International Academy
Washington

EMPLOYEE BENEFITS GUIDE

Effective 6/1/2023-5/30/2024

Prepared By:

BTG benefits

International
Academy
Washington

BENEFITS CONTACT DIRECTORY

Company Benefits Contact

Rory O'Connor	rory.oconnor@lfciawashington.com
Company Phone Number	425-340-4581

BTG Benefits

Liverpool Football Club has partnered with BTG Benefits to be your health care advocates. If you have questions about your benefits or have issues that you are unable to resolve with the carriers, they are here to help!

Ben Belur - Broker	ben@btgbenefits.com
Kim Pankow - Sr. Account Manager	kim@btgbenefits.com
BTG Benefits Phone Number	206-607-2551

Kaiser Permanente – Medical Plan

Customer Service	888-901-4636
Member Website	www.kp.org/wa/member
New Member Welcome Team	888-844-4607
Mail Order Rx Customer Service	800-245-7979
24 Hour Nurse Hotline	800-297-6877
First Choice Health Network (WA, OR, ID, AK, MT)	www.fchn.com/providersearch
First Health Network (All other states)	www.myfirsthealth.com/LocateProvider

Delta Dental of Washington – Dental Plan

Customer Service	800-554-1907
Member Website	www.deltadentalwa.com

Connexion Insurance - Medicare Resources

Contact - TJ Claflin	425-918-8331
Email Address	TJ.Claflin@ConnexionInsurance.com

Employee Monthly Cost Sheet

LFC contributes 50% of the cost of employee Medical & Dental. Your portion of the monthly costs are listed below.

MEDICAL PLAN - Core/HMO Gold LX			
These medical plans are a per member cost based on these age groupings:	Monthly Cost Per Member	ISC Contribution	YOUR COST
Employee Age 21+	$401.67	$200.84	**$200.84**
Employee Age 18-20	$260.07	$130.04	**$130.04**
Dependent Age 21+	$401.67	$0.00	**$401.67**
Dependent Age 0-20	$260.07	$0.00	**$260.07**

MEDICAL PLAN - Access PPO Gold LX			
These medical plans are a per member cost based on these age groupings:	Monthly Cost Per Member	ISC Contribution	YOUR COST
Employee Age 21+	$539.84	$269.92	**$269.92**
Employee Age 18-20	$343.08	$171.54	**$171.54**
Dependent Age 21+	$539.84	$0.00	**$539.84**
Dependent Age 0-20	$343.08	$0.00	**$343.08**

DENTAL PLAN - Adult Basic Delta Dental			
	Total Monthly Cost	Employer Cost	YOUR COST
Employee Only	$40.58	$20.29	**$20.29**
Employee & Spouse / DP	$81.15	$20.29	**$60.86**
Employee & Child(ren)	$101.61	$20.29	**$81.32**
Employee, Spouse & Child(ren)	$166.69	$20.29	**$146.40**

SMALL GROUP | WASHINGTON

2023 Core VisitsPlus Gold LX

Core Provider Network

The Core VisitsPlus Gold LX plan gives members a lower cost for services at a higher premium. This plan provides members unlimited office visits without having to pay the deductible. It features the Core network, which offers access to specially selected providers for the greatest value.

Features	In-network
Plan type	Deductible
Annual medical deductible (individual/family)	$600/$1,200
Annual out-of-pocket maximum (individual/family)	$7,900/$15,800
Coinsurance	25%
Benefits	
Preventive care	
Routine physical exam, mammogram, etc.	No charge
Outpatient services (per visit or procedure)	Upfront office visits prior to deductible
Primary care office visit	$15
Specialty care office visit	$35
Most X-rays	$25
Most lab tests	$25
MRI, CT, PET	25% after deductible
Outpatient surgery	25% after deductible
Mental health visit	$15
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	25% after deductible
Maternity	
Routine prenatal care visits, first postpartum visit	No charge
Delivery and inpatient well-baby care	25% after deductible
Worldwide emergency and urgent care	
Emergency department visit	25% after deductible
Urgent care visit	$35
Retail prescription drugs (up to 30-day supply)	
Tier 1: Preferred generic	$15*
Tier 2: Preferred brand	$45*
Tier 3: Nonpreferred generic and brand	40% after deductible*
Tier 4: Specialty	40% after deductible*
Alternative medicine	
10 chiropractic visits and 12 acupuncture visits	$15
Optical hardware	
Pediatric (18 and younger)	Covered in full
Adult (19 and over)	$100 allowance per calendar year

EO = Employee only HD = High deductible LD = Low deductible LX = Lab and X-ray

* 1 maintenance drug fill allowed at any In-network pharmacy. Subsequent maintenance fills must be filled via mail order or at a Kaiser Permanente pharmacy.

For more information, including premium rates, visit **kp.org/wa/smallgroup**.

PRIMARY CARE: Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic • Emergency Medicine (where ER copay doesn't apply) • Family Planning • Family Practice • General Practice • Gerontology/Geriatrics • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics-Gynecology • Optometry • Osteopathy • Pediatrics • Pharmacist • Urgent Care • Women's Health Care (nonpreventive)

SPECIALTY CARE: Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • General Surgery (all specific surgeries) • Genetics • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Hematology/Oncology • Nutrition (nonpreventive) • Occupational Medicine • Occupational Therapy • Oncology Pharmacist • Ophthalmology • Orthopedics • ENT/ Otolaryngology • Pain Management • Pathology • Physiatry (Physical Medicine) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (Nuclear Medicine, Radiation Therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • Urology

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington.

kp.org/wa/smallgroup

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Core HMO network

Get access to high-quality primary and specialty care clinicians who are dedicated to helping you stay healthy – and caring for you when you're not. You can choose the doctor you want and change doctors at any time, for any reason.

Our Core HMO network includes quality care from the high-performing physicians at Kaiser Permanente medical facilities plus thousands of network providers.[1]

● Kaiser Permanente Medical Facility

Western Washington

Smokey Point
Everett
Lynnwood
Bothell
Poulsbo
Northgate
Silverdale
Ballard
South Lake Union
Capitol Hill
Redmond
Bellevue
Port Orchard
Rainier
Factoria
Burien
Renton
Kent
Gig Harbor
Federal Way
Tacoma
Steele Street
Puyallup
Olympia
West Olympia

Spokane area

Northpointe
Lidgerwood
Riverfront
Kendall Yards
Veradale
South Hill

37 Kaiser Permanente medical facilities and pharmacies[1]

1,600 Kaiser Permanente doctors and other clinicians[2]

16,000 Additional network providers[1]

Go to **kp.org/wa/find-a-doctor** to search for doctors, medical facilities, pharmacies, hospitals, and more.

