2025

Benefit Summary

Yakima County

Active Employees

WELCOME TO YOUR BENEFITS!

Yakima County is proud to offer a robust benefits package to our employees and their families! Our benefits package is designed around choice, flexibility and value.

To learn about the available plans and choose which ones are right for your lifestyle and budget, take a look at this Benefits Guide. If you have general questions on your benefits or how to enroll, reach out to Human Resources or a Gallagher Benefit Advocate—their contact info is toward the back of this Guide under "*Your Benefits Contacts*."

In addition, a Summary of Benefits and Coverage (SBC) has been provided to help you make your healthcare coverage choices. The SBC summarizes information about your medical plan options and is in a standard format required by the Affordable Care Act. The SBC is available on the web at: https://yakimacounty.sharepoint.com/SitePages/YCShare.aspx. Additional copies are also available, free of charge. Please contact Human Resources at human.resources@co.yakima.wa.us to request a copy.

When open enrollment wraps up, we'll provide detailed booklets on each plan element you chose. But for now, check out this guide and online resources, and begin benefitting!

IMPORTANT:
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 pages 24-25 where Notice of Creditable Coverage begin for more details.

ACTIVES (Does Not Include Teamsters and PEBB)

- Plan #1: Premera Classic Medical/Vision/Delta Dental/Symetra Life/AD&D/Symetra Base LTD
- Plan #2: Premera CDHP Medical/Vision/Delta Dental/Symetra Life/AD&D/Symetra Base LTD

BENEFITS OVERVIEW

THE BENEFIT PLANS OFFERED ARE:

- Premera Blue Cross medical insurance covering a broad network of doctors
- Prescription drug insurance
- Dental insurance
- Life and accidental death & dismemberment insurance*
- Long-term disability insurance*
- Flexible spending accounts for tax savings on health and dependent care expenses*
- Voluntary benefits*

*NOTE: Available to Active employees only.

QUESTIONS

Contact a Benefit Advocate
(a service provided by Gallagher).
You can reach a Benefit Advocate at:
bac.yakimacounty@ajg.com or by phone:
Toll free: 833.246.1289
8:00 a.m.- 6:00 p.m. PT
Monday - Friday

WHAT'S NEW?

- **Premera Blue Cross Classic PPO plan:**
  - Deductible is increasing from $250 / $750 to $500 / $1,500
  - Out of Pocket Maximum increasing from $2,000 / $4,000 to $3,000 / $6,000
  - Coinsurance is increasing from 15% to 20% after deductible
  - Pharmacy Deductible increasing from $100 / $300 to $200 / $600
  - Pharmacy Retail Tier Maximums: $30 for generics / $80 for preferred / $160 for specialty
  - Pharmacy Mail Order Tier Maximums: $90 for generics / $240 for preferred
- **Premera Blue Cross HSA plan:**
  - Deductible is increasing from $1,600 / $3,200 to $1,650 / $3,300 due to HSA qualified HDHP guidelines for 2025.
- **Sunsetting the Voluntary Long-Term and Short-Term Disability plans:** Due to participation requirements.
  - There is not an option to continue these contracts independently, however, there are options to replace with similar coverage.

Short-Term Disability – Washington State's Paid Family and Medical Leave (PFML) State program, offers a paid leave for the care of yourself and or qualifying family member. For more information, please visit https://paidleave.wa.gov/

Long Term Disability – Individual products are available to many carriers on a direct bill basis. A quick Google search, using "individual long term disability insurance", will provide many options for review. Or, if you attended our 2024 Wellness Fair, the vendor, New York Life, does sell individual policies.

Please contact either agent:
Lisa Mansfield / Benjamin Hull
(509) 945-4859

- **Additional Voluntary Benefits:**
  - ID Theft - Allstate
  - Legal - MetLife

COST

The amount you pay depends upon which plans you elect and which dependents you choose to enroll. Yakima County contributions are listed in the payroll cost sheets which will be distributed to you from HR. Please note that a Tobacco and/or Spouse Surcharge may apply to your coverage costs. Costs for coverage of state-registered domestic partners and their children might not be deducted on a pre-tax basis. If your state-registered domestic partner is not an eligible tax dependent as defined in Section 152 of the Internal Revenue Code, then a portion of your contribution will be deducted after-tax and the company's contribution for domestic partner coverage will be taxable income to you and reported as imputed income on your paycheck. For more information, please contact Human Resources.

