City of Seattle

Seattle Human Resources

Kimberly Loving, Director

January 15, 2025

:

These notices are for your information only. No immediate action is required.

The City is pleased to provide employees with several healthcare plans for their personal needs. This packet contains two types of information:

1. The page on top of this letter are directions to review your 2025 benefits in Workday. **Please make sure your records match the City's information.** Contact your department's Benefits Representative with any questions.

2. The following pages contain annual notices about your City health care coverage; not all may apply to you. These notices (summarized below) are for your information only; no immediate action is required. **Please keep this information with your other important papers** to refer to them later if needed.

Women's 1998 Health and Cancer Rights Act (page 4)
→ This notice applies to employees and family members with medical coverage.

Grandfathered Plan Notice (page 4)
→ This notice applies to employees and family members with medical coverage.

Medicare Part D (Creditable Coverage) (pages 5-6)
→ This notice applies to employees and family members enrolled in a City of Seattle-sponsored Aetna or Kaiser Permanente medical plan. It confirms your prescription drug coverage is at least as good as Medicare Part D coverage.

Initial Notice of COBRA Continuation Coverage Rights (pages 7-10)
→ This notice applies to employees and family members with medical/dental/vision coverage.

Notices of Privacy Practices (pages 11-14)
→ This notice applies to employees and family members with medical/dental/vision coverage and describes your health information rights.

Medicaid and the Children's Health Insurance Program (CHIP) Notification (page 15)
→ This notification describes premium assistance through the State.

Privacy Notice (pages 16-17)
→ This notice describes the protection of your data.

Health Care Exchange Notice (last insert)
→ This notice describes the medical coverage options through the Health Care Exchange.

If you have questions about these notices, please call the Benefits Unit at (206) 615-1340.

****

Women's 1998 Health and Cancer Rights Act

Annual Notice

As required by the Women's Health and Cancer Rights Act of 1998, the group health plans offered by the City of Seattle provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance and
- Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

A group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles, copays, and coinsurance amounts consistent with those that apply to other benefits under the plan. Contact your health plan for more information.

****

Health Care Reform Notice -- Grandfathered Plan Status Disclosure

The City of Seattle's Aetna and Kaiser Permanente medical plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As the Affordable Care Act permits, a grandfathered health plan can preserve specific basic health coverage already in effect when Congress enacted that law. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement to provide preventive health services without cost-sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as eliminating lifetime limits on benefits. Questions? Contact the Benefits Unit at (206) 615-1340.

Important Notice from the City of Seattle About Your Prescription Drug Coverage and Medicare for Plan Year 2025

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Seattle and 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. At the end of this notice is information about where to get help making decisions about your prescription drug coverage.

There are two critical things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) offering prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also provide more coverage for a higher monthly premium.
2. The City of Seattle has determined that the prescription drug coverage offered by Aetna, Kaiser Permanente, and UnitedHealth Care is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. It is, therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

However, suppose you lose your current creditable prescription drug coverage through no fault of your own. In that case, 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 City of Seattle coverage will be affected. Your current prescription drug coverage is part of a City of Seattle medical plan. You cannot drop your City of Seattle prescription drug coverage unless you also drop your City of Seattle medical coverage. If you enroll in an individual Medicare Part D prescription drug plan and drop your creditable coverage with the City of Seattle, you and your dependents cannot return to the City of Seattle plan. Suppose you or your dependents enroll in a different employer active employee or retiree group medical plan with creditable Part D coverage and drop your creditable coverage with the City of Seattle. In that case, you and your dependents can return if you involuntarily lose coverage on the employer group plan. It is essential you compare your current plan, including which drugs are covered, with the coverage and costs of Medicare Part D plans.

If you decide to join a Medicare drug plan and drop your current City of Seattle coverage, be aware that you and your dependents may not be able to get this coverage back.

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 City of Seattle 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) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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

Contact your medical plan for further information. **NOTE:** You'll receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan and if this coverage through the City of Seattle changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the guide by U.S. mail yearly 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.

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

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

Date:	10/31/2024
Name of Entity/Sender:	City of Seattle
Contact--Position/Office:	Seattle Human Resources Benefits Unit
Address:	P.O. Box 34028 MS SMT- 55-01 Seattle, WA 98124-4028
Phone Number:	(206) 615-1340

CMS Form 10182-CC

INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
It is important that all covered individuals (employee, spouse/domestic partner, and eligible dependent children, if able) take the time to read this notice carefully and be familiar with its contents. If a covered dependent is not living at your address, please provide written notification to your department's Benefits Representative so the City of Seattle can also send a notice to that dependent.

You are receiving this notice because you may have recently become covered under one or more of the following group health plans: Aetna, Kaiser Permanente, Delta Dental of Washington, Dental Health Services, VSP, UnitedHealthCare, and the Health Care Flexible Spending Account (Health Care). This notice contains important information about your right to COBRA continuation coverage, a temporary extension of group health coverage under a plan under certain circumstances when coverage would otherwise end due to a qualifying event. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plans listed above (medical, dental, vision, and the Health Care FSA) and not to any other benefits offered by the City of Seattle (such as life insurance, long term disability, or accidental death and dismemberment insurance). **Should an actual qualifying event occur, the City of Seattle will send you additional information and an election notice at that time.**

A federal law created the right to COBRA coverage, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available when you would otherwise lose your group health coverage under a plan. It can also become available to your spouse/domestic partner and dependent children if they are covered under a plan, when they would otherwise lose their group health coverage under the plan. This notice does not fully describe COBRA coverage or other rights under a plan. For additional information about your rights and obligations under a plan and federal law, you should review the plan booklet or contact the City of Seattle Human Resources Benefits Unit, the COBRA Plan Administrator. A plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are in this notice. After a qualifying event occurs and any required notice of that event is correctly provided to your department's Benefits Representative, COBRA coverage must be offered to each person losing plan coverage who is a "qualified beneficiary." You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under a plan is lost because of the qualifying event. Under a plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage.

Who is entitled to elect COBRA Continuation Coverage?
If you are an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason.

If you are the spouse/domestic partner, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because any of the following qualifying events happens:

- your spouse/domestic partner dies;
- your spouse's/domestic partner's hours of employment are reduced;
- your spouse's/domestic partner's employment ends for any reason other than their gross misconduct or
- you become divorced or legally separated from your spouse or terminate your domestic partnership. Also, if your spouse (the employee) reduces or eliminates your group health

coverage in anticipation of a divorce or legal separation, and a divorce or legal separation occurs within three months of the reduction or elimination of coverage, then the divorce or legal separation will be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if they lose group health coverage under a plan because any of the following qualifying events happen:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The child stops being eligible for coverage under a plan as a "dependent child."

When is COBRA Continuation Coverage Available?
When the qualifying event is the end of employment, reduction of hours of work, or employee death, a COBRA election notice will be made available to qualified beneficiaries. You do not need to notify the Benefits Representative in your department of the occurrence of any of these three qualifying events. However, notice must be provided to your department's Benefits Representative for other qualifying events, as explained below in the section entitled "You Must Give Notice of Some Qualifying Events."

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse, termination of domestic partnership, or a dependent child's loss of eligibility for coverage as a dependent child), a COBRA election notice will be available to you only if you complete and submit a *Health Care Benefits Change Form* to the Benefits Representative for your department within 60 days after the date on which the qualified beneficiary loses or would lose coverage under the terms of the plan as a result of the qualifying event. If this procedure is not followed during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE. (A *Health Care Benefits Change Form* is available from your department's Benefits Representative.)

Electing COBRA Coverage
Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses/domestic partners (if the spouse/domestic partner is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the COBRA election notice WILL LOSE THEIR RIGHT TO ELECT COBRA COVERAGE.

Qualified beneficiaries entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, they become entitled to Medicare benefits or become covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied.

How Long Does COBRA Coverage Last?
COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce, legal separation or termination of domestic partnership, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months. However, COBRA coverage under the Health Care FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health Care FSA Component.")

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months BEFORE the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a

result of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse/domestic partner and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). However, COBRA coverage under the Health Care FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health Care FSA Component.")

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. However, COBRA coverage under the Health Care FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health Care FSA Component."

Extension of Maximum Coverage Period
If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Plan Administrator of a disability or a second qualifying event to extend the COBRA coverage period. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. (The period of COBRA coverage under the Health Care FSA cannot be extended under any circumstances.)

Disability extension of an 18-month period of continuation coverage
If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above.)

The disability extension is available only if you complete and submit a *Notice of Disability* and a copy of the Social Security Administration's determination of disability to the COBRA Plan Administrator: (a) during the 18 months after the covered employee's termination of employment or reduction of hours, and (b) within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of a plan due to the covered employee's termination of employment or reduction of hours.

If these procedures are not followed or if the notice is not provided to the COBRA Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. You can obtain a copy of a *Notice of Disability* from the COBRA Plan Administrator.