(continues on next page)

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2023 Access PPO VisitsPlus Gold LX

Access PPO Provider Network

The Access PPO VisitsPlus Gold LX plan provides low cost for care at a higher premium. It provides unlimited in-network office visits without having to pay the deductible. This plan features the Access PPO network, which offers virtually unlimited provider choice – locally, regionally, and nationally.

Features	In-network - Enhanced	In-network - Standard	Out-of-Network
Plan type	Deductible		
Annual medical deductible (individual/family)	$600/$1,200		$1,200/$2,400
Annual out-of-pocket maximum (individual/family)	$6,500/$13,000		No limit
Coinsurance	20%		50%
Benefits			
Preventive care			
Routine physical exam, mammogram, etc.	No charge	No charge	50% after deductible
Outpatient services (per visit or procedure)	Upfront office visits prior to deductible		
Primary care office visit	$10	$30	50% after deductible
Specialty care office visit	$30	$50	50% after deductible
Most X-rays	$20	$40	50% after deductible
Most lab tests	$20	$40	50% after deductible
MRI, CT, PET	20% after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	20% after deductible	50% after deductible
Mental health visit	$10	$30	50% after deductible
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible		50% after deductible
Maternity			
Routine prenatal care visits, first postpartum visit	No charge		50% after deductible
Delivery and inpatient well-baby care	20% after deductible		50% after deductible
Worldwide emergency and urgent care			
Emergency department visit	20% after deductible		
Urgent care visit	$30	$50	50% after deductible
Retail prescription drugs (up to 30-day supply)			
Tier 1: Preferred generic	$15	$25	Not covered
Tier 2: Preferred brand	$45	$50	Not covered
Tier 3: Nonpreferred generic and brand	35% after deductible	40% after deductible	Not covered
Tier 4: Specialty	40% after deductible	40% after deductible	Not covered
Alternative medicine			
10 chiropractic and 12 acupuncture visits	$10 primary/$30 specialty		50% after deductible
Optical hardware			
Pediatric (18 and younger)	Covered in full		
Adult (19 and over)	$100 allowance per calendar year		

EO = Employee only HD = High deductible LD = Low deductible LX = Lab and X-ray

kp.org/wa/smallgroup

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Primary Care

These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic • Emergency Medicine (where ER copay doesn't apply) • Family Planning • Family Practice • General Practice • Gerontology/Geriatrics • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics and Gynecology • Optometry • Osteopathy • Pediatrics • Pharmacist • Urgent Care • Women's Health Care (nonpreventive)

Specialty Care

These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • General Surgery (all specific surgeries) • Genetics • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Hematology/Oncology • Nutrition (nonpreventive) • Occupational Medicine • Occupational Therapy • Oncology Pharmacist • Ophthalmology • Orthopedics • ENT/Otolaryngology • Pain Management • Pathology • Physiatry (Physical Medicine) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (Nuclear Medicine, Radiation Therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • Urology

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

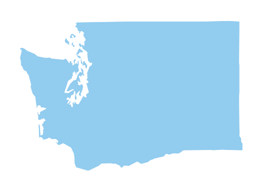
For more information, including premium rates, visit **kp.org/wa/smallgroup**.

Access PPO network

With Access PPO you can choose from an extensive network of preferred primary and specialty care providers, including our exclusive medical group at Kaiser Permanente medical facilities. You also have the option to get care through our regional and national networks.

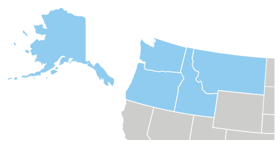
1. Care with Kaiser Permanente clinicians

- Nearly 1,600 Kaiser Permanente doctors and other clinicians[1]
- 37 Kaiser Permanente medical facilities and pharmacies[2]
- Visit **kp.org/wa/find-a-doctor**.



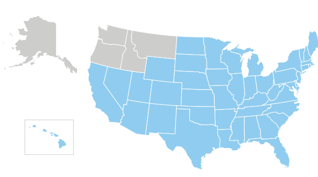
2. Care from other network providers

- 26,000 additional network providers
- Includes most major providers and designated pharmacies in our service area
- Visit **kp.org/wa/find-a-doctor**.



3. Care from First Choice Health network

- Regional care in Alaska, Idaho, Montana, Oregon, and Washington
- Visit **kp.org/wa/find-a-doctor**.



4. Care from First Health network

- Care in all other states
- More than 5,000 hospitals
- More than 1 million health professionals
- Visit **myfirsthealth.com**

5. Care from nonparticipating providers

- Care from any licensed provider in the United States
- Covered at the out-of-network benefit level; balance billing may apply

Pharmacy access

With Access PPO, you have in-network access to the OptumRx pharmacy network at **kp.org/wa/optumrx-wa** in addition to the many pharmacies listed at **kp.org/wa/find-a-doctor**.

Safe travels

You're covered for emergency care and medically necessary urgent care anywhere in the world.

[1]Washington Permanente Medical Group personnel records
[2]OIC Provider Network Form A

All plans offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.
XB0001836-50-21

Care with Kaiser Permanente clinicians

You're in great hands when you choose care from Kaiser Permanente clinicians practicing at Kaiser Permanente facilities – either online or in person.

1 **They come from some of the top medical schools**, and many have practiced at leading hospitals across the country.

Care is connected. Your doctor, nurses, and other specialists work together to help keep you healthy.

You and your care team are linked through your electronic health record, so you all know what care you've had and what you need.

Care with other network clinicians

We look for the same quality and philosophy of care in our community providers that we expect from our own doctors and staff.

- **All providers must meet our high clinical quality** and patient satisfaction standards.
- **We remind your community providers** about preventive care you might need.
- **Our community providers can access Kaiser Permanente's clinical resources**, including:
  - Detailed treatment guides on a wider range of conditions
  - Clinical tips for daily practice
  - Safety information on new drugs
  - New research results that can benefit patients
  - Additional training and continuing education opportunities.

Safe travels

You're covered for emergency care and medically necessary urgent care anywhere in the world.

[1]OIC Provider Network Form A
[2]Washington Permanente Medical Group personnel records

2023 adult and pediatric dental coverage

As a Kaiser Permanente member, you have access to dental coverage through Delta Dental of Washington. The Standard Family plan includes adult coverage for members and their dependents 19 and older and mandated pediatric coverage for members or their dependents 18 and younger.