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

PREMERA BLUE CROSS

MEDICAL BENEFITS - PREMERA BLUE CROSS

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. The plan provides excellent coverage of preventive services that are very important to you and your family's health.

	Premera Classic		Premera CDHP	
PCY = Per Calendar Year *(January 1-December 31)*	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual/Family)	$500/$1,500		$1,650/$3,300*	
What You Pay	20%	50%	15%	50%
Annual Out-of-Pocket Maximum (Individual/Family)	$3,000/$6,000		$4,200/$8,400**	
Preventive Care	No charge	Not covered	No charge	Not covered
Outpatient Services				
Office Visit	20% after deductible	50% after deductible	15% after deductible	50% after deductible
Specialist Visit	20% after deductible	50% after deductible	15% after deductible	50% after deductible
Telemedicine	20% after deductible	Not covered	15% after deductible	Not covered
Mental Health	20% after deductible	50% after deductible	15% after deductible	50% after deductible
Diagnostic Lab & X-Ray	20% after deductible	50% after deductible	15% after deductible	50% after deductible
Surgery	20% after deductible	50% after deductible	15% after deductible	50% after deductible
Rehabilitation	20% after deductible	50% after deductible	15% after deductible	50% after deductible
	60 visits combined PCY		60 visits combined PCY	
Other Services				
Chiropractic Care	20% after deductible	50% after deductible	15% after deductible	50% after deductible
	10 visits combined PCY		10 visits combined PCY	
Acupuncture	20% after deductible	50% after deductible	15% after deductible	50% after deductible
	16 visits combined PCY		16 visits combined PCY	
Urgent Care	$75 copay + 20% after deductible	50% after deductible	15% after deductible	50% after deductible
Emergency Room (copay waived if admitted)	$75 copay + 20% after deductible		15% after deductible	
Inpatient Hospitalization	$200 per day up to $600, then			
	20% after deductible	50% after deductible	15% after deductible	50% after deductible
Vision Services				
Routine Exam (1 PCY)	No charge	No charge	No charge	No charge
Frames & Lenses Allowance	$150 every 2 calendar years		$150 every 2 calendar years	

*Employees + 1 or more dependents will have one $3,300 deductible for the whole family.
**The family out-of-pocket maximum is $8,400; however, no individual will pay more than $4,200 as their individual out-of-pocket maximum.
Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

IMPORTANT! Premera Blue Cross requires prior authorization to receive coverage for certain planned services. If prior authorization is not obtained for a required service, you will be subject to additional cost shares not outlined here. A complete list of services requiring prior authorization is available at www.premera.com.

PRESCRIPTION DRUG BENEFITS - PREMERA BLUE CROSS

Your medical insurance includes comprehensive prescription drug coverage. The level of coverage depends on whether the drug is generic or brand name, and whether it is on the Premera formulary or preferred drug list. Your out-of-pocket cost is lowest when you buy generic drugs, and highest when you buy brand name drugs that are not on the drug list. To find out if your medication is on the drug list, please check the online list at Premera.com.

When filling a prescription. present your Premera member ID card to any participating pharmacy. If using an out-of-network pharmacy, you will need to pay the drug cost out-of-pocket and then submit a claim form to Premera to be reimbursed for the amount of coverage.