Second qualifying event extension of COBRA coverage
If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse/domestic partner and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Plan Administrator. This extension may be available to the spouse/domestic partner and any dependent children receiving COBRA coverage if the employee or former employee dies, gets divorced or legally separated, or terminates a domestic partnership or if the dependent child stops

being eligible under a plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under a plan had the first qualifying event not occurred. (This extension is not available to the spouse/domestic partner and any dependent children under a plan when a covered employee becomes entitled to Medicare after electing COBRA coverage.)

This extension due to a second qualifying event is available only if you notify the COBRA Plan Administrator by completing and submitting a *Notice of Second Qualifying Event* within 60 days after the date of the second qualifying event. You can obtain a copy of a *Notice of Second Qualifying Event* from the COBRA Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the COBRA Plan Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Health Care FSA Component
COBRA coverage under the Health Care FSA will be offered to qualified beneficiaries. Health Care FSA COBRA coverage will consist of the Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. Health Care FSA COBRA coverage will consist of the Health Care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and Health Care FSA COBRA coverage will terminate at the end of the plan year.

More Information About Individuals Who May Be Qualified Beneficiaries

- *Children born to or placed for adoption with the covered employee during COBRA coverage period*
  A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in a plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in a plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

- *Alternate recipients under QMCSOs*
  A child of the covered employee who is receiving benefits under a plan according to a qualified medical child support order (QMSCO) received by the COBRA Plan Administrator during the covered employee's period of employment with the City of Seattle is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Keep Your Plan Informed of Address Changes
To protect your family's rights, you should keep your department's Benefits Representative informed of any changes in the addresses of family members. For your records, you should also keep a copy of any notices you send to your department's Benefits Representative or COBRA Plan Administrator.

If You Have Questions
Address questions concerning your Plan or COBRA coverage to the:

COBRA Plan Administrator
City of Seattle Human Resources
Benefits Unit
700 5th Ave., Suite 5500
PO Box 34028
Seattle, WA 98124-4028 **Phone**: (206) 615-1340

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Safeguarding Your Protected Health Information

The City of Seattle self-insured group health plans administered by Aetna, Inc., Kaiser Permanente, Delta Dental of Washington, VSP, and the Health Care Flexible Spending Account Plan administered by Navia Benefits Solution (the "Plans") are set up to protect the privacy of your health information. The Plans are required by applicable federal and State laws to maintain the privacy of your Protected Health Information. This notice explains the Plans' privacy practices, their legal duties, and your rights concerning your Protected Health Information (referred to in this notice as "PHI"). The term "PHI" includes any personally identifiable information transmitted or maintained by the Plans, regardless of form (oral, written, electronic). This includes information regarding your health care and treatment and identifiable factors such as your name, age, and address. The Plans will follow the privacy practices described in this notice while it is in effect.

Why do the Plans collect Protected Health Information?
The Plans collect PHI for a number of reasons, including determining the appropriate benefits to offer individuals, pay claims, provide case management services, and provide quality improvement services.

How do the Plans collect Protected Health Information?
The Plans collect PHI through covered members, their healthcare providers, and the Plans' Business Associates. For example, the Plans' claims administrators, which are Business Associates, receive PHI from health care providers, such as through the submission of a claim for reimbursement of covered benefits.

How do the Plans safeguard your Protected Health Information?
The Plans protect your PHI by:

- Treating all of your PHI that is collected as confidential;
- Stating confidentiality policies and practices in the Plans' group health plan administrative procedure manual, as well as disciplinary measures for privacy violations;
- Restricting access to your PHI to those individuals who need to know your personal information to provide services to you, such as paying a claim for a covered benefit;
- Only disclosing your PHI that is necessary for a service company to perform its function on the Plans' behalf, and the company agrees to protect and maintain the confidentiality of your PHI; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and State regulations to guard your PHI.

How do the Plans use and disclose your Protected Health Information?
The Plans will not disclose your PHI unless they are legally allowed or required to make the disclosure or if you (or your authorized representative) give the Plans permission. Uses and disclosures other than those listed below require your authorization. If you authorize a Plan to use or disclose your PHI, you may revoke the authorization, in writing at any time. If you revoke your authorization, the Plan will no longer use your PHI for the reasons covered by the written authorization. If other legal requirements under applicable state laws further restrict a Plan's use or disclosure of your PHI, it will also comply with those legal requirements. Following are the types of disclosure the Plans may make as allowed or required by law:

> **Treatment**: They may use and disclose your PHI for the treatment activities of a health care provider. It also includes consultations and referrals between one or more of your providers. Treatment activities include disclosing your PHI to a provider so that that provider can treat you.

Payment: They may use and disclose your medical information for their payment activities, including the payment of claims from physicians, hospitals, and other providers for services delivered to you. Payment also includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, utilization review, and preauthorizations).

For example, a Plan may tell a physician whether you are eligible for benefits or what percentage of the bill will be paid by the Plan.

Health Care Operations: They may use and disclose your medical information for their internal operations and customer service activities. Healthcare operations include but are not limited to quality assessment and improvement, disease and case management, medical review, auditing functions including fraud and abuse compliance programs, and general administrative activities.

Business Associates: They may also share PHI with third-party "business associates" who perform certain activities for the Plans. They require these business associates to afford your PHI the same protections afforded by themselves.

Plan Sponsor: They may disclose your PHI to the Plans' sponsor with your authorization or when required by law to permit it to perform administrative activities.

To You or Your Authorized Representative: Upon your request, a Plan will disclose your PHI to you or your authorized representative. If you authorize a Plan to do so, it may use your PHI or disclose it to the person or entity you name on your signed authorization. After you provide a Plan with an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. In certain situations when disclosure of your information could be harmful to you or another person, a Plan may limit the information available to you or use an alternative means of meeting your request.

To Your Parents, if You are a Minor: Some state laws concerning minors permit or require disclosure of PHI to parents, guardians, and persons with similar legal status. The Plans will act consistently with the laws of the State where the treatment is provided and make disclosures consistent with such laws.

Your Family and Friends: If you cannot consent to disclosing your PHI, such as in a medical emergency, a Plan may disclose your PHI to a family member or friend to the extent necessary to help with your health care or with payment for your health care. A Plan will only do so if it determines that the disclosure is in your best interest.

Research; Death; Organ Donation: They may use or disclose your PHI for research purposes in limited circumstances. They may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: They may disclose your PHI if they believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. They may disclose your PHI to appropriate authorities if they reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: They must disclose your PHI, including workers' compensation laws, when required to do so by law.

Process and Proceedings: They may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement: They may disclose limited information to law enforcement officials.

Military and National Security: They may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. They may disclose to authorized federal officials the PHI required for lawful intelligence, counterintelligence, and other national security activities.

What rights do you have as an individual regarding a Plan's use and disclosure of your Protected Health Information?

You have the right to request all of the following:

Access to your PHI: You have the right to review and receive a copy of your PHI. Your request must be in writing. A Plan may charge a nominal fee to provide copies of your PHI. This right does not include the

right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to other state or federal laws that prohibit a Plan from releasing such information. A Plan may also limit your access to your PHI if they determine that providing the information could harm you or another person; you have the right to request a review of that decision.

Amendment: You have the right to request that a Plan amend your PHI. Your request must be in writing, and it must identify the information you think is incorrect and explain why the information should be amended. A Plan may decline your request for certain reasons, including if you ask it to change information it did not create. If a Plan declines your request to amend your records, it will provide a written explanation. You may respond with a statement of disagreement to be appended to the information you want to be amended. If a Plan accepts your request to amend the information, it will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in any future disclosures of that information.

Accounting of Disclosures: You have the right to receive a report of instances in which a Plan or its business associates disclosed your PHI for purposes other than treatment, payment, health care operations, and certain other activities. You are entitled to such an accounting for the 6 years before your request, though not for disclosure made before April 14, 2003. A Plan will provide you with the date on which it made a disclosure, the name of the person or entity to whom it disclosed your PHI, a description of the PHI it disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a 12-month period, a Plan may charge you a reasonable fee for creating and sending these additional reports.

Restriction Requests: You have the right to request that a Plan place additional restrictions on its use or disclosure of your PHI for treatment, payment, health care operations, or to persons you identify. It may be unable to agree to your requested restrictions. If the Plan does, it will abide by its agreement (except in an emergency).

Confidential Communication: You have the right to request that a Plan communicate with you confidently about your PHI by alternative means or to an alternative location. If you advise a Plan that disclosure of all or any part of your PHI could endanger you, it will comply with any reasonable request provided you specify an alternative means of communication.

Electronic Notice: If you receive this notice on the Plan sponsor's Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact the Plans using the information listed at the end of this notice to obtain this notice in written form.