If you purchase the Delta Dental Standard Family plan, which includes pediatric and adult coverage, you fulfill the federal mandate to provide pediatric dental coverage. However, if you do not purchase the Standard Family plan, the medical plan will automatically be paired with a pediatric-only dental plan offered by Delta Dental to fulfill the federal mandate.

Please review this summary of benefits to get familiar with the Standard Family plan, and refer to your Delta Dental benefits booklet for full details.

Summary of Dental Benefits	STANDARD FAMILY PLAN Maximum allowed amount paid by Delta Dental of Washington			
	PEDIATRIC 18 and younger		ADULT 19 and older	
	Delta Dental participating dentist	Nonparticipating dentist	Delta Dental participating dentist	Nonparticipating dentist
Maximum benefit	No annual maximum		$1,500 annual plan maximum $1,000 lifetime adult ortho maximum $1,000 annual TMJ[1] maximum $5,000 lifetime TMJ[1] maximum	
Annual deductible Deductible is waived for diagnostic, preventive, and medically necessary orthodontia	$50 per child per year		$50 per adult per year	
Annual out-of-pocket maximum	$350 per child per year $700 per year for families with 2 or more children	Not applicable	Not applicable	
Diagnostic and preventive Deductible is waived for exams, prophylaxis, fluoride, X-rays, sealants	100%	100%	100%	100%
Restorative Restorations (includes posterior composites), endodontics, periodontics, oral surgery	80%	80%	80%	80%
Major Crowns, dentures, partials, and bridges. Implants and TMJ[1] are for adults 19 and older.	50%	50%	50%	50%
Orthodontia Coinsurance Lifetime maximum Deductible is waived for medically necessary orthodontia	50% Unlimited Medically necessary[2]		50% $1,000 lifetime adult ortho maximum	

Pediatric Benefits: Only fees paid to a Delta Dental PPO Plus Premier™ dentist accrue to the annual out-of-pocket maximum.

[1] TMJ = Temporomandibular joint [2] Requires preauthorization

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Extra dental benefit for members with qualifying conditions

Regular preventive care is especially important for people with certain health conditions. To help reduce the risk of potential problems, our adult plans include a special dental benefit for members 19 and older who are pregnant, managing heart disease, or living with diabetes.

- Members with these qualifying conditions can receive an extra dental cleaning and exam with a Delta Dental PPO Plus Premier™ provider each year, at no additional charge.
- Delta Dental of Washington will notify those who qualify for this extra benefit. Importantly, the member's specific diagnosis will remain confidential.
- This extra cleaning and exam doesn't apply to the annual maximum benefit or to the dental plan's cleaning and exam limitations.

Visit a participating Delta Dental network dentist

To get the most from your benefits, we encourage you to see a participating dentist. These dentists contract with Delta Dental to provide services at discounted fees and file all claims for you. Dentists who are part of Delta Dental's networks will not charge more than their approved fees and cost you less than out-of-network dentists.

You may choose any licensed dentist to provide services under this plan. However, if you go to an out-of-network dentist, Delta Dental has no control over their fees. You will be responsible for submitting claims and paying any difference in the charges. This is called balance billing.

Finding a Delta Dental network dentist

Visit **deltadentalwa.com** and use the Find a Dentist tool. Remember to choose the Delta Dental PPO Plus Premier network.

The online directory is easy to use anytime, at home or on your smartphone. You can search based on preferences that matter to you, including dentist name, specialty, location, and language. You can even see endorsements from other Delta Dental patients for categories including extended office hours, friendly staff, kid-friendly, and if they help ease anxiety.

You can also call Delta Dental at **1-800-554-1907** for assistance finding a network dentist.

Questions?

Call Delta Dental of Washington at **1-800-554-1907**, Monday through Friday, 7 a.m. to 5 p.m., or go online to **deltadentalwa.com** for answers.

This is a brief summary of benefits and does not constitute a contract. For complete plan information, please refer to your Delta Dental of Washington benefits booklet.

Kaiser Permanente refers to Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc.

Dental coverage is provided by Delta Dental of Washington, 400 Fairview Ave N., Suite 800, Seattle, WA 98109-5371.

kp.org/wa/smallgroup

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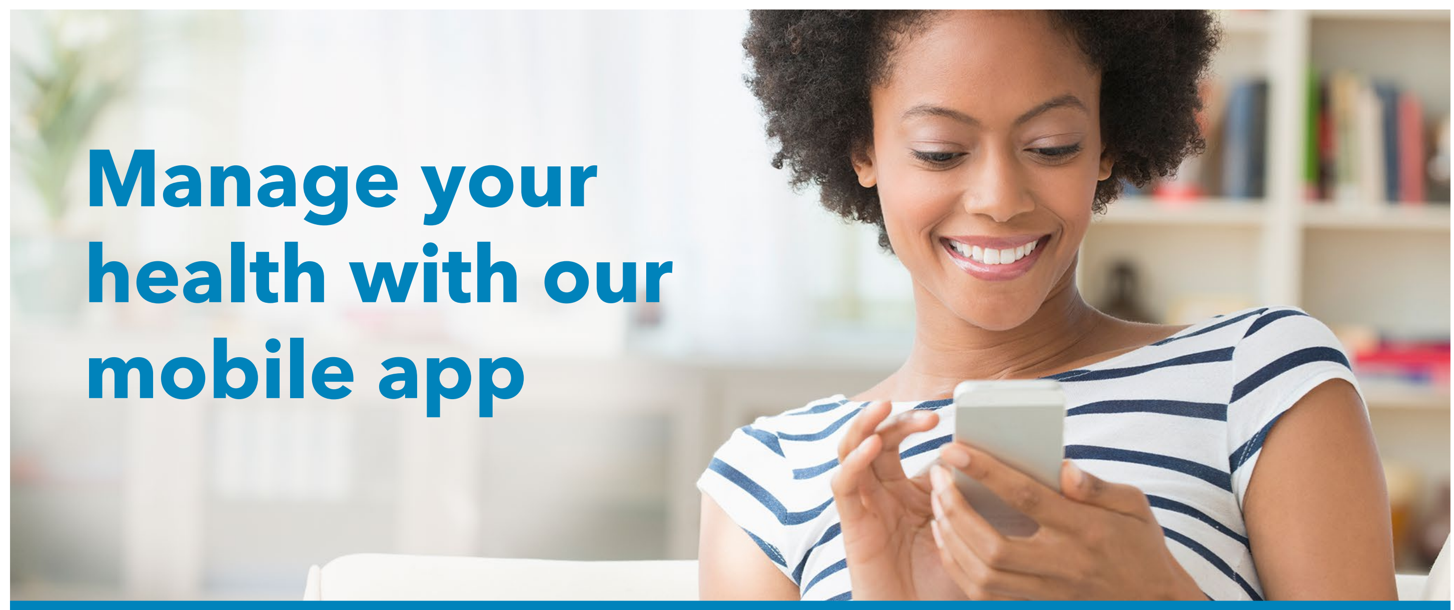
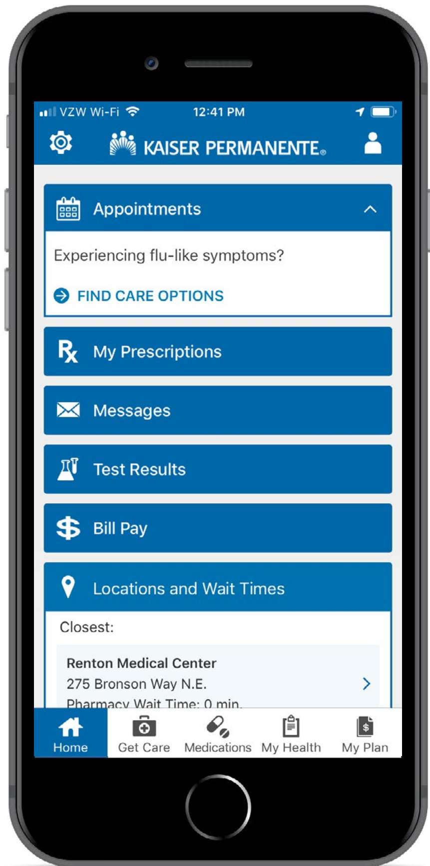


Manage your health with our mobile app

It’s easy to connect to care and get helpful resources right from your phone.



Use the **Kaiser Permanente Washington** app to:

- Refill prescriptions
- Access Care Chat
- Connect with the consulting nurse line
- Use your digital member ID card
- Access Explanation of Benefits

Teens ages 13–17 can also use the app. For more information about teen online access, visit **kp.org/wa/teenaccess-faq**.

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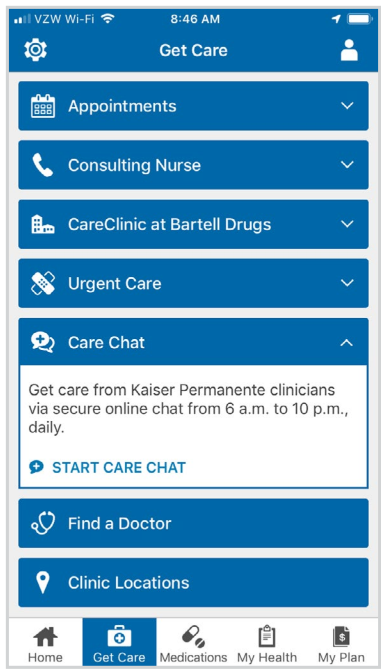
How to get online access via the mobile app

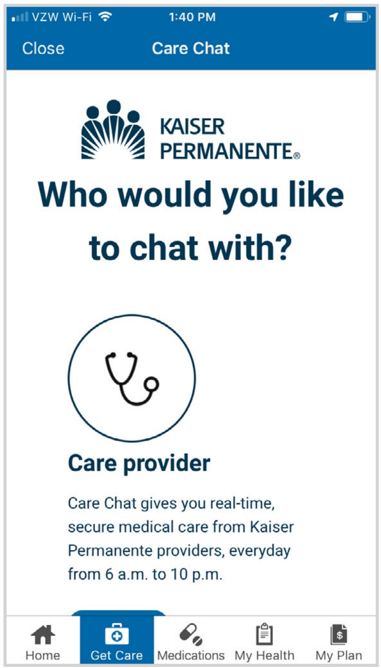
1. Download the **Kaiser Permanente Washington** app. (Note: Only the **Kaiser Permanente Washington** app will work for Washington members. You won't be able to sign in with the Kaiser Permanente app.)
2. Launch the app.
3. Register using your **member ID number** to access your online account.
4. Start accessing great services, right from your phone!

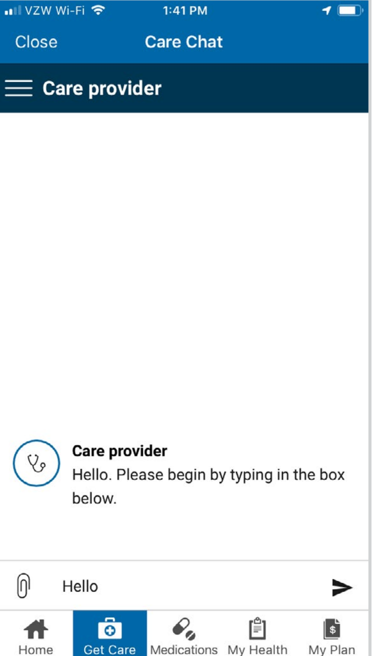
Download on the App Store

Get care on the go

With **Care Chat**, you can get real-time care online from a Kaiser Permanente clinician right from your phone – 7 days a week, 6 a.m. to 10 p.m. Once you've downloaded the app, go to **Get Care**, and click **Care Chat**.







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Why Kaiser Permanente is a better choice

Care at Kaiser Permanente feels easier with the help of dedicated caregivers, more ways to get care at home or on the go, and support for the whole you. We can help you get to your healthy place – no matter where it is.

Quality care

At Kaiser Permanente, you're in skilled hands. Our doctors come from some of the top medical schools, and many have practiced at leading hospitals around the country.

Dedicated support

Our New Member Welcome Team is ready to help you get started. And our Member Services representatives are there for you once you're on your way.

Prevention

With care focused on prevention, we help you stay on top of your health. When you do need care, you get great doctors, the latest technology, and evidence-based care to help you recover quickly.

Lots of resources

Members have access to coaching, personalized programs, fitness discounts, trusted health information, and classes and support groups.

Care options

Care is available in person and by instant message, email for nonurgent issues, video, or phone – so you get the help you need in a way that works for you.*

Easy to use

Care and coverage are tied together, so you'll spend less time figuring out how to use your health plan and more time getting on with your life.

*Virtual care is offered when appropriate and available. If you travel out of state, virtual care could be limited due to state laws that may prevent doctors from providing care across state lines. Laws differ by state.