	Premera Classic	Premera CDHP
Drug List	Preferred B4	Preferred B3
Prescription Deductible (Individual/Family)	$200/$600 waived for Generic & Specialty	Shared with medical deductible
Separate Prescription Out-of-Pocket Maximum	$2,000 per person	Shared with medical out-of-pocket maximum
Retail Pharmacy	30-day supply	90-day supply
Generic	10% up to $30	$20 after deductible
Preferred Brand	30% up to $80	$40 after deductible
Non-Preferred Brand	50% after deductible	50% up to $250 after deductible
Mail Order Pharmacy	90-day supply	90-day supply
Generic	10% up to $90	$40 after deductible
Preferred Brand	30% up to $240	$80 after deductible
Non-Preferred Brand	50% after deductible	50% up to $750 after deductible
Specialty	30-day supply	30-day supply
	50% up to $160	50% up to $250 after deductible

PREMERA BLUE CROSS

PRESCRIPTION DRUG BENEFITS - PREMERA BLUE CROSS

Included below is the Premera Generic Preventive Drug List (called PV Core Plus), which applies to both medical plan offerings. If your medication is listed, it will be covered in full at a participating network pharmacy. Please note this list is updated frequently on Premera.com. Please refer to the most recent listing on the Premera website

PV Core Plus Drug List

The drugs listed are covered in full on your pharmacy drug benefit with Premera Blue Cross.

LIST OF DRUGS

Ace Inhibitors (hypertension)
benazepril
captopril
enalapril
fosinopril
lisinopril
moexipril
perindopril
quinapril
ramipril
trandolapril

Angiotensin II Receptor Blockers (hypertension)
candesartan
candesartan/HCTZ
eprosartan
irbesartan
irbesartan/HCTZ
losartan
losartan/HCTZ
olmesartan
olmesartan/HCTZ
telmisartan
telmisartan/HCTZ
valsartan
valsartan/HCTZ

Antiarrhythmic Agents
sotalol
sotalol AF

Blood Thinning Agents
aspirin
aspirin/dipyridamole
clopidogrel
prasugrel
warfarin

Beta Blockers (hypertension)
acebutolol
atenolol
betaxolol
bisoprolol
carvedilol
labetalol
metoprolol succinate
metoprolol tartrate
nadolol
nebivolol
pindolol
propranolol
timolol

Calcium Channel Blockers (hypertension)
amlodipine
diltiazem
felodipine
isradipine
nicardipine
nifedipine
nimodipine
nisoldipine
verapamil

Cholesterol Lowering Agents
atorvastatin
cholestyramine
cholestyramine light
colesevelam
colestipol
ezetimibe
ezetimibe/simvastatin
fenofibrate
fenofibric acid
fluvastatin
fluvastatin ER
gemfibrozil
lovastatin
niacin
niacin ER
omega-3 acid ethyl esters
pravastatin
rosuvastatin
simvastatin

Antidiabetic Agents (diabetes)
Bydureon
Byetta
Farxiga
glimepiride
glipizide
glipizide/metformin
glyburide
glyburide micronized
glyburide/metformin
Janumet
Janumet XR
Januvia
Jardiance

This is not a complete list of medications covered under your plan. This list represents certain generic and brand medications that are covered in full for HSA-qualified and some larger commercial PPO plans and is subject to change without prior notification. If you have questions about your pharmacy benefit, please visit Premera.com/MyPharmacyPlus. If you don't have access to our website, please call the customer service number listed on the back of your ID card.

PREMERA BLUE CROSS

PRESCRIPTION DRUG BENEFITS - PREMERA BLUE CROSS

Included below is the Premera Generic Preventive Drug List (called PV Core Plus), which applies to both medical plan offerings. If your medication is listed, it will be covered in full at a participating network pharmacy.

Jentadueto
Jentadueto XR
metformin
metformin ER
nateglinide
Ozempic
pioglitazone
pioglitazone/glimepiride
pioglitazone/metformin
Qtern
repaglinide
repaglinide/metformin
Rybelsus
Symlin
Synjardy
Synjardy XR
Tradjenta
Trulicity
Xigduo XR

Other Antihypertensive Combinations (hypertension)

amlodipine/benazepril
amlodipine/olmesartan
amlodipine/valsartan
atenolol/chlorthalidone
benzapril/HCTZ
bisoprolol/HCTZ
captopril/HCTZ
enalapril/HCTZ
fosinopril/HCTZ
lisinopril/HCTZ
metoprolol/HCTZ
propranolol/HCTZ
quinapril/HCTZ
telmisartan/amlodipine
trandolapril/verapamil

Osteoporosis Therapy

alendronate
ibandronate
raloxifene
risedronate

Diuretics (hypertension)

amiloride
amiloride/HCTZ
bumetanide
chlorthalidone
eplerenone
furosemide
hydrochlorothiazide (HCTZ)
indapamide
metolazone
spironolactone
spironolactone/HCTZ
torsemide
triamterene
triamterene/HCTZ

Antidepressants

bupropion
bupropion ER
bupropion SR
bupropion XL
citalopram
desvenlafaxine ER
duloxetine DR
escitalopram
fluoxetine
fluvoxamine
mirtazapine
paroxetine
paroxetine CR
paroxetine ER
sertraline
venlafaxine
venlafaxine ER

Beta Agonists Inhalers (asthma)

albuterol sulfate HFA
Ventolin HFA

Inhaled Corticosteroids (asthma)

Alvesco
Armonair Digihaler
Arnuity Ellipta
Asmanex
Asmanex HFA
budesonide inhaled suspension
Flovent Diskus
Flovent HFA
fluticase propionate HFA
Pulmicort Flexhaler
Qvar Redihaler

Insulin Therapy (diabetes)

Fiasp
insulin aspart
Lantus
Levemir
Novolin 70/30
Novolin N
Novolin R
Novolog
Novolog Mix 70-30
Toujeo
Tresiba

Vasodilators (hypertension)

hydralazine
minoxidil

DIABETES MANAGEMENT - Teladoc Health

LIVE HEALTHIER - AT NO COST TO YOU

With the Diabetes Management program, get tools and support to track blood sugar levels and develop a healthier lifestyle.

The Diabetes Management program includes:

- A blood glucose meter that seamlessly connects to your mobile device
- Unlimited strips and lancets
- One-on-one coaching to manage nutrition activity and health goals
- Real-time support for out-of-range readings

You may also be eligible for additional tools and devices to help you live healthier, including:

- Connected blood pressure monitor to help track your numbers
- Smart scale to help achieve your weight goals and track progress over time
- Digital tools that support your mental health

Join by visiting www.teladochealth.com/happy/PREMERAFI -WA25
or call 800-835-2362 and use registration code: PREMERAFI-WA25

HEALTH SAVINGS ACCOUNT (HSA) - KEY BANK

Available for eligible Active employees and their dependents.

WHAT IS AN HSA?

If you enroll in the High Deductible Health Plan (HDHP), then you may be eligible to open an HSA. An HSA is a bank account where you can set aside money to pay for expenses that your health plan does not cover. The money in your HSA is not considered income, so it is not subject to taxes. Please contact Human Resources for instructions on how to enroll.

HOW DOES AN HSA WORK?

You can use the money in your HSA at any time to pay for eligible healthcare expenses.

When you visit a provider, no copay is required at the time of service. The provider will submit a claim to your health plan for the services you received.

Your health plan will then send you an Explanation of Benefits (EOB) outlining the negotiated/allowed charges. The provider will then send you an invoice reflecting the allowed charges. Make sure the amount matches the EOB sent to you by your health plan.

You can then pay the invoice with money from your HSA (either your HSA debit card or as a reimbursement to you). Remember to keep your receipts, in case the IRS requests them.

WHO CAN OPEN AN HSA?

You are eligible to open and contribute to an HSA if you meet the following requirements:

- You must be covered by a qualified high-deductible health plan.
- You must not be enrolled in or covered by Medicare or Tricare.
- You must not be covered by your own or a spouse's general Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or any other non HSA-qualified health plan.
- You must not be claimed as a tax dependent on another person's taxes.
- You have not received any Veteran's Administration health benefits for a non-service connected disability in the last three months.
- You have not used Indian Health Services coverage in the last three months.

CONTRIBUTIONS

Yakima County may make an employer contribution to your HSA. Please check your premium sheet for your contribution amount. You can also add your own tax-free contributions.

Employee and employer combined contributions cannot exceed $4,300 (individual) or $8,550 (family) in 2025.

For individuals age 55 or older, an additional $1,000 in "catch-up" contributions are allowed for 2025.

Your money rolls over every year. There is no "use it or lose it" rule.

Enrollment via paper form only. Contact Human Resources for more information.

Allowed maximums are based on health tier enrollment.

KeyBank
www.Key.com

SPECIAL NOTES ON HSA'S AND DOMESTIC PARTNERS:

- Domestic partners are eligible to be enrolled in an HDHP plan;
- Distributions from the HSA are only allowed if your domestic partner is an IRS qualified tax dependent. Consult your tax advisor for details.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN

NON-NETWORK COSTS

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

ORGAN TRANSPLANT

There is no pre-existing condition limitations for this health plan. Organ and bone marrow transplants have a $7,500 travel and lodging maximum. Please see your plan contract booklet for further details.

WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Premera Classic (Individual: 20% coinsurance and $500 deductible; Family: 20% coinsurance and $1,500 deductible)

Plan 2: Premera CDHP (Individual: 15% coinsurance and $1,650 deductible; Family: 15% coinsurance and $3,300 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 509.574.2217 or mayling.chin@co.yakima.wa.us.

OUT-OF-AREA BENEFITS

If you are traveling or living outside of Washington and need medical care, you may use a Blue Cross or BlueShield PPO provider to receive the same benefits as the preferred level of your plan. When you are outside of the service area and need medical care, call the BlueCard Access Line at 800.810.BLUE (2583) for information on the nearest PPO doctors and hospitals. The doctor or hospital will verify your membership and coverage information after you present your identification/membership card. The doctor or hospital will electronically route your claim to your Blue Cross plan for processing. Because all PPO providers are paid by the plan directly, you are not required to pay for the care at time of service and then wait for reimbursement. You will only need to pay for out-of-pocket expenses, such as non-covered services, deductible, copays and coinsurance.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN (*CONTINUED)*

HIPAA SPECIAL ENROLLMENT RIGHTS

Yakima County Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Yakima County Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Mayling Chin - Benefits & Compensation Manager at 509.574.2217 or mayling.chin@co.yakima.wa.us.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN (*CONTINUED)*

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
Yakima County is committed to the privacy of your health information. The administrators of the Yakima County Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Mayling Chin - Benefits & Compensation Manager at 509.574.2217 or mayling.chin@co.yakima.wa.us.

PATIENT PROTECTIONS DISCLOSURE

The Yakima County Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Premera Blue Cross designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Premera Blue Cross at 800.722.1471 or www.premera.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Premera Blue Cross 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 the Premera Blue Cross at 800.722.1471 or www.premera.com.

PREVENTIVE CARE

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. A list of these preventive services can be found on the HHS website at: healthcare.gov/preventive-care-benefits.

HEALTHCARE REFORM & YOUR BENEFITS

Yakima County offers medical plan options that provide valuable comprehensive coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. Also note, it's unlikely that you are eligible for financial help from the government to help you pay for insurance purchased through a Marketplace because you have access to an employer plan that complies with the affordability standard.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN *CONTINUED)*

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

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

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

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

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

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

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

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN (*CONTINUED)*

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN (*CONTINUED)*

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Yakima County
Mayling Chin - Benefits & Compensation Manager
128 N 2nd St
Yakima, Washington 98901-2639
United States
509.574.2217

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

DENTAL BENEFITS - DELTA DENTAL OF WASHINGTON

Oral care is very important to your health and general well being. Under this plan, you may access dental care services from any licensed dentist you wish. However, if you obtain services from a preferred provider, you will save money on your out-of-pocket expenses. To find an in-network dentist, please visit www.deltadentalwa.com and use the "Find a Dentist" tool.

Delta Dental PPO

	Delta Dental PPO	Premier and Non-Participating Providers
Annual Deductible	$50 per person	
(waived for Preventive & Diagnostic)	$150 per family	
Annual Benefit Maximum	$1,750 per person	
Services		
Preventive & Diagnostic	No charge	20%
Basic	20% after deductible	30% after deductible
Major	50% after deductible	60% after deductible
Periodontics	Covered under Basic	
Endodontics	Covered under Basic	
Dentures	Covered under Major	
Orthodontia (Adult & Child)		
Services	50%	50%
Lifetime Benefit Maximum	$1,750 per person (deductible waived)	
Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.		

MAXIMUM ALLOWABLE FEE

Benefits are paid at the negotiated fee level for in-network dentists. When you use out-of-network providers, your plan will pay a percentage of the maximum allowable fee. If your dentist charges more than the maximum allowable fee, you will be responsible for the difference, plus your coinsurance responsibility.

DeltaCare

	DeltaCare
Annual Deductible	$0 per person
	$0 per family
Annual Benefit Maximum	No general plan maximum
Services	
Preventive & Diagnostic	No charge
Oral Surgery	$15 - $90 to extract teeth
Periodontics	$45 - $195
Endodontics	$45 - $220
Dentures	$100 for complete upper or lower
Orthodontia (Adult & Child)	
Services	Up to $2,000 copay per case
Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to published schedule of copayments, frequencies, age limitations, terms and conditions of the contract.	

NONPARTICIPATING DENTISTS

Dental care for employees and their dependents is covered only when they seek care from their assigned DeltaCare dentists. Employees are responsible for any costs incurred when they are treated by non-DeltaCare dentists. Delta Dental will reimburse $100 for an out-of-area emergency.

DeltaCare has limited providers. Please ensure to visit www.DeltaDentalWA.com prior to enrolling.

LIFE INSURANCE BENEFITS - SYMETRA

Available only for eligible Active employees.

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

To help you protect your family, we offer and fully pay for basic life and accident insurance.

	Life/AD&D
Benefit Amount	
Life Insurance	$35,000
Accidental Death & Dismemberment	$35,000
Benefits Begin to Reduce at Age:	N/A

- Portability and conversion available.

WHEN YOU FIRST ENROLL

When you first enroll in life insurance benefits, you will need to designate a beneficiary who would receive the benefits in the event of your death. You may change or update your beneficiary designation at any time via paper form in HR.

LONG TERM DISABILITY (LTD) COVERAGE

Available only for eligible Active employees.

When you cannot work for an extended period of time, an LTD plan can help cover a portion of your pre-disability earnings. For an approved, occupational or non-work related illness or injury, LTD benefits usually begin after an STD plan has ended.

	Long Term Disability
Monthly Benefit Amount	60%
Maximum Monthly Benefit	$240
Elimination Period	90 days
Benefit Duration	RBD to SSNRA
Definition of Disability	Own Occupation for 24 months

- Portability and conversion are not available.

IMPORTANT

Restrictions and limitations apply to these benefits. Please review the insurance booklet or certificate for complete details.

Note: If you are located in an area that offers disability coverage or has a paid leave program, it may impact the benefit you receive under our coverage. For specific benefit coverage information, please contact the Benefit Advocate at bac.yakimacounty@ajg.com or by phone 833.246.1289(toll-free) 8:00 a.m. - 6:00 p.m. PT (Monday - Friday).

VOLUNTARY INSURANCE BENEFITS

Available only for eligible Active employees and their dependents.

GALLAGHER VCHOICE

Since everyone's insurance needs are different, we provide you the option to buy additional insurance for yourself and your family members on a voluntary basis, but at discounted group rates. You may purchase the following voluntary plans:

- Life insurance
- Accidental death & dismemberment (AD&D) insurance
- Accident
- Critical illness
- Vision
- NEW ID Theft
- NEW Legal

Most policies are eligible for portability or conversion. Please refer to the vChoice guide for more information.

WWW.GALLAGHERVCHOICEENROLL.COM

Complete your Gallagher vChoice online enrollment at www.GallaghervChoiceEnroll.com. On the home page, enter your Employee ID/Social Security number and PIN and click on "Log On." Your PIN will be the last four digits of your Social Security number followed by the two digit year of your birth. Example: Someone with a SSN of 123-45-6789 and born in 1980 would have the PIN 678980.

GUARANTEE ISSUE

The amount of coverage you are guaranteed to receive without completing a medical questionnaire.
For voluntary life insurance, your coverage may be guaranteed up to $300,000 if you enroll when you are first eligible. The spouse/domestic partner guaranteed amount is $100,000 and $10,000 per child.

EVIDENCE OF INSURABILITY

Document used for medical underwriting. You may be required to complete this form if you choose to enroll after you are first eligible or you request an amount over the Guarantee Issue.

FLEXBILE SPENDING ACCOUNTS (FSA)-ALLEGIANCE

Available only for eligible Active employees and their dependents.

Looking for a way to save money on healthcare and/or dependent day care? Flexible Spending Accounts (FSAs) save you money by reducing the taxes you pay. Your FSA contributions are deducted from each paycheck before federal, FICA and, in most cases, state taxes are calculated. So in effect, you do not pay taxes on your eligible FSA expenses.

HOW DOES AN FSA WORK?

FSA contributions are taken from your paycheck on a pre-tax basis according to your annual elections. Once you have elected your annual deductions, you cannot change your elections under most circumstances.

When you have an eligible healthcare or dependent day care expense, you can pay for it with tax -free money. The accounts are not connected: you pay for healthcare expenses and dependent day care expenses with separate accounts.

You may use money in your FSA to pay for eligible expenses incurred by you, your spouse and your dependents. You and/or your dependents do not have to be enrolled in the medical plan to participate in the healthcare FSA.

If you have an HSA, your healthcare FSA can only be used for eligible dental and vision expenses. Once you've met your deductible, you can use your healthcare FSA for eligible medical expenses. ***It is not automatic that the FSA will reimburse for eligible medical expenses once the deductible is met.***

If you are enrolled in a Health Savings Account, you are only allowed to make contributions to a Limited Purpose FSA.

REIMBURSEMENTS

You will need to submit a claim form and proper documentation in order to receive reimbursement for your expenses. A claim form may be found at askallegiance.com. Keep your receipts! It is your responsibility to provide the detailed copy of your store receipt (not just a credit slip stating dollar amount). Reimbursements will be completed via direct deposit.

HEALTHCARE FSA (NOT AVAILABLE TO HSA PARTICIPANTS)

This plan allows you to pay for eligible medical, dental and vision out-of-pocket expenses with non-taxed dollars. The amount you designate will be deducted from your paycheck in equal amounts throughout the plan year. Once you incur an eligible expense, you can request reimbursement from your account. Note: You may request reimbursement of up to your entire annual election, even though the money has not yet been placed into your account.

Examples of eligible healthcare expenses

- Co-pays for doctor visits and prescription drugs
- Co-insurance for your medical, dental and vision plans
- Deductible amounts for your medical, dental and vision plans
- Over-the-counter medicines
- Menstrual care products

Is enrollment in the Healthcare FSA tied to the medical plan?
No. You and/or your dependents do not have to be enrolled in the medical plan to participate in the healthcare FSA.

MAXIMUM CONTRIBUTIONS

Healthcare FSA: $3,200*

Dependent Care FSA: $5,000* for single employees or married employee filing jointly. $2,500 for married employees filing separately

*As of the date of printing, the IRS has not released 2025 FSA limits. Therefore, the 2024 limit has been listed. It is projected that there will be an increase."

www.AskAllegiance.com
800.877.1122

FSA BENEFITS *(CONTINUED)*

DEPENDENT CARE FSA

Available only for eligible Active employees and their dependents.

This plan allows you to pay for daycare expenses on a pre-tax basis so you and your spouse can go to work or school. You can use this account for children up to the age of 13 (other individuals may qualify if they are incapable of self-care and are considered taxable dependents).

The amount you designate will be deducted from your paycheck in equal amounts throughout the plan year. You are eligible to be reimbursed as the account is funded. Reimbursements cannot exceed the account balance. The IRS will not allow you to claim a dependent care credit on your Federal Tax Return for reimbursed expenses from the dependent care reimbursement account. Consult your professional tax advisor to determine whether you should enroll.

Examples of qualified daycare providers

- Daycare centers
- Before and after school providers
- In-home daycare providers*
- Day camp (not overnight)

Does my daycare provider need to be licensed?
No. Your provider must be over the age of 18 and cannot be a qualified dependent living in your household. Your provider's Social Security number must be provided at the time of claim. The amount you pay this provider will be reported on your Federal Tax Return and the amount paid should be claimed as income on your provider's Federal Tax Return.

LIMITED PURPOSE HEALTHCARE FSA – FOR HSA PARTICIPANTS ONLY

This plan allows you to pay for eligible dental and vision out-of-pocket expenses with non-taxed dollars. The amount you designate will be deducted from your paycheck in equal amounts throughout the plan year. Once you incur an eligible expense, you can request reimbursement from your account. Note: You may request reimbursement of up to your entire annual election, even though the money has not yet been placed into your account.

Examples of eligible healthcare expenses:
Dental and vision expenses

Is enrollment in the Healthcare FSA tied to the medical plan?
No. You and/or your dependents do not have to be enrolled in the medical plan to participate in the healthcare FSA.

HRAveba® KeyBank®

HRA VEBA / HSA (Health Savings Account)

Available only for eligible Active employees and their dependents.

Yakima County offers and participates in both the HRA VEBA Plan and Key Bank Health Savings Account, which are tax-free medical reimbursement plans. Participants in these plans are based on the employee's medical election for the year. Employer Contributions to the either Plans vary based on bargaining group, and might change year to year. Employees are allowed to contribute their own funds to the HSA based on IRS regulations. If you have additional questions, please contact HR.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

NOTICE OF CREDITABLE COVERAGE

Important Notice from Yakima 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 Yakima 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. **Yakima County has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Yakima County coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current Yakima County coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company benefit plan.

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 Yakima 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 Yakima County changes. You also may request a copy of this notice at any time.

NOTICE OF CREDITABLE COVERAGE

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:	**January 01, 2025**
Name of Entity/Sender:	**Yakima County**
Contact—Position/Office:	**Mayling Chin - Benefits & Compensation Manager**
Office Address:	**128 N 2nd St** **Yakima, Washington 98901-2639** **United States**
Phone Number:	**509.574.2217**

YOUR BENEFITS CONTACTS

GALLAGHER BENEFIT ADVOCATES

Benefit Advocates (a service provided by Gallagher), are available to provide confidential, free help with your insurance needs.

Please do not include any confidential or sensitive information, such as social security numbers or health information, via email. Once you are connected to a Benefit Advocate, more sensitive information can be shared.

You can reach a Benefit Advocate at:
bac.yakimacounty@ajg.com
or by phone: 833.246.1289
8:00 a.m. - 6:00 p.m. PT
Monday - Friday

Benefit	Administrator	Group Number	Contact Information		Website
Medical	Premera Blue Cross	4018721	Customer Service	800.722.1471	www.premera.com
			24-hour Nurseline	800.841.8343	
Dental	Delta Dental PPO Plan	9621	Customer Service	800.554.1907	www.deltadentalwa.com
	DeltaCare HMO Plan	9622			
Life/AD&D, LTD	Symetra	01-018083-00	Customer Service	800.796.3872	www.symetra.com
			Claims	877.377.6773	
Flexible Spending Accounts	Allegiance		Claims	800.877.1122	www.askallegiance.com
			All Other Questions	800.737.3137	www.askallegiance.com
HRA VEBA	HRA VEBA		Customer Service	888.659.8828	www.hraveba.org
Voluntary Benefits	Gallagher vChoice		Customer Service	833.246.1289	www.gallaghervchoiceenroll.com

NOTES

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting