CHC Community Health Center OF SNOHOMISH COUNTY











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 page 34 for more details.

Benefits Guide July 1, 2021 – June 30, 2022

USI

Table of Contents

A Message from Human Resources at Community Health Center of Snohomish County

At Community Health Center of Snohomish County (CHC), we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable.

The cost of health care and other benefits continue to rise. Each year, we analyze our costs and try to manage increases by reviewing our plan carriers and their benefit provisions. We are conscious of the fact that changing health insurance plans is often difficult for our employees, so whenever possible, we work with our current benefit providers to create solutions that will work financially and will be less disruptive. CHC continues to promote a culture of health and wellness, establishing a work environment that encourages healthy lifestyles, decreases the risk of disease and enhances your quality of life.

Please review the information contained within the guide. This guide has been prepared to help you review the key factors that are associated with our benefit plans. It does not provide all the contractual provisions, limitations, or exclusions included in our policies and should be considered only as a summary of our current benefits. If any differences exist between the guide and the official contracts, the contracts shall prevail.

You can view detailed summaries of our benefit plans by accessing our employee benefit page on InfoConnect.

Sincerely,

Lynell Hartman, PHR
Human Resources Manager

Eligibility

Eligible Employees:
You may enroll in the CHC Employee Benefits Program if you are a full-time employee working at least 30 hours per week.

Eligible Dependents:
Eligible dependents include your spouse, registered domestic partner and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship, as well as children of same sex state-registered domestic partners.

When Coverage Begins:
The effective date for your benefits is July 1, 2021. Newly hired employees and dependents will be effective in CHC's benefits programs first of the month following 30 days of employment. You must be actively at work for your coverage to be effective on your eligibility date. All elections are in effect for the entire plan year and can only be changed during the annual open enrollment period unless you experience a change in family status event.

Family Status Change:
A change in family status is an event in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 60 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 60 days of the event may result in having to wait until the next open enrollment period to make your change. Please contact Human Resources to make these changes.

Retirement Savings Plan:
Employees are also eligible to participate in the Retirement Savings Plan as of their first day of employment or may join at any other time throughout the year. All contributions are fully vested when made. Additionally, CHC matches contributions according to our safe harbor matching schedule found on our Retirement Savings Plan page on InfoConnect.

Cost of Coverage

How You Pay for Health Care Costs

You share the cost of health care services with the medical, dental, and vision plans.

Premium: A premium is the total cost for your medical insurance. You and CHC share this cost. You pay your portion through pre-tax payroll deductions.

Deductible: A deductible is the amount you must pay before the medical and dental plans begin sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits. The deductibles on the medical and dental plans accumulate on a calendar year basis.

Coinsurance: When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, on the Premera Blue Cross HDHP, after you satisfy your deductible, the plan will pay 80% and you will pay 20% for most of the medical care you receive from in-network preferred providers.

Out-of-Pocket Maximum: The calendar year out-of-pocket maximum protects you from major medical expenses. This is the most you would pay and includes your medical deductible, copays and coinsurance, for eligible expenses during a calendar year. Once you reach the out-of-pocket maximum, the plan pays 100% of the usual, customary and reasonable charges for the balance of the calendar year for covered care.

Your Total Costs

Remember, the total cost you pay for health care services in a plan year is the combination of your out-of-pocket costs when you access care and the premium payments you are required to make for coverage.

Premiums + Out-of-Pocket Costs = Total Cost of Health Care

In addition, with access to the Health Savings Account (HSA) you can contribute additional funds on a pre-tax basis to pay for health care expenses not covered by your plan.

Get More Value From Your Plans

Minimize your out-of-pocket expenses

Below are a few key points to help you get the most value out of your health plan:
Look for a Family Practice, Internal Medicine, General Practice, OB/GYN, and/or Pediatric physician. You will always save money by using providers in your medical plan's network. What are your options? You may want to consider the following the next time you need care:

<u>For a Life-Threatening Emergency</u>
In a true medical emergency – such as an apparent heart attack, serious injury, or other life-threatening situation – always call 911 or your local emergency number right away!

Use the Emergency Room ONLY for emergencies

<u>For Less Critical Issues if the Emergency is NOT Life Threatening</u>

- Call your physician's office (even after hours, someone is typically on call to answer questions). Your doctor will know you and your medical history and may be able to schedule you for a visit the same (or next) day.
- If your condition starts or worsens on the weekend, or after your doctor's office has closed for the day, you may want to consider a visit to an Urgent Care facility. These clinics are not affiliated with hospitals, but they do have doctors and nurses on staff and are open in the evenings and on weekends.

<u>If You are Traveling and You Need Urgent Care</u>
Your medical plan covers urgent care. An urgent condition is one that requires immediate care but is not life-threatening. If you seek urgent care while traveling, you or someone acting on your behalf should notify your doctor within 48 hours of the onset of the urgent condition.

Annual physical exams and cancer screening tests are covered in full

<u>Other Plan Considerations</u>
Take advantage of the fact the Medical plan covers 100% of scheduled annual physical exams and cancer screening tests related to the physical exam when you use an in-network provider. There is no copay or deductible, however, keep in mind that if your physician orders a test that is not part of the scheduled preventative care exam/test, those procedures may result in some out-of-pocket expense for you. It is always a good idea to check with your doctor's office before your visit, to see what tests or exams are planned. Then, call your health plan to make sure you understand if and how those tests will be covered.

Preventive dental care is covered at 100%

Your dental plan is designed to provide the dental coverage you need with the features you want. Take advantage of what this plan has to offer without compromising what matters most - including the freedom to visit the dentist of you and your dependents choice – an "in-network" dentist or an "out-of-network" dentist. Do not forget that your preventive care – is covered at 100% once every six months.

Medical Options – What is the difference?

CHC offers a choice between two Preferred Provider (PPO) medical plans through Premera Blue Cross; a Base Qualified High Deductible Health Plan ("QHDHP"), which allows eligible enrollees to contribute to a Health Savings Account (HSA) and a more traditional Buy-up PPO medical plan. Both plans utilize the same "Heritage Plus" network through Premera and the level of benefits you receive is dependent upon your choice of an In-Network Heritage Plus provider or an Out-of-Network/Non-Contracted provider. Significantly higher benefits will be received when you obtain care from an In-Network provider.

We also offer an HMO option with Kaiser Permanente. It is important to note there is no out-of-network benefit on the HMO plan except in the case of emergencies. All services must be received at a Kaiser Permanente HMO provider location. The Kaiser plan is also a QHDHP which will allow you to contribute to the HSA. The chart below is a brief outline of the plans. Please refer to the Summary Plan Description for complete plan details.

	Premera Blue Cross QHDHP (Heritage Plus Network)		Premera Blue Cross Buy-up PPO Plan (Heritage Plus Network)		Kaiser Permanente HMO QHDHP
	In- Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Only
Calendar Year Deductible					
Individual	$1,500	$3,000	$1,500	$3,000	$1,500
Family	$3,000 Aggregate*	$6,000 Aggregate*	$4,500	$9,000	$3,000 Aggregate*
Coinsurance	80%	50%	80%	50%	80%
Maximum Out-of-Pocket					
Individual	$2,500 (includes deductible)	Unlimited	$3,000 (includes deductible and copays)	Unlimited	$3,500 (includes deductible)
Family	$5,000 Aggregate* (includes deductible)	Unlimited	$9,000 (includes deductible and copays)	Unlimited	$7,000 Aggregate* (includes deductible)
Physician Office Visit					
Primary Care	80%	50%	$25 copay	50%	80%
Specialty Care	80%	50%	$25 copay	50%	80%
Preventive Care					
Adult Periodic Exams	100% (dw)	Not covered	100% (dw)	Not covered	100% (dw)
Well-Child Care	100% (dw)	Not covered	100% (dw)	Not covered	100% (dw)
Diagnostic Services					
X-ray and Lab Tests	80%	50%	80% (dw)	50%	80%
Complex Radiology	80%	50%	80% (dw)	50%	80%
Urgent Care Facility	80%	50%	$25 copay	50%	80%
Emergency Room Facility Charges	80%	80%	$100 copay (waived if admitted), 80%	$100 copay (waived if admitted), 80%	80%
Inpatient Facility Charges	80%	50%	80%	50%	80%

(dw) = deductible waived

*Aggregate: If more than one person is covered on the QHDHP, the family deductible must be satisfied before services are covered for any one covered individual. In addition, the family out-of-pocket maximum will also apply for services obtained by any one individual.

	Premera Blue Cross QHDHP (Heritage Plus Network)		Premera Blue Cross Buy-up PPO Plan (Heritage Plus Network)		Kaiser Permanente HMO QHDHP
	In- Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Only
Outpatient Facility and Surgical Charges	80%	50%	80%	50%	80%
Mental Health					
Inpatient	80%	50%	80%	50%	80%
Outpatient	80%	50%	$25 copay	50%	80%
Substance Abuse					
Inpatient	80%	50%	80%	50%	80%
Outpatient	80%	50%	$25 copay	50%	80%
Other Services					80%
Chiropractic (12 visits per year)	80%	50%	$25 copay	50%	80% (10 visits/yr)
Retail Pharmacy (30 Day Supply)					
Generic (Tier 1)	80%	80%	$15 copay	$15 copay, plus 40% to allowable amount	80%
Preferred (Tier 2)	80%	80%	$30 copay	$30 copay, plus 40% to allowable amount	80%
Preferred Specialty (Tier 3)	80%	Not Covered	$50 copay	Not Covered	80%
Non-Preferred (Tier 4)	80%	80%	70%	70% of allowed amount	Not Covered
Mail Order Pharmacy (90 Day Supply)*					
Generic (Tier 1)	80%	Not Covered	$37.50 copay	Not covered	80%
Preferred Brand (Tier 2)	80%	Not Covered	$75 copay	Not covered	80%
Preferred Specialty (Tier 3) (30 Days)*	80%	Not Covered	$50 copay	Not covered	80%
Non-Preferred (Tier 4)	80%	Not Covered	70%	Not covered	Not Covered

Note: We enhanced our prescription formulary to include more preventive medications that are covered in full at no cost to you. In addition, cost shares for insulin have been limited to $100 for each 30-day supply of a covered insulin drug.

Employee Contributions (Monthly Pre-Tax)			
	Base QHDHP Plan	Buy-up PPO Plan	Kaiser Permanente
Employee	$0	$159.66	$0
Employee & Spouse/DP	$497.12	$753.47	$418.09
Employee & Child	$248.56	$456.56	$209.04
Employee & Children	$461.62	$711.07	$388.23
Employee & Spouse/DP & Child	$745.68	$1,050.36	$627.12
Employee & Spouse/DP & Children	$958.74	$1,304.87	$806.31

Domestic partners and their children who do not qualify as dependents under Section 152 of the Internal Revenue Code, the Premium associated with your domestic partner coverage will be paid by the employee with after-tax dollars.

Prescription Drug Program

Premera's prescription drug plan requires the use of generic drugs when available. Your doctor may request a brand-name drug instead of a generic, but if a generic equivalent is available, payment of the difference in price between the brand-name drug and the generic equivalent is required in addition to paying the applicable brand-name drug copay. Under the Premera QHDHP there are no charges for specific preventive drugs.

"Specialty drugs" are drugs that are used to treat complex or rare conditions and that require special handling, storage, administration or patient monitoring. Premera has contracted with Accredo, a specialty pharmacy manager in the delivery and clinical management of specialty drugs. Specialty drugs must be dispensed through the Specialty Pharmacy Program. These medications are limited to a 30-day supply and are subject to the copays or coinsurance levels specified under the prescription drug benefit. For more information call Premera Blue Cross or visit Premera's website at www.premera.com. CHC is using the Essentials "E4" formulary. Individuals currently taking specialty medication will be contacted directly by Premera for assistance in moving your prescription.

To determine what tier applies to a specific medication under the Kaiser Permanente plan you can review the formulary list at www.kp.org/wa. If you are taking maintenance drugs, prescriptions you take every day, week or month, you can take advantage of the Mail Order Program with Kaiser Permanente. Under the Kaiser Permanente HMO plan, all prescriptions must be filled at a Kaiser Permanente facility or through Kaiser Permanente's mail order program. Prescriptions filled at non-participating pharmacies are not covered. On the HMO plan it is also important to note prescriptions that are not on Kaiser Permanente's formulary are not covered.

Out of Area Benefits

Individuals are able to receive the In-Network level of benefits while traveling or living outside of the Premera Blue Cross service area through the Blue Cross/BlueShield Association's BlueCard Program. However, if you obtain care from a Non-PPO Provider, the claim will be processed at the Out-of-Network level, and you may also be responsible for any charges above the Usual, Customary or Reasonable (UCR) or allowable amounts as well as the applicable coinsurance and deductible. In order to utilize this benefit when outside the service area and in need of health care, call 1-800-810-BLUE (2583) from within the United States, or go to www.bcbs.com.

If you are on the HMO Plan, whenever you travel outside the Kaiser Permanente of Washington service area you can receive care at any of Kaiser Permanente's nationwide facilities in the event of an illness or injury. Cost shares will be the same as they are at Kaiser Permanente Washington facilities. However, some services will require preauthorization from Kaiser Permanente, and you will need to call Kaiser Permanente of Washington in advance of the visit.