Can I "opt out" of certain disclosures?
You may have received notices from other organizations that allow you to "opt out" of certain disclosures. The most common type of disclosure that applies to "opt outs" is the disclosure of personal information to a non-affiliated company so that company can market its products or services to you. Self-insured group health plans must follow many federal and State laws that prohibit them from making these types of disclosures. Because they do not make disclosures that apply to "opt outs," it is not necessary for you to complete an "opt out" form or take any action to restrict such disclosures.

When is this notice effective?
This notice takes effect April 14, 2003, and will remain in effect until the Plans revise it.

What if the Plans change their notice of privacy practices?

The Plans reserve the right to change their privacy practices and the terms of this notice at any time and to make the revised or changed notice effective for PHI they already have about you, as well as any information they receive in the future, provided such changes are permitted by applicable law. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your individual rights, the Plans' duties or other privacy practices stated in this notice. For your convenience, a copy of the Plans' current notice of privacy practices is always available on the Plans sponsor's Website at https://www.seattle.gov/human-resources/rules-and-resources/documents#legalnotices, and you may request a copy at any time by contacting the Plans' Privacy Officer at the number listed below.

How can you reach us?

If you want additional information regarding the Plan's Privacy Practices, or if you believe the Plans have violated any of your rights listed in this notice, please contact the Plan's Privacy Officer at the City of Seattle Human Resources, Benefits Unit, 700 Fifth Avenue, Suite 5500, Seattle, WA 98104; 206-615-1340. If you have a complaint, you may also submit a written complaint to the U.S. Department of Health and Human Services, 2201 Sixth Ave., Suite 900, Seattle, WA 98121-1831, or by e-mail to OCRComplaint@hhs.gov. Your privacy is one of the Plan's greatest concerns, and there is never any penalty to you if you file a complaint with the Plan's Privacy Officer or the U.S. Department of Health and Human Services.

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer but cannot afford the premiums, some States have premium assistance programs to help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people eligible for employer-sponsored health coverage but need assistance paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

You may be eligible for assistance paying your employer health plan premiums. Contact the Medicaid office for Washington for further eligibility information.

Washington – Medicaid

Website: https://www.dshs.wa.gov/altsa/home-and-community-services/medicaid

Phone: 1-800-562-3022 ext. 15473

For more information on special enrollment rights, you can contact either:

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

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

Privacy Notice – Benefit and Deferred Compensation Plans and Programs

What you should know about our protection of your data

Protecting the personal information of individuals eligible to participate in City of Seattle-sponsored benefit plans and programs is a priority for the Benefits and Deferred Compensation Units of the Seattle Department of Human Resources (SDHR). SDHR is compliant with the City of Seattle Privacy Policy. The Benefits and Deferred Compensation Units and our contracted vendors collect, retain, and use personal information about City employees, retirees, and their covered dependents to offer and provide benefits, services, and programs.

This notice outlines how SDHR handles the personal information of employees and retirees and their dependents for whom we administer benefits. It is only informational; no action is required. If you have questions regarding this notice, please e-mail the Benefits Unit at benefits.unit@seattle.gov.

What type of information is collected and stored?

The types of information SDHR may collect to administer the City's Benefit and Deferred Compensation plans and programs include identifying information such as name, address, date of birth, gender, e-mail addresses, mailing addresses, social security number and employee I.D. This data is stored in the City's Human Resource Information System (HRIS) and some personnel files. It may be gathered through information the employee provided upon hire, information the employee provided in Employee Self Service (ESS), and information about the employee's benefits elections.

Contracted vendors may collect additional metadata and data voluntarily provided by users from user accounts housed on their platforms to personalize programs and services or provide aggregate utilization reporting. The City of Seattle does not receive individual personal health information from program vendors.

What information is disclosed, and how is it used?

The SDHR Benefits and Deferred Compensation Units may share nonpublic personal information about eligible employees, retirees, and covered dependents with contracted vendors and service providers. In doing so, we comply with state and federal laws and follow information security practices to protect physically and electronically stored and transmitted data.

Contracted vendors may use the nonpublic personal information provided by SDHR, such as mailing addresses, e-mail addresses, or phone numbers, to communicate changes, provide program or service information, or perform outreach with the expressed written approval from SDHR. Contracted vendors generally include third-party plan administrators, insurance carriers, program administrators, consultants, technology companies, and data analytics companies. A current list of contracted Benefit and Deferred Compensation vendors is available at https://bit.ly/34YIOSW. Contracted vendors are prohibited from distributing the nonpublic personal information provided by SDHR to affiliated partners or other organizations that do not offer services within the contract.

Due to system limitations, employees, retirees, and