Options for care, any way you want it

You've got more ways to get care than ever before, so it's easier to stay on top of your health.

Get care now[1,2]
Connect anytime for video and phone visits with Kaiser Permanente clinicians who have access to your medical record and health history. No appointment needed.

24/7 phone advice
Call our advice line for care, day or night.

In-person care
Visit your doctor for routine care or when you're not feeling well.

Care Chat[1,2]
Get real-time medical care online from a clinician at no additional charge on most plans.

Video visit[1,2]
Schedule a face-to-face visit with a Kaiser Permanente clinician by video.

Phone appointment[1]
Make a phone appointment to talk with your doctor over the phone.

E-visit[1,2]
Get an online diagnosis and care plan, including a prescription if needed, for common medical issues that don't require a physical exam.

Email[2]
Message your Kaiser Permanente care team with nonurgent questions and get a reply, usually within 2 business days.

Virtual care is covered at no cost[3]

Virtual care isn't an add-on at Kaiser Permanente – it's been part of how we deliver care for years. It's easy for our members to connect virtually with their doctors and care teams.

[1] When appropriate and available.
[2] These features are available when you get care from Kaiser Permanente doctors and care teams.
[3] For high-deductible plan members, phone and video appointments, e-visits, and Care Chat are subject to your plan's annual deductible.

Exclusive access to top-notch clinicians

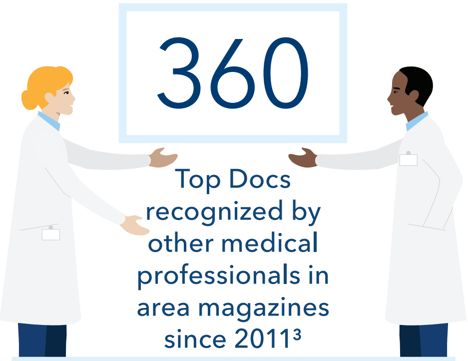
When you're a Kaiser Permanente member, you benefit from access to the state's largest multispecialty medical group – Washington Permanente Medical Group. These highly skilled, experienced primary and specialty care doctors provide care at our medical facilities and via all our virtual care channels. When you choose Kaiser Permanente, you can rely on high-quality care from these knowledgeable clinicians from almost anywhere you are.

Washington Permanente Medical Group is one of the top-ranked medical groups in the state and has been for well over a decade.[1]

- Our doctors come from some of the top medical schools.
- Many of them teach at world-renowned universities.
- Many have practiced at the nation's leading hospitals.
- They're paid to provide the right care for you, not by procedure like fee-for-service doctors.
- Their performance is measured by the quality of the care they provide you.
- Our doctors don't have to run a practice, so they can focus on what really matters: you.

97%

Kaiser Permanente Washington doctors who are board-certified.[2] (The national average is 80%.)



360

Top Docs recognized by other medical professionals in area magazines since 2011[3]

37

Top Docs in 2021 Magazines: *Seattle Magazine, Seattle Met, Spokane Coeur d'Alene Living*

[1] Washington Health Alliance 2008-2022 Community Checkup reports, www.wacommunitycheckup.org. The 2017-2022 year rankings apply to Kaiser Permanente Washington's medical group, Washington Permanente Medical Group, P.C. Rankings for years prior to 2017 apply to the then-named Group Health Cooperative's medical group, formerly named Group Health Permanente, P.C. and now named Washington Permanente Medical Group, P.C.

[2] Washington Permanente Medical Group personnel records

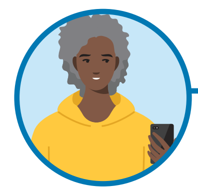
[3] Recognized by *Seattle Magazine, Seattle Met*, and *Spokane/Coeur d'Alene Living*, 2011–2022

Respecting who you are

We believe your story, background, and values are as important as your health history. To help deliver care that's sensitive to your culture, ethnicity, and lifestyle, we:

- Hire doctors and staff who speak more than one language
- Offer phone interpretation services in more than 150 languages
- Improved health outcomes among diverse populations for conditions like high blood pressure, diabetes, and colon cancer[4]

Care is better with a connected team



At Kaiser Permanente, your whole care team is connected – to you and to each other – through your electronic health record.

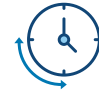
Your doctor coordinates your care, so you don't have to worry about where to go or who to call next.

If you need to see a specialist, they'll have important information about your health before they even meet you.

Every visit is captured, so your doctors, nurses, and pharmacists can consult each other on important health decisions and use your health history to inform your care.

Greater in-person convenience for you

Get care when and how you need it – and do more in less time at our facilities. At many of our locations we offer services:



same-day next-day after-hours weekends

In most of our facilities, you can see your doctor, get a lab test, have an X-ray, and pick up prescriptions – all in a single trip.

doctor lab X-ray pharmacy

Go to kp.org/wa/find-a-doctor to read about Kaiser Permanente's clinicians.

[4] Kaiser Permanente improved blood pressure control in our Black/African-American members with hypertension, raised colorectal cancer screening rates in our Hispanic/Latino members, and improved blood sugar control in our members with diabetes. Self-reported race and ethnicity data are captured in KP HealthConnect, and HEDIS® measures are updated quarterly in the interregional CORE Datamart.

Prescription drug convenience

Whether you rely on prescription medication as part of your ongoing care or a one-time drug for a sudden condition, it's easy to get what you need.

Get started

Transfer your prescriptions | It's easy to transfer your prescriptions so your treatment is uninterrupted. You can do it online or via our mobile app, or ask our New Member Welcome Team for help.

Find a pharmacy | Visit **kp.org/wa/directory** to find pharmacies in our health plan networks.

Get prescriptions delivered

Prescription home delivery | Order prescription refills online, by phone, or with our mobile app and get them delivered to your home in as few as 1 to 2 days. Delivery is free of charge.[1]

Same-day prescription delivery[2] | We can deliver most prescription medications to your home or office in most areas of Puget Sound, Spokane, and Bellingham. A $10 delivery fee applies.

Automatic prescription refills | Have your ongoing medications automatically shipped to you before you run out – no call or login required. Most routine medications are eligible.

Get help

Pharmacy Chat | Get real-time answers to your pharmacy or medication questions online via chat at **kp.org/wa** or on our mobile app.

Phone | Pharmacy representatives are available to help you by phone.

Specialty Pharmacy | Members taking specialty drugs for a wide range of conditions can get ongoing, phone-based support from pharmacists and technicians who work closely with your doctor.

[1] Available on most prescription orders; additional fees may apply.

[2] Eligible prescriptions include non-narcotic and non-refrigerated medications that don't require a signature when delivered. We're unable to deliver medications to Medicaid/Molina members at this time.

Care for your mind, body, and spirit

Emotional and physical wellness are connected. We're here for you with mental health and alternative care options that can help you stay healthy from head to toe, inside and out.

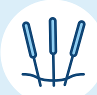
Mental health care

If you're struggling with depression, anxiety, substance use, or other mental health concerns, we're here to help. Whether you get care from Kaiser Permanente's mental health clinicians or from other caring network providers, your personal physician and our Mental Health Access Center are your first stops for help when you need it.

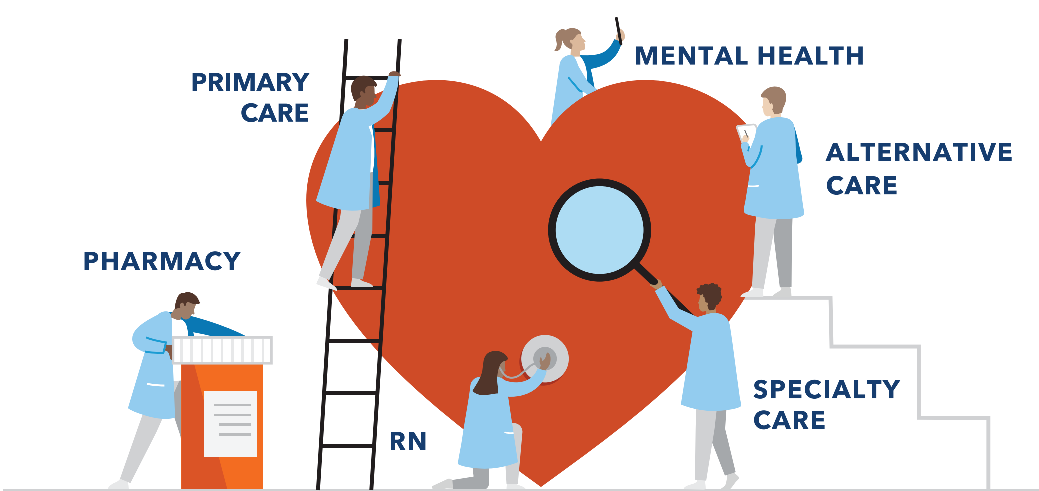
- At Kaiser Permanente locations, mental health clinicians are on staff, and mental health screening is standard at most doctor visits.
- You can call our 24/7 advice line; clinicians can consult with an on-call psychiatrist if needed.
- You can choose a video visit* for follow-up appointments, when clinically appropriate.
- Depending on the severity of your issue, you may be able to access on-demand, text-based health coaching via chat, 24/7, with video visits available.*

Alternative care

Most of our health plans include coverage for complementary or alternative care. Coverage varies by plan and includes a network of chiropractors, naturopaths, acupuncturists, and massage therapists.



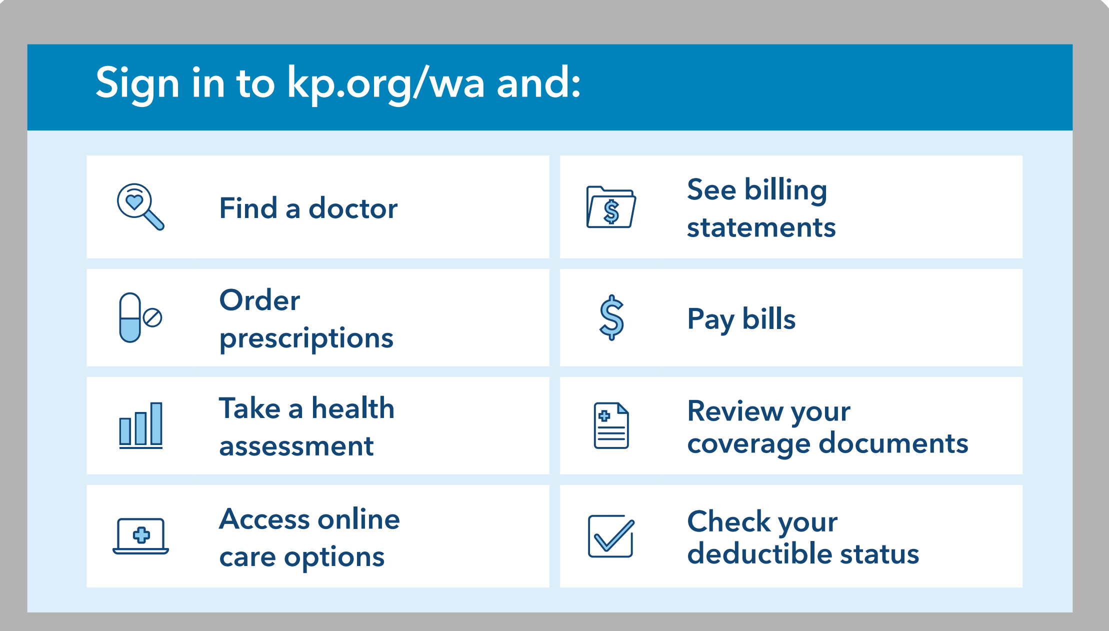
Our ChooseHealthy® program gives you 25% off participating provider standard fees for acupuncture, chiropractic care, and therapeutic massage. ChooseHealthy is offered in addition to any health plan coverage as an extra resource and is not covered by health plan benefits.



* When appropriate and available.

Hubs for managing your health

No matter which Kaiser Permanente health plan you choose, our secure member website at **kp.org/wa** and our mobile app let you manage your health online, on the go, and on your schedule.



When you get care from Kaiser Permanente doctors and care teams, you can also:

- Email your health care team with nonurgent questions
- See preventive care reminders
- Make appointments
- Review scheduled appointments
- View lab and test results
- Review your after-visit summaries
- See medical records for you and your children under 13

Get care on the go with our mobile app*

The Kaiser Permanente Washington mobile app gives you easy access to many features available in your secure online account for care anytime, anywhere.

* To use the Kaiser Permanente Washington app, you must be a Kaiser Permanente Washington member registered on kp.org/wa. If you travel out of state, virtual care could be limited due to state laws that may prevent doctors from providing care across state lines. Laws differ by state.

Tools and resources for better health

Good health goes beyond the doctor's office. That's why we offer many convenient self-help resources to our members.

Mindfulness and meditation apps:*

Offered at no cost to members.

- Calm is designed to lower stress, reduce anxiety, and much more.
- myStrength® is a personalized program that helps adults improve awareness and change behaviors.

Fitness classes

Work out from anywhere with ClassPass, a partnership with 40,000 gyms and studios around the world. Classes include yoga, dance, cardio, boxing, Pilates, boot camp, and more. Also includes:

- Unlimited on-demand video workouts at no cost
- Reduced rates on in-person fitness classes

Fitness discounts

ChooseHealthy® provides discounts on fitness gear and home equipment, plus access to fitness centers for $25 a month plus a $25 enrollment fee. Includes 11,000 fitness centers nationwide.

Health information and support

Our Resource Line can provide printed health materials and DVDs about certain diseases and conditions, help you find and register for classes and support groups, and much more. Service is free for members.

Wellness blog

Visit our trusted source of information about wellness, fitness, and nutrition at **thrive.kp.org/thrive-together**.

* These apps are not intended to replace treatment or advice. myStrength® is a trademark of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc. The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your Evidence of Coverage or other plan documents. These services may be discontinued at any time without notice.

Personalized support to reach your health goals

Getting to a healthy place is easier with others by your side. With programs, classes, and support groups to help you, you can make progress toward better health.

Wellness coaching

Health educators with expertise in preventive health care and behavior-change counseling can provide one-on-one phone support. Your coach can create a personalized action plan and teach techniques to make positive life changes, manage stress, be more active, eat healthier, and achieve other goals.

Complex case management

Members with ongoing conditions like diabetes, asthma, high blood pressure, high cholesterol, and heart disease have access to programs offering personalized, phone-based help from nurses and clinical social workers.

Help to quit smoking

Phone-based or online support from one of the country's most successful programs. Coverage varies by plan.

Support groups and classes

- Alzheimer's caregiver support group
- Bariatric surgery support groups
- Bereavement classes and support groups
- Breast cancer education and connection group
- Breastfeeding basics
- Cancer support groups
- Childbirth and parenting classes
- End-of-life care workshops
- Ongoing health condition workshops (diabetes, pain, and more)

Easy steps to get started

Switching plans can seem like a lot of work, but at Kaiser Permanente, we guide new members through each step. So you get the care you need without missing a beat.

Start with our New Member Welcome Team

They can help you find the right doctor and transfer your ongoing care or prescriptions from other providers and pharmacies to Kaiser Permanente, answer plan questions, and more.

Search profiles to find the right doctor

Our online doctor profiles let you browse the many doctors and locations in your area, even before you enroll. So you can join knowing you've found a doctor who fits your needs.

Transition your care seamlessly

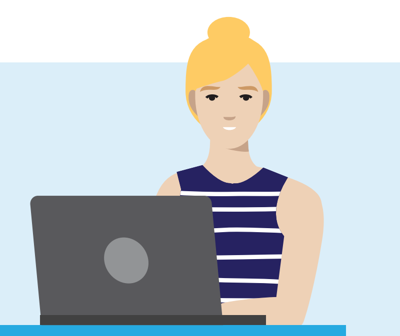
Easily move prescriptions and schedule a visit with a doctor who's close to your home, work, or school. From day one, you'll have the support you need to help reach your health goals.

Connect to care online

After you enroll, create an account at **kp.org/wa** or download the Kaiser Permanente Washington mobile app. Then manage your health on your schedule — whenever, wherever.

Health care doesn't have to be confusing

If you don't know an HMO from an HSA, you're not alone. But rest assured — we're here to make health care easier to understand. Get help learning the basics at **healthy.kp.org/learn**.



Ready to choose Kaiser Permanente?

We make it easy.

Our dedicated representatives can help you make the switch to Kaiser Permanente, get you started with your care, and provide answers to your questions along the way.

Want to learn more?

Call Member Services.

1-888-901-4636
206-630-4636
711 (TTY)

Already a new member?

Call the New Member Welcome Team.

1-888-844-4607
206-630-0029

kp.org/wa

All plans offered and underwritten by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. LG0002719-52-22

KAISER PERMANENTE®

MEDICAL PLAN TERMINOLOGY

Aggregate Deductible - The shared family deductible amount that applies when you enroll on a High Deductible Health Plan with one or more dependents. There is no individual deductible limit within the family deductible.

Allowed Amount - The maximum amount that a carrier will pay for a service, including any amount that the patient will be responsible for paying.

Balance Billing - When a provider bills you the difference between the provider's charge and the carrier allowed amount, typically when you use out-of-network providers.

Coinsurance - After you meet the deductible amount, you and your health plan share the cost of covered expenses.

Coinsurance is always a percentage totaling 100%. For example, if the plan pays 80% coinsurance, you are responsible for paying your coinsurance share, 20% of the cost.

Copay - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

Deductible - A deductible is your first dollar responsibility for health care expenses every year before the plan will begin to pay benefits. The deductible is only charged once per year and typically applies to any service where coinsurance would otherwise apply. Please see your plan highlights and booklet for a full outline of when the deductible will apply to covered services.

Embedded Deductible - A family deductible limit that has an individual deductible limit per member. This is common to traditional copay based PPO plans.

Health Maintenance Organization (HMO) – HMO plans cover services performed solely by providers in a network. This tends to be a low-cost system but is more restrictive than other plans. HMO plans do not have out-of-network benefits.

Medically Necessary - A health service or supply required to prevent or treat an injury, illness, or symptoms that meet accepted standards of medicine.

Network - The providers, suppliers, and facilities your insurance plan has contracted with to provide services.

Out-of-Network Provider - A provider without a contract with your insurance plan. You'll generally pay more to see this type of provider.

Out-of-Pocket Limit (Maximum) - The maximum that you would pay out of your own pocket for covered healthcare expenses in one plan year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance, and copays), the plan pays for all eligible expenses for the rest of the plan year.

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

Preauthorization or Prior Authorization - A decision made by your insurer that a service or drug is medically necessary. Your plan may require preauthorization for specific services before you receive them.

Physician Services - Services treated by your physician to treat an illness or injury.

Preferred Provider Organization (PPO) - Plans that allow members to use any healthcare professional without a referral. Staying in-network offers lower copays and more coverage. If you go out-of-network, you'll have higher out-of-pocket costs, and not all services may be covered.

Primary Care Physician (PCP) - A primary care physician (PCP) is your main doctor. Your PCP is responsible for managing most of your healthcare issues. PCPs are typically required on HMO plans.

MEDICAL PLAN TERMINOLOGY - CONTINUED

Provider - A physician, healthcare professional, or facility that is licensed and certified as required by state law.

Rehabilitation Services - Services that help a person keep or reclaim skills and functioning for daily living lost due to an illness or injury. Examples include occupational therapy, speech therapy, and select psychiatric services.

Specialist - A physician that focuses on a specific area of medicine.

Summary of Benefits and Coverage (SBC) - The SBC provides simple and consistent information about health plan benefits and coverage. The purpose is to help you better understand the coverage you have and to make easy comparisons of different options when selecting new coverage.

Telemedicine or Virtual Visits - Telemedicine allows healthcare professionals to evaluate, diagnose and treat patients at a distance using telecommunications technology.

Usual, Customary, and Reasonable (UCR) - The amount paid for a service in a geographic area based on what local providers typically charge.

Urgent Care - Care for a condition or injury serious enough that one would seek care right away but not one severe enough to require emergency room care.

Waiting Period - The time that must pass before coverage becomes effective for an employee and his or her dependents.

PRESCRIPTION DRUG TERMINOLOGY

Brand-Name Drugs - Prescription drugs marketed with a specific brand name by the vendor that manufactures it, usually the vendor which develops and patents it. You generally pay a higher copay for brand-name drugs.

Generic Drug - A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

Non-Preferred Brand Drug - A drug that is neither generic nor on the plan's preferred formulary drug list.

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

Specialty Drugs - Specialty drugs are powerful medications used to treat certain complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis.

Legal Notices

Women's Health and Cancer Rights Act

Enrollment Notice

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.

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).

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth, or Adoption

If you have a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the event.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later,

you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

Washington Paid Family Medical Leave

Washington workers can use Paid Family and Medical Leave benefits that started in January 2020. These benefits generally allow up to 12 weeks of paid leave per year to care for yourself or a family member. You can get up to 16 weeks if you have both family and medical events in a year or up to 18 weeks if your serious health condition is the result of pregnancy.

Beginning January 1st, you will be able to apply for paid leave benefits. This is an online process. You will need to create an account, complete an application, and provide medical documentation of your need for leave, either due to your own serious illness or for the care of your family member (or bonding with a baby).

You are required to provide 30 days written notice to your employer of your intent to take leave if the need is due to a foreseeable event like the birth of a child, a planned surgery, etc. Written notices can be emails, text messages, printed or handwritten notes. If you are unable to provide notice you need to tell your employer as soon as it is possible and practical for you to do so. If you are unable to provide notice yourself, someone else can do it on your behalf.

If you have questions or need more information about the Washington PFML, please visit www.paidleave.wa.gov, email paidleave@esd.wa.gov, or call 833-717-2273.

Healthcare Reform and the Affordable Care Act

The healthcare reform law, or Affordable Care Act (ACA), is complicated and you may have questions about how it impacts you, your family, and your benefits. There are three items you should know.

First, the individual mandate (the requirement that all individuals have health insurance) remains in place. What has changed is the penalty associated with it. As of January 1, 2019, the ACA tax penalty is repealed, and you will not have to pay anything if you do not enroll.

Second, the Health Insurance Marketplace still exists. You can shop for and enroll in insurance plans through the exchange and still apply for income-based subsidies.

Third, for most people the plans we offer are considered affordable and neither you nor any family members are eligible for the federal subsidies available in the Health Insurance Marketplace, even if you choose not to enroll in your employer's plan.

For additional information on Marketplace options in your area and subsidy calculators, go to www.healthcare.gov or call 1-800- 318-2596.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162 ext 2131
ALASKA – Medicaid	**INDIANA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
ARKANSAS – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (1-855-692-7447)	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/HawkiHawki Phone: 1-800-257-8563
CALIFORNIA – Medicaid	**KANSAS – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-916-440-5676	Website: http://www.kdheks.gov/hcf/default.htmPhone: 1-800-792-4884
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KENTUCKY – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 https://www.colorado.gov/pacific/hcpf/health-insurance-buy-programHIBI Customer Service: 1-855-692-6442	Kentucky Integrated Health Insurance Premium Payment Program(KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 / Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
FLORIDA – Medicaid	**LOUISIANA – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Medicaid & CHIP (continued)

MAINE – Medicaid	OREGON – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MASSACHUSETTS – Medicaid and CHIP	**PENNSYLVANIA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/Phone: 1-800-862-4840	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
MINNESOTA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rite Share Line)
MISSOURI – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htmPhone: 1-573-751-2005	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
MONTANA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEBRASKA – Medicaid	**TEXAS – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEVADA – Medicaid	**UTAH – Medicaid and CHIP**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW HAMPSHIRE – Medicaid	**VERMONT– Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW JERSEY – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
NEW YORK – Medicaid	**WASHINGTON – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
NORTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://medicaid.ncdhhs.gov Phone: 1-919-855-4100	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
NORTH DAKOTA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/Phone: 1-844-854-4825	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
OKLAHOMA – Medicaid and CHIP	**WYOMING – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

Important Notice About 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 and your options under Medicare's prescription drug coverage. This information can help you decide whether 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 precription 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 prescription drug coverage offered by your employer 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 considered Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current employer/group coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current employer/group coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment.

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 your employer/group plan 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 Open enrollment period to join.

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

Contact your plan administrator 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 or if the coverage through your employer 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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

GENERAL NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.
Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days of when the qualifying event occurs. You must provide this notice to your plan administrator.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions..

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your plan administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

WHO WE ARE

We are a privately held brokerage in Bellevue, Washington. Our main priority is to provide local representation combined with white-glove service to employers of all sizes. With a combined 75+ years of experience in the employee benefits space, we have become experts in helping employees navigate this complex topic.

NEED HELP?

Determining the plan that's right for you may feel overwhelming. We understand that there is a lot to consider when making important healthcare decisions. We encourage you to reach out to us for assistance. Our Team can help you better understand all options available to you over the phone or via email.
See Contact Sheet at the beginning of this guide for your dedicated account team.

THE FINE PRINT

The information contained in this guide is for illustrative purposes only. It is not a guarantee of coverage. In the event of a discrepancy between the information provided in this guide and the Summary of Benefits & Coverage (SBC), the SBC will prevail. In addition, the information provided in this guide is intended to assist you in electing coverage that best fits your family's needs. It should not be construed as legal or tax advice. The information contained in this guide is intended for internal company use. It should not be shared with anyone outside of your company.

BTG benefits