-pocket health-related expenses. The HRA VEBA is administered by BPAS, Inc.

Here's how it works

For employees enrolled in the LEOFF Trust Premera HDHP, City of Kirkland sets aside a fixed amount of money into your HRA VEBA:

Employee Only: $2,000
Family[6]: $3,000

For employees enrolled in the Kaiser plan:

Employee/Family[6]: $600

Your account will be funded in two lump sums and will be reflected on your second paycheck in January and July.

You can use this money for yourself and your covered dependents. When you have a healthcare expense, you can use your VEBA Benefits Card or submit a request for reimbursement to BPAS directly including a receipt. You can use your HRA for eligible expenses, until you've used up your funds.

Eligible expenses include:

- Prescription drug co-pays
- Over-the-counter (OTC) medications
- Health plan deductibles, copays, and coinsurance
- Lasik surgery
- Eyeglasses/contact lenses
- Dental and vision services

Three reasons to love an HRA

- **It's 100% employer-funded.** All contributions are made by City of Kirkland. In fact, the rules prohibit employee contributions.
- **It's tax-free.** HRA reimbursements are excluded from your gross income, so they are 100% tax-free.
- **No "use it or lose it."** Unused money rolls over to use in future years, even into retirement.

[5] VEBA is an acronym for Voluntary Employees' Beneficiary Association. It is a type of trust used to hold plan assets for the purpose of providing employee benefits. VEBAs are authorized by Internal Revenue Code § 501(c)(9).
[6] Family refers to an employee enrolled with one or more dependent.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- naviabenefits.com
- Eligible Expenses
- Ineligible Expenses

Do you pay for dependent care?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

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. The FSA is administered by Navia.

How it works

You estimate what you and your dependents' 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, and even eligible drugstore items.

You can contribute up to $3,050 in 2024, which is the annual limit set by the IRS. 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 forfeit the leftover balance at the end of the year.

FSA TAX SAVINGS EXAMPLE

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

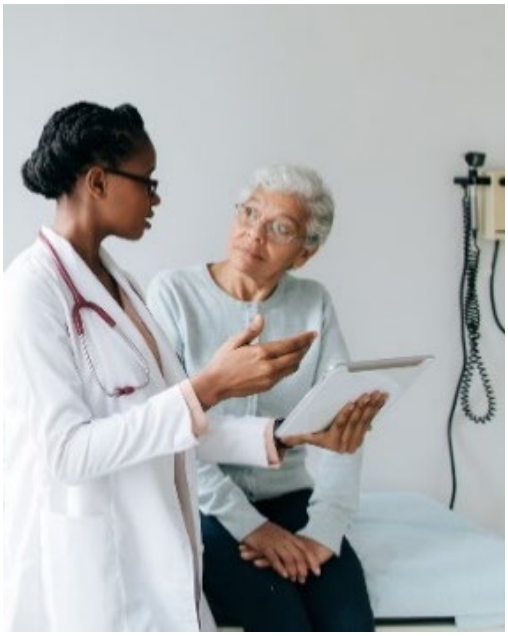
$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,850 FSA Contribution

$684 24% Federal income tax	**$219** 7.65% FICA tax	**$903** Annual FSA tax savings

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

HOW TO FIND A PROVIDER



Willamette Dental facilities

1. Go to willamettedental.com[7]
2. Click 'Locations' and enter you zip code or city, state then hit 'Enter'
3. A list of facilities in your area will appear

Vision Service Plan
Network: VSP Signature

1. Go to vsp.com[7]
2. Click 'Find a Doctor'
3. Click on 'Advanced Search' and select 'Signature' network
4. Enter as much information as possible to narrow your search
5. A list of in-network providers as well as contact information will appear

Premera providers, dentists and pharmacies
Network: Heritage Plus

1. Go to premera.com[7]
2. Under **Find Care**, click 'Find a Doctor'
3. If you already have a username and password, click 'Sign in to search your providers' and the click 'Search your network' under **Explore our Find Care directory**
4. If you do not have a username and password, click 'Browse all doctors and specialists' and after clicking 'Continue' under **Just browsing?** enter your zip code or city, state
5. At the top right, if **Network** doesn't say 'Providers in your network' then select 'Heritage & Heritage Plus 1' for Network and verify the location details
6. You can **Browse by Category**, or search for specific provider names or specialties
7. Once you press 'Enter' or find the category you'd like, a list of in-network providers along with contact information will appear

Kaiser Permanente providers and pharmacies
Network: Core

1. Go to kp.org/wa[7]
2. From the home page click 'Find a doctor or location'
3. Under **Hello, member** either select 'sign in and search' or click 'Quick search'
4. If you continue as a visitor, make sure that for **network** you select 'Core'
5. Enter your city, state or zip
6. Browse by category or search for names and specialties
7. A list of providers as well as contact information will appear

[7] Provider information and carrier websites are subject to change.

