2026 BENEFITS

CITY OF KIRKLAND
WASHINGTON

PD Commissioned

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

2026 BENEFITS

January 1, 2026 through
December 31, 2026

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 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

- HMA 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 HMA 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

- HMA 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.

HMA HDHP

HMA Preferred 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	$2,500 per individual $5,000 family limit	
Preventive Services	Plan pays 100% *(see contract for limitations)*	Plan pays 60% after deductible
Office Visit		
Primary visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Virtual visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Chiropractic	Plan pays 80% after deductible *(up to 20 visits per calendar year)*	Plan pays 60% after deductible
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 80% after deductible	
Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible
PRESCRIPTION DRUGS		
Generic	$4 copay then plan pays 100%	Not covered
Brand Name	$15 copay then plan pays 100%	
Non-preferred Brand	$35 copay then plan pays 100%	
Supply Limit	34 days	
Mail Order		
Generic	$8 copay then plan pays 100%	Not covered
Brand Name	$30 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.

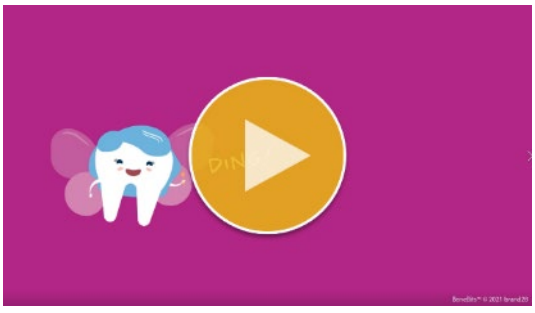
	IN-NETWORK ONLY
Annual Deductible	$0 per individual $0 family limit
Annual Out-of-Pocket Maximum	$2,000 per individual $4,000 family limit
Preventive Services	Plan pays 100% *(see contract for limitations)*
Office Visit	
Primary visit	$10 copay then plan pays 100%
Specialist visit	$10 copay then plan 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

- Delta Dental PPO 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.

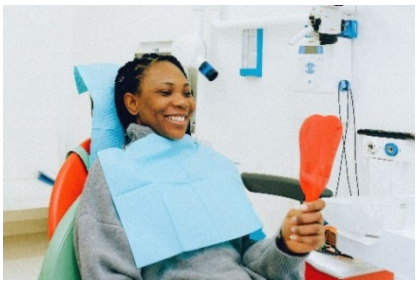
DELTA DENTAL PPO PLAN

PPO 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	$0 per individual $0 family limit	
Annual Plan Maximum	$1,500 per individual	
Diagnostic and Preventive Services	Plan pays 100%	
Basic Services Fillings Root canals Periodontics	Plan pays 70% to 100% (based in annual visits[1])	
Major Services	Plan pays 50%	
ORTHODONTIC SERVICES		
Orthodontia	Plan pays 50%	
Lifetime Maximum	$1,500 per person	
Adults	Covered	
Children	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[2]
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.

[1] Every year preventive care is received, the benefit for basic services increases by 10% paid by the plan. Maximum upper limit (highest coinsurance amount) is plan pays 100%, or four years of visits. If preventive care is **not** received, the benefit amount will decrease 10% paid by the plan the following year, never to go below that standard benefit amount of plan pays 70%.

[2] When utilizing a Delta Dental 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.

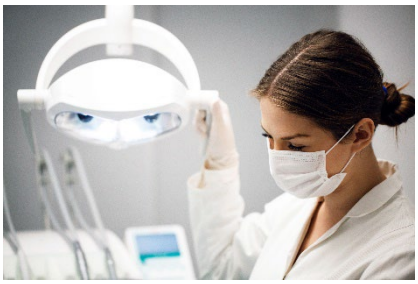
WILLAMETTE DENTAL DMO PLAN

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%[1]
Basic Services Fillings Root canals Periodontics	$10 copay then plan pays 100%[1]
Major Services	$10 copay then plan pays 100%[1]
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.

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

VISION

OUR PLAN

- 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.

VSP VISION PLAN

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 the HMA HDHP.

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 on the HMA HDHP with an HRA (Health Reimbursement Arrangement) to help pay for medical expenses in the form of a VEBA[1]. 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 an 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

Your account will be funded in two lump sums and will be reflected on your second paycheck in January and July. For employees enrolled in the HMA HDHP, City of Kirkland sets aside a fixed amount of money into your HRA VEBA:

Employee Only: $1,200
Family[2]: $2,400

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.

[1] 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).
[2] Family refers to an employee enrolled with one or more dependent in the HMA HDHP.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

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.**

A healthcare flexible spending account, or 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 $3,400 in 2026, 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.

Expenses must be incurred between January 1, 2026 and March 15, 2026 and submitted for reimbursement no later than March 31, 2027.

Potential tax savings

Because FSA contributions are pre-tax, they reduce the total amount of your income the government makes you pay taxes on. Tax savings vary depending on filing status and other variables, but here's an example using single-filer status and marginal federal income tax rates:

FSA Tax Savings Example

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

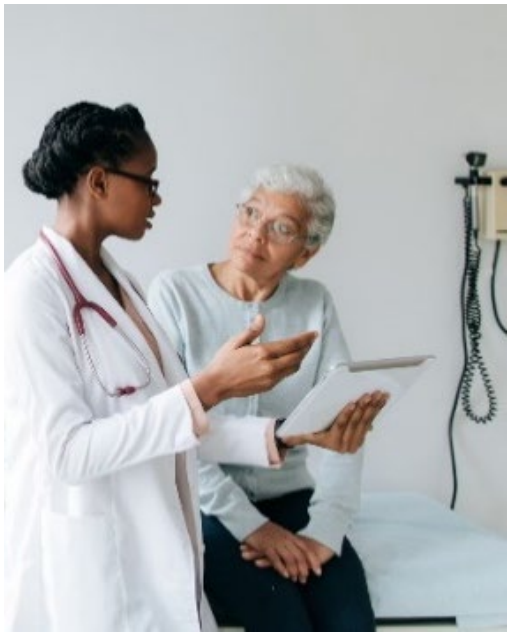
$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $3,400 FSA Contribution

$816 24% Federal income tax	**$260** 7.65% FICA tax	**$1,076** Annual FSA tax savings

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

HOW TO FIND A PROVIDER



Delta Dental providers
Network: Delta Dental PPO

1. Go to deltadentalwa.com[1]
2. If you already have a username and password, under **Sign in**, enter your credentials, then click 'Sign in'
   If you do not have an account, under **Resources** click 'Find a dentist'
3. Enter your address or city, zip and desired radius
4. For **Choose your network** select 'Delta Dental PPO' then click 'Search'
5. A list of providers as well as contact information will appear

Willamette Dental facilities

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

HMA providers
Network: HMA Preferred

1. Go to accesshma.com[1]
2. From the homepage, click 'Member'
3. **If you have an account**, click 'HMA Member Login'
   If you do not have an account, click 'Find a Provider'
4. Select the region in which you'd like to search
5. You may need to enter your location information
6. Select a category in which you'd like to search or select 'Search all', then type your search criteria
7. A list of providers and contact information will appear

HMA/CVS Caremark pharmacies

1. Go to caremark.com[1]
2. **If you have an account**, click 'Sign In'
   If you do not have an account, click 'Register'
3. Once logged in, click 'Locations' and enter your zip code or city, state then hit 'Enter'
4. A list of facilities in your area will appear

Kaiser Permanente providers and pharmacies
Network: Core

1. Go to kp.org/wa[1]
2. From the home page click 'Doctors & Locations'
3. Scroll down and click 'Search our full network of contracted doctors and facilities' under 'Find a partner network doctor'
4. Enter your city, state or zip and select 'Core' for the **network**
5. Browse by category or search for names and specialties
6. A list of providers as well as contact information will appear

Vision Service Plan
Network: VSP Signature

1. Go to vsp.com[1]
2. Click 'Find a Doctor'
3. Click on 'Advanced Search' and select 'Signature' for **Doctor 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

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

ENGAGE

IN THIS SECTION

- Know Where to Go
- Preventive Care
- Prescription Savings
- Vera Whole Health
- Healthcare Bluebook
- Quality & Engagement Rewards

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

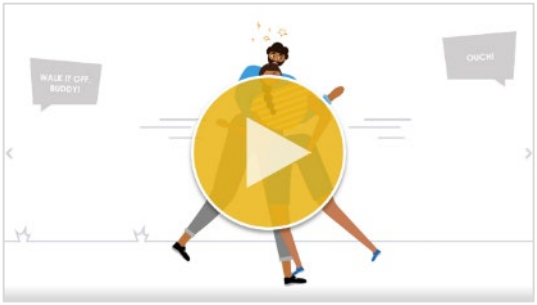
Where you get medical care can significantly influence the cost. Here's some information to help you know where to go, based on your condition, budget, and time.

