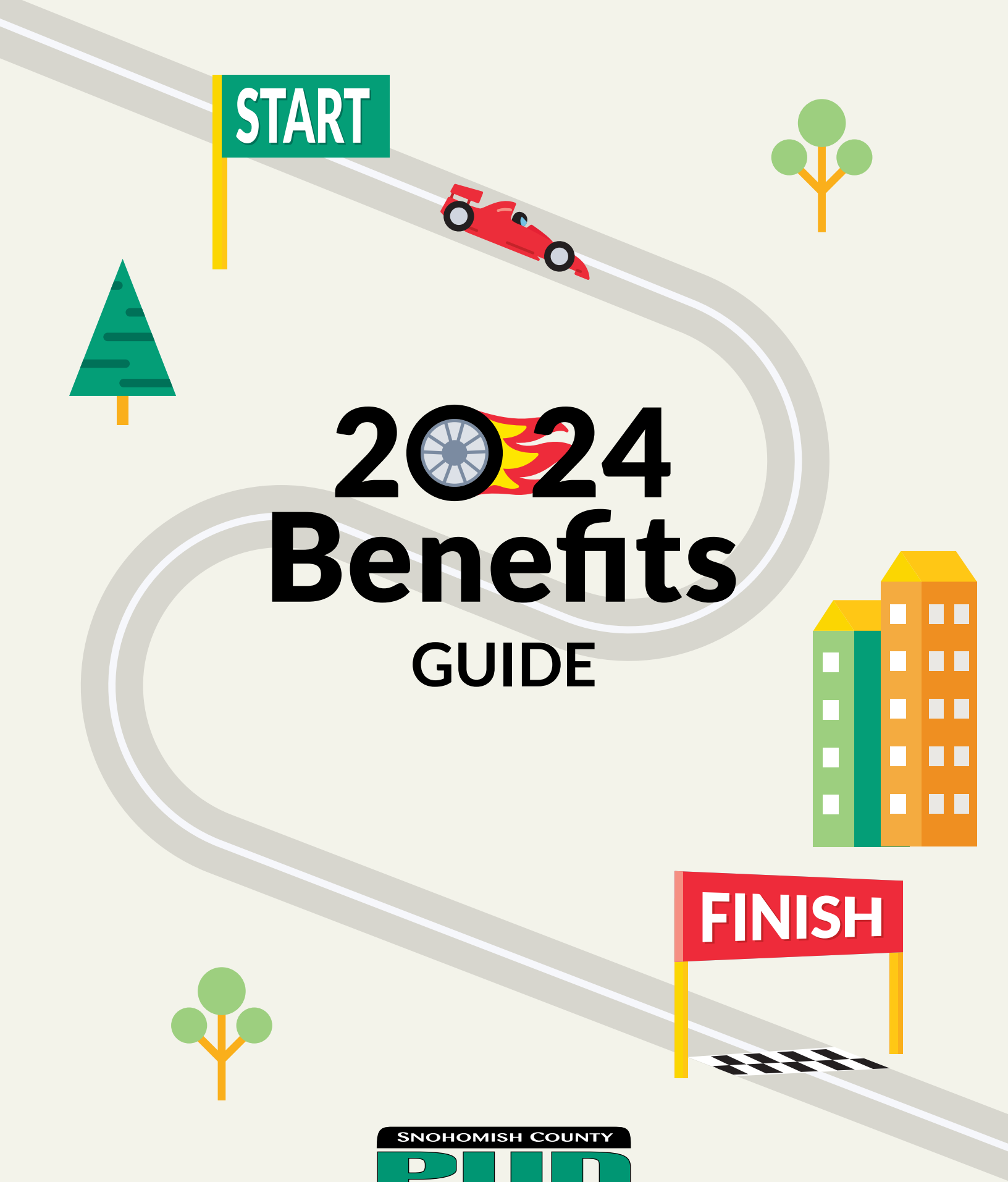

2024 Benefits GUIDE

SNOHOMISH COUNTY PUD
PUBLIC UTILITY DISTRICT NO. 1

Legal Notice:

This guide is a summary that has been prepared to give employees a brief overview of the benefits available. It is in no way a binding contract and should be viewed as an explanation only. If there is a conflict between the information in this document and the plan(s) source documents, the latter will govern. The District established the plan(s) outlined in this document with the intention that it will be maintained indefinitely. However, the District reserves the right at any time to amend any or all provisions of the plan(s) described herein or terminate the plan(s), in whole or in part, for any reason.

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MEDICARE PART D DISCLOSURE NOTICE: PAGE 19

This Benefits Guide is primarily information on the District's Employee Health Benefits Program (the "Plan") that allows employees to choose the benefits and coverage levels that work best for them and their family. Benefit choices under the Plan include medical, dental, vision hardware, life insurance, long-term disability, flexible spending accounts, and health savings account.

There are other benefits that an employee receives outside of the Plan, such as short-term disability, paid-time off, extended sick leave, Retirement Health Savings (RHS) and Employee Assistance Program (EAP).

This booklet also touches on employee retirement benefits and savings options. Use the resources cited on those pages to learn more.

2024 Benefits

FOR MORE INFORMATION

See the Employee Health Benefits Program Document on Benefit Central's "Health Benefits/Overview" page.

This section:
Employee Eligibility • Dependent Eligibility • Coverage Levels • District Contribution • Enrollment and Change Opportunities

Employee Eligibility

All regular full-time employees and regular part-time employees, including the District's Commissioners, are eligible to participate in the District's Plan.

Employees enroll in the Plan when they first become eligible and can make election changes during the annual Open Enrollment period. See the Employee Health Benefits Program document on Benefit Central for more details.

When Does Coverage Become Effective?

Your first day of employment determines when your coverage becomes effective under the Plan.

- When the date of hire or status change is the first of the month, the effective date for benefits and the District Contribution will be the first of the same month. (Example: Hired July 1, benefits and District Contribution are effective July 1).
- When the effective date of the hire or status change is between the second and last day of the month, the effective date for benefits and the District Contribution will be the first of the following calendar month. (Example: Hired July 2 to July 31, benefits and District Contribution are effective August 1).

Newly eligible employees will have 30 calendar days from hire/status change date to elect benefits. If the employee fails to do so within that time-frame, a full-time employee will be defaulted to the following benefits: HMO employee-only coverage, DEPO employee-only coverage, basic term life insurance coverage, and Long-Term Disability 120-day wait.

Dependent Eligibility

Refer to each specific benefit plan document to verify dependent eligibility under the plan

Eligibility for dependents under each District plan varies. Please review the following definitions for a summary of dependent eligibility under the various District plans.

For the District's medical, dental & vision hardware plans, "Dependent" means:

- Your spouse, your state-registered domestic partner (SRDP) or your grandfathered domestic partner,
  - "Spouse" means your legal spouse.
  - "Grandfathered Domestic Partner" means a domestic partner who was on a District medical, dental or vision hardware plan as of December 31, 2014, and has remained on a District plan continuously since that time.
  - "State Registered Domestic Partner" (SRDP) means a domestic partnership within the meaning of the Revised Code of Washington (currently one partner must be at least age 62 and registered as a domestic partnership in Washington state).
- Your child, adult child or disabled child. Grandchildren are not eligible.
  - "Child" means your natural child, adopted child, foster child or step-child, or the child of your grandfathered domestic partner or SRDP up to age 19.
  - "Adult Child" means your natural child, adopted child, foster child or step-child, or the child of your grandfathered domestic partner or SRDP age 19 up to age 26.
  - "Disabled Child" means your child who has attained age 26, is disabled, and meets the specific plan guidelines.

Domestic Partner Tax Implications:

If an employee covers a SRDP, grandfathered domestic partner or their child(ren) who is/are not the employee's tax dependent(s) as defined by the IRS, the value of health benefits for the SRDP, grandfathered domestic partner and/or their child(ren) constitute taxable income for the employee.

For the District's AD&D and Voluntary Term Life plans, "Dependent" means:

- Your spouse or your SRDP.
- Your unmarried child, as follows:
  - From birth to age 23.
  - 23 or older but less than age 25, if enrolled in an accredited school as a full-time student.
  - Age 23 or older, disabled adult child primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap.

"Child" means your natural child, adopted child or

step-child living with and financially dependent upon you, or the child of your SRDP living with you and financially dependent upon you.

Cross Coverage

Each active District employee is eligible to cross cover their spouse, SRDP, grandfathered domestic partner and dependents on medical, dental, and vision hardware.

Cross coverage is not available for Voluntary Term Life (VTL) and Accidental Death & Dismemberment (AD&D). District employees and dependents cannot be covered twice under the VTL and AD&D policy.

Examples include:

- Employee and spouse both work at the District and decide to cover each other on their medical, dental and vision hardware. Both would be considered cross covered.
- If the employee wanted to cover their spouse on VTL or AD&D, the spouse would not be able to elect VTL or AD&D on their own benefit elections.

Coverage Levels

The District's medical, dental and vision hardware plans have four coverage levels. The cost of the benefit and District contribution (if applicable) varies by the coverage level selected for these benefits. The coverage levels are as follows:

Coverage Level
Employee only
Employee + spouse/SRDP
Employee + child(ren)
Employee + family

District Contribution

Regular Full–time Employees

For full-time employees, the District contribution is based on an employee's coverage selection for the Plan's core benefit plan offerings. To be eligible to receive the District contribution toward benefits, full-time employees must receive at least 1 paid hour each month.

IMPORTANT

Regular full-time employees must be enrolled in medical, dental, long-term disability and basic term life coverage (core benefits).

The Core Plans are:

- **Medical**
- **Dental**
- **Basic Term Life**
- **Long-Term Disability**

See ***2024 Monthly Insurance Costs & Contribution*** on pages 29 and 30 for contribution amounts.

Regular Part-Time Employees

Part-time employee benefit offers are based on hours worked per week, either: working less than 30 hours; or working at least 30 hours but less than 40 hours per week. Applies to both represented and non-represented employees.

Newly hired or newly eligible (i.e., change in employment status full-time to part-time) part-time employee benefit offers will be based on the anticipated hours worked per week (less or more than 30 hours per week), and will be reviewed one year from date of hire or date of employment status change.

Part-time employees will be reviewed each fall based on the prior year actual hours worked (i.e., in October 2023, look back at hours worked October 1, 2022 to Sept. 30, 2023) to determine the benefits to offer for the next calendar year.

Based on anticipated or actual hours worked per week, part-time employees will be offered the following:

Hours per week	Benefits offered
Less than 30 hours	Health Care FSA, Dependent Care FSA Pay-in-lieu rate+
At least 30 hours, but less than 40 hours	Optional (bundled) - Medical* (PPO, HMO, HDHP/HSA), dental*, vision hardware Optional (stand-alone) - Health Care FSA, Dependent Care FSA *If enrolled, will receive District Contribution (see page 29 for amounts). If medical is waived, employee will receive the Pay-in-lieu rate+.

+The Pay-in-lieu-rate is paid on straight-time hours only and the rate will be $9.11 per hour as of Jan. 1, 2024.

Part-time employees are not eligible for Long-Term Disability, Basic Term Life, Accidental Death & Dismemberment or Voluntary Term Life coverages.

Enrollment & Change Opportunities

New Employees/Newly Eligible Employees

A new employee or newly eligible employee must enroll in benefits through Benefit Central within the deadline provided by Human Resources. Failure to complete enrollment by the deadline provided will result in the following default enrollment:

- Regular, full-time employees:
  - HMO employee-only coverage, DEPO employee-only coverage, Core Term Life and LTD 120-day wait
- Regular, part-time employees – no benefits coverage.

Annual Open Enrollment

Employees eligible to participate in the Plan are provided an annual Open Enrollment each fall. During that time, employees may make changes to their benefit coverage, add or remove dependents, and enroll or re-enroll in a Flexible Spending Account (FSA). Information on benefit options, enrollment opportunities, requirements and deadlines is provided to employees. Other than Open Enrollment, the only time an employee may make a change to their benefits is when they have a qualified Life Event. For details (including deadlines), see the Mid-Year Life Events section below.

Mid-Year Life Events

Other than Open Enrollment, the only time benefits can be changed is when an employee has a qualified Life Event or special enrollment event as defined by the IRS and the District (i.e., marriage, divorce, birth, loss of other coverage, etc.)

Changes in benefit elections may be allowed consistent with the reason for the change and your **Life Event must be initiated in Benefit Central within 30 days of the event.** Coverage changes are generally effective the first of the month following the date your Life Event is received in Benefit Central by Human Resources.

Newborn or newly adopted children may be added to an employee's coverage effective upon the date of birth or assumption of a legal obligation for total or partial support of a child in anticipation of adoption. **Employees must initiate a Life Event in Benefit Central within 60 days of a birth or adoption.**

NOTE

Removal of a grandfathered domestic partner from coverage due to a qualified Life Event will result in the domestic partner losing District coverage permanently.

COBRA Continuation Coverage

When dependents are no longer eligible for medical/dental/vision hardware benefits, a qualified beneficiary may be eligible for benefit continuation rights under COBRA (Consolidated Omnibus Budget Reconciliation Act). To obtain COBRA coverage, a qualified beneficiary must make a COBRA election within 60 days of loss of eligibility. COBRA election information will be sent directly from Benefitfocus. For more info, contact Human Resources at 425-783-8557 or hrbenefits@snopud.com.

TAKE NOTE!

*A Life Event must be entered in **Benefit Central within 30 days of the event (60 days for newborn or adopted children) to make a mid-year benefit change.** Failure to initiate the event within this time-frame will impact your benefits, including losing the ability to add your dependent until the next Open Enrollment.*

*Enrollment, Life Event and Effective Date Examples**

Event	*Election Period*	*Benefit Effective Date*	*Changes Allowed*
New Hire and employment status change	Within 30 days of event	– Event 1st day of month, effective that day – Event 2nd day of month through end of month, effective first day of following month	– Ability to enroll in all eligible benefits – If elections not made within Election Period, full-time employee will be defaulted to; • HMO – Employee-only coverage • DEPO – Employee-only coverage • Basic Term Life • LTD 120-day wait – Part-time employees are defaulted to no coverage
Open Enrollment	Open Enrollment period (usually around first week of November each fall)	January 1 of the following year	Can make any benefit changes; add/remove dependents FSAs must be re-elected each year
Life Event (i.e., marriage, loss of other coverage, eligible for other coverage, etc.)	30 days from date of event	1st of month following date entered into Benefit Central	Changes must be consistent with life event
Life Event (divorce, loss of eligibility)	30 days from date of event	End of month from loss of eligibility	Changes must be consistent with life event
Life Event – birth/adoption	60 days from date of event	Medical – benefits effective date of birth All other benefits – effective 1st of month following date entered in Benefit Central	Benefit changes consistent with life event

***NOTE:** *This is for illustrative purposes. For more information about Life Events and allowed benefit changes, please refer to the Employee Health Benefits Program document on Benefit Central.*

This section:
Medical • Prescription Drug Benefits • Dental • Coordination of Benefits • LTD • Basic Term Life Insurance

Core Pre-Tax Benefits Choices

Medical

Employees have the flexibility to choose among several medical plan options – a preferred provider organization (PPO) plan, a health maintenance organization (HMO) plan, and a new High Deductible Health Plan (HDHP).

All three of the District's medical plans are self-funded. That means the District is responsible for paying all medical claims incurred by its members. The District contracts with Premera Blue Cross (Premera) and Kaiser Permanente (Kaiser) to process claims, allow access to provider networks and provide customer service for the corresponding plan.

GO PAPERLESS!

The District receives $1 off per month for every employee/retiree who opts for electronic Premera EOBs. Help us save on admin costs by going paperless!

Just visit www.premera.com, log into Member Services, then under "Manage My Account" select "Go Paperless."

– The District's PPO and HMO plans require employees to pay deductibles/coinsurance and/or copays for most services. Primary care physicians are not required.

– The HDHP requires the annual deductible to be met before plan benefits are paid with the exception of preventive care.

Included in this guide on page 27 is a brief comparison of all three of the District's medical plan options. Refer to the corresponding plan document on Benefits Central for details.

Example for a PPO Plan in-network inpatient hospitalization:

	Member Cost Share	*Counts towards OOP Max?*
Deductible	$150	No
Hospital Co-pay	$100	Yes
Coinsurance	10%	Yes
Out-of-Pocket (OOP) Maximum per person (co-pay + coinsurance, not to exceed) $1,500		

Example: PPO Plan Inpatient Hospitalization

Description	*Cost*	*Member*	*Plan*
Cost (allowable charge)	$20,000		
Less Deductible		$150	
Less Hospital Co-pay		$100	
Net Cost (subject to coinsurance)	$19,750		
Coinsurance Plan @ 90%			$17,775
Coinsurance Member @ 10% (not to exceed OOP max, Plan pays balance)		$1,400	$575
Total (Deductible + Co-pay + Coinsurance)		$1,650	$18,350

24-Hour Nurse & Online Services

All of the medical plans have resources available online and offer members a free 24-hour NurseLine/Consulting Nurse. PPO Plan members can enroll in free credit monitoring, sign up to receive electronic explanation of benefits (EOBs), view claims history and more. Visit www.premera.com for details.

With the HMO Plan, members can look up benefits, refill prescriptions, complete a health profile and more. Visit www.kp.org/wa for details.

Telehealth Virtual Office Visits

All three medical plans offer Telehealth virtual office visits. See Coverage Comparison Chart on page 27 for more details.

PPO Plan and HDHP

Care

- Primary Care - Cold and flu, allergies, pink eye, sore throat, etc.
- Dermatology - rashes, acne, etc.
- Behavorial Health - anxiety/depression

Visit options:

- Your personal doctor/clinic (i.e., Everett Clinic uses Vsee Clinic Mobile App)
- Doctor on Demand, a video chat with a doctor. Visit www.doctorondemand.com
- 98point6, a text-based primary care app. Visit www.98point6.com/premera/

HMO Plan

Visit Options:

- 24/7/365 phone access to a licensed care provider for medical care and advice/urgent prescription refills at 1-800-297-6877 or 206-630-2244 (TTY 711).
- Scheduled phone appointment with your current provider for health concerns that don't require an in-person visit or follow-up care after an in-office appointment.
- E-visit through completion of a short questionnaire for diagnosis/treatment for common conditions and prescriptions.
- 24/7 Care Chat with a provider to get immediate care, treatment, and prescriptions.
- Video visit with a provider the same day or next for a broad range of symptoms or health concerns for chronic conditions, follow-up care after an appointment, prescriptions, or lab test orders.

Visit https://wa.kaiserpermanente.org/html/public/get-care

Networks

PPO and HDHP Plan Network

Premera uses the **Heritage & Heritage Plus 1** network in Washington and Alaska. Services outside of Washington and Alaska can be accessed through the BlueCard PPO nationwide provider network. These networks are very broad and comprehensive. Employees will receive the highest level of benefits if an in-network (IN) provider is used. An employee who utilizes an out-of-network (OON) provider will receive a lower level of benefits.

To find a network provider, visit www.premera.com and select "Find a Doctor," then select "Find a Doctor, Dentist and More." Under "Search as a visitor," select the network (Heritage & Heritage Plus 1 or BlueCard PPO). You can then search by location and specialty. You can also call Premera at 1-800-722-1471.

HMO Plan Network

Kaiser provides care through its **Core** network of doctors and facilities. An employee must go to a Kaiser provider, or contracted provider, to receive benefits from the plan (other than emergency care). Kaiser also provides visiting member access to Kaiser facilities outside of Washington, including California, Colorado, District of Columbia, Hawaii, Georgia, Virginia and Oregon.

To find an in-network health care provider, visit www.kp.org/wa and click on "Find a Doctor." Under "Welcome, Visitor," select "Employer Plans" and select the "Core" network. You can then search by location and specialty. You can also call Kaiser at 1-888-901-4636 to find a provider.

Prescription Drug Benefits

All of the District's medical plans provide prescription drug benefits. Included in this guide on pages 27-28 is a brief overview of the prescription drug plans.

HMO Plan Prescription Drug Benefit

The HMO plan has a three-tiered prescription drug benefit in its Core Network. Follow the instructions on HMO Plan Network to search for a network provider. To find out if a drug is in the HMO formulary, go to www.kp.org/wa, select "Get Care" and under Pharmacy, select "Drug Formulary." Under "Large Employer," select the "3-Tier In-Network Pharmacy Benefit."

HMO Plan Mail Order Benefit

Employees can get up to a 90-day supply of medication by purchasing through mail order. For more information on the mail-order benefit, log into your online Kaiser member website and go to the Medications page or call 1-800-245-7979.

PPO Plan Prescription Drug Benefit

The PPO plan has a four-tiered prescription drug benefit:

- Tier 1 Preferred Generic
- Tier 2 Preferred Brand
- Tier 3 Specialty Rx
- Tier 4 Non-preferred Generic/Brand/Speciality
- Excluded – Not Covered

Follow the instructions on the PPO Plan Heritage provider network pharmacy search to find a participating pharmacy. Prescriptions obtained through a non-participating pharmacy are not covered under the plan.

Our Drug List is Essentials 4-Tier (E4) Premera's Drug List (Formulary). If a medication you take is in a higher-cost tier or on the excluded list, ask your doctor if there is a lower-cost alternative.

- Go to www.premera.com/visitor/covered-drugs
- Drug List = Essentials 4-Tier (E4), click on "E1/E4"
- Search for your medication to determine the Tier or if it's excluded.
- See page 27-28 Pharmacy Comparison Chart for your member cost shares

"Mandatory Generic" - This means the pharmacy will automatically attempt to fill a prescription at the Tier 1 Preferred Generic level but if you choose to purchase Brand instead, you will pay your copay/cost share + the cost difference between Preferred Generic and Brand. Some exceptions apply.

"Prior Authorization" - the drug may be on the plan drug list, but it requires an authorization before the prescription is covered.

"Step-therapy" - This encourages the use of Preferred Generic/Brand drugs prior to using Non-preferred drugs.

PPO & HDHP Plan Mail-order Benefit

Employees can get up to a 90-day supply of non-specialty medication through Express Scripts mail order.

For Express Scripts mail order info, visit www.premera.com/mypharmacyplus or call 800-391-9701.

Specialty Rx via Accredo (Specialty Pharmacy)

Tier 3 & Tier 4 Specialty Rx must be filled via Mail Order with Accredo. To contact Accredo, call 1-800-689-6592.

HDHP Prescription Drug Benefit

Step-Therapy, Prior Authorization and mandatory specialty Rx via Accredo apply to the HDHP, see information above.

To review Premera's Drug List (Formulary) for the HDHP:

- Go to www.premera.com/visitor/covered-drugs
- Drug List = Essentials 1-Tier (E1), click on "E1/E4"
- Determine if your drug is covered, excluded or a specialty drug
- See page 27-28 Pharmacy Comparison Chart for your member cost shares

For more details on pharmacy/Rx, view the Coverage Comparison Chart on pages 27-28.

Coordination of Benefits

The PPO Plan prescription drug benefit has coordination of benefits. If the PPO prescription plan is your secondary provider, you can request reimbursement for the balance of your prescription costs by completing the Secondary Insurance Drug Claim Form available on the Premera website.

Dental

Employees have the flexibility to choose from two dental plan options:

- **DPPO – provided by Delta Dental of Washington**
- **DEPO – provided by Willamette Dental Group**

The District's DEPO plan is fully insured. The DPPO plan is self-funded. Included in this guide on page 28 is a brief comparison of the District's dental plans. Please refer to the corresponding plan documents available on Benefit Central, or contact the member services number listed at the back of this guide to inquire about specific benefits and treatments.

Networks

Listings of participating dentists and facilities are available for both plans.

DPPO Network

Employees can see any licensed dentist. Benefit payment may vary depending on network: Premier, PPO or non-network dentist. You may have lower costs if you see a dentist in the PPO Network. Search for a provider at www.deltadentalwa.com.

DEPO Network

You must select a participating clinic from Willamette Dental Group. Search for providers and locations at www.willamettedental.com.

Coordination of Benefits

Coordination of Benefits (COB) is the process of coordinating health plan payments (including prescription drug payments) between two different medical and/or dental plans. A claim may be eligible for COB where an individual is enrolled in more than one health plan (typically an employee's medical/dental plan and a spouse/SRDP/domestic partner's medical/dental plan). The benefits must be payable under both plans and both plans must offer COB (some health care plans have limitations or restrictions on COB).

Employees who are cross-covered on their spouse/SRDP/domestic partner's plan should keep in mind that they are primary on the plan they select and secondary on their spouse/SRDP/domestic partner's plan. Employees may want to check with their spouse's, SRDP's or domestic partner's insurer as to how that insurance carrier handles COB.

For COB of covered children, the general rule is that the plan of the parent with the birth date (month/day) falling first in the calendar year is the primary coverage.

See the corresponding plan document for details on COB rules.

Long-Term Disability (LTD)

LTD insurance provides income protection for employees in the event of disability due to injury or illness sustained either on or off the job. An employee's LTD coverage level is based on regular monthly earnings in effect on the date of coverage, or October 15 of the previous year, whichever is later.

Employees may be eligible to receive a monthly benefit of 60% of regular monthly earnings (to a maximum benefit of $5,000 per month) based on the selected waiting period (120, 90 or 60 calendar days). The monthly benefit is reduced by other sources of disability-related income (e.g., State Industrial, Occupational Disability Allowance, Sick Leave, Extended Sick Leave, Social Security Disability, Pension Disability, etc.) to a minimum benefit of $100 per month. However, if an employee is doing rehabilitative work, the total of earnings through the rehabilitative work and rehabilitative benefit cannot exceed 100% of their regular monthly earnings. This may result in a minimum benefit of less than $100.

Upon approval of an employee's claim, they are eligible for a "waiver-of-premium" beginning the first of the month following the claim effective date and for the remaining time they have an active LTD claim.

Basic Term Life Insurance

An employee will have $50,000 of Basic Term Life Insurance, which provides a benefit to their beneficiary upon the employee's death.

The Basic Term Life plan includes a terminal illness benefit (accelerated benefit) and a waiver-of-premium provision. The terminal illness benefit is 50% of an employee's Basic Term Life Insurance coverage amount. At the time of an employee's death, the beneficiary will receive the remaining life insurance benefit.

The waiver-of-premium provision applies if an employee becomes totally disabled prior to age 60 and that disability lasts for six consecutive months. The insurance company will continue insurance to age 70 or retirement (other than retirement due to disability), whichever occurs first, without further payment of premiums so long as total disability continues. This benefit is subject to proof of continuing disability each year.

The Basic Term Life policy also includes seat belt, portability and conversion features.

This section:
Vision Hardware • FSA • HSA

Optional Pre-Tax Benefits Choices

Vision Hardware

An employee and their dependents are eligible for vision hardware insurance provided through EyeMed Vision Care. Eligible members and their covered dependents receive an annual allowance for a one-time purchase of lenses/contact lenses and frames every calendar year with the Vision Hardware Plan. Eye exams are covered under the District's medical plans.

Network

Participating providers are in the Access Network and are located in stores such as LensCrafters, Target Optical, participating Pearle Vision Centers, and other independent locations. To obtain the name of the nearest participating EyeMed Vision Care optical provider, call the EyeMed Customer Care Center at 1-866-939-3633 or visit https://eyemed.com/en-us and click on "Find an Eye Doctor."

Out-of-Network Provider Coverage

If you use an Out-of-Network provider, you will be responsible for paying the provider in full at the time services are rendered and for submitting the claim directly to EyeMed Vision Care.

In-Network Coverage & Out of Network Reimbursement

View the Vision Coverage Comparison Chart on page 28 for details on In-Network benefits and Out-of Network Reimbursement. In addition, you will be eligible for discounts on:

- LASIK: Members receive discounts on LASIK or Photorefractive keratectomy (PRK) from the US Laser Network, owned and operated by LCA Vision. For a location near you and to obtain discount authorization for LASIK, please call 1-877-5LASER6.
- Additional complete pairs of eyeglasses or partial replacement and conventional contact lenses.
- Amplifon Hearing Health Care hearing exams and low-price guarantee on discounted hearing aids. Call 1-855-526-5432 to find a hearing provider.

Glasses or Contact Lenses by Mail

You may order glasses or replacement contact lenses at competitive prices via the Internet and have them mailed directly to your home.

For contact lenses, this service is for replacement lenses only, and your core benefit allowance or discount will not apply to this service. Your initial pair of contact lenses must still be purchased from your eye care provider to ensure proper fit and follow-up care. Visit www.contactsdirect.com for details.

For glasses, visit www.glasses.com for details on purchasing online.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money – before it's taxed – through payroll deductions. The money can be used for eligible healthcare and dependent day-care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have less income to be taxed! Any unused account balance at the end of the plan year must be submitted by the end of the run-out period (i.e. March 31 of every year), otherwise the unused amount will be lost – so plan carefully. It's better to underestimate. You must re-enroll in FSAs each year.

IMPORTANT

Use it or lose it. Any money in an FSA that is not used for reimbursement of expenses incurred during the plan year (or grace period) will be forfeited.

Health Care FSA (HCFSA)

This plan allows you to pay for eligible out-of-pocket heath care expenses for you, your spouse and your tax dependents (spouse, child under age 19, etc.) and adult children up to age 26, even if they are not enrolled on your medical plan. Eligible expenses include medical, dental, or vision costs including deductibles, copays, coinsurance amounts, and other non-covered health-care costs. You may access your entire annual election from the first day of the plan year and you can set aside up to $3,050 this year. **This plan also has a grace-period, which allows you to incur expenses through March 15 of the year following, however you still need to submit expenses by March 31.**

Dependent Care FSA (DCFSA)

This plan allows you to pay for eligible out-of-pocket dependent day care expenses to allow an employee (and their spouse) to work, look for work, or be a full-time student. Eligible expenses my include daycare centers, in-home childcare, and before or after school care for your dependent children under age 13. You can only be reimbursed up to your DCFSA balance.

All caregivers must have a tax ID or Social Security number and must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine where you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

Important Considerations

- Expenses must be incurred within the plan year for the DCFSA, or by March 15 of the following year for the HCFSA (grace period) or once your benefits become effective, whichever is later.
- FSA accounts are use-it-or lose it, any money left over at the end of the plan year (or grace period for the HCFSA) will be forfeited. It's better to underestimate than overestimate expenses!
- Elections cannot be changed during the plan year, unless you have a qualified life event and the election change must be consistent with the event.

Claims Substantiation

The IRS requires you to retain all documentation/proof (such as Explanation of Benefits or itemized statement from the provider/merchant) of FSA debit card charges to substantiate eligible FSA expenses. Documentation for substantiation can be submitted via the ThrivePass website, mobile app, fax, email, or mail.

CARRIER CONNECT

Carrier Connect is a portal that imports your Explanation of Benefits (EOBs) from your medical, dental, and vision carriers for claims substantiation. To register for Carrier Connect, log into the ThrivePass Member Portal at app.thrivepass.com, click on "Pre-Tax" and then "Personal Dashboard." Once there, click on the "Connect your Plans" widget and follow the steps to complete your registration.

ThrivePass FSA Debit Card Substantiation

The debit card may be a convenient way to pay for your qualified health expenses (paid directly from your FSA account). The IRS requires you to retain all documentation/proof of debit card charges with your tax documents so you can substantiate your eligible expenses.

In most cases, you may need to provide documentation to verify debit card charges were for eligible expenses. Preferred documentation is an Explanation of Benefits (EOB) because it includes all the information the IRS requires. If an EOB is not applicable/available, submit an itemized statement from the provider/merchant. Some examples of ***unacceptable*** documentation are credit card receipts/statement, cash register receipts, and canceled checks.

HSA participants – *you don't need to provide documentation to ThrivePass, just keep all documentation (i.e. receipts, EOB's, provider statements, etc.) with your tax records for audit purposes.*

Documentation for substantiation can be submitted several ways:

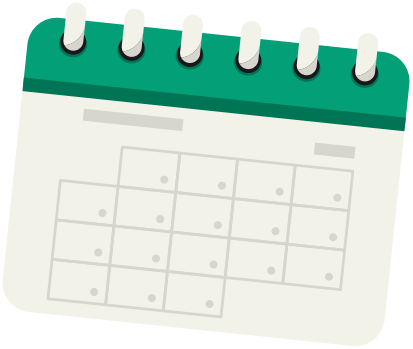
Web: Log in to app.thrivepass.com and navigate to my accounts, then upload receipts

Mobile App: Install "ThrivePass Pre-Tax Accounts" App, log in and tap "claims" to review list of your pending claims and attach your documentation.

Email: tpa@thrivepass.com

Mail: P.O. Box 220 Minneapolis, MN 55440

Fax: 1-888-265-5413



Debit card transaction/substantiation timeline

- **Day 1** – The participant swipes the debit card and substantiation is needed. The card swipe will display in the 'New' status in the 'Transaction History,' within the participant portal, and mobile app.
- **Day 45** – ThrivePass emails (or mails if no email is on file) a letter to the participant showing all the information about the card swipe and the information needed to substantiate the transaction. The card swipe will display in a 'Pending' status in the 'Transaction History,' within the participant portal, and mobile app.
- **Day 75** – ThrivePass emails (or mails if no email is on file) a second reminder letter requesting the same information.
- **Day 90** – ThrivePass emails an ineligible letter alerting the participant that their card is temporarily suspended. At that time, the card swipe moves to an 'Ineligible' status and shows as a 'Balance Due.' The debit card is suspended until the transaction is resolved (per IRS rules).

Health Savings Account (HSA)

A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified health expenses. You must be enrolled in the District's High Deductible Health Plan to be eligible to enroll in the HSA.

The District provides the following HSA contribution based on HDHP Coverage Level :

HSA Employer/ District Contribution – Lump Sum	Individual	Family
First year enrolled	$1,000	$2,000
Annual / ongoing	$350	$700

The IRS sets the annual HSA contribution limit (employee + employer). The unused account balance at year end rolls over, it is not forfeited.

You are ineligible for employee & employer HSA contributions if you have other types of medical coverage, such as:

- Full-purpose Health Care FSA or HRA (regardless of balance) under your own, spouses' or parent's plan
- Major medical plan (i.e., PPO, HMO) under a spouses' or parent's plan
- Governmental plans (i.e. Medicare (either Part A or B), Tricare, etc.)
- Triple tax Savings – no taxes on contributions, investment earnings, or reimbursements

Health Care FSA (HCFSA) vs. Health Savings Account (HSA)

	HCFSA	HSA
Medical plan	PPO or HMO	Qualified High Deductible Health Plan (HDHP) (i.e., IRS HDHP deductible limit, OOP max, etc.)
Unused balance	Use it or lose it with a Grace Period*	Rollover year-to-year
Dependent Reimbursment Eligibility	• Tax dependents (spouse, child under age 19, etc.) • Adult children up to age 26	Tax dependents only (spouse, children under age 19, or under age 24 if full-time student)
Contribution sources	Employee only	Employee, employer and any individual (directly into HSA)
Contribution limit 2024	$3,050	• Individual $4,150 • Family (2+) $8,300 • (age 55+ additional $1K)
Investments	None	Account balances $1,000+
Reimbursements max.	Up to annual election	Up to account balance (no tax on investment earnings)
Roll-in allowed	N/A	Yes
Debit card	Yes	Yes
Qualified expenses	IRS Publication 502 (www.irs.gov/forms-pubs/about-publication-502)	• IRS Publication 502 (www.irs.gov/forms-pubs/about-publication-502) • Insurance premiums (Long-Term Care, COBRA, Medicare [Medigap not eligible])
Non-qualified expenses	N/A	Non-qualified distributions are allowed, but subject to income tax + 20% penalty (if under age 65)

**Annual FSA Grace Period: If an unused FSA balance remains at year end, additional FSA expenses can be incurred through March 15 of following year, but must be submitted to ThrivePass by March 31.*

This section:
AD&D • VTL Employee • VTL Spouse • VTL Child

Optional After-Tax Benefits Choices

Accidental Death & Dismemberment (AD&D)

AD&D coverage is additional protection that covers an employee and their family in the event of accidental death or serious accidental injury. It is offered by Unum.

The AD&D plan includes a waiver of premium provision. For more information, visit the Life Insurance (Basic/VTL/AD&D) page on Benefit Central.

Employees may select this optional benefit in increments from $25,000 to $250,000 for "Employee Only" or "Family Plan" coverage. Under the Family Plan, dependent coverage amounts are equal to the following percentages of the coverage the employee has chosen for himself/herself:

1. ***At time of loss, the family consisted of employee, spouse or SRDP, and dependent child(ren):***
   - › Employee 100%
   - › Spouse/SRDP.....40%
   - › Each child 10%
2. ***At time of loss, the family consists of employee and spouse or SRDP but NO dependent child(ren):***
   - › Employee 100%
   - › Spouse/SRDP.....50%
3. ***At time of loss, the family consists of employee and dependent child(ren) but NO spouse or SRDP:***
   - › Employee 100%
   - › Each child 15%

What is Covered

Depending on the type of accidental loss or injury, this policy pays up to 100% of the benefit amount the employee has chosen. For example, Unum coverage includes the following:

- › Loss of life 100%
- › Loss of both eyes 100%
- › Loss of two limbs (hand/foot) 100%
- › Paraplegia 75%
- › Loss of one limb (hand/foot) 50%

This benefit also includes a seat belt and air bag provision that would pay an additional benefit in the event of death as a result of an auto accident.

What is Not Covered

Plan benefits are not payable if a loss results from, or is caused by, self-inflicted injuries or suicide; any felony committed by the insured; any act of war; sickness, disease, physical or mental impairment; bacterial or viral infection regardless of how it was contracted; and any medical or surgical treatment for any of the above.

Benefits are also not payable under certain other circumstances, such as while you are on full-time active duty in the armed forces or traveling in an aircraft that is owned, leased or controlled by the District.

ADDITIONAL INFORMATION

Refer to the policy information located on Benefit Central.

IMPORTANT

No one may be covered more than once under the AD&D/VTL plan. If covered as an employee, an employee cannot also be covered as a spouse, SRDP or dependent child.

Voluntary Term Life (VTL)

This benefit can provide voluntary term life insurance for an employee, their spouse or SRDP and/or dependent child(ren) including dependent children of their SRDP. It is offered by Unum.

The VTL plan includes a terminal illness benefit and a waiver-of-premium provision. For more information, visit the Life Insurance (Basic/VTL/AD&D) page on Benefit Central.

Guaranteed Issue

Guaranteed issue (GI) is a specific amount of insurance coverage available to all newly-eligible employees and spouses/SRDPs that is not subject to medical underwriting or approval by Unum. Coverage requested over this guaranteed issue for both employee and spouse or SRDP is subject to medical underwriting and approval by Unum and requires the employee to submit evidence of insurability (EOI).

EOI must be submitted to Unum within 60 days of electing coverage over the guaranteed issue. Coverage amounts requiring submittal of EOI will become effective the first of the month following receipt of Unum's approval.

EOI is available through Benefit Central or by contacting Human Resources. Failure to submit the EOI to Unum will limit the maximum coverage to the guaranteed issue amount.

VTL Employee

VTL is available to employees in $10,000 increments. Coverage can be up to 5 times base salary not to exceed $750,000.

During an initial enrollment period, a newly-eligible employee may elect up to the GI amount of $200,000 without needing to submit an EOI to Unum.

Employees may request new or higher coverage during a Life Event or Open Enrollment period, but will be subject to medical underwriting and required to submit EOI to Unum.

SMOKER STATUS

Defined as the use of any form of tobacco in the last 12 months.

VTL Spouse/SRDP

To cover a legal spouse or SRDP, an employee must be enrolled in VTL employee coverage. An employee may elect coverage for their spouse/SRDP in $10,000 increments with a minimum of $10,000 up to a maximum of $250,000, not to exceed 100% of the employee's approved coverage amount.

A newly-eligible spouse or SRDP is eligible for the guaranteed issue amount of $30,000, not to exceed 100% of the employee's approved coverage amount. Amounts over the guaranteed issue require EOI approval and will become effective the first of the month following receipt of Unum's approval.

VTL Child

If you are enrolled in VTL employee coverage, you may elect $10,000 of coverage for your dependent children (see the "Dependent Eligibility" section of this guide). The maximum benefit for children under six months of age is $500.

PREMIUM CALCULATIONS

Premiums for an employee, their spouse or SRDP are calculated based upon that individual's age as of Jan. 1 and smoker status. To calculate the monthly premium for an employee/spouse or SRDP:

Take your level of coverage ÷ $1,000 x premium rate (age as of Jan. 1, 2024) = total monthly premium.

Note: Premium rates can be found on page 29 of this guide.

One monthly premium will insure all of the employee's eligible children, regardless of the number of children covered.

This section:
Employee Assistance Program (EAP) • Retirement Health Savings (RHS)

Additional Benefits

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is available to all District employees, household members, and dependent children. The District's EAP offers up to **five (5) sessions per family member/per incident, each calendar year.** EAP services are provided by Wellspring EAP.

The EAP provides short-term, confidential counseling for you and your family at no out-of-pocket expense to you. EAP therapists can provide assistance with issues related to:

- Stress
- Abuse
- Marriage
- Finances
- Relationships
- Parenting
- Grief
- Work
- Depression
- Retirement
- Free legal consultation & discounted legal referrals

All discussions between you and the EAP therapist are confidential. Personal information is never shared with anyone, including the District, at any time without your direct knowledge and approval. (Exceptions are made only in cases governed by law to protect individuals threatened by violence.)

Wellspring EAP

1-800-553-7798

www.wellspringeap.org/login
Username: Snohomish County PUD

Retirement Health Savings (RHS)

All regular (represented and non-represented) employees hired/rehired, on or after July 1, 2009, are eligible for the Retirement Health Savings (RHS) Plan. The RHS plan, also known as a Health Reimbursement Arrangement, is a way for you to pay for future health care costs. The RHS Plan is tax-advantaged (i.e., pre-tax contributions, tax deferred earnings and withdrawals) and has investment options.

Employee (represented & non-represented) who have 1 paid hour in a month receive a monthly District contribution (outlined in CBA 5.11.6.1) into the RHS account. The RHS account/monies can't be withdrawn while employed at the District. Upon separation or retirement, the RHS account may be used to request reimbursement for qualified out-of-pocket health-care expenses, including premiums.

The RHS plan (Plan #803083) is administered by MissionSquare Retirement. Login to MissionSquare Retirement Account Access (same login as 401(k) and 457 plans) at www.missionsq.org to access the RHS account (i.e. balance, investment funds, etc.)

This section:
Retirement Plan • Retirement Savings/Deferred Compensation

Savings & Retirement

PLANNING TO RETIRE?

Check out the "Countdown to Retirement" brochure on Benefit Central's Savings & Retirement page

Retirement Plan

Snohomish County PUD is not a Social-Security-covered employer; new employees participate in the Medicare portion of Social Security only.

Eligible employees* of the PUD are enrolled as members of the **Washington State Public Employees' Retirement System (PERS)** administered by the Department of Retirement Systems (DRS) in one of the following plans:

- PERS Plan 2
- PERS Plan 3

Both the District and the employee contribute to PERS.

*If receiving a retirement benefit, employees may not be eligible to participate in PERS.

New Employees to PERS

To learn about the differences between PERS 2 and PERS 3, visit the "Choose a plan" page at www.drs.wa.gov/choice.

- You have 90 days to choose either PERS 2 or PERS 3, it's a permanent decision. Completed Member Information Form (MIF) should be returned via interoffice mail to Human Resources, Mailstop E2.
- Create/login DRS Account www.drs.wa.gov/account/
  - » Review service credit balance
  - » Estimate your retirement benefit
  - » Update beneficiaries

Webinars (live & recorded): www.drs.wa.gov/webinars/ Choosing a plan (Plan 2 or Plan 3), getting ready for retirement, early retirement, benefit options at retirement, Medicare, etc.

For general information about the PERS plans, visit www.drs.wa.gov, under Plans, select PERS Plan 2 or PERS Plan 3.

Note: the District does not participate in the DRS Deferred Compensation Program (DCP) or the Public Employees Benefits Board (PEBB).

Retirement Savings/Deferred Compensation

The District offers **two deferred compensation plans**: a 457 Deferred Compensation Plan and a 401(k) Savings Plan. Effective Jan. 1, 2024, employees will have the option to elect contributions to the 401(k) and 457 on a ROTH (after tax basis) in addition to pre-tax contributions. Each plan is subject to different Internal Revenue Services requirements with limitations on the amount employees can defer. The PUD will deposit a pre-tax only match equal to 100% of an employee's pre-tax and Roth 401(k) elective contributions, up to the first three percent (3%) of an employee's eligible wages. The PUD's matching contribution is vested after three years of employment.

MissionSquare Retirement administers both the 401(k) and 457 plans. To enroll or change your contributions, go to www.missionsq.org and set-up/login to Account Access.

When will my enrollment/change take effect?

401(k) / 457 new enrollments/re-enrollments and deferral changes will be effective the first of the next pay period (or as soon as administratively feasible).

Want to roll over $$? You can roll over your retirement savings from a previous plan by logging into Account Access. Contact our Retirement Plans Specialist for details.

Visit the MissionSquare website for education, financial planning webinars, to schedule an appointment with our Retirement Plans Specialist, complete a financial plan, and much much more!

MissionSquare Retirement: www.missionsq.org,
800-669-7400

Retirement Plans Specialist – David Goren
dgoren@missionsq.org
202-759-7065

Below is a plan comparison chart to show the differences between the 401(k) and 457 plans:

	457 Plan	*401(k) Plan*
Plan number	306931	106638
Annual contribution limit (combined pre-tax & Roth)	100% of adjusted gross income[1], not to exceed a maximum of $23,000	99% of adjusted gross income[1], not to exceed a maximum of $23,000
Pre-tax employer match (pre-tax and/or Roth)	N/A	Yes 100% of employee's elective contributions, up to the first 3% of an employee's eligible wages[2]
Age 50 Catch-up	Additional $7,500 contribution	Additional $7,500 contribution
457 Double Catch-up (age 59 or older)	Additional $23,000 catch-up contributions for 3 tax years prior to the year of full retirement age (unreduced PERS benefit)[3]	N/A
Vesting	Fully vested	EMPLOYEE CONTRIBUTIONS: Fully vested EMPLOYER CONTRIBUTIONS: Vested after 3 years of employment
Inservice withdrawal options (pre-tax & Roth)	Unforeseeable emergency	• Hardship withdrawal • Age 59 ½ no penalty • Roth: 59 ½ & 5+ years contributions & earnings tax free • Withdrawal of rollover monies
Loan provisions (pre-tax only)	N/A	Loans up to lesser of $50k or 50% of balance
Distribution options upon separation from service	Lump sum, systematic payments (i.e., monthly, quarterly, etc.)	
Withdrawal from *pre-tax* assets upon separation from service	Any age – no early withdrawal penalty	• Less than age 59 ½ – subject to 10% early withdrawal penalty, except if an employee separates from service during or after the year employee turns Age 55 • After age 59 ½ – no early withdrawal penalty
Withdrawal from Roth assets upon separation from service	Roth withdrawals are taken on pro-rated basis between (nontaxable) Roth contributions and Roth earnings. Withdrawals will be tax-free if the below criteria are met: • You're at least 59 ½[1] (or disabled or deceased) **AND** • A period of 5 years has passed since Jan. 1 of the year of your first Roth contribution If the above criteria are **not** met, the Roth 401(k) ***earnings*** portion will be subject to taxes and may be subject to a 10% early withdrawal penalty. A common exception to this penalty is if an employee separates from service during or after the year employee turns age 55.	
Required Minimum Distributions (RMDs)	Roth – not applicable Pre-tax – at least age 73 or separation from service, whichever is later	Roth- not applicable Pre-tax – at least age 73 or separation from service, whichever is later
Eligible prior plan rollovers	Pre-tax or Roth 457	Pre-tax or Roth 401(k), 401(a), 403(a), 403(b), Traditional IRA 408(a) or (b)

1 Adjusted gross income = Gross Earnings, plus Benefit Refund, minus SPF, Benefit Deduction/PERS/FSA/HSA, not to exceed $345,000
2 Eligible wages – W2 wages, including OT and bonuses, not to exceed $345,000. Refer to 401(k) plan document Section 2.10.
3 Subject to certain limitations

This section:
Medicare Part D Disclosure Notice • Women's Health & Cancer Rights Enrollment Notice • Premium Assistance Under Medicaid and the Children's Health Insurance Program • HIPAA Special Enrollment Rights Notice • No Surprises Act Notice

Legal Information and Notices

Medicare Part D Disclosure Notice

Important Notice from PUD #1 of Snohomish County About Your Prescription Drug Coverage and Medicare

This Notice is for employees and their dependents who are eligible for Medicare or who will be eligible for Medicare in the next 12 months. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PUD #1 of Snohomish County ("the District") 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 is available 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. This coverage is sometimes referred to as Medicare Part D prescription drug coverage. In general, Medicare Part D provides coverage for prescription drugs not covered under Medicare Part A and Part B. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The District has determined that the prescription drug coverage offered by the District's medical plans (PPO Plan, HDHP and the HMO Plan) 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 enrolled in Medicare Parts A and/or B and each year during the Medicare Part D open enrollment period from Oct. 15 to Dec. 7 (with coverage beginning the following Jan. 1).

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 District coverage will not be affected. However, the coverage provided by the District coverage will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. The coverage provided by the District Plan will pay prescription drug benefits as the primary payer in most instances. Medicare will pay benefits as a secondary payer, and thus the value of your Medicare prescription drug coverage will be greatly reduced.

Full-Time employees are not able to drop District coverage. However, if you are a dependent of a District employee and you decide to join a Medicare drug plan and your District coverage is dropped, be aware that you will not be able to rejoin a District plan until the next open enrollment period or the next time you have a qualifying life event allowing you to rejoin the District coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the District 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 Medicare Part D open enrollment period to join.

PPO Plan	HMO Plan
Participating pharmacy (up to 31-day supply*): • Preventive - $0 copay • Tier 1 Preferred Generic - $10 copay • Tier 2 Preferred Brand - $25 copay • Tier 3 Preferred Specialty* - $45 copay • Tier 4 Non-Preferred (generic/brand/specialty*) – 30% coinsurance • Excluded – Not Covered **Mail order (up to 90-day supply*):** • Preventive - $0 copay • Tier 1 Preferred Generic - $25 copay (2.5x retail) • Tier 2 Preferred Brand - $62.50 copay (2.5x retail) • Tier 3 Preferred Specialty* - $45 copay • Tier 4 Non-Preferred (generic/brand/specialty*) – 30% coinsurance • Excluded – Not Covered	**Retail (30-day supply):** • Preventive: $0 copay • Tier 1 Preferred Generic - $10 copay • Tier 2 Preferred Brand - $30 copay • Tier 3 Non-Preferred Generic/Brand - $50 copay **Mail order (90-day supply):** • Tier 1 Preferred Generic -$20 copay • Tier 2 Preferred Brand - $60 copay • Tier 3 Non-Preferred Generic/Brand - $100 copay **HDHP** • Retail (up to 90-day supply) – 20% coinsurance after deductible is met • Mail Order (up to 90-day supply) – 20% coinsurance after deductible is met • Specialty Rx* (Up to 30-day supply) 20% coinsurance after deductible is met

**PPO & HDHP Specialty Rx have quantity limits and must be filled via Accredo mail order*

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

Contact Human Resources for further information at (425) 783-8557. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the District 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 www.medicare.gov/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).

Oct. 1, 2023
PUD #1 of Snohomish County, Human Resources
PO Box 1107, Everett, WA 98206-1107
425-783-8557
hrbenefits@snopud.com

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).

Women's Health & Cancer Rights Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan (PPO, HMO, HDHP), see the Comparison Charts (Medical) in this booklet for the applicable deductible and coinsurance.

If you would like more information on WHCRA benefits, call Human Resources at 425-783-8557.

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

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

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

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

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

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

ALABAMA – Medicaid
Website: myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: myarhipp.com
Phone: 1-855-692-7447

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Phone:
1-800-221-3943/ State Relay 711
CHP+ Website: www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Phone: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI) Website: www.mycohibi.com
HIBI Phone: 1-855-692-6442

FLORIDA – Medicaid
Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
HIPP Phone: 678-564-1162, press 1

CHIPRA Website: medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorization-act-2009-chipra
CHIPRA Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)
Medicaid Website:
dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: www.kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
KI-HIPP Phone: 1-855-459-6328
KI-HIPP Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kidshealth.ky.gov/Pages/index.aspx
KCHIP Phone: 1-877-524-4718
Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Medicaid Phone: 1-888-342-6207
LaHIPP Phone: 1-855-618-5488

MAINE – Medicaid
Website: www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Website:
www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid & CHIP
Website: www.massgov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Website: dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Phone: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid & CHIP
Medicaid Website:
www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid & CHIP
Website: www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid & CHIP
Website: www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-5437

RHODE ISLAND – Medicaid & CHIP
Website: www.eohhs.ri.gov/
Phone: 1-855-697-4347
Direct RIte Share Line: 401-462-0311

SOUTH CAROLINA – Medicaid
Website: www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid & CHIP
Medicaid Website: medicaid.utah.gov/
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid & CHIP
Website: coverva.dmas.virginia.gov/learn/premium-assistance/famisselect or coverva.dmas.virginia.gov/learn/premium-assistance/healthinsurance-premium-payment-hipp-programs
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid & CHIP
Website: dhhr.wv.gov.bms or mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Phone: 1-855-699-8447

WISCONSIN – Medicaid & CHIP
Website:
www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

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

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

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

HIPAA Special Enrollment Rights Notice

A federal law called HIPAA requires that we notify you of your right to enroll in the District's group health plan under the plan's special enrollment provisions if you acquire a new dependent, or if you decline coverage under the District's plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents under the following circumstances.

If you declined enrollment for the District's medical, vision or dental benefits for yourself or your eligible dependents because of other health, vision or dental insurance or group health plan coverage, you may be able to enroll yourself and/or your eligible dependents in, or change your coverage under, the medical, vision or dental benefits provided by the District if coverage under the other plan is lost due to one of the following:

- Loss of eligibility for coverage under the other plan for reasons including, but not limited to, termination of employment, divorce, death, loss of dependent status or a reduction in hours that affected plan eligibility;
- Coverage ended because you or your dependents no longer live or work in the other plan's service area;
- Employer contributions to the other plan stopped;
- The other plan was terminated or discontinued; or
- COBRA coverage under the other plan ended.

However, you must request enrollment in or a change under the District's plan within 30 days after your or your dependents' other plan coverage ends for one of these listed reasons. Changes are effective the first of the month following receipt of your request for coverage, or coincident with the date your request is received, if it is on the first of the month

In addition, if you have a new dependent as a result of marriage or commencement of State Registered Domestic Partnership, you may enroll in or change coverage for yourself, your spouse or Domestic Partner and/or dependent children. However, you must request enrollment or a change within 30 days after the marriage or commencement of the State Registered Domestic Partnership . Coverage is effective as of the first of the month following receipt of your request for coverage, or coincident with the date your request is received, if it is on the first of the month. For example, you get married on May 1 and the District receives your request to add your new spouse to coverage on May 15. The coverage for your new spouse will be effective June 1.

In addition, if you have a new dependent as a result of birth, adoption, or placement for adoption, you may enroll, or change

coverage for, yourself, your spouse or State Registered Domestic Partner and/or your dependent children. However, you must request enrollment or a change within 60 days after the birth, adoption, or placement for adoption. The new coverage will be effective as of the date of the birth, adoption or placement for adoption.

The District also allows a HIPAA special enrollment for eligible employees and eligible dependents who are not enrolled in the District coverage if (1) they lose Medicaid or CHIP coverage because they are no longer eligible for Medicaid or CHIP: or (2) if they become eligible for a state's Medicaid or CHIP premium assistance program under which the program will pay some or all of the premiums for coverage under Plans. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the District's plans. Changes are effective the first of the month following receipt of your request for coverage, or coincident with the date your request is received, if it is on the first of the month.

Please note that special enrollment rights will be extended only if you notify the District within 30 days or 60 days (as indicated above) of the event.

You may also be allowed to enroll in or change coverage under the plan outside of the District's open enrollment period in other situations. Please see the Benefits Booklets for your group health plan benefits or the Employee Health Benefits Program document for more information.

No Surprises Act Notice

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal and state law from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with Premera (or a contract with another Blue Cross and/or Blue Shield licensee) or Kaiser to provide services for your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Washington state law and your Premera or Kaiser health coverage also protect you from balance billing for emergency care from an out-of-network hospital in Washington, Oregon and Idaho, and from an out-of-network provider that works at the hospital. If you have made an overpayment for such emergency care, the provider must refund the overpayment within 30 business days after the provider received it. For more information, please see the Consumer Rights Notice under the Balance Billing Protection Act, available at:

www.insurance.wa.gov/sites/default/files/documents/final-consumer-notice-of-surprise-billing-rights_0.pdf

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Washington state law and your Premera or Kaiser health coverage also protect you from balance billing for the following services by an out-of-network provider at an in-network hospital or outpatient surgery center in Washington: surgery, anesthesia, pathology, radiology, laboratory and hospitalist care. If you made an overpayment for such services, the provider must refund the overpayment within 30 business day after the provider received it. For more information, please see your benefit booklet and the Consumer Rights Notice under the Balance Billing Protection Act, available at

www.insurance.wa.gov/sites/default/files/documents/final-consumer-notice-of-surprise-billing-rights_0.pdf

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact Premera or Kaiser, the Department of Labor, CMS or your medical provider.

Visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059 for more information about your rights under federal law. More information about your rights under Washington law is available at www.insurance.wa.gov/surprise-billing-and-balance-billing-protection-act. For information on how these protections apply to your Premera coverage or if you have questions on a specific claim, please contact Premera at 1-800-722-1471 or www.premera.com. For information on how these protections apply to your Kaiser coverage or if you have questions on a specific claims, please contact Kaiser at 1-206-630-4636 or 1-888-901-4636 or www.kp.org/wa.

Benefit Definitions

Allowed Amount aka *Allowable Charges, usual, customary, and reasonable:* The highest amount that a contracted or in-network provider is allowed to charge for a service. In-network providers that charge over the allowed amount are required to write-off or not bill the patient. If the plan does not have a contract with the healthcare provider, this is the dollar amount considered by a health insurance plan to be a reasonable charge for medical services or supplies based on the rates in your area. See *Out-of-Network* definition.

Balance Billing: Amount billed in excess of the allowed amount. Out-of-network providers aren't subject to allowed amounts and can bill the patient for charges over the allowed. See *Out-of-Network* definition.

- **Example 1 - No balance billing:** John goes to in see an in-network facility for a $1,000 billed procedure. The allowed amount is $750, so the facility writes off the difference of $250. John pays his $150 deductible and also 10% coinsurance of the $600 ($60) that's left. The insurance company pays $540 to the facility and total cost to John is $210. (Deductible plus coinsurance).
- **Example 2 - Balance billing:** John goes to an out-of-network facility. They also bill $1,000 for the procedure. The allowable charge is still $750. Since the facility doesn't have to go by the allowable charge, John pays the $250 difference (balance billed charge), as well as his deductible of $150 and higher 40% coinsurance. Total cost to John is $640. (Deductible plus co-insurance plus balance billed charge).

Brand Drug: When a drug is initially developed, the pharmaceutical company is granted a patent on the drug for a period of 20 years (brand drug). During the life of the patent, no other manufacturer is allowed to produce or sell the same drug product without the patent holder's approval, thus eliminating direct price competition. See *Formulary* definition.

Coinsurance: The percentage share payable by the member of the allowed amount, after the deductible is paid. *Example:* If the member has a 10% coinsurance for inpatient hospitalization, plan pays 90% and the member pays 10%.

Coordination of Benefits (COB): Coordination between insurance carriers to determine who pays first, second, or third when 2 or more health insurance plans are responsible for paying the same medical claim. Coordination of benefits are also used to make sure that reimbursements are not higher than billed charges.

Copay: A fixed amount due at the time of service, which the member is required to pay for certain services and supplies provided under the plan. A member is responsible for the payment

of a copay directly to the provider of the service or supply. *Example:* If the plan has a $20 copay for office visits, the member would pay $20 to their provider directly.

Cost Share: member portion (e.g., copay, coinsurance, etc.)

Coverage Level: a term to identify who is covered on a plan, typically medical, dental and vision plans (e.g., employee only, employee + spouse, employee + child(ren), employee + family).

Deductible: The amount a member must pay and satisfy before the insurance company starts to pay. Once a deductible is met, most benefits apply coinsurance.

Formulary: A list of prescription drugs established by the insurance company, Third Party Administrator (TPA), and/or Pharmacy Benefit Manager (PBM) that has been created to represent drugs in each therapeutic class that represent the best combination of cost and effectiveness. Also, see *Tiered Benefit, Brand Drug* and *Generic Drug* definitions.

Fully Insured: An insurance company assumes all liability for claims paid. The employer agrees to pay premium payments to the insurance company. Premiums are used to pay current-year claims for benefits and claims processing and administrative charges, as well as build reserves to cover certain contingent obligations and unexpected high claims.

Generic Drug: After the patent on a brand drug expires, other pharmaceutical manufacturers may develop, test, and market the same drug. These identical products: *generic drugs*, contain the exact active ingredients at the same strength and purity as their brand-name counterparts but at a fraction of the price.

Health Maintenance Organization (HMO): A health care financing and delivery system that provides comprehensive health-care services for enrollees in a particular geographic area. Services must be accessed through the HMO provider network or contracted providers. Employees are encouraged, but not required, to choose a primary care physician (PCP).

High Deductible Health Plan (HDHP): With the exception of preventive care, the annual deductible must be met before plan benefits are paid.

Health Savings Account (HSA): Must be enrolled in HDHP to be enrolled in the HSA.

In-Network (IN): Refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount.

Life Event/Special Enrollment: The opportunity to enroll in a group health plan when certain work or life events occur, regardless of the plan's regular enrollment dates. Generally, if certain conditions are met, special enrollment is available when you, your spouse or your dependents lose other coverage (including exhaustion of COBRA continuation coverage), when you marry or when you have a new child by birth, adoption or placement for adoption. The plan must give you at least 30 days–from the loss of coverage or from the date of the marriage, birth, adoption or placement for adoption–to request special enrollment.

Out-of-Network (OON): Refers to providers or health care facilities that have not contracted with the plan for reimbursement at a negotiated rate. Some health plans, like HMOs, do not reimburse out-of-network providers at all. An out-of–network provider may bill you for the difference between its charge and the allowed amount; this is called balance billing.

Out-of-Pocket Maximum (OOP): The dollar limit of coinsurance amounts that a member is responsible to pay during a calendar year; after a member has reached this limit, the plan will pay most benefits at 100% of the allowed amount for the remainder of the calendar year. Some benefits are not subject to the Maximum Out-of-Pocket provision such as the difference between the allowed amount and the provider's actual charge, any balances due that remain after benefit limits have been reached, and services that are not covered by the plan.

Preferred Provider Organization Plan (PPO): PPOs maintain networks of participating doctors and hospitals who have agreed to charge lower rates for services. When in-network providers are used, the level of benefits is highest and the member avoids having to file claims. A primary care physician (PCP) is not required to coordinate care.

Self-Funded: The employer assumes all liability for claims paid under the health plan. The employer normally contracts for a fee with a TPA to provide claims processing, customer service, and access to provider networks. Advantages to the employer to self-fund include: Optional compliance to state mandated benefits, lower administrative fees, and avoidance of state insurance premium taxes.

SRDP: State Registered Domestic Partner

Step Therapy: The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy medication, only if necessary, to control costs and minimize risks.

Third Party Administrator (TPA): A TPA provides administration services on behalf of a health plan. Services can include: Claims processing, customer service, provider networks, discount arrangements, legal, and plan communications. (i.e., Premera Blue Cross, Kaiser Permanente, Regence, etc.)

Tier: Different levels of payment coverage; drugs in a lower tier will often cost less than drugs in a higher tier [e.g., preferred generic (Tier 1), preferred brand (Tier 2), preferred specialty (Tier 3), non-preferred (Tier 4), etc.].

Coverage Comparison Charts

MEDICAL
Medical Plans: IN = in-network provider; OON = out-of-network provider

Benefit/ Provision	PPO Plan administered by Premera	HMO Plan administered by Kaiser	HDHP (High Deductable Health Plan) administered by Premera
Provider Choice	Your choice of IN provider. Reduced benefits for OON providers	You must select a Kaiser provider or contracted provider.	Your choice of IN provider Reduced benefits for OON providers
Network	**Heritage & Heritage Plus 1** www.premera.com/visitor/find-a-doctor	**Core** wa.kaiserpermanente.org/html/public/fad	**Heritage & Heritage Plus 1** www.premera.com/visitor/find-a-doctor
Telehealth Virtual Visit	$5 copay for in-network provider Your provider, Doctor on Demand, or 98point6	$0 copay	Estimated cost ranges from $39-100
Preventive Care	IN: 100% of allowable expenses, no deductible, no copay OON: 40% coinsurance of allowable expenses, no deductible, no copay	Provided in full	IN: 100% of allowable expenses, no deductible, no copay OON: 40% of allowable expenses, no deductible, no copay
Office Visits	IN: 100% after $20 copay OON: 40% of allowable expenses after deductible and $20 copay	Primary care: $15 copay Specialty care: $20 copay	IN: 20% coinsurance after deductible met OON: 40% coinsurance after deductible is met
Deductible	$150 per person/$450 per family Based on calendar year	None	$1,600 individual/$3,200 per family Based on calendar year
Medical Maximum Out-of-Pocket *(certain expenses don't apply)*	$1,500 per person/$4,500 per family Based on calendar year	$1,250 per person/$3,750 per family Includes pharmacy (Rx) Based on calendar year	$3,200 per person/$6,400 per family Based on calendar year Includes pharmacy (Rx) Based on calendar year
Alternative Care	Office Visit cost-share applies; Chiropractic (18 visits/year), Acupuncture (12 visits/year), Naturopathic (no limit)	Office Visit cost-share applies; Chiropractic (18 visits/year), Acupuncture (12 visits/year), Naturopathic & massage therapy (no limit)	Office Visit cost-share applies; Chiropractic (18 visits/year), Acupuncture (12 visits/year), Naturopathic & massage therapy (no limit)
Outpatient Services	IN: $50 copay + Deductible + 10% coinsurance OON: $50 copay + Deductible + 40% coinsurance	$50 copay (per visit)	IN: 20% coinsurance after deductible met OON: 40% coinsurance after deductible is met
Inpatient Hospitalization	IN: $100 copay + Deductible + 10% coinsurance of allowable expenses OON: $100 copay + Deductible + 40% coinsurance	$100 copay (per admission)	IN: 20% coinsurance after deductible met OON: 40% coinsurance after deductible is met
HSA District Contribution	N/A - not eligible for HSA or HSA District Contribution	N/A - not eligible for HSA or HSA District Contribution	1st year enrolled: Individual $1,000 / Family* $2,000 Annual: Individual $350 / Family* $700 **Family = 2 or more people covered*

PHARMACY (RX)

Benefit/ Provision	PPO Plan administered by Premera	HMO Plan administered by Kaiser	HDHP Plan administered by Premera
Rx Out-of-Pocket Maximum	$1,000 individual/$3,000 family *excluded drugs (EX) do not apply to Rx OOP	Included in medical maximum out-of-pocket expenses above	Included in medical maximum out-of-pocket expenses above
Drug List ("Formulary")	www.premera.com/visitor/covered-drugs • Drug list Essential 4-Tier, Select "E1/E4" • Search for the medication name to find the Tier #1-4 or EX (Excluded) and Requirements/Limits	Large Employer with 3 Tiers for Core Network	www.premera.com/visitor/covered-drugs • Drug list Essential 1-Tier, Select "E1/E4" • Search for the medication name to find the Tier #1-4 or EX (Excluded) and Requirements/Limits
Retail	Supply: Up to 31-day supply Preventive: $0 copay • Tier 1 Preferred Generic - $10 copay • Tier 2 Preferred Brand - $25 copay • Tier 3 See Specialty Rx below • Tier 4 Non-Preferred (generic/brand) – 30% coinsurance • Excluded – Not Covered*	Supply: 90-day (Tier copay per 30-day) Preventive: $0 copay • Tier 1 Preferred Generic - $10 copay • Tier 2 Preferred Brand - $30 copay • Tier 3 Non-Preferred Generic/Brand - $50 copay	Supply: Up to 90-day 20% coinsurance after deductible met

Pharmacy table continues on next page ▶

PHARMACY (RX) - CONT'D.

Benefit/ Provision	PPO Plan administered by Premera	HMO Plan administered by Kaiser	HDHP Plan administered by Premera
Mail Order	Supply: Up to 90-day supply Preventive - $0 copay • Tier 1 Preferred Generic - $25 copay (2.5x retail) • Tier 2 Preferred Brand - $62.50 copay (2.5x retail) • Tier 3 See Specialty RX below • Tier 4 Non-Preferred (generic/brand) – 30% coinsurance • Excluded – Not Covered*	Supply: 90-day supply • Tier 1 Preferred Generic -$20 copay • Tier 2 Preferred Brand - $60 copay • Tier 3 Non-Preferred Generic/Brand - $100 copay	Supply: Up to 90-day 20% coinsurance after deductible met
Specialty Rx	Must be filled via mail order Accredo. You or your doctor can call Accredo (1-800-689-6592) Up to 30-day Supply Tier 3 Preferred Specialty- $45 copay Tier 4 - Non-Preferred Specialty - 30% coinsurance	Supply: 30-day supply based on Retail tier HMO Plan copays on previous page In some cases, refills can be mailed vs. picking up at a Kaiser pharmacy	Supply: Up to 30-day 20% coinsurance after deductible met

DENTAL PLANS

Benefit	DPPO provided by Delta Dental of WA	DEPO provided by Willamette Dental
Provider Choice	Choice of any licensed dentist. Benefit payment may vary depending on network: Premier, PPO or non-network dentist	You must select a participating clinic from Willamette Dental Group
Maximum Benefit Paid	$1,750 per year, per covered person	No limit
Deductible/Copay	No copays. Class I Services: None Class II Services: None Class III Services: $50 person / $150 family per year*	No deductible • $10 copay per visit. Major dental work requires additional service copay • $30 specialty provider copay per visit
Preventive Care	Class I – Covered at 100%. Limited to twice in a calendar year.* Does not count towards Maximum Benefit Paid!	No additional copay
Filling	Class II - Covered at 80%. Deductible waived. Fillings based on resin allowable amount	No additional copay
Crown	Class III - Covered at 60% after deductible met*	$250 service copay
Implants	Class III - Covered at 60% after deductible met*	Benefit maximum of $1,500 per calendar year
Orthodontia	Not covered	Interceptive and/or comprehensive treatment: Children and Adults: $1,600 copay
Invisalign®	Not covered	Invisalign copay applies in addition to orthodontia copay

** Applies to annual maximum benefit paid. Charges exceeding the annual maximum are the employee's responsibility. For more details on the benefits listed above and additional coverage, please refer to the corresponding plan document on Benefit Central.*

VISION HARDWARE

Benefit	In-Network	Out-of-Network Reimbursement
Provider Choice	"Access" Network Independent Provider Network + retailers including LensCrafters, Pearle Vision and Target Optical and other participating ACCESS retailers	
Frequency	Lenses/Frames AND contact lenses once/calendar year	
Annual Allowance - Frames	$0 copay; $200 Allowance; 20% off balance over $200	Up to $100
Standard Plastic Lenses	Single Vision/Bifocal/Trifocal/Lenticular: $10 copay Standard Progressive Lens: $75 copay; Premium Progressive Lens: $75 copay (80% of charge less $120 allowance)	Up to $25/$40/$55 Up to $40/$40
Lens Options	• UV Treatment/Tint (Solid and Gradient)/Standard Plastic Scratch Coating: $15 • Standard Polycarbonate – Adults/Kids under 19: $40 • Standard Anti-Reflective Coating: $45 • Polarized/Other Add-ons: 20% off retail price	N/A
Additional Pairs Benefit	40% discount off complete pair eyeglass purchases + 15% discount off conventional contact lenses once funded benefit has been used	N/A
Contact Lenses *(Contact lens allowance includes materials only)*	• Conventional: $0 copay; $200 Allowance; 15% off balance over $200 • Disposable: $0 copay; $200 Allowance + balance over $200 • Medically Necessary: $0 copay, Paid in Full	Up to $160 Up to $160 Up to $210
Non-prescription Sunglasses – *Sunglass Hut*	15% off retail price or 5% off promotional price	N/A
Laser Vision Correction *Lasik or PRK from U.S. Laser Network*	15% off retail price or 5% off promotional price	N/A
Amplifon Hearing Health Care Network	Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A

2024 Monthly Insurance Costs & Contribution

Medical Plans

Benefit Plan Premium/Contribution	*Employee Only*	*Employee + Spouse/SRDP*	*Employee + Child(ren)*	*Employee + Family*
PPO Plan	$889.16	$1,867.24	$1,644.94	$2,623.02
District Contribution*	$889.16	$1,652.50	$1,538.02	$2,400.06
Net Cost	**$0.00**	**$214.74**	**$106.92**	**$222.96**
HMO Plan	$832.94	$1,749.20	$1,540.96	$2,457.20
District Contribution*	$832.94	$1,696.72	$1,494.74	$2,383.48
Net Cost	**$0.00**	**$52.48**	**$46.22**	**$73.72**
HDHP	$775.76	$1,629.12	$1,435.18	$2,288.52
District Contribution*	$775.76	$1,612.82	$1,420.82	$2,265.64
Net Cost	**$0.00**	**$16.30**	**$14.36**	**$22.88**

Dental Plans

Benefit Plan Premium/Contribution	*Employee Only*	*Employee + Spouse/SRDP*	*Employee + Child(ren)*	*Employee + Family*
Dental PPO (Delta Dental)	$53.24	$111.80	$98.48	$157.06
District Contribution*	$53.24	$98.94	$92.08	$143.70
Net Cost	**$0.00**	**$12.86**	**$6.40**	**$13.36**
Dental EPO (Willamette)	$57.00	$114.06	$127.76	$185.36
District Contribution*	$57.00	$110.64	$123.92	$179.80
Net Cost	**$0.00**	**$3.42**	**$3.84**	**$5.56**

Basic Life Insurance

Benefit Plan	*$50,000*
Premium	$7.50
District Contribution*	$7.50
Net Cost	**$0.00**

Long-Term Disability (LTD)

	60-day	*90-day*	*120-day*
Long-Term Disability	$47.38	$34.18	$27.18
District Contribution*	$34.18	$34.18	$34.18
Net Cost	**$13.20**	**$0.00**	**($7.00)**

Vision Hardware

Benefit Plan	*Employee Only*	*Employee + Spouse/SRDP*	*Employee + Child(ren)*	*Employee + Family*
EyeMed Vision Care	$5.84	$11.02	$11.60	$17.00

**Regular full-time employees and eligible part-time employees (enrolled in medical and dental) receive District Contribution*
Please note: SRDP and domestic partner costs for non-tax dependents are paid after tax

2024 Monthly Insurance Costs & Contribution

Accidental Death & Dismemberment (AD&D)

Coverage	Employee Only	Family Plan
$25,000	$.50	$1.00
50,000	$1.00	$2.00
75,000	$1.50	$3.00
100,000	$2.00	$4.00
150,000	$3.00	$6.00
200,000	$4.00	$8.00
250,000	$5.00	$10.00

Part-time Pay-In-Lieu-of Benefits Rate

Effective Jan. 1, 2024: $9.11 per hour

Voluntary Term Life (VTL)

Employee & Spouse rates per $1,000 of Benefit

Age**	Smoker	Non-Smoker
Under 20	$0.053	$0.042
20 to 24	$0.053	$0.042
25 to 29	$0.055	$0.045
30 to 34	$0.072	$0.058
35 to 39	$0.108	$0.083
40 to 44	$0.173	$0.125
45 to 49	$0.272	$0.198
50 to 54	$0.424	$0.289
55 to 59	$0.559	$0.422
60 to 64	$0.712	$0.556
65 to 69	$0.983	$0.794
70 to 74	$1.843	$1.503
75+	$5.364	$4.693
***Age as of Jan. 1, 2024.*		
Monthly cost for all dependent children: $2/$10,000 coverage.		

Please note: SRDP and domestic partner costs for non-tax dependents are paid after tax

Vendor Contact

PPO & HDHP Plans, Group #1039248

Premera Blue Cross (claims administrator) 1-800-722-1471
- 24-hour NurseLine 1-800-841-8343
- Website ..... www.premera.com
- Network (Washington & Alaska) ..... Heritage & Heritage Plus 1
- Network (USA, outside Washington & Alaska) ..... BlueCard PPO (Prefix=SQN)
- Network (out of the country) ..... BlueCard Worldwide Program 1-800-810-BLUE (2583)

Telehealth online providers:
- Doctor On Demand ..... www.doctorondemand.com/premera
- 98point6 ..... www.98point6.com/premera

PPO Plan Pharmacy:
- Drug List="E4" ..... www.premera.com/visitor/covered-drugs

Express Scripts (pharmacy benefit administrator) 1-800-391-9701
- Website ..... www.premera.com/pharmacy
- Mail Order ..... www.premera.com/mypharmacyplus

Specialty RX Pharmacy – Accredo 1-800-689-6592

HMO Plan, Group #0061600

Kaiser Permanente (claims administrator) 1-888-901-4636

24-hour Consulting Nurse 1-800-297-6877

Website ..... www.kp.org/wa

Network ..... Core

Pharmacy Mail Order 1-800-245-7979

DPPO, Group #0602

Delta Dental of Washington 1-800-554-1907

Website ..... www.deltadentalwa.com

Networks ..... Dental Dental PPO and Delta Dental Premier

DEPO, Group #WA156

Willamette Dental Group 1-855-433-6825

Website ..... willamettedental.com

Snohomish County PUD custom microsite: ..... willamettedental.com/snohomish_county_pud/

Vision Hardware Plan, Group #1040734

EyeMed Vision Care. 1-866-939-3633

Website ..... www.eyemed.com/en-us

Websites for Network Providers:
..... www.glasses.com, www.contactsdirect.com, www.lenscrafters.com, www.targetoptical.com, www.ray-ban.com/usa

Lasik 1-877-552-7376

Network ..... Access

Flexible Spending Accounts & Health Savings Account (Pre-Tax Benefits Unit)

ThrivePass ..... 1-866-855-2844 | **Press 1 (Pre-tax),** 7:30 am - 5:30 pm M-Th; 7:30 am - 5:00 Fri (CT)

Website ..... www.thrivepass.com

Email ..... tpa@thrivepass.com

Life, ID# 417392 and VTL/AD&D, ID# 417393 (VTL Division #001) and Universal Life with Long Care Rider, Group #56644

Unum 1-877-225-2712

Website ..... www.unum.com

Additional Resources

Benefit Central

From a District device (logged into District network):

Click on the Employee Central icon on your District desktop, then go to Benefit Central.

From an external device:

Go to snopud.com and click on the "PUD Employees/Retirees" link at the bottom of the page, then click on Active Employees link for Employee Central login & then Benefit Central tile.

Human Resources Benefits Team

Questions on specific benefits? Contact the Human Resources Benefits Team:

Phone 425-783-8557
Email ..... hrbenefits@snopud.com
Fax 425-783-8675

Retirement

Department of Retirement Systems (DRS)

Phone 1-800-547-6657
Website ..... www.drs.wa.gov

Mission Square Retirement (401K/457/RHS plans)

Plan Numbers: 401K = 106638; 457 = 306931; RHS = 803083

Phone 1-800-669-7400
Website ..... www.missionsq.org
David Goren, Retirement Plans Specialist ..... 202-759-7065 / dgoren@missionsq.org

Life / Long-Term Care

Allstate (American Heritage Life Insurance Company)

Phone ..... 1-800-521-3535 Ext 3 ("Life")
Website ..... mybenefits.allstate.com

Employee Assistance Program

Wellspring EAP

Phone 1-800-553-7798
Website ..... www.wellspringeap.org/login
Username: Snohomish County PUD

You are not alone. Mental health matters.

In the U.S., 1 in 3 adults report symptoms of depression or anxiety.

If you or someone in your family would like help, there are many resources available at the District.

Scan the QR code or visit teampud.com/mentalhealth.

snopud.com | hrbenefits@snopud.com | 425-783-8557

SNOHOMISH COUNTY PUD
PUBLIC UTILITY DISTRICT NO. 1

From home, click on PUD employee link at snopud.com, then select Employee Central to get to Benefit Central