

Spokane Regional Emergency Communications 2024 BENEFITS



Benefits You Can Depend On



SPOKANE REGIONAL
EMERGENCY
COMMUNICATIONS

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



GETTING STARTED

2024 BENEFITS

January 1, 2024 through December 31, 2024

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the *Important Notices* section for more details.

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

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

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

WHO'S ELIGIBLE FOR BENEFITS?



Employees

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

IMPORTANT: Employees with variable hours and seasonal schedules may be considered eligible if they work on average 30 hours a week or 130 hours a month. SREC measures hours worked based on the number of hours you work each month as required by the Affordable Care Act (ACA). Refer to Determining Eligibility later in this guide for details.

Eligible dependents

- Legally married spouse
- State registered domestic partners
- Natural, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

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

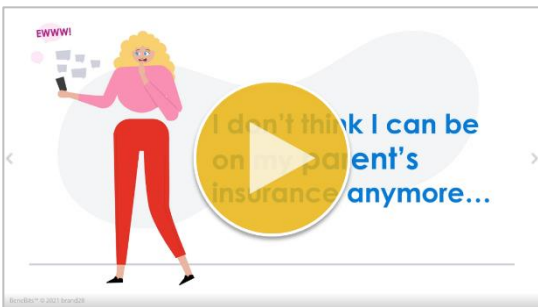
When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following your date of hire as long as you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

CHANGING YOUR BENEFITS

Click to play video



LIFE HAPPENS

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

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

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

You must submit your change within 30 days after the event.



HEALTHCARE

MAKE TIME FOR HEALTH

OUR COMMITMENT

We believe that our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their eligible dependents can enroll in medical, dental, and vision coverage through the Spokane Regional Emergency Communications benefits program.

Medical Including Vision

We offer 2 medical plans. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and budget.

Dental

Some people don't like going to the dentist, but no one likes big dental bills. Regular checkups and cleanings are fully covered and can identify issues before they become serious. And if you do need dental services, insurance helps cover the cost for fillings, gum disease, orthodontia, and more.

WHICH PLAN IS RIGHT FOR YOU?



Consider an HMO (Health Maintenance Organization) or an EPO (Exclusive Provider Organization) 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

Plans To Consider

- Kaiser Permanente Core Medical HMO Plan

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Plans To Consider

- Kaiser Permanente Medical PPO Plan

MEDICAL

	KAISER PERMANENTE MEDICAL PPO PLAN		KAISER PERMANENTE MEDICAL HMO PLAN	
BENEFITS	In-Network	Out-of-Network	In-Network Only	
Annual Deductible	\$500 per individual \$1,500 family limit		\$200 per individual \$600 family limit	
Annual Out-of-Pocket Maximum	\$2,000 per individual \$6,000 family limit		\$1,000 per individual \$3,000 family limit	
Office Visit – PCP	Standard: \$30 copay Enhanced: \$20 copay	Plan pays 60% after deductible	\$30 copay	
Office Visit – Specialist	Standard: \$30 copay Enhanced: \$20 copay	Plan pays 60% after deductible	\$30 copay	
Chiropractic	\$30 copay (up to 20 visits per year)	Plan pays 60% after deductible (in-network limitations apply)	\$30 copay (up to 10 visits per year)	
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	
Urgent Care	Standard: \$30 copay Enhanced: \$20 copay	Plan pays 60% after deductible	Designated Facility: \$30 copay then plan pays 100%; Non-designated \$150 copay then plan pays 90% after deductible (non-network providers covered when temporarily outside the service area)	
Emergency Room	\$150 copay then plan pays 80% after deductible (copay waived if admitted)	\$150 copay then plan pays 80% after deductible (copay waived if admitted)	\$150 copay then plan pays 90% after deductible (copay waived if admitted)	
Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible	\$30 copay then plan pays 90% after deductible	
PRESCRIPTION DRUGS	In-Network: Retail Pharmacy	In-Network: Mail Order Pharmacy	In-Network: Retail Pharmacy	In-Network: Mail Order Pharmacy
Generic	Standard: \$15 copay Enhanced: \$10 copay	\$20 copay	\$15 copay	\$30 copay
Preferred Brand	Standard: \$25 copay Enhanced: \$20 copay	\$40 copay	\$30 copay	\$60 copay
Non-Preferred Brand	Standard: \$45 copay Enhanced: \$40 copay	\$80 copay	\$50 copay	\$100 copay
Number of Days Supply	30 days	90 days	30 days	90 days
VISION				
Exam/Materials	Exam: Plan pays 100% Materials: \$300 per 12 months (see contract for limitations)		Exam: \$30 copay then plan pays 100% Materials: \$150 per 24 months (see contract for limitations)	



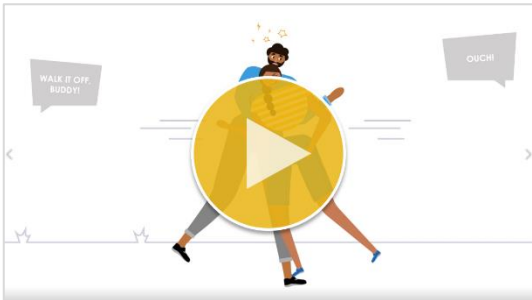
DENTAL

BENEFITS	DELTA DENTAL OF WA DENTAL PPO PLAN		WILLAMETTE MANAGED DENTAL PLAN
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
Annual Deductible	\$50 per individual \$150 per family		\$0 per individual \$0 per family
Annual Plan Maximum	\$2,000 per individual (major and basic services only)		Unlimited
Diagnostic & Preventive (exams, cleanings, x-rays, sealants, fluoride)	Plan pays 100%	Plan pays 100%	\$15 copay then plan pays 100% (varies by service; see contract for fee schedule)
Basic Services (fillings, root canals, periodontics)	Plan pays 90% after deductible	Plan pays 90% after deductible	\$15 copay then plan pays 100% (varies by service; see contract for fee schedule)
Major Services (dentures, implants, bridges, crowns)	Plan pays 60% after deductible	Plan pays 60% after deductible	\$15 copay then plan pays 100% (varies by service; see contract for fee schedule)
Orthodontia	Plan pays 50%		\$1,500 copay then plan pays 100% (see contract for limitations)
Dependent Children	Covered to age 19	Covered to age 19	Covered
Adults and eligible full-time students	Not covered	Not covered	Covered
Lifetime Maximum	\$1,500		Unlimited



ENGAGE

Click to play video



Urgent Care vs ER

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:

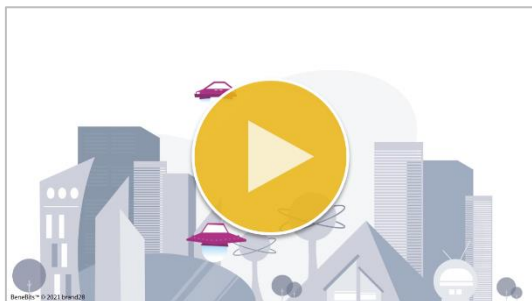
- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

KNOW WHERE TO GO

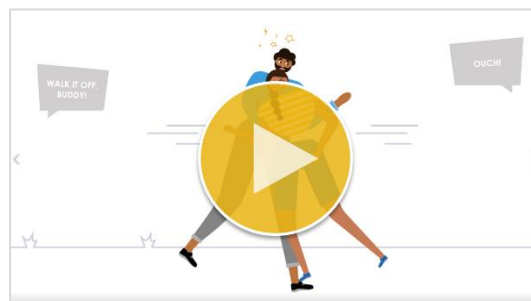
Where you get medical care can significantly influence the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Examples
Nurse line (24/7—\$0) Quick answers from a trained nurse	Identifying if immediate care is needed Home treatment options and advice
Online visit (24/7—\$) Many nonemergency health issues	Cold, flu, allergies, headache, migraine Skin conditions, rashes Minor injuries Mental health concerns
Office visit (\$\$) Routine medical care and management	Preventive care Illnesses, injuries Managing existing conditions
Urgent care (\$\$\$) Non-life-threatening conditions requiring prompt attention	Stitches, sprains Animal bites High fever, respiratory infections
Emergency room (24/7—\$\$\$\$) Life-threatening conditions needing immediate care	Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing

Click to play videos



Virtual Healthcare



Urgent Care vs ER

ALTERNATIVE FACILITIES

If you have time to evaluate your options for nonemergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
SURGERY	Ambulatory Surgery Center (ASC)	<ul style="list-style-type: none"> Specializes in same-day surgeries Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more Held to same safety standards as hospitals 	Up to 50% over hospital stay*
PHYSICAL THERAPY	Outpatient physical therapy facility	<ul style="list-style-type: none"> Important part of the recovery process after an injury or surgery 	40 to 60% over a hospital setting*
SLEEP STUDY	Home testing	<ul style="list-style-type: none"> Diagnoses sleep apnea and other conditions Cost is often covered by insurance if considered medically necessary 	Approx. \$4,500*
INFUSION THERAPY	Home or outpatient infusion therapy	<ul style="list-style-type: none"> For drugs that must be delivered by intravenous injections or epidurals Delivered by licensed infusion therapy provider Maintain normal lifestyle and comfort of home or outpatient center 	Up to 90% over hospital stay* *in-network

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, and similar services on your plan’s website, or call member services for assistance. Online tools such as [healthcarebluebook.com](https://www.healthcarebluebook.com) and [healthgrades.com](https://www.healthgrades.com) help you compare costs and doctor ratings.

Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE



TYPICAL SCREENINGS FOR ADULTS

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

You take your car in for maintenance; why not do the same for yourself?

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

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

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

Check out our [Preventive Care Guide](#) for information on recommended screenings for adults, children, and LGBTQ+ individuals.



PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video



THE FORMULARY DRUG TIERS DETERMINE YOUR COST

\$ Generic Drug

\$\$ Brand Name Drug

\$\$\$ Specialty Drug

Understanding the formulary can save you money

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

What is a formulary?

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

Get the most from your coverage

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

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



LIFE & DISABILITY

YOUR BENEFICIARY = 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.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children’s education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

COMPANY- PROVIDED LIFE AND AD&D INSURANCE



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.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. 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. The cost of coverage is paid in full by the company and provided by The Standard.

THE STANDARD BASIC LIFE AND AD&D PLAN

Employee Coverage

Benefit Amount*:	\$25,000
Guaranteed Issue:	\$25,000

Spouse Coverage

Benefit Amount*:	\$5,000
Guaranteed Issue:	\$5,000

Child Coverage

Benefit Amount:	\$1,000
Guaranteed Issue:	\$1,000

**Benefits begin to reduce at age 65. Refer to your plan document for details.*

LONG-TERM DISABILITY INSURANCE (LTD)



3 THINGS TO KNOW ABOUT LTD INSURANCE

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

LTD benefits cushion the financial impact of a disability

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

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

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Spokane Regional Emergency Communications pays the cost of this coverage.

THE STANDARD LONG-TERM DISABILITY

Employee Coverage

Monthly benefit:	60% of covered monthly earnings up to a maximum of \$5,000
Benefits begin:	After 90 days of disability
Maximum payment period*:	To Social Security Normal Retirement Age

*The age at which you become disabled may affect your period of payment

VOLUNTARY LIFE & AD&D INSURANCE



GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase 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.

In the event of a serious or fatal accident

Voluntary AD&D insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

THE STANDARD VOLUNTARY LIFE AND AD&D

Employee Coverage

Benefit Amount*:	Increments of \$10,000 up to \$300,000
Guaranteed Issue:	\$100,000

Spouse Coverage

Benefit Amount*:	Increments of \$5,000 up to \$15,000
Guaranteed Issue:	\$10,000

Child Coverage

Benefit Amount:	Increments of \$2,000 up to \$10,000
Guaranteed Issue:	\$10,000

**Benefits begin to reduce at age 65. Refer to your plan document for details.*



VOLUNTARY BENEFITS

Voluntary benefits provide an extra layer of financial protection when unexpected events occur. Spokane Regional Emergency Communications offers voluntary benefits (you pay the premium) to help you source and buy protection and services you may need for your family—at rates that may be more attractive than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are offered through Aflac. For more information on what is available and how to sign up please Contact Human Resources for more information.



Pet insurance from Nationwide®

With two budget-friendly options, there's never been a better time to protect your pet.



Our popular My Pet Protection® pet insurance plans now feature more choices and more flexibility

- ✓ **Get cash back on eligible vet bills:** Choose your reimbursement level of 50% or 70%¹
- ✓ **Available exclusively for employees:** Plans with preferred pricing only offered through your company
- ✓ **Use any vet, anywhere:** No networks, no pre-approvals

Choose your level of coverage with My Pet Protection®



How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed for eligible expenses.

Get a quote at: benefits.petinsurance.com/srec • 877-738-7874

¹Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states.

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SREC's Student Loan Repayment Program

Spokane Regional Emergency Communications (SREC) offers employees a Student Loan Repayment benefit through BenefitEd once signed off from training.

Through this benefit you can receive **\$300** per month toward a student loan, in your name, funded by SREC.

SIGNING UP IS EASY!

Once you sign up through HR, you'll receive a registration email from BenefitEd.



Please note, if enrollment is completed by the 10th of the month, the first payment will be made on the 6th business day of the following month. If enrollment is completed after the 10th of the month, then the first payment will be made on the 6th business day of the month after the following.

What will I need to register?

Make sure you have the following information ready to register with BenefitEd:

- 1** Gather your student loan information which will include: student loan servicer, servicer's payment address and student loan account number.
- 2** Complete your enrollment using "Enroll Now" button that will be in the email you receive from BenefitEd. *Enrollment is most successful when using Google Chrome.*
- 3** Validate your first name, last name and employee ID. Your employee ID is located on your paystub. If you have any problems locating your employee number, please contact HR.
- 4** Register your student loan(s).

After completing enrollment BenefitEd will send you an email confirming that you are enrolled.

WASHINGTON PAID FAMILY AND MEDICAL LEAVE



The Benefits

As a Washington worker, you may be able to use Paid Family and Medical Leave benefits to care for yourself or your family. Benefits will generally allow up to 12 weeks of paid leave for:

- Bonding after the birth or placement of a child
- Your serious health condition
- A serious health condition of a qualifying family member
- Certain activities related to a family member's military duty.

This statewide insurance program is funded by premiums paid by workers and employers through payroll withholding.

To receive benefits under the Paid Family and Medical Leave program, you must have worked a total of at least 820 hours for any Washington employers during the previous 12 months. Benefits will provide a percentage of your gross wages – between \$100-1,427 per week (2023 maximum) – while you are on approved leave.

To learn more about the program, including additional eligibility criteria, benefits information, and application instructions, visit paidleave.wa.gov/workers.



IMPORTANT PLAN INFORMATION

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

- Your medical including vision and dental benefit contributions for the 2024 plan year
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, and how many dependents you cover. 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	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
KAISER PERMANENTE MEDICAL PPO PLAN	\$43.02	\$134.98	\$120.64	\$201.46
KAISER PERMANENTE HMO PLAN	\$38.20	\$111.30	\$98.56	\$170.34

DENTAL	Composite Rate
WILLAMETTE MANAGED DENTAL PLAN	\$13.49
DELTA DENTAL OF WASHINGTON DENTAL PPO PLAN	\$13.00

VOLUNTARY LIFE AND AD&D

Your cost for employee coverage will depend on your age and how much coverage you buy. The cost increases for a higher age and higher benefit amount. The cost of spouse coverage is based on your spouse's age and amount of spouse coverage. The cost of child coverage is based on the policy amount selected and covers all children. These rates will be calculated for you when you enroll.

A Note about Domestic Partners

Imputed Income Domestic Partners will not receive tax favored employer sponsored group health plan benefits under Federal or State law. This means that Domestic Partners will have the Fair Market Value (FMV) of coverage imputed as income under Federal and State law (there are State Exceptions). Note that the term Domestic Partner can refer to registered Domestic Partners recognized by state law and confirmed by registration with the state, as well as Domestic Partners that are simply recognized in an employer's plan eligibility provisions and usually confirmed by employee affidavit. Same sex spouses are now legally recognized under Federal and State law and are different from Domestic Partners.

After-tax deductions Please note that unless your domestic partner is also your tax- dependent as defined by the IRS, contributions for domestic partner coverage must be made on an after-tax basis. Similarly, the company contribution toward the cost of domestic partner coverage and his/her dependents is taxable income to you. Contact your tax advisor for more details on how this tax treatment applies to your specific situation. Contact Human Resources directly if your domestic partner is also your tax dependent.

PLAN CONTACTS

If you need to reach out to our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website/Email	Policy/Group #
Medical/Rx Including Vision PPO	Kaiser Permanente	1-888-901-4636	Wa.kaiserpermanente.org	#4171500
Medical/Rx Including Vision HMO	Kaiser Permanente	1-888-901-4636	Wa.kaiserpermanente.org	#8537500
Dental PPO	Delta Dental of WA	1-800-554-1907	www.deltadentalwa.com	#14244
Managed Dental	Willamette Dental Insurance, Inc.	1-855-433-6825	www.willamettedental.com	#WA178
Life and AD&D	The Standard	1-888-937-4783	www.standard.com	#166154
Long-Term Disability (LTD)	The Standard	1-888-937-4783	www.standard.com	#166154
Flexible Spending Account (FSA)	Rehn & Associates	1-509-534-0600	www.rehnonline.com	N/A
Voluntary Benefits	Aflac	1-800-992-3522	www.Aflac.com	#25802
Student Loan Reimbursement	BenefitED	Contact HR department for more information		
Pet Insurance	Nationwide	1-877-738-7874	www.petinsurance.com	#11072
Employee Assistance Program (EAP)	Wellspring	1-206-826-3050	www.wellspringfs.org	N/A

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS



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

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

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

If, like most people, you become eligible for Medicare at age 65, you have a seven-month window to enroll, starting three months before you turn age 65 and ending three months after your birthday month.

Introducing Alliant Medicare Solutions

Choosing a Medicare plan – and understanding how it can affect your employer-provided medical coverage – can be confusing. That’s why we are offering Alliant Medicare Solutions to 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.

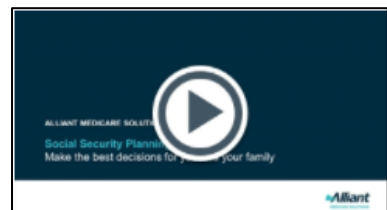
Find Out More



[Your Guide to Medicare](#)



[Medicare 101 Video](#)



[Social Security Planning Video](#)

GLOSSARY

-A-

AD&D Insurance

An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount

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

Ambulatory Surgery Center (ASC)

A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit

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

-B-

Balance Billing

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

Beneficiary

The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug

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

-C-

COBRA

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

Claim

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

Coinsurance

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

Copayment

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

-D-

Deductible

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

Family coverage may have an **aggregate** or **embedded** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services

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

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

Dental Major Services

Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)

An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age

13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense

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

Excluded Service

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

-F-

Formulary

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

-G-

Generic Drug

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

Grandfathered

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

-H-

Health Reimbursement Account (HRA)

An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)

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

High Deductible Health Plan (HDHP)

A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network

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

-L-

Life Insurance

An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance

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

-M-

Mail Order

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

-O-

Open Enrollment

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

Out-of-Network

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

Out-of-Pocket Cost

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

Out-of-Pocket Maximum

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

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

Outpatient Care

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

-P-

Participating Pharmacy

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

Plan Year

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

Preferred Drug

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

Preventive Care Services

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

Primary Care Provider (PCP)

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

-S-

Short Term Disability Insurance

Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc

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

-U-

UCR (Usual, Customary, and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

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

-V-

Vaccinations

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

Voluntary Benefit

An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

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.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this guide.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

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

ANNUAL NOTICES

Medicare Part D Notice

Important Notice from Spokane Regional Emergency Communications 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 Spokane Regional Emergency Communications 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. Spokane Regional Emergency Communications has determined that the prescription drug coverage offered by the Kaiser Permanente Medical PPO Plan and Medical HMO 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 Spokane Regional Emergency Communications coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Kaiser Permanente Medical PPO Plan and Medical HMO 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 Spokane Regional Emergency Communications 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 Spokane Regional Emergency Communications 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 Spokane Regional Emergency Communications 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](https://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 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](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

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

Date: 01/01/2024
Name of Entity: Spokane Regional Emergency Communications
Contact-Position/Office: Megan Schneider – HR Analyst
Address: 1620 N Rebecca Street, Spokane, WA 99208
Phone Number: (509) 532-8973

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 (800) 297-6877.

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 (800) 297-6877.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Spokane Regional Emergency Communication’s health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Spokane Regional Emergency Communication’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 on the date of birth, adoption or placement for adoption date. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Spokane Regional Emergency Communication’s health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

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

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

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

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

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ 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://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.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

Healthy Indiana Plan for low-income adults 19-64 Website: <http://www.in.gov/fssa/hip/> | Phone: 1-877-438-4479

All other Medicaid Website: <https://www.in.gov/medicaid/> | Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members> | Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki> | Hawki Phone: 1-800-257-8563

HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp> | HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/> | Phone: 1-800-792-4884 | 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: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx> | Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicicaid.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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm> | Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084 | email: HSHIPPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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 CHIPWebsite: <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 CHIPWebsite: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm> | Phone: 1-800-362-3002**WYOMING – Medicaid**Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/> | Phone: 1-800-251-1269

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

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

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 (8.39% in 2024) of your modified adjusted household income.

The ‘No Surprises’ Rules

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

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

[View a sample notice and consent form](#) (PDF).

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

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA ****

Introduction

You’re getting this notice because you recently gained coverage under a group health plan (the 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; or
- 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 after the qualifying event occurs. You must provide this notice to Human Resources.

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 18-month 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, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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.

Plan contact information

Name of Entity:	Spokane Regional Emergency Communications
Contact-Position/Office:	Megan Schneider – HR Analyst
Address:	1620 N Rebecca St, Spokane, WA 99208
Phone Number:	(509) 532-8973

PLAN DOCUMENTS

Important documents for our health plan are available in the Annual Notices section of this guide. Additional copies of these documents and notices are available if requested. If you would like a paper copy, please contact Human Resources.

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.

- Spokane Regional Emergency Communications Benefits Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

- Kaiser Permanente Medical PPO Plan
- Kaiser Permanente Medical HMO Plan

STATEMENT OF MATERIAL MODIFICATIONS

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