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 Vera 24/7 Nurse Line to help you decide.

TYPE	CONSIDER FOR
VERA NURSE LINE (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?

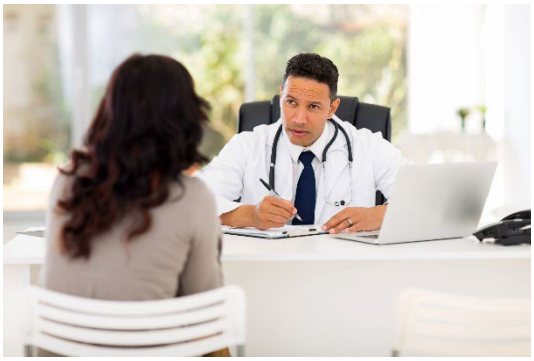
The emergency room shouldn't be your first choice, unless there's a true emergency. Sometimes it's difficult to know. Watch this video to see an example of a situation that resulted in different results.

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—$) Many nonemergency health issues that can be handled by phone or video	• Cold, flu, and allergies • Headaches and migraines • Rashes • Minor injuries • Short term medication needs
VERA CLINIC ($) Preventive, primary, and acute care at the Employee Health Center	• Annual physical and biometrics screenings • Cold, flu, and allergies • Headaches and migraines • Chronic disease management • Lab work • Flu shot
RETAIL CLINIC ($) Often found in grocery stores 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

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/chronic-disease/prevention/preventive-care.html** 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

Click to play video

FORMULARY DRUG TIERS DETERMINE YOUR COST[1]

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

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.

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

VERA WHOLE HEALTH

EMPLOYEE HEALTH CENTER

Totem Lake Location

13123 121st Way NE, Suite D
Kirkland, WA 98034

Phone

(206) 470-1925

Hours

8:00am – 6:00pm PT

Website

my.verawholehealth.com

My Vera

My Vera is the only way to access all your patient information and care services, in one place. My Vera puts you in touch with us fast to get the care you need. Schedule same- or next-day appointments, visit with a provider virtually, view your patient chart, or message your care team.

City of Kirkland's Employee Health Center

The City of Kirkland has partnered with Vera Whole Health to establish an Employee Health Center. The Employee Health Center is available to employees and their eligible dependents who are enrolled in one of the City of Kirkland medical plans.

The health professionals at the clinic provide top of the line care that includes both coaching and education. Appointments are available for a variety of preventive and basic services, as well as wellness and nutritional counseling. Consider the clinic for needs such as:

Preventive care

- Annual Whole Health Evaluation (includes biometric screening, provider visit, health survey and coaching)
- Physical Exams
- Blood pressure screening
- Immunizations and routine injections

Primary care

- Episodic sick care
- Chronic disease and prescription management
- Coordination of specialty and acute care
- On-site labs
- Blood tests (including prostate-specific antigen (PSA)-based screening for prostate cancer)

Acute care

- Suturing/basic wound care
- Rashes
- Colds/upper respiratory infections

Behavioral Health

- Mood disorder management (anxiety, depression, etc.)
- Stress, trauma, & grief support
- Eating concerns

Have a medical question after hours?

You can reach a Vera provider after care center hours for any medical issue by calling the care center at (206) 470-1925.

The provider will determine if immediate care is needed, a prescription should be sent to a pharmacy, if it can wait until tomorrow, or if you can treat at home!

HEALTHCARE BLUEBOOK

Click to play video

DOWNLOAD THE APP

Watch the video to see how you can access Healthcare Bluebook from your phone on the go!

Access code: Mobile9876

Healthcare cost transparency

You wouldn't buy a house or new car without knowing the price, so why do that for healthcare services? Healthcare Bluebook brings transparency to healthcare costs allowing you to shop around and compare prices **before** you receive services. For the exact same service, the price difference can be anywhere from $100 to $1,000 depending on the facility you choose.