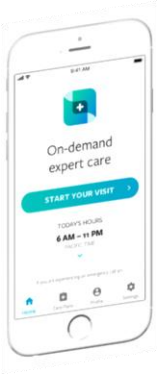
In an emergency, after your condition has stabilized, you or a family member must call the Kaiser Permanente Notification Line within 24 hours or as soon thereafter following the emergency. If you receive urgent or emergency care at a nonaffiliated hospital or medical center, you may be required to pay in full at the time of service. If so, save your medical receipts and Kaiser Permanente will reimburse you for covered services. If you need urgent care while away, call the Kaiser Permanente Consulting Nurse for assistance regarding your care. If you are away from home but still in the U.S., a nurse will help direct you to a facility that can provide the medical care you need. By calling before you seek care, Kaiser Permanente may be able to arrange for you to go to a facility with which they have a reciprocal agreement. This may help reduce your share of the costs.

---

24 Hour NurseLine

Registered Nurses are available to consult with enrollees 24 hours a day, 7 days a week regarding health concerns, answer questions about diseases, medications and medical tests, as well as discuss what to ask your doctor. Other information on exercise, nutrition, alternative health care, and other wellness topics are also available. The NurseLine does not diagnose; however, having access to additional information can often put your mind at ease. To access care, please see the number on your ID card. Services are offered for both Premera and Kaiser Permanente.

98point6 On Demand Primary Care



98point6 is an on-demand primary care option via secure in-app, text-based messaging that is accessible wherever you are and whenever you need assistance. Service extends beyond episodic care, including medical questions, diagnosis and treatment, prescriptions, labs, referrals, follow-up, reminders and more. Care is provided by quality U.S. based board-certified physicians who can diagnose, treat and follow-up. It is accessible through private in-app messaging making connecting with 98point6 as accessible as your mobile phone. During the 2021 calendar year the copay is waived to use the program on both the QHDHP and PPO plans. Beginning 2022 there will be a $5 cost per visit on the QHDHP and $0 on the PPO for the first 36 visits.

98point6 is available to you and your enrolled dependents age 1 or older, 24 hours a day, 7 days a week and can treat more than 350 conditions. For more information and to register to be visit ready, go to https://www.98point6.com/how-it-works/

Kaiser Permanents – Online Visit

The Online Visits is available to enrollees on Kaiser Permanente. It is an affordable and accessible way to receive health care—combining quality care with the convenience of a computer, smartphone, or tablet. Online Visit can address common medical issues (cold, flue, allergies, pink eye, etc.) that can be safely and accurately diagnosed without a physical examination. With Online Visits you can connect online with a Kaiser Permanente clinician for a fast diagnosis, often within an hour.

A fast diagnosis is the quickest way to a speedy recovery. And it's a great way to help you avoid time off for doctor visits, traffic, and long lines when you don't feel well. If you need to get back on track fast, get quick care at www.kp.org/wa/onlinevisit.

Livongo

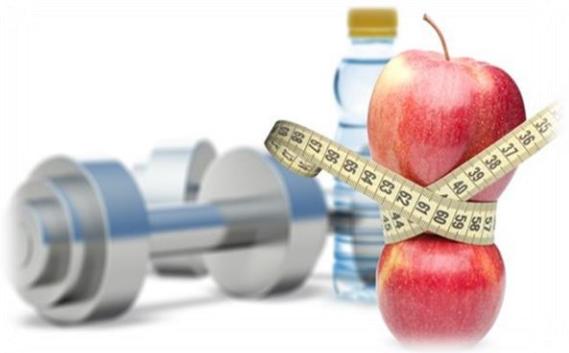
We understand how hard it can be to manage your diabetes. The Premera Livongo program focuses on taking away the daily stress and hassle of managing this chronic condition through a cellular enabled blood glucose meter, real-time analytics, expert coaching and free unlimited supply of test strips. The touchscreen meters make it easy to see health data in one convenient location and participants receive real-time analytics and feedback based on their current readings. The analytics make it easy to track or share data with your provider. Coaches are available 24/7 and you can customize your notification levels.

Kaiser Permanente Extras!

Take advantage of the Kaiser Permanente healthy discounts available to members covered under the HMO plan. Programs include:

- Fitness Discounts with Active&Fit
- Discounts for vision, acupuncture, chiropractic care and massage therapy
- Wellness Coaching and Lifestyle Programs
- Tobacco Cessation Programs
- Classes and Support Groups

Visit wa.kaiserpermanente.org for more information.



Dental Insurance

Benefit eligible employees and their dependents may enroll in the dental benefits through Delta Dental of Washington. Although you can go to any dentist you wish, your plan year maximum will stretch farther if you go to a Delta Dental Preferred Provider (PPO) who offers the greatest discounts on their usual fees and cannot balance bill. A dentist contracted with Delta Dental as a Premier Provider also offers discounts and cannot bill for amounts over the contracted rate. If you go to an out-of-network/non-participating provider, you may need to submit your claims to Delta Dental of Washington and can be billed for costs over Delta Dental's allowable amount for care received ("balance billing"). To find a contracted provider, visit www.deltadentalwa.com.

Please Note: It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to know what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.

(dw) = deductible waived	Delta Dental of Washington	
	In-Network Benefits Preferred and Premier Dentists	Out-of-Network Benefits
Calendar Year Deductible (Waived for Preventive Care)		
Individual / Family	$50/$150	(Shared with In-Network)
Calendar Year Maximum		
Per Person	$2,000	(Shared with In-Network)
Preventive	100% (dw)	100% of allowable amount (dw)
Basic	80%	80% of allowable amount
Major	50%	50% of allowable amount
Orthodontia		
Benefit Percentage	100%	100% of allowable amount
Adults & Dependent Children	Covered	Covered
Lifetime Maximum	$1,000	(Shared with In-Network)
Delta Dental Employee Contributions (Monthly Pre-Tax) Domestic partners and their children who do not qualify as dependents under Section 152 of the Internal Revenue Code, the Premium associated with your domestic partner coverage will be paid by the employee with after-tax dollars.		
Employee	$0.00	
Employee & Spouse/DP	$36.00	
Employee & Child	$17.99	
Employee & Children	$33.42	
Employee & Spouse/DP & Child	$53.99	
Employee & Spouse/DP & Children	$69.42	

Vision Insurance

Vision examinations not only determine the need for corrective eye wear but also may help detect other general health problems such as glaucoma, cataracts, and diabetes. Plus, eye exams for children can help detect problems that can impact learning and development. You will obtain the best value from your vision care plan when you visit a Vision Service Plan (VSP) network doctor. If you decide not to see a VSP doctor, the out-of-network benefits will apply, you will need to pay for your services and submit to VSP for reimbursement. The choice is yours—either way, your vision benefits are a tremendous part of your overall benefits package. To find a provider, visit www.vsp.com.

	Vision Service Plan	
Copay	**In Network**	**Out of Network**
Routine Exams (every 12 months)	$20 copay	$50 Allowance
Vision Materials		
Materials Copay	$20 copay	Not Applicable; see Allowance
Standard Lenses (every 12 months)	Covered in Full	Single Vision: $50 Allowance Lined Bifocal: $75 Allowance Trifocal: $100 Allowance
Contacts Covered in lieu of frames and lenses (every 12 months). Medically necessary contacts may be covered at a higher benefit level	Elective Contacts $130 Allowance In lieu of glasses; $60 fitting fee may apply	$105 Allowance
Frames (every 24 months)	$130 Allowance Featured Frames $150 Allowance 20% savings over the Allowance	$70 Allowance

Vision Service Plan (VSP) Employee Contributions (Monthly Pre-Tax)	
Employee	$0.00
Employee & Spouse/DP	$2.84
Employee & Child(ren)	$2.84
Employee & Spouse/DP & Child(ren)	$10.09

Domestic partners and their children who do not qualify as dependents under Section 152 of the Internal Revenue Code, the Premium associated with your domestic partner coverage for Dental and Vision, will be paid by the employee with after-tax dollars.

Life and AD&D

CHC provides Basic Life and Accidental Death and Dismemberment Insurance (AD&D) benefits to eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Prudential Insurance Co of America	
Employee Only Coverage	
Life Benefit	1 times salary to $300,000
AD&D	1 times salary to $300,000

The above benefit will reduce to 65% at age 65 and 50% at age 70. Imputed income will apply for any amount of Basic Life Insurance in excess of $50,000.

Important Reminder! Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.

Voluntary Offerings

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance through Prudential. Your election, however, could be subject to medical questions and evidence of insurability. Your contributions will depend on your age and the amount of coverage you elect. Employees may purchase Life/AD&D insurance coverage in increments of $10,000, not to exceed $500,000 or seven times your salary. The Guarantee Issue amount is $150,000 at the time of your initial eligibility.

Spouse/Domestic Partner Life/AD&D insurance may be purchased in increments of $5,000, not to exceed 50% of the employee election up to $150,000. The Guarantee Issue amount is $50,000 at the time of their initial eligibility. Child Life/AD&D insurance may be purchased for your unmarried dependent child(ren) in increments of $2,000 to a maximum of $10,000 for ages 14 days to 26 years. The Guarantee Issue amount is the full $10,000 at their initial eligibility.

Voluntary Life/AD&D Rates
Premiums Effective July 1, 2021

Age	Rates per $1,000
Under Age 30	$0.05
Age 30-34	$0.07
Age 35-39	$0.08
Age 40-44	$0.10
Age 45-49	$0.14
Age 50-54	$0.23
Age 55-59	$0.42
Age 60-64	$0.56
Age 65-69	$1.08
Age 70-74	$1.75
Age 75+	$2.00
Child/Children	$0.086

AD&D	Rates per $1,000
Employee	$0.009
Spouse	$0.013
Child/Children	$0.004

Guarantee Issue

At the time of your initial eligibility, you may purchase a certain amount of insurance without underwriting. This is known as “Guarantee Issue”. Amounts elected over the Guarantee Issue amount will require Evidence of Insurability (EOI) and need to be approved by Prudential. During the annual open enrollment period, enrolled employees may increase coverage by any increment up to $50,000, not to exceed the guaranteed issue amount, without providing EOI to Prudential. All other elections or enrolling after the enrollment period, will require EOI and approval by Prudential.

Considerations

There are two points to consider when deciding how much life insurance coverage you might need:

1. If you have dependents that rely on you, how much will they need to pay your funeral expenses, current debts such as your mortgage, car loans, or credit card balances?
2. What will it cost your beneficiaries to maintain their current standard of living in the short and long term?

Voluntary life/AD&D benefits are non-taxable when funded with post-tax dollars. The price you pay for voluntary group term life/AD&D insurance is a function of your age and your coverage amount. The table shows the price per $1,000 of coverage for voluntary life/AD&D insurance. You may purchase life with or without AD&D, however you must purchase life in order to purchase AD&D insurance.

The voluntary life plan is portable. This means you can apply to take the coverage with you if you leave CHC.

Voluntary Short-Term Disability Offering

CHC offers a voluntary short-term disability option through Prudential Insurance Co of America. This benefit covers 60% of your weekly base salary up to $2,000/week. The benefit begins after 14 days of injury or illness and lasts up to 11 weeks. This benefit will offset with any state statutory benefits including Washington Paid Family Medical Leave (WPFML). The WPFML benefit pays a maximum of $1,206 per week and may not completely replace your income.

Pre-existing condition exclusions will apply. A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in the three (3) months prior to your enrollment date. The plan will not pay a benefit for any pre-existing condition that results in a disability during your first twelve (12) consecutive months of coverage. Please see the Certificate for complete plan details. In the event of a disability claim, payments would not be considered taxable income.

Monthly Short-Term Disability Post-Tax Rates (Per $10 of Benefit) - Effective July 1, 2021

Employee Age	Rate	Employee Age	Rate	Employee Age	Rate	Employee Age	Rate
Under 35	$.316	40-44	$.239	50-54	$.297	60-64	$.381
35-39	$.265	45-49	$.265	55-59	$.336	65+	$.413

Employer Paid Long-Term Disability Insurance

CHC offers long term income protection through Prudential Insurance Co of America in the event you become unable to work due to an illness or injury. This benefit covers 60% of your monthly base salary up to a maximum of $10,000. Benefit payments begin after 90 days of disability. Benefits under the Long-Term Disability plan are payable up to your Social Security Normal Retirement Age (SSNRA) as long as you remain disabled. This plan may offset with any state statutory disability plans, including Washington Paid Family Medical Leave. The definition of disability is classified as:

- Providers and Pharmacists: Your own occupation or 20% earnings loss
- All other employees: Your own occupation or 20% earnings loss for the first 24 months. Any occupation thereafter.

Pre-existing condition exclusions will apply to the plan. This is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in the three (3) months prior to your enrollment date. The plan will not pay benefits for any pre-existing conditions that results in a disability during the first twelve (12) consecutive months of coverage. See Certificate of Coverage for benefit duration. Please see the Certificate for complete plan details. In the event of a disability claim, payments would be considered taxable income.

Health Savings Account (HSA)

When you are enrolled in either of the Qualified High Deductible Health Plans (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account. CHC will contribute $1,000 to your HSA account per plan year. The contribution is evenly distributed throughout the plan year on the first paycheck of each month. CHC contributions will begin once you have opened and established your account. You must be employed and on a QHDHP to receive the contribution.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so unused funds grow.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP). Both the Premera Base Plan and Kaiser Permanente plans are QHDHP's.
- You cannot be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional General Purpose Healthcare Flexible Spending Account (FSA). This includes your spouse's FSA. Enrollment in a Limited Purpose FSA is allowed.

HEALTH SAVINGS ACCOUNTS (HSA)
Calendar Year Contribution Limits
Includes Community Health Center of Snohomish County
Pro-Rated Contribution of $1,000

QHDHP Medical Plan Enrollment	Calendar Year 2021	Calendar Year 2022
Employee Only Enrollment Maximum	$3,600	$3,650
Employee + 1 or more Enrollment Maximum	$7,200	$7,300
HSA Account Owners Age 55 or Over	Additional $1,000 "Catch-up"	

If you are eligible to contribute to an HSA, an account must be opened for an expense to be eligible for reimbursement through the HSA. An HSA is a bank account and you cannot be reimbursed for more than you have in the account. However, you can make partial reimbursements, or alternatively delay reimbursement until you have sufficient funds to cover the expense. You may change your payroll contribution amount to your HSA on a monthly basis.

All employees who enroll for the first time in either of the QHDHP medical plans will need to complete an application to open an HSA at Optum Bank in order to receive the employer contribution and any elected payroll deferrals. For information on how to open this account, please speak with Human Resources. The company will pay the monthly account fee for your HSA account at Optum Bank. Any other fees, including investment/transaction fees, are your responsibility. Once your account is open you will receive a debit card to easily pay for eligible expenses. Additionally, should you elect to open your HSA at another bank, you will be responsible for all account fees at that institution.

You can use the funds in your HSA for any Section 213(d) eligible health expenses (medical, dental and vision) for yourself, your spouse and your tax dependents, even if they are not covered under the medical plan. If you use your HSA funds for an eligible expense they remain tax-free; however, if you use your HSA funds for a non-eligible expense, the distribution will be subject to income tax and if you are under age 65, a 20% penalty.

Important note regarding domestic partners: While you may enroll your registered domestic partner in our benefit plans, the expenses for non-tax dependent domestic partners are generally not eligible for reimbursement through an HSA under IRS regulations. However, your domestic partner may be able to open their own HSA, assuming they have no other disqualifying coverage.

Flexible Spending Accounts

One of the valuable opportunities CHC offers is tax savings through two Flexible Spending Accounts (FSAs). An FSA is a type of cafeteria plan authorized under Section 125 of the Internal Revenue Code. FSA's allow employees to purchase certain benefits, such as medical or dental expenses, on a pre-tax basis. When you participate in an FSA plan via salary reduction, you reduce your federal, FICA, Social Security, Medicare taxes and increase your take-home pay. The money that is deposited into your Flexible Spending Account comes straight out of your gross pay, therefore reducing taxes.

The Flexible Spending Account (FSA) is with Navia Benefit Solutions. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

The Health Care FSA

With the CHC Health Care FSA you can set aside up to $2,750 into a General Purpose or a Limited Purpose Health FSA. A Limited Purpose FSA is for those individuals enrolled in the QHDHP and participating in an HSA. FSA's are offered each year on a pre-tax basis to pay for expenses you know you are going to have, such as medical out-of-pocket costs (General Purpose only), plan deductibles, copayments, dental and vision care or other out–of–pocket health and dental expenses. The dollars you contribute to your Health Care FSA are deducted from your paycheck pre-tax and are available to pay for most necessary health care services that are not covered by insurance.

Examples of eligible expenses for reimbursement from the General Purpose Health Care FSA include: deductibles and coinsurance amounts not covered by medical dental and vision plans; over–the–counter medications (e.g. aspirin and cough syrup); copays or coinsurance for prescribed drugs; smoking cessation programs; immunizations; surgery to improve vision (LASIK); in vitro fertilization; orthodontic care; psychological and psychiatric care; surgery to reverse sterilization; chiropractic expenses; eyeglasses and contact lenses, hearing exams and hearing aids; and prescription vitamins.

Examples of eligible expenses for reimbursement from the **Limited** Purpose Health Care FSA include deductibles, coinsurance and copay amounts not covered by the dental and vision plans; surgery to improve vision (LASIK); orthodontic care; eyeglasses and contact lenses.

New participants will receive a debit card from Navia to pay for eligible expenses under the health care FSA. If you already participate and have a debit card, it is typically replaced by Navia every 2-3 years.

The Dependent Care FSA

With the Dependent Care FSA you can set aside up to $5,000 each year to pay for dependent care expenses you incur in order to work (if you're married but filing separately, federal regulations limit the use of a Dependent Care FSA to $2,500 per household each year). For the 2021 tax year, the IRS is allowing up to $10,500 per household. This must be adjusted in 2022 as it is anticipated the maximum will return to $5,000. In order to participate, you and your spouse must be actively at work or attending school. As with your Health Care FSA, you can save 25% or more on your dependent care expenses, depending on your personal tax rate. You should consult your tax advisor to determine whether the Dependent Care FSA or the dependent care deduction on IRS Form 1040 would be more advantageous for you.

In order to qualify for a Dependent Care FSA, the IRS has established two regulations. The first is that an eligible dependent is any child under the age of 13 or an eligible dependent who is physically or mentally incapable of caring for his or her own needs, such as an invalid parent. The second is that if you claim the dependent care credit on your tax return or collect compensation through your Dependent Care FSA, you must report the name, address, and taxpayer identification number of each dependent care provider. If you do not comply, you will either lose the credit or pay taxes on the income placed in your Dependent Care FSA.

How an FSA Works

Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year. The amount is automatically deducted from your pay at the same level each pay period. As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

The Important "Use It or Lose It" Rule

Because of the tax-advantages offered by both the Health Care FSA and Dependent Care FSA, the IRS has established strict guidelines for how these plans may be used. One of these guidelines is known as the "use it or lose it" rule. This rule states if you contribute your pre-tax dollars to an FSA and do not use all of the dollars you deposit, you will lose any remaining balance in the account at the end of the plan year. For this reason, it is essential that you plan ahead before deciding how much to contribute to an FSA account. Put aside only those dollars you are confident you will use.

Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event. You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. Re-enrollment in an FSA is required each year. A General Purpose FSA must have a zero balance at the end of the plan year to be eligible to enroll in the QHDHP.

	Plan Year Maximum Annual Election
Health Care FSA	$2,750 General Purpose or Limited Purpose
Dependent Care FSA	$10,500 for the 2021 Tax Year; $5,000 for the 2022

Employee Assistance Plan (EAP)

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices or locating additional help.

It's free…CHC covers the cost of up to five face to face sessions per occurrence per year and referral services. If there is a need for further counseling or treatment, your counselor will help you explore various options.

It's confidential…Your EAP services are provided by ComPsych offered through Prudential Insurance Co of America. This is an outside counseling resource to assure confidentiality. No one at work will know you have chosen to seek assistance from the EAP and nothing concerning your use of EAP will appear in your personnel file.

ComPsych is only a phone call away at 800-311-4327 and available 24 hours a day, 7 days a week or visit online at www.guidanceresources.com webID: GEN311.

Travel Assistance Program

Emergencies happen. When they happen far from home, it's comforting to know there's a team of multilingual professionals standing by to help. Prudential Insurance's Travel Assistance Program (provided by IMG Global) offers a variety of services worldwide—and everyone is just a phone call away.

IMG provides medical assistance services including convalescence arrangements, inpatient/medical monitoring, referrals, prescription transfer/shipping, interpretation and telemedicine. They are also there to assist with emergency medical transportation services, repatriation, lost documents/luggage, identity theft, pre-trip planning and cultural information. Their Travel Intelligence app gives you the tools and information you need to stay informed and minimize risk when away from home. It provides 24/7 support to keep users up to date about global developments regardless of where you are in the world. For more information on the program, please refer to the IMG summary. We recommend putting their brochure in your suitcase when you travel.

Voluntary Legal and ID Theft Services

Benefit eligible employees may enroll in a voluntary pre-paid legal service program through LegalShield. LegalShield gives you the ability to talk to an attorney on any matter without worrying about high hourly costs. For one flat monthly fee you can access legal advice, no matter how traumatic or trivial the issue, including emergency assistance 24/7. From real estate to divorce advice, identity theft and beyond, LegalShield is available to assist you. Visit www.legalshield.com or call 800-654-7757. Information is also available via their mobile app at MyLegalShield and MyIDShield.

- Access for covered emergency situations, 24/7
- Assistance with traffic-related issues
- Lawyers prepare your will, living will and healthcare power of attorney
- Letters/call made on your behalf
- Trial Defense – pre-trial and representation at trial
- 25% discount on additional legal services not covered under your LegalShield plan

Your LegalShield plan covers you, your spouse and your dependent children (never married children under age 21 and living at home, dependent children under age 18 for whom you are the legal guardian, never married full-time college student children up to age 23, and physically or mentally challenged child living at home).

LegalShield and IDShield	LegalShield Monthly Rate	IDShield Monthly Rate	Combined Monthly Rate
Individual	$16.95	$8.95	$25.90
Family	$18.95	$18.95	$33.90

Critical Illness, Accident and Hospital Indemnity Programs

CHC is pleased to offer three voluntary programs through The Hartford. Together, the Critical Illness, Accident and Hospital Indemnity programs help to fill potential financial gaps in the event of a covered illness or accident. The Critical Illness plan provides a lump-sum benefit when you are diagnosed with a covered major illness. The Accident benefit provides a flat payment for related expenses and treatments due to a covered injury and the Hospital Indemnity plan provide a cash benefit in the event you are hospitalized. These cash benefits are independent from coverage provided by your medical insurance. There are no restrictions on how to use the benefits. You can use them to pay deductibles, copays or on whatever you need the most.

Voluntary Critical Illness

If you enroll in the Critical Illness plan, you'll receive a lump-sum payment when you or a covered dependent are diagnosed with a covered illness. You can elect $10,000 or $20,000 of coverage for yourself. Your spouse can be covered at 50% of your election and children at $5,000. In addition, the plan includes a $50 Health Screening Benefit per covered person, per year. If you, or a covered dependent, visit the doctor for a wellness exam and participate in a covered screening, the plan will reimburse you $50.

Covered Illnesses	Benefit
Benign Brain Tumor*; Invasive Cancer*	100% of coverage amount
Non-invasive Cancer	25% of coverage amount
Heart Attack*, Heart Transplant*, Stroke*	100% of coverage amount
Aneurysm; Angioplasty/Stent; Coronary Artery Bypass Graft	25% of coverage amount
Coma*, End Stage Renal Failure; Loss of Hearing, Speech or Vision; Major Organ Transplant*; Paralysis	100% of coverage amount
Bone Marrow Transplant	25% of coverage amount
Child Conditions	
Cerebral Palsy; Congenital Heart Disease; Cystic Fibrosis, Muscular Dystrophy; Spina Bifida	100% of coverage amount
Additional Benefits	
Recurrence – Pays a benefit for a subsequent diagnosis of conditions marked with an asterisk	100% of original benefit amount
Health Screening Benefit	$50 once per year per covered person

Critical Illness Rates (Monthly Post-Tax)								
	$10,000 Employee Coverage Amount				$20,000 Employee Coverage Amount			
Age	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
18-24	$3.64	$6.02	$7.34	$10.33	$6.08	$9.70	$9.79	$14.02
25-29	$4.30	$7.03	$7.74	$11.03	$7.33	$11.56	$10.76	$15.56
30-34	$4.76	$7.73	$7.72	$11.18	$8.19	$12.88	$11.15	$16.33
35-39	$5.94	$9.52	$8.63	$12.65	$10.55	$16.41	$13.24	$19.54
40-44	$8.24	$13.06	$10.69	$15.91	$15.05	$23.30	$17.50	$26.15
45-49	$12.50	$19.68	$14.89	$22.47	$23.49	$36.35	$25.88	$39.14
50-54	$17.16	$26.91	$19.48	$29.62	$32.80	$50.79	$35.13	$53.50
55-59	$23.17	$36.27	$25.48	$38.96	$44.81	$69.48	$47.12	$72.18
60-64	$32.27	$50.37	$34.56	$53.04	$63.02	$97.70	$65.30	$100.36
65-69	$44.09	$68.38	$46.37	$71.04	$86.64	$133.70	$88.93	$136.36
70-74	$58.33	$90.22	$60.61	$92.88	$115.12	$177.39	$117.41	$180.05
75-79	$76.14	$117.27	$78.42	$119.94	$150.75	$231.50	$153.03	$234.16

Please see the summary of benefits for more information on the Critical Illness Plan. This plan is portable, allowing you to take it with you if you leave employment with Community Health Center of Snohomish County.

New

Voluntary Hospital Indemnity

Hospital Indemnity insurance pays a cash benefit if you or an insured dependent are confined in a hospital for a covered illness or injury. It also provides additional daily benefits for related services. The benefits are paid in a lump sum amount to you and can help offset expenses which are not covered by your plan (i.e. deductibles, copays or coinsurance) or it can be used to pay any non-medical expenses such as housing costs or groceries.

- Initial Confinement: $500, once per year
- Daily Hospital Confinement: $100 per day, up to 30 days per year
- Daily ICU Confinement: $200 per day, up to 20 days per year
- Health Screening Benefit: $50, once per year

Voluntary Accident Insurance

Injuries occur and children get hurt each year playing sports or participating in recreational activities. When covered under the Accident insurance you will receive a cash benefit for covered accidental injuries, related services and treatments. These may include:

- Diagnostic exams, x-rays and other emergency services
- Hospital Treatment and Surgical Care
- Initial and Follow-up Physician Visits
- Ambulance Transportation
- Bone Fractures and Dislocations
- Concussions, Lacerations and Burns
- Follow-up/recovery services, including physical therapy and more

You can use the payment any way you choose – from expenses not covered by your major medical plan to day-to-day costs of living.

(Monthly Post-Tax Rates)	Hospital Indemnity Monthly Premium	Accident Insurance Monthly Premium
Employee Only	$9.28	$5.18
Employee + Spouse/Partner	$16.06	$7.82
Employee + Child(ren)	$17.33	$7.66
Employee + Family	$25.44	$12.08

Please see the summary of benefits for more information and details on the benefit reimbursements for the Accident plan. This plan is portable, allowing you to take it with you if you leave employment with Community Health Center of Snohomish County.

Changes in Benefit Elections

Open Enrollment:

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage
- Enroll, or re-enroll in dependent or health care flexible spending accounts. To continue your FSA benefits, you must re-enroll each plan year.

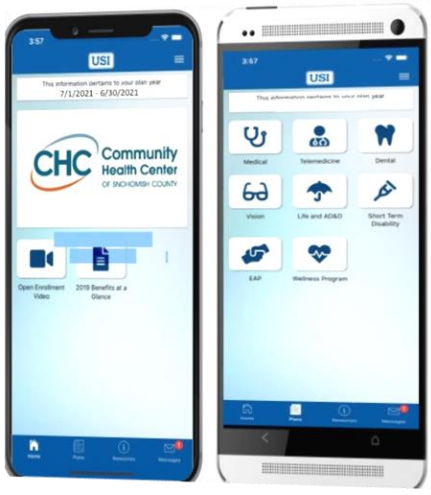
If you do not make your 2021 benefit elections, you will automatically be defaulted to your prior year elections, except for the FSA, which will default to zero ($0).

Mobile Benefit App

Access all your benefits insurance policy details and contact information while on the go! The free application will provide you with:

- The CHC Benefit Guide
- Policy Numbers
- Plan Summaries / Details
- Benefit Resource Center (BRC) contact information
- Ability to store photos of your ID cards for your benefit plans
- The Human Resource team contact information

It is easy to install. From your App Store, search for **usieb**.
When prompted, enter the code **814833** to access the Community Health Center of Snohomish County benefit details.



Other Benefits

CHC Retirement Savings Plan

As a CHC employee, you become eligible to participate in the CHC Retirement Savings Plan. Enrollment is available year-round, and members are eligible to enroll as of the first day of employment.

CHC's Retirement Savings Plan, also known as a Safe Harbor 403(b) Plan, is designed to help you prepare the foundation today for your financial independence at retirement. CHC's Plan offers several special advantages which play a large part in making savings for retirement easy and affordable:

1. 403(b) (pre-tax contribution)

- Your contributions reduce your taxable income. You can reduce your current taxable income (and, therefore your current taxes).
- Your earnings compound on a tax-deferred basis. No taxes are owed on your earnings until you withdraw money from your account. You will have more money that could benefit from years of compounded growth.
- Withdrawals at retirement are taxable. Because you have not yet paid taxes on your plan contributions, you will be taxed when you take a cash withdrawal from your plan account.

2. 403(b) Roth (post-tax contribution)

- Your contributions are taxed up front. Roth contributions come out of your paycheck after taxes have been calculated; therefore, your current taxable income is not reduced.
- Qualified withdrawals are tax-free. Your qualified withdrawals at retirement – including earnings – will be tax-free.

3. Employer Matching Contributions

To encourage you to participate in the CHC Retirement Savings Plan, CHC may match a portion of your salary reduction contribution. Matching percentage contributions are discretionary and can be subject to change from one plan year to another. A combination of the CHC matching contribution, your individual contribution, and the tax deferred status of the plan promotes the growth of your retirement account. Please refer to the CHC Retirement Savings Summary Plan Description for full details.

When you retire or leave CHC, you will be eligible to receive the value of the funds that have accumulated in your account.

Investments

Currently, the plan investments are offered through The American Funds, one of the largest and most successful mutual fund companies in the world. The American Funds offer a wide variety of stock and bond mutual funds, as well as money market funds that will allow you to invest in a diversified manner according to your own risk tolerance. You can control how your funds are allocated by phone at 800-421-6621 or online using the American Funds robust web site at https://www.americanfunds.retirementpartner.com/participant/#/login?accu=AmFunds.

The web site requires only your Social Security number to set up a PIN. However, when you contact American Funds by phone, your Social Security number will be required, and you will be asked to answer several personal questions to determine your identity. An automated, touch-tone service is available 24 hours per day, and a live account representative is available Monday through Friday, from 5:00 a.m. – 5:00 p.m. Pacific Time.

Contributions

The maximum plan contribution permitted by the IRS in 2021 is $19,500. If you reach age 50 by December 31, you may make an additional "catch-up" contribution of $6,500. These maximums are subject to change each year.

Distributions

Distributions from your deferred account are not permitted before the age of 59½ except in the event of:

- Death
- Disability
- Separation from employment (penalties apply)
- Financial hardship
- Age 55 deferred payment

Additional Information

CHC's Retirement Savings Plan Advisor, Ross Rettenmier, is a registered principal and representative of SagePoint Financial, Inc. Ross is available to answer your investment related questions and can be reached at:

3209 Colby Avenue, suite 106
Everett, Washington 98201
Phone: 425-303-8338 or 800-729-9816
Email: rrett@sagepointadvisor.com

Refer to CHC's intranet site for the following plan information:

Summary Plan Description	Fund Matrix (investment suggestions from the plan advisor)
Enrollment	Risk Profile Quiz
Information/Booklet	Investment Options
Participant Fee Disclosure	

All questions related to enrollment, payroll deduction changes, distributions, rollovers, and pension plan administration may be directed to CHC's Human Resources Department.

Home Ownership/relocation Program

This program offered Enhanced Benefits Group, Inc. (EBGI) can help save you time and money on home ownership and relocation services. The program is available to all employees, their families and friends in all 50 states, at no cost to you. The program includes free consultations without obligation, extensive relocation assistance, refinancing loan options, home purchase and sale services—including a dedicated customer service representative throughout the process—and discounted closing costs.

Answers For All Your Home Ownership Needs

- All EBGI service providers have passed EBGI's extensive prescreening process
- Pre-negotiated discounts with all EBGI service providers to save you money
- Free consultations provided with no obligation, plus you can pick and choose the services you use
- Services available in all 50 states
- Extensive relocation assistance
- All of these benefits are available to you, your friends and your family

Refinancing

- Free consultations with EBGI mortgage brokers to help you decide if refinancing makes sense for you
- Discounted closing costs
- Many loan options available to make sure your loan makes sense in the short term and the long term

Purchasing a Home

- Programs available for first time home buyers, repeat buyers and investment buyers
- Discounted closing costs with EBGI mortgage brokers
- Real estate agents who contribute a portion of their commissions towards your closing costs
- Dedicated EBGI customer service rep to stay with you throughout the process

Selling A Home

- Prescreened real estate agents to ensure you receive expert representation
- Pre-negotiated discounts on real estate commissions
- Dedicated EBGI customer service rep to stay with you throughout the process

Moving Services

- Rental assistance
- Temporary housing
- Moving and storage services

Let EBGI help you achieve your home ownership dreams—call today! For more information or to schedule a free consultation, call 866.505.3244 or visit www.ebgi.org.

Intalere Perks at Work

We are pleased to provide you with Intalere Perks at Work, your one-stop shop for employee pricing. It leverages the purchasing power of all Intalere members to help you save money on all of your large purchases (computers, travel, etc.) as well as everyday purchases (food, utilities, etc.).

Once you register on Intalere Perks at Work, you will have access to 30,000 merchants and over 25 savings categories. You will be awarded WOWPoints in addition to the deep discounts. WOPoints are a virtual currency that you accumulate over time. They never expire and can be used to make purchases directly on the site.

Creating a new account is easy:

1. Visit Intalere Perks at Work at www.perksatwork.com
2. Click on "Register For Free" under the new hires section
3. Complete the short registration process. Note: Intalere in the "Your Company" field and use "savings12" in the Company Code" field.
4. Click on the "Complete my Profile" button. Complete the form and click the "Start Discovering Perks" button to get started.

Your account comes with a family membership. Simply logon, click on My Account and choose Family Invitations to add family members.

Contact Information

Carrier Customer Service

	CARRIER	Group Number	PHONE NUMBER	WEBSITE
Medical Plans	Premera Blue Cross	1000186	800-722-1471	www.premera.com
	Kaiser Permanente	1978900 Ind. 1979000 Fam.	888-901-4636	www.kp.org/wa
Dental PPO	Delta Dental of Washington	09291	800-554-1907	www.deltadentalwa.com
Vision	Vision Service Plan	12006891	800-877-7195	www.vsp.com
Life and AD&D	Prudential Insurance Co of America	G-52823-WA-1	800-524-0542	www.prudential.com
Short Term Disability (STD)	Prudential Insurance Co of America	G-52823-WA-1	800-842-1718	www.prudential.com
Long Term Disability (LTD)	Prudential Insurance Co of America	G-52823-WA-1	800-842-1718	www.prudential.com
Voluntary Life	Prudential Insurance Co of America	G-52823-WA-1	800-524-0542	www.prudential.com
Employee Assistance Program (EAP)	Prudential Insurance Co of America	GEN311	800-311-4327	www.guidanceresources.com
Travel Assistance	IMG	N/A	855-847-2194	www.assist@imglobal.com
Flexible Spending Account	Navia Benefit Solutions	CHC	800-669-3539	www.naviabenefits.com
Health Savings Account	Optum Bank	N/A	866-234-8913	www.optumbank.com
Critical Illness	The Hartford	00094513	866-547-4205	www.thehartford.com
Accident Insurance	The Hartford	00094513	866-547-4205	www.thehartford.com
Hospital Indemnity	The Hartford	00094513	866-547-4205	www.thehartford.com
Voluntary Legal & Identity Theft	LegalShield	N/A	800-654-7757	www.legalshield.com
Home Ownership Program	Enhanced Benefits Group	N/A	866-505-3244	www.ebgi.org
Retirement Savings Plan Advisor	Ross Rettenmier SagePoint Financial	N/A	425-303-8338	rret@safepointfinancial.com
Retirement Savings Plan 403(b)	American Funds	344368-01	800-204-3731	www.americanfunds.com/retire
Discount Program	Intalere Perks at Work	Intalere Savings12	877-711-5600	www.intalere.com

Benefit Resource Center

Have Questions? Need Help?

Community Health Center of Snohomish County is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 6:00 am to 6:00 pm Pacific Time at 866-468-7272 or via e-mail at BRCWest@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Additional information regarding benefit plans can be found on InfoConnect. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. Therefore, the following deductibles and coinsurance apply:

Premera Base QHDHP	In-Network	Out-of-Network
Calendar Year Deductible	$1,500 Individual / $3,000 Aggregate Family	$3,000 Individual / $6,000 Aggregate Family
Coinsurance	80%	50%
Premera Buy-up PPO Plan	In-Network	Out-of-Network
Calendar Year Deductible	$1,500 per person (3x family maximum)	$3,000 per person (3x family maximum)
Coinsurance	80%	50%
Kaiser Permanente QHDHP	In-Network	Out-of-Network
Calendar Year Deductible	$1,500 Individual / $3,000 Aggregate Family	N/A
Coinsurance	80%	N/A

NEWBORNS ACT DISCLOSURE - FEDERAL

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).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment 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 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

Kaiser Permanente generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at kp.org/wa/provider-directory or call 888-844-4607.

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

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at kp.org/wa/provider-directory or call 888-844-4607.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Lynell Hartman
8609 Evergreen Way
Everett, Washington 98208
425-789-3729
lhartman@chcsno.org

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of this Notice: July 1, 2021
- Dion Kapetanov, Chief Administrative Officer, 8609 Evergreen Way, Everett, WA 98208
  425-789-3723, dkapetanov@chcsno.org

Important Notice from Community Health Center of Snohomish County 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 Community Health Center of Snohomish County 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. Community Health Plan of Snohomish County has determined that the prescription drug coverage offered by Premera Blue Cross and Kaiser Permanente are, 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 current Community Health Care of Snohomish County coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Community Health Care of Snohomish County coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

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 Community Health Center of Snohomish County 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 Community Health Center of Snohomish County 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).

Date:	July 1, 2021
Name of Entity/Sender:	Community Health Plan of Snohomish County
Contact--Position/Office:	Lynell Hartman, Human Resource Manager
Address:	8609 Evergreen Way, Everett, WA 98208
Phone Number:	425 789 3729

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 January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**FLORIDA – 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	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	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: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Lynell Hartman at lhartman@chcsno.org.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Community Health Center of Snohomish County	4. Employer Identification Number (EIN) 91-1255170	
5. Employer address 8609 Evergreen Way, Everett, WA 98208	6. Employer phone number 425-789-3729	
7. City Everett	8. State WA	9. ZIP code 98208
10. Who can we contact about employee health coverage at this job? Lynell Hartman		
11. Phone number (if different from above)	12. Email address lhartman@chcsno.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Full-time employees working at least 30 hours per week are eligible for health benefits effective on the first of the month following 30 days of employment. You must be actively at work for your coverage to be effective on your eligibility date.

  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    A legal spouse or registered domestic partner, as well as your children up to age 26 regardless of their marital or student status.

  - [ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Lynell Hartman
8609 Evergreen Way
Everett , Washington 98208