ENGAGE

IN THIS SECTION

- Know Where to Go
- Preventive Care
- Prescription Savings

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:

- Finding the right care at the right cost
- Finding high quality providers
- Understanding preventive care benefits
- Saving money on prescription drugs

Health Enhancing Programs

To supplement the medical coverage, we provide programs and services to help you access care when and how you need it and address special health concerns.

KNOW WHERE TO GO

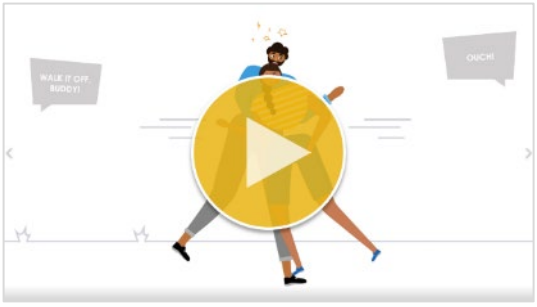
Where you get medical care can significantly influence the cost. Here's some information to help you know where to go, based on your condition, budget, and time.

Immediate medical care

There are some situations that require immediate medical care, but that doesn't always mean the emergency room. Urgent care centers cost much less than the ER and are often open on weekends and later into the evening. Consider the urgent care for immediate needs and keep the life-threatening issues to the emergency room—if you're not sure, consider the 24/7 Nurse Line to help you decide.

TYPE	CONSIDER FOR
NURSELINE (24/7—$0) Quick answers from a trained nurse	• Identifying if immediate care is needed • Home treatment options and advice
URGENT CARE ($$$) Non-life-threatening conditions requiring prompt attention	• Stitches and sprains • Animal bites • Flu, earaches and sore throat • Fever up to 104 degrees • Respiratory infections
EMERGENCY ROOM (24/7—$$$$) Serious or life-threatening conditions needing immediate treatment	• Chest or severe abdominal pain • Suspected heart attack or stroke • Loss of consciousness • Major bone breaks • Excessive bleeding • Large broken bones • Difficulty breathing • Fever above 104 degrees

Click to play video



Emergency room or urgent care?

The emergency room shouldn't be your first choice, unless there's a true emergency. Sometimes it's difficult to know. Watch this video to see an example of a situation that resulted in different results.

Routine and non-emergency care

There are also options for ongoing, more personalized other routine care for you to consider. These options may save you time or money and help in the long run with regular check-ups.

TYPE	CONSIDER FOR
VIRTUAL CARE (24/7—$) Many nonemergency health issues that can be handled by phone or video	• Cold, flu, and allergies • Headaches and migraines • Rashes • Minor injuries • Short term medication needs
RETAIL CLINIC ($) Often found in grocery store or pharmacies to help with routine care	• Sinus infection • Minor allergic reaction • Fever • Rash • Flu shot
PRIMARY CARE PHYSICIAN/ OFFICE VISIT ($$) Ongoing, more personalized care based on an understanding of medical history	• Preventive care • Illnesses • Injuries • Managing chronic and acute conditions • Prescription management

VIRTUAL CARE

Skip the waiting rooms and scheduling hassles with Virtual Care. Virtual care allow you to see a doctor right away from your mobile device or computer. Within minutes you'll be connected via video with a board-certified physician who can diagnose, treat and even prescribe if necessary. Think of it like having your own personal doctor on call.

What can Virtual Care physicians treat?

Virtual care physicians can treat hundreds of conditions including 18 of the top 20 issues seen in urgent care and the emergency room. Physicians are board-certified US based doctors ready to treat your medical issues. Top medical issues include but are not limited to:

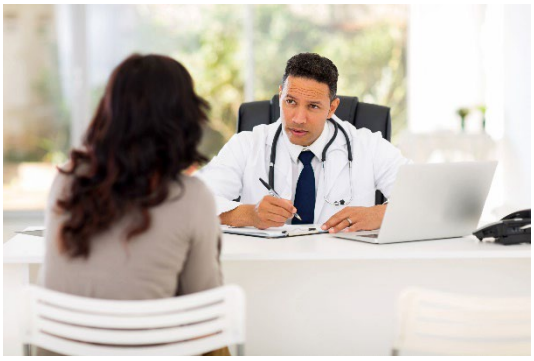
- Cough
- Cold
- Flu
- Rash
- Pink eye
- Bronchitis
- Sore throat
- Allergies

How much does it cost?

If you are enrolled on the Kaiser Permanente plan, it costs you $0 per visit. If you're enrolled on the LEOFF Trust Premera plan, it costs you $0 per visit when utilizing 98point6.

If you're enrolled on the **Kaiser Permanente plan**, visit kp.org to register. If you're enrolled on the **LEOFF Trust Premera plan**, visit 98point6.com/premera or **download the 98point6 app** to setup your account and get started.

PREVENTIVE CARE



TYPICAL SCREENINGS FOR ADULTS

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

Annual preventive checkups

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.

Preventive vs. other care

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.

Prevention is a habit

- Make healthy lifestyle choices —food, exercise, sleep, safety.
- Schedule an annual physical with your primary care doctor and follow your doctor's recommendations.
- Set health and wellness goals and work towards them daily.
- If you're enrolled on a medical plan through the City earn incentive dollars!
- Know your numbers! Keep a record of your health screening dates and results, like blood pressure and cholesterol, so you can talk to your doctor about any changes.

PRESCRIPTION SAVINGS

Understanding the formulary can save 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 be as effective as brand-name drug equivalents.

Click to play video

FORMULARY DRUG TIERS DETERMINE YOUR COST[8]

$	Generic Drug
$$	Preferred Brand Name Drug
$$$	Non-Preferred Brand Name Drug
$$$$	Specialty Drug

[8] Not all medical plans have the same drug tiers. Please refer to the plan documents for additional details.

LIFE & DISABILITY

OUR PLANS

- Basic Life and AD&D
- Voluntary Life
- Life with Long Term Care
- Long Term Disability

Is your family protected?

Life, AD&D and disability insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

If you need more

In addition to company-provided coverage, we offer voluntary life coverage that you can purchase for yourself, your spouse, and your children.

Your beneficiary is who gets paid

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

LIFE AND AD&D INSURANCE

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Employer paid Basic Life and AD&D

Life insurance can fill a number of financial gaps for a family recovering from the death of a loved one. Without enough life insurance, many families have to reduce their standard of living after the loss of an income. Consider your current and future financial needs when evaluating how much coverage you need.

The most common short and long-term financial needs include:

- Medical bills and funeral expenses
- Living expenses for the surviving family (housing, food, clothing, utilities, etc.)
- Large expenses, e.g., college education, or home mortgage
- Taxes and debts that need to be settled.

Basic life insurance pays your beneficiary a lump sum if you die. Additionally, AD&D (accidental death & dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. This coverage is provided by New York Life and the **cost of coverage is paid in full by City of Kirkland.**

NYL LIFE AND AD&D PLAN	
Employee[9]	2 times covered annual earnings up to $350,000. Guaranteed issue of $250,000.

[9] The benefit amounts will be reduced if you are age 65 or older. Refer to the plan document for details.

VOLUNTARY LIFE INSURANCE

Voluntary Life for you and your family

Voluntary Life Insurance allows you to purchase[10] additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

You pay the full cost of this coverage (refer to cost of coverage section for premium information).

NYL VOLUNTARY LIFE PLAN	
Employee	Increments of $10,000 up to $500,000. Guaranteed issue is $100,000.
Spouse	Increments of $5,000 up to lesser of 100% of employee amount or $250,000. Guaranteed issue is $10,000.
Child(ren)	Birth to 6 months: $500 or 6 months and older: up to $5,000. Guaranteed issue is $5,000.

WHAT'S GUARANTEED ISSUE?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status in order to qualify for the requested amount of coverage

[10] If you select coverage above the guaranteed issue amount or after your initial eligibility period, you will need to have coverage approved by submitting an Evidence of Insurability.

LIFE + LONG TERM CARE

WA CARES FUND

Electing Life + LTC coverage through Chubb during open enrollment will not exempt you from the WA Cares Fund payroll tax. This plan will provide additional coverage to the WA Cares Fund program, not replacement coverage. For more information on eligibility and benefits through the WA Cares Fund program, go to wacaresfund.wa.gov.

Life + Long Term Care (LTC) Insurance is designed to pay for long-term care services received at home, in an assisted living facility or nursing home if you are unable to perform defined "activities of daily living" or suffer from severe cognitive impairment. When you apply for Life + LTC insurance, there are no health questions, guaranteeing approval for coverage if you enroll when you are first eligible. Spousal coverage is also available, and dependent on employee coverage.

If you leave employment, your plan is portable, and you can maintain direct billing with Chubb. Coverage can be elected once per year at open enrollment.

CHUBB LIFE AND LONG-TERM CARE PLAN	
LTC Benefit	4% of death benefit for 25 months
Death Benefit	up to $250,000 Life Insurance benefit, minus any LTC benefits paid out
Premium	Stable premium over lifetime of policy based on age at time of application
Elimination Period	90 days
Care Coverage	Any state
Benefit Trigger	Loss of two of six activities of daily living (ADLs) or Cognitive Impairment. ADLs • Bathing • Dressing • Transfer Assistance • Toileting • Eating • Continence

LONG-TERM DISABILITY INSURANCE

Long-term disability (LTD) insurance replaces part of your monthly income for longer term issues that prevent you from working, such as:

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

Payments may be reduced by state, federal, or private disability benefits you receive while disabled. City of Kirkland pays the cost of this coverage.

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.

NYL LTD PLAN	
Monthly Benefit Amount	60% of covered monthly earnings up to a maximum of $10,000
Benefits Begin	After 90 days of disability
Maximum payment period	Social Security normal retirement age

FINANCIAL WELLNESS

OUR PLANS

- Dependent Care Flexible Spending Account (DC FSA)
- Medicare Options
- Retirement Plans

Is it time for a "financial wellness" checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? What about retirement?

Ignoring your financial health can take a toll on your quality of life today and in the future. And worrying about money can make you stressed, even to the point of physical illness.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

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 childcare. This program is administered by Navia Benefit Solutions.

Here's how the Navia plan works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children younger than 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.

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?

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.

MEDICARE OPTIONS

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65. Most people become eligible for Medicare at age 65 and when that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

Alliant
MEDICARE SOLUTIONS

ANYONE CAN CALL

Alliant Medicare Solutions is a no-cost service available to you, your family members, and friends nearing age 65.

alliantmedicaresolutions.com

How does it work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More

Your Guide to Medicare

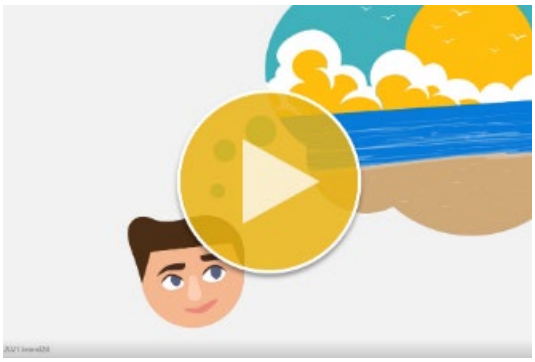
Medicare 101 Video

Social Security Planning Video

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

RETIREMENT PLANS

Click to play video



LTD PLAN AND SURVIVOR INCOME PLAN

Regardless of whether you participate in the MEBT Savings Plan, MEBT provides a Long-Term Disability Plan and Survivor Income Plan.

These two plans protect you and your dependents by providing monthly income should you become disabled (for more than 90 days) or pass away while employed by the City.

Municipal Employees' Benefit Trust (MEBT)

For City of Kirkland employees, MEBT is a 401(k) plan which replaces Social Security benefits. It provides employees a voluntary way to save an amount equal to the current Social Security tax rate which is currently 6.2%. For seasonal and on call employees this does not apply, and you will be accruing social security benefits.

- Effective your date of hire
- Enroll whenever you're ready and increase, decrease, or stop contributions at anytime.

  NOTE there is a suspension if you stop contributions, and you must wait 6 months to re-enroll.
- Option to elect pre-tax and/or after-tax and Roth deductions
- A quarterly fee of approximately $25 will be deducted from your MEBT account
- **City of Kirkland adds a matching contribution of up to 6.2% of your annual income** and you can elect additional contributions over 6.2% that will not be matched
- After 3 years of participation in the Plan, you are fully vested in the employer matching contribution.
- Contributions by the employee are capped at the IRS annual limit – Employees who are 50 or older may contribute an extra $7,500 in "catch-up" contributions.

Learn more at mebt.org, or by reviewing the Summary Plan Description on Kirknet.

MissionSquare Retirement (formerly ICMA Retirement Trust)

Replacement for Social Security Program

The 457 deferred compensation plan allows employees to contribute to a pre-tax retirement plan.

- Participants select their own investments, with a range from low to high risk
- Participants may contribute a fixed dollar amount or percentage of pay
- No City matching contribution
- Enroll whenever you're ready and increase, decrease, or stop contributions at anytime
- Receive a quarterly and year-end statement
- Contributions by the employee are capped at the IRS annual limit – Employees who are 50 or older may contribute an extra $7,500 in "catch-up" contributions
- Deductions are pre-tax

Learn more at missionsq.org or more information regarding the retirement plans available to you, please contact Human Resources

LEOFF Plan 2

The LEOFF 2 Plan is available to Law Enforcement Officers and Fire Fighters and is administered through the Department of Retirement Systems (DRS). This plan is a defined benefit plan, meaning, retirement benefits are based on service credit and final average compensation.

The state of Washington sets the employee and employer rates to ensure the pool is funded and all deductions are pre-tax. The plan also includes a $150,000 death benefit as a result of a work-related injury or illness resulting in death.

If you terminate, you can receive your contributions plus interest and earnings in a lump sum, rollover, or you may leave your money in the account. All statements are available on the DRS website, drs.wa.gov.

Medical Expense Reimbursement Plan (MERP)

The Medical Expense Reimbursement Plan (MERP) is a welfare benefit plan providing medical expense reimbursement benefits during retirement for IAFF members only. The City of Kirkland contributes $75 per month. Upon retirement, an employee is eligible for monthly reimbursement of covered medical expenses, however, there is a monthly reimbursement cap.

WELLBEING & BALANCE

IN THIS SECTION

- Voluntary Programs
- Employee Assistance Program
- Mental Health Resources
- Perks
- Time Away From Work

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Find peace of mind for you and your family.
- Manage stress, substance use disorder, mental health and family issues.
- Maximize your physical well-being.
- Take time to spend with family and friends, take care of personal business, or just for yourself.

Taking care of yourself helps you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

"The key to keeping your balance is knowing when you've lost it."

VOLUNTARY PROGRAMS

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs. You pay the entire cost for these plans, but rates may be more affordable than individual coverage.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. You can also choose not to sign up for voluntary benefits at all—it's up to you.

Identity Theft Protection

PROTECT YOUR IDENTITY

Enrollment Site

myaip.com/cityofkirkland

Member Services

(800) 789-2720

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from **Allstate Identity Protection** helps protect your personal information through proactive monitoring, identity restoration, and resolution.

With Allstate Identity Protection you receive access to services like:

- Lost wallet protection ($500 reimbursement)
- Data breach notifications
- Credit monitoring and reports
- Credit score tracking
- Medical fraud protection
- Wi-Fi scan
- Pre-existing ID theft remediation
- Address change verification

You can enroll in this program at any time. The monthly premium is **$11.95 for individual coverage or $20.95 for family coverage.** Payments will be set up on a direct bill basis to employees.

Legal Services Plan

GET LEGAL SUPPORT

Enrollment Site

shieldbenefits.com/cityofkirkland/legal

Member Services

(800) 654-7757
memberservices@legalshieldcorp.com

Do you have an attorney on retainer? Most people don't, so our legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, legal coverage from **LegalShield** offers reputable attorney assistance for you and your family.

You can enroll in this program at any time. The monthly premium is $21.95, and payments will be set up on a direct bill basis to employees.

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. Plans offer coverage for costs associated with both accidents and illnesses—even medications. **Figo Pet Insurance** offers an employer benefit **discount of 5%, plus a multi-pet discount of 5%.** The cost of coverage is based on age, breed, and location of your pet.

Employees can choose to add Veterinary Exam Fees for Accident and Illness Visit, Wellness & Dental, and Extra Care Pack to their coverage for an additional cost.

Coverage also includes access to the Figo Pet Cloud with 24/7 Pet Telehealth, A.I. Claims, Document Storage, and chat/plan play dates with other pet owners near by!

GET A QUOTE & SIGN UP AT ANYTIME

Enrollment Site

bit.ly/3CMia1S

Member Services

(844) 738-3446

CATEGORY	OPTIONS
Benefit Limits	$5,000, $10,000 or Unlimited
Deductibles	$100, $250, $500 or $750
Reimbursements	70%, 80%, 90%, 100%
Preventive Care	Optional coverage

SAMPLE PET INSURANCE RATES

3-Year-Old Small Mixed-Breed Dog

$27.98/month $5,000 Benefit, $250 Deductible, 80% plan	**$32.64/month** $10,000 Benefit, $250 Deductible, 80% plan	**$37.06/month** Unlimited Benefit, $250 Deductible, 80% plan

3-Year-Old Domestic Shorthair Cat

$17.21/month $5,000 Benefit, $250 Deductible, 80% plan	**$20.09/month** $10,000 Benefit, $250 Deductible, 80% plan	**$22.80/month** Unlimited Benefit, $250 Deductible, 80% plan

Coverage cost is based on age, breed, and location of the pet.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT WELLSPRING EAP

wellspringeap.org
(username: COKEAP)

Member Services
(800) 553-7798

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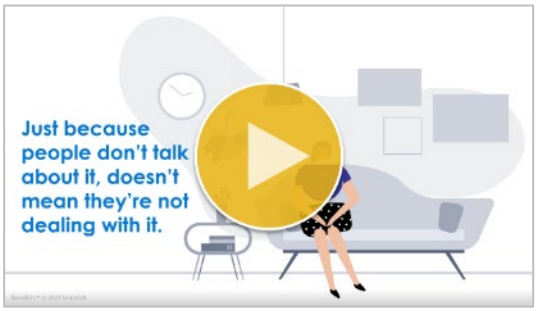


CONTACT THE LAP

guidanceresources.com
(Web ID: NYLGBS)

Member Services
(800) 344-9752

Wellspring EAP

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through **Wellspring** can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's **completely confidential, free and available to you and your eligible dependents.**

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 6 sessions per person, per incident
- Unlimited web access to helpful articles, resources, and self-assessment tools

Legal Services

Includes a free initial 30-minute phone consultation, a discount for ongoing services, and unlimited access to legal documents online.

Financial Services

Includes a free initial 30-minute phone consultation, and access to financial calculators and resource documents.

Family Planning Resources

Unlimited phone or live chat consultations for childcare, parenting resources, older adult resources, and eldercare.

ID Theft Victim Services

Including[11] a free initial 60-minute phone consultation, ID theft response kit, and prevention information.

Life Assistance Program

Whether your needs are big or small, there is also our Employee Assistance & Wellness Support program provided by **New York Life**. Sometimes referred to as a Life Assistance Program (LAP), it can help you and your family find solutions and restore your peace of mind. The LAP provides:

- A maximum of three sessions, per issue, per year in addition to those included in the EAP.
- Access to articles, podcasts, videos, slideshows, on-demand trainings and "Ask the Expert" which provides personal responses to your questions.
- Five one-on-one, telephonic, sessions with a certified coach to address health and well-being issues.
- Access to a family care service specialists to help create customized research, educational materials and prescreened referrals for childcare, adoption, elder care, and more.

[11] Employer or benefit provider breaches are not covered.

MENTAL HEALTH RESOURCES

Too often, stigma around mental health prevents people from getting the support they need. But challenges with mental health are very common—every year, 1 in 5 U.S. adults experiences a mental health issue. Regardless of age, ethnicity, background, or income, people from all walks of life can struggle with their mental health.

If you or any of your dependents are experiencing feelings of isolation, depression, or despair, please make use of the mental health services available to you through our medical plans. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

	IN-NETWORK MENTAL HEALTH SERVICES	
	OUTPATIENT	**INPATIENT**
Premera HDHP	$35 copay then plan pays 100%	You pay 20% coinsurance after deductible
Kaiser HMO Plan	$10 copay then plan pays 100%	$100 copay per day (up to 4 days per admission)

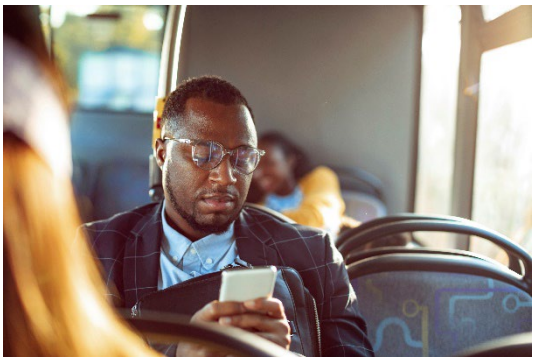
Mental Health Services through Ginger and Online Kaiser Support

Kaiser members have access to Ginger, a one-on-one texting program with an emotional support coach anytime, anywhere. 24/7 text-based emotional support coaching to discuss goals, share challenges, and create an action plan including self-care resource recommendations for your needs.

In addition, Kaiser provides online services which includes access to online visit options including live chat, e-visits, and scheduled and unscheduled video visits.

Go to kp.org/wa/mental-health to see all mental health resources available to you and access these benefits and more, including online resources.

PERKS



Onsite Facility Fitness Center

The City of Kirkland has a free on-site fitness room and locker rooms located in the lower level of City Hall. If you are interested in using the on-site fitness room, you must sign a waiver.

Contact Human Resources for additional information.

Commuter and transportation programs

ORCA Cards

Make your commute easier with the ORCA Business Passport Card Program. ORCA cards can be used on Community Transit, Everett Transit, Kitsap Transit, Metro Transit, Pierce Transit, and Sound Transit. You can even use your ORCA card on the Monorail or to travel to and from the airport via the Link light rail.

The ORCA Business Passport Card Program is a non-taxed benefit provided to you at no additional cost. For more information or to join the program, please contact Human Resources.

Free onsite employee parking

City of Kirkland provides free onsite parking for employees.

Onsite bicycle storage

In an effort to support additional commuting opportunities, City of Kirkland also provides onsite bicycle storage.

Paid Management Leave

For select leadership positions, leaders can take advantage of the Paid Management Leave program. Please contact Human Resources for more details.

TIME AWAY FROM WORK

Vacation

There is no perfect, one-size-fits-all balance between work and home. We provide time off[12] so you can take some "me time" to relax, recover from illness, or take care of personal and family business.

24-Hour Shift

YEARS OF EMPLOYMENT	MONTHLY ACCRUAL HOURS	ANNUAL VACATION HOURS
1-2 years	12 hours	144 hours
3-5 years	14 hours	168 hours
6-9 years	17 hours	204 hours
10-13 years	21 hours	252 hours
14-17 years	22.5 hours	270 hours
18-21 years	24.5 hours	294 hours
22-24 years	25.5 hours	306 hours
25 years and thereafter	26 hours	312 hours

40-Hour Workweek

YEARS OF EMPLOYMENT	MONTHLY ACCRUAL HOURS	ANNUAL VACATION HOURS
1-2 years	11.6 hours	139.2 hours
3-4 years	12 hours	144 hours
5-7 years	13.6 hours	163.2 hours
8-10 years	14.25 hours	171 hours
11-13 years	15 hours	180 hours
14-16 years	16.25 hours	195 hours
17-19 years	17.6 hours	211.2 hours
20-24 years	19 hours	228 hours
25 years and thereafter	19.27 hours	231.2 hours

Sick

Members covered by LEOFF 1 Retirement System may use up to five shifts (120 hours) annually. Upon appointment as Firefighter 1, members covered by LEOFF 2 Retirement System shall have 288 hours of paid sick leave.

Employee's sick leave[12] with pay shall accrue at the rate of 24 hours per month beginning with the 13th month.

[12] For union employees, please refer to your collective bargaining agreement for further details.

Observed Holidays

24-Hour Shift

All Employees on 24-hour shift shall receive 130 hours in lieu of Holidays. Holiday time will be credited to the employee on January 1 of each calendar year. Employees hired after January 1 shall accrue Holiday time on a prorated monthly basis.

Unless specifically waived in writing by the Fire Chief, no Employee may carry over more than 24 hours from December 31 to January 1 of the following year. Those holiday hours exceeding 24 hours shall automatically be converted at the employee's regular rate of pay during the next payroll period.

40-Hour Workweek

City of Kirkland provides, to benefitted full-time employees, 13 holidays[13] per year without a reduction in pay.

HOLIDAY	2024 OBSERVED
New Year's Day	Monday, January 1
Martin Luther King, Jr. Birthday	Monday, January 15
President's Day	Monday, February 19
Memorial Day	Monday, May 27
Juneteenth	Wednesday, June 19
Independence Day	Thursday, July 4
Labor Day	Monday, September 2
Veteran's Day	Monday, November 11
Thanksgiving Day	Thursday, November 28
Day after Thanksgiving	Friday, November 29
Christmas Eve (Half Day)	Tuesday, December 24
Christmas Day	Wednesday, December 25
New Year's Eve (Half Day)	Tuesday, December 31

Floating Holiday

In addition, employees employed in a regular or temporary position for at least six (6) consecutive months, are granted one additional Floating Holiday to be used on a date of the employee's choice.

Community Service Day

Employees are also granted one Community Service Day for the purpose of participation and volunteering for legitimate non-profit organizations, community service organizations or public agencies. Authorization and scheduling shall be in accordance with the same procedures as a Floating Holiday.

[13] This is a list of City observed holidays. Please check your CBA to verify the list of approved holidays.

PLAN INFORMATION

IN THIS SECTION

- Cost of Coverage
- Contact Information
- Important Health Plan Notices

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

- Your medical, dental and vision benefit contributions
- Contact information for our benefit carriers and vendors
- Important health plan notices you are entitled to receive annually

COST OF COVERAGE

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Benefit costs are pro-rated for FTEs less than 1.0.

In general, your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

Medical

	PREMERA HDHP		KAISER HMO	
	CITY COST	YOUR COST	CITY COST	YOUR COST
Employee Only	$708.52	$0	$737.27	$0
Employee + Spouse/DP	$1,509.96	$0	$1,474.54	$0
Employee + Spouse/DP + Child	$1,951.36	$0	$1,847.93	$0
Employee + Spouse/DP + Children	$2,183.62	$0	$2,221.32	$0
Employee + Child	$1,149.92	$0	$1,110.66	$0
Employee + Children	$1,382.20	$0	$1,484.04	$0

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. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify City of Kirkland if your domestic partner is your tax dependent.

Dental

	PREMERA DENTAL		WILLAMETTE DENTAL GROUP	
	CITY COST	YOUR COST	CITY COST	YOUR COST
Employee Only	$58.66	$0	$69.15	$0
Employee + Spouse/DP	$126.12	$0	$129.15	$0
Employee + Spouse/DP + Child	$170.12	$0	n/a	n/a
Employee + Spouse/DP + Children	$187.72	$0	$206.40	$0
Employee + Child	$102.66	$0	n/a	n/a
Employee + Children	$120.26	$0	n/a	n/a

Vision

	VSP VISION PLAN	
	CITY COST	YOUR COST
Employee Only	$9.72	$0
Employee + Spouse/DP	$15.53	$0
Employee + Children	$15.87	$0
Employee + Family	$25.57	$0

Voluntary Life Insurance (employee paid)

If you elect voluntary life coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck.

	NEW YORK LIFE VOLUNTARY LIFE		
		PER $1,000 COVERAGE	
EMPLOYEE & SPOUSE/DP	**CITY COST**	**YOUR COST** (NON-SMOKER)	**YOUR COST** (SMOKER)
Age 19 & younger	$0	$0.059	$0.098
20-24	$0	$0.059	$0.098
25-29	$0	$0.060	$0.098
30-34	$0	$0.080	$0.110
35-39	$0	$0.090	$0.165
40-44	$0	$0.129	$0.278
45-49	$0	$0.219	$0.474
50-54	$0	$0.366	$0.772
55-59	$0	$0.650	$1.211
60-64	$0	$0.826	$1.363
65-69	$0	$1.271	$1.881
70-74	$0	$2.477	$3.393
75-79	$0	$3.930	$5.400
Age 80 & older	$0	Benefits terminate upon retirement	
CHILD(REN)			
Per $1,000 benefit	$0	$0.250	

CONTACT INFORMATION

CARRIER	PHONE	WEBSITE	POLICY #
Helpful Resources			
Alliant Benefit Advocates	(800) 489-1390	BenefitSupport@alliant.com	City of Kirkland
Employee Self-Serve (Enrollment)		ess.kirklandwa.gov/ess/login.aspx	
Medical			
Premera (HDHP)	(800) 722-1471	premera.com	4000190
Kaiser Permanente (HMO)	(888) 901-4636	kp.org/wa	1274000
Dental			
Premera (PPO)	(800) 722-1471	premera.com	4000190
Willamette Dental (Managed Care)	(855) 433-6825	willamttedental.com	WA39
Vision			
VSP	(800) 877-7195	vsp.com	30023349
Health Reimbursement Arrangement (HRA)			
BPAS, Inc. (VEBA)	(855) 404-8322	bpas.com	City of Kirkland
Flexible Spending Accounts (FSA)			
Navia	(800) 669-3539	naviabenefits.com	CKI
Life, AD&D & Disability			
New York Life	(800) 644-5567	mynylgbs.com	FLX 966323 (Life/Vol Life) OK 967861 (AD&D) LK 964339 (LTD)
Chubb/LTC Solutions (Life + LTC)	(877) 286-2852	myltcguide.com/kirkland	ZBG
Employee Assistance Program (EAP)			
Wellspring EAP	(800) 553-7798	wellspringeap.org	COKEAP
GuidanceResources (LAP)	(800) 538-3543	guidanceresources.com	NYLGBS
Voluntary Programs			
Figo Pet Insurance	(844) 738-3446	bit.ly/3CMia1S	City of Kirkland
LegalShield	(800) 654-7757	shieldbenefits.com/cityofkirkland/legal	City of Kirkland
Allstate Identity Protection	(800) 789-2720	myaip.com/cityofkirkland	City of Kirkland
Retirement Plans			
Municipal Employees Benefit Trust (MEBT)		mebt.org	City of Kirkland
Department of Retirement Systems (DRS)	(800) 547-6657	drs.wa.gov	City of Kirkland

IMPORTANT PLAN NOTICES

What You Need To Know About 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.

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.

Medicare Part D Notice

Important Notice from the City of Kirkland About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Kirkland 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. The City of Kirkland has determined that the prescription drug coverage offered by the City of Kirkland Health & 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.

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 Kirkland coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Important Note for Retiree Plans: Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under the City of Kirkland Health & Welfare 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 Kirkland 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 the City of Kirkland and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Kirkland 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:	October 30, 2023
Name of Entity/Sender:	City of Kirkland
Contact-Position/Office:	Human Resources
Address:	123 5th Ave, Kirkland, WA 98033
Phone Number:	(425) 587-3210

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. If you would like more information on WHCRA benefits, call your plan administrator (425) 587-3210.

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) 587-3210.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for the City of Kirkland describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting (425) 587-3210.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the City of Kirkland 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 the City of Kirkland'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 30 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 30 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 30-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 the City of Kirkland'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.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: 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 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/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 | Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms | Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms | 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 Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov 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 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/ | Medicaid Phone: 609-631-2392 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 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 | 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 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/ | 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, 2022, 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

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 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.

OMB Control Number 1210-0137 (expires 1/31/2023)

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available in this guide. 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. SBC documents are available on Kirknet.

- LEOFF Trust – Premera Blue Cross HDHP
- Kaiser Permanente HMO Plan

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the City of Kirkland medical plans. 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

Employee Eligibility: Monthly Measurement Method

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

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. City of Kirkland uses the monthly measurement method to determine whether an employee meets this eligibility threshold.

Termination Of Coverage For Ineligible Dependents

Knowingly enrolling an ineligible dependent or intentionally keeping a dependent on the plan when they have lost eligibility constitutes insurance fraud and is a material misrepresentation of fact. When the plan discovers any such ineligible dependent it will terminate coverage retroactively and reprocess any claims, making them payable by such an individual. The employer plan sponsor will also explore disciplinary action against any employee who engages in this misconduct including but not limited to termination of employment.

Image courtesy of Chris Neir

IAFF

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