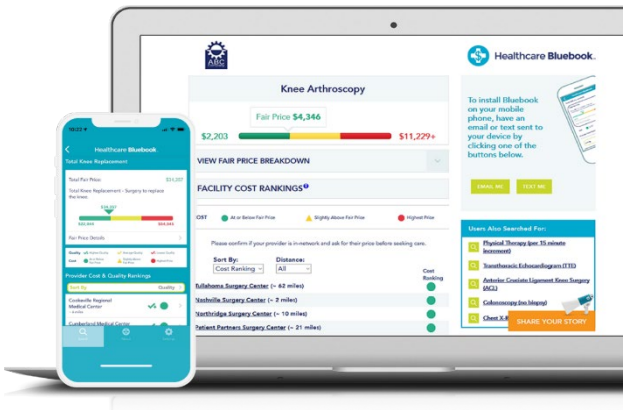
Healthcare Bluebook allows you to search the most common surgeries, labs, x-rays and tests in order to view the price range in your area and find doctors and facilities that offer a **Fair Price**. You can also see quality ratings and patient ratings for doctors and hospitals. Access the Healthcare Bluebook through the HMA employee portal.

Doctor Quality

Many people assume that a hospital that provides high-quality surgeries would have high-quality surgeons as well, but that's not always the case. Healthcare Bluebook created their Doctor Quality feature to highlight how individual doctors perform on a variety of procedures, including complex surgeries, like joint replacement and heart surgeries. The doctor quality rankings ensure that you are accessing the highest-quality care whenever possible.

How it works

1. Search for a medical procedure
2. Find providers in your area and compare those that offer great quality at a Fair Price
3. Save hundreds to thousands of dollars on out-of-pocket costs



QUALITY & ENGAGEMENT REWARDS

Rewards for Fair Price

All employees and dependents enrolled in the HMA HDHP have access to the **Quality + Engagement Rewards** program. This is an enhanced and tiered incentive rewards program that provides rewards for employees who use Healthcare Bluebook to shop for Fair Price providers for specific procedures. The program features an expanded selection of over 400 shoppable procedures and higher reward amounts ranging from $25 to $1,500.

Eligible services

Here are examples of eligible services with their rewards amounts. Please note that this list is not exhaustive. Additional information about qualifying procedures and reward amounts can be found by logging onto Healthcare Bluebook.

EARNING ENGAGEMENT REWARDS

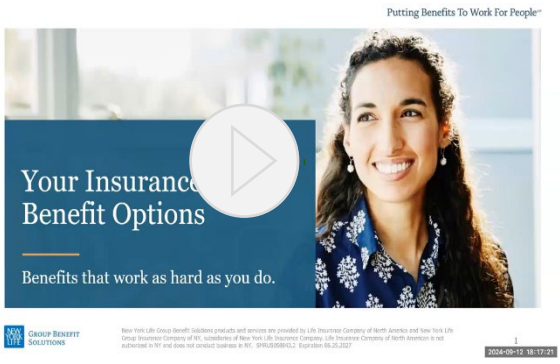
1. Log into the Healthcare Bluebook and search for a reward-eligible procedure up to 12 months prior to date of service (must be within same procedural category)
2. Reference the FairPrice™ and use a green price/green quality facility and provider to qualify for maximum rewards
3. The Healthcare Bluebook validates and issues reward via check in the mail

PROCEDURE	REWARD
Spinal Fusion	**$1,500**
Total Hip Replacement	**$1,000**
Hernia Repair	**$750**
Benign Breast Tumor Removal	**$500**
Tonsillectomy	**$350**
Knee Arthroscopy	**$350**
Colonoscopy (screening with and without biopsy)	**$150**
Upper GI Endoscopy (with and without biopsy)	**$150**
Cataract Surgery	**$150**
Sleep Study	**$125**
Most MRI's and CT's	**$100**
Abdominal Ultrasound	**$35**
Digital Screening Mammography	**$35**
Hand or Wrist X-Ray	**$25**

LIFE & DISABILITY

OUR PLANS

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



Click to play video

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[1]	2 times covered annual earnings up to $350,000. Guaranteed issue of $250,000.

Have questions about life and disability benefits?
Scan the QR code to visit the NY Life website. Use the online Life Insurance Calculator, view your benefit options, and more!

[1] 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[1] 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. This is known as Evidence of Insurability (EOI). You can complete the EOI Form online.

[1] 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 and may be cancelled at any time.

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.

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

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.

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

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 $7,500 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.

Click to play video

EVERY OPPORTUNITY TO SAVE

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

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

Alliant
MEDICARE SOLUTIONS

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

ANYONE CAN CALL

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

alliantmedicaresolutions.com

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.

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

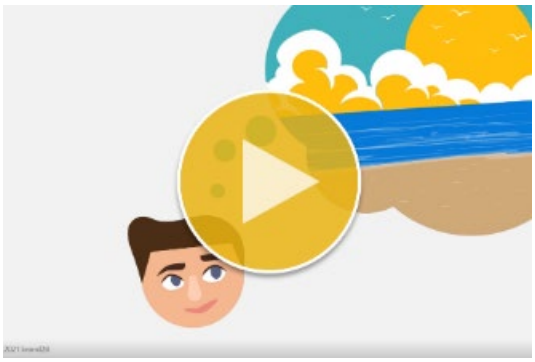
Your Guide to Medicare

Medicare 101 Video

Social Security Planning Video

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.
- 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 $8,000 in "catch-up" contributions.

Learn more at mebt.org, or by reviewing the MEBT Summary Plan Description available via Healthcare Corner – Retirement Forms and Documents.

MissionSquare Retirement (formerly ICMA Retirement Trust)

The 457 deferred compensation plan allows employees to contribute to a pre-tax retirement plan or post-tax to a Roth 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 $8,000 in "catch-up" contributions
- Deductions will be on a pre-tax or post-tax basis, depending on the plan you select

Learn more at msqplanservices.org/my-plan/300630 or for 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.

WELLBEING & BALANCE

IN THIS SECTION

- Voluntary Programs
- Employee Assistance Program
- Mental Health Resources
- Chronic condition management
- Musculoskeletal Care
- 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.

PROTECT YOUR IDENTITY

Enrollment Site

myaip.com/cityofkirkland

Member Services

(800) 789-2720

Identity Theft Protection

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 and 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.

GET LEGAL SUPPORT

Enrollment Site

shieldbenefits.com/cityofkirkland/legal

Member Services

(800) 654-7757
memberservices@legalshieldcorp.com

Legal Services Plan

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.

GET A QUOTE & SIGN UP AT ANYTIME

Enrollment Site

bit.ly/3CMia1S

Member Services

(844) 738-3446

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!

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

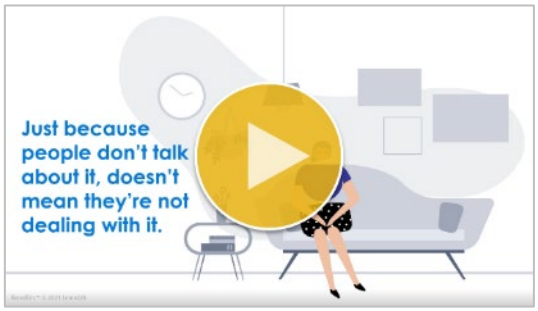
3-Year-Old Domestic Shorthair Cat

$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)

Click to play video



CONTACT SUPPORTLINC

Website

mysupportlinc.com
(group code: COKEAP)

Phone

1-888-881-5462

Mobile

SupportLinc Mobile App

LIFE ASSISTANCE PROGRAM

Employee Assistance & Wellness Support program provided by New York Life is also available including three additional sessions per issue and many online resources!

guidanceresources.com

(Web ID: NYLGBS)

(800) 344-9752

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through **SupportLinc,** formerly 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, **the consultation is completely confidential, free and available to you and your eligible dependents**. SupportLinc will also make referral to additional resources if the need falls outside the scope of what EAP can provide.

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

Work-Life Benefits

Receive expert referrals for financial and legal issues. Work-life specialists also provide convenience resources for everyday needs such as child or elder care, pet care, home improvement or auto repair.

Text and Self-Guided Therapy

Exchange text messages, voice notes and resources with a licensed counselor or strengthen your mental health and overall wellbeing at your own pace with self-guided digital resources and daily inspiration to foster meaningful and lasting behavior change.

Explore Mindstream

A fitness studio for your mind with live and on-demand sessions to help you strengthen your life skills and emotional health. Engage with sessions anytime and anywhere. Return daily to track progress and discover new releases.

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**
HMA HDHP	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
Mental Health Services through Talkspace If you're enrolled in the HMA HDHP, you have access to virtual mental health support through Talkspace. With Talkspace, you can find an available therapist in minutes and send private messages (text, voice, and video) the same day you register for support. Also, you can find an available psychiatric prescriber in minutes. With Talkspace Psychiatry, you can schedule video appointments with an in state, licensed provider who specializes in psychiatric evaluation. **Get started at talkspace.com/partnerinsurance and select 'HMA' as the plan.**		
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.**		

CHRONIC CONDITION MANAGEMENT

GETTING STARTED

Depending on your eligibility, you may see communications for one or more of these programs. Upon enrollment, you'll receive support for the programs that fit your unique needs.

Download the Teladoc Health app, call **1-800-835-2362**, or visit teladochealth.com to get started

Take a look at Teladoc Health

Teladoc Health is a set of comprehensive, personalized programs that provide monitoring and health management support members who have been diagnosed with common chronic conditions, including diabetes, prediabetes, and hypertension. The best part—no cost!

Why Teladoc?

The no-cost benefit uses data and technology to monitor your personal health status and give you support when you need it. Coaching and recommendations tailored to your specific needs will help you make better decisions and, long term impact.

Customized offerings are given to participants based on condition, with unique support for people that are pre-diabetic, diabetic, or have hypertension.

What you get

- **Diabetes Management**: a personalized way to help manage diabetes. Get tools and support to track blood sugar levels and develop healthier lifestyle habits. Program includes a connected blood glucose meter; unlimited strips and lancets; tips, action plans and one-on-one coaching; and real-time support for out-of-range readings.
- **Hypertension Management:** take control of your heart health with guidance and a personalized plan. With a smart blood pressure monitor, you can track, get support, set up reminders and message a coach, all in one place. Program includes a connected blood pressure monitor; step-by-step action plans based on your goals; tips on nutrition and activity; and one-on-one support from expert coaches.
- **Diabetes Prevention:** take your first step toward a healthier tomorrow and reduce your risk of type 2 diabetes. With the Diabetes Prevention program, you'll get access to a team of expert coaches, a library of online lessons and a smart scale— at no cost to you. Program includes expert coaches to help with diet, nutrition, activity and more; a smart scale that syncs to the app and web portal; and an all-in-one app to track weight, activity, and food.

MUSCULO-SKELETAL CARE

WHO'S ELIGIBLE?

City of Kirkland employees who are enrolled in an HMA medical plan are eligible for this service

To schedule an appointment:

Phone

(800) 404-6050

Website

airrosti.com

What's Airrosti?

Airrosti is a health care group that employs and trains providers who specialize in delivering high quality, outcome-based musculoskeletal care.

Airrosti combines hands-on care with personalized rehab to get you out of pain and back to doing what you love, often in just a few visits. No long treatment plans. No unnecessary procedures. Just proven results that last.

How will Airrosti treat my injury?

During your Airrosti appointment, your Provider will conduct a thorough evaluation to understand the source of your pain. They will test for limited range of motion, loss of muscle strength, nerve tension, and joint mobility to identify and understand the source of your discomfort.

After discussing their findings and their recommended approach, your Airrosti Provider will begin hands-on soft tissue manual therapy (also known as Myofascial Release) to stimulate the healing process and deeply release adhesions/tightness throughout the problem areas. While intense, this release helps the body to begin to return to normal, pain-free movement.

This treatment, combined with the customized active rehab regimen prescribed to each patient, allows your body to strengthen, stabilize, and move while the pain decreases between each subsequent visit.

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.

You can find more information about the ORCA card program on Kirknet under the ORCA Card Program section.

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 off12 so you can take some "me time" to relax, recover from illness, or take care of personal and family business.

Each regular full-time employee shall accrue vacation leave at the rate of one-twelfth (1/12) of annual vacation per month of service based on the following schedule:

YEARS OF EMPLOYMENT	ANNUAL VACATION (WORKING HOURS)
1st year of employment	104 hours
2-4 years	114 hours
5-7 years	138 hours
8-10 years	146 hours
11-13 years	154 hours
14-16 years	170 hours
17-19 years	186 hours
20 years and thereafter	202 hours

Vacation leave cannot be accrued during any leave without pay, but such leave shall not be considered an interruption of consecutive years of employment for the purpose of determining entitlement to additional vacation days under the foregoing schedule.

Sick

After completion of the first year of employment, employee sick leave with pay shall accrue12 at the rate of eight (8) hours of leave for each full month of employee service. Employees who work a mandated 10-hour workday shall accrue at the rate of 10 hours of leave for each full calendar month of employee service, and any such leave accrued, in any year, shall be accumulative for succeeding years to a maximum of 1,010 hours.

Patrol Officers

Sick leave pay, for Patrol Officers, shall accrue at the rate of 10 hours of leave for each full calendar month of employee service in that classification. Any such leave accrued, in any year, shall be accumulative for succeeding years to a maximum of 1,010 hours.

After completion of the one-year period, Patrol Officers sick leave pay shall accrue at the rate of 10 hours of leave for each full calendar month.

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

Observed Holidays

City of Kirkland provides, to benefitted full-time employees, 13 holidays[1] per year without a reduction in pay.

HOLIDAY	2026 OBSERVED
New Year's Day	Thursday, January 1
Martin Luther King, Jr. Birthday	Monday, January 19
President's Day	Monday, February 16
Memorial Day	Monday, May 25
Juneteenth	Friday, June 19
Independence Day	Friday, July 3
Labor Day	Monday, September 7
Veteran's Day	Wednesday, November 11
Thanksgiving Day	Thursday, November 26
Day after Thanksgiving	Friday, November 27
Christmas Eve (Half Day)	Thursday, December 24
Christmas Day	Friday, December 25
New Year's Eve (Half Day)	Thursday, 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.

[1] 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 City of Kirkland covers 100% of the cost for medical, dental, and vision coverage for you and your dependents. 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

	HMA HDHP		KAISER HMO	
	CITY COST	YOUR COST	CITY COST	YOUR COST
Employee Only	$765.48	**$0**	$828.63	**$0**
Employee + Spouse/DP	$1,639.66	**$0**	$1,657.27	**$0**
Employee + Spouse/DP + Child	$1,951.98	**$0**	$2,076.93	**$0**
Employee + Spouse/DP + Children	$2,411.27	**$0**	$2,496.59	**$0**
Employee + Child	$1,186.48	**$0**	$1,248.29	**$0**
Employee + Children	$1,607.52	**$0**	$1,667.94	**$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

	DELTA DENTAL OF WA		WILLAMETTE DENTAL GROUP	
	CITY COST	YOUR COST	CITY COST	YOUR COST
Employee Only	$60.45	**$0**	$82.75	**$0**
Employee + Spouse/DP	$117.20	**$0**	$154.60	**$0**
Employee + Family	$190.81	**$0**	$247.05	**$0**

Vision

	VSP VISION PLAN	
	CITY COST	YOUR COST
Employee Only	$10.17	**$0**
Employee + Spouse/DP	$16.24	**$0**
Employee + Children	$16.60	**$0**
Employee + Family	$26.75	**$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			
HMA (HDHP)	(800) 869-7093	accesshma.com	020489
Kaiser Permanente (HMO)	(888) 901-4636	kp.org/wa	1274000
Employee Health Center			
Vera Whole Health	(206) 470-1925	my.verawholehealth.com	City of Kirkland
After-Hours Support	(206) 470-1925	my.verawholehealth.com	City of Kirkland
Dental			
Delta Dental (PPO)	(800) 554-1907	deltadentalwa.com	00749
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	CITKIR6117
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) OK 967861 (AD&D) LK 964339 (LTD)
Chubb/LTC Solutions (Life + LTC)	(877) 286-2852	myltcguide.com/kirkland	ZBG
Employee Assistance Program (EAP)			
SupportLinc	(800) 553-7798	supportlinc.com	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

HEALTH 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 27, 2025
Name of Entity/Sender:	City of Kirkland
Contact-Position/Office:	Human Resources
Address:	123 5th Ave, Kirkland, WA 98033
Phone Number:	(425) 587-3210

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.

Notice of Choice of Providers

The Kaiser HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente.

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

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

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.

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.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

Notice of Availability of Alternative Standard for Wellness Plan

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at (425) 587-3210 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

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.govor 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, 2025. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
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
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
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://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
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.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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: https://www.hhs.nd.gov/healthcare | Phone: 1-866-614-6005
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/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, 2025, 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

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.

- HMA 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.

PD Commissioned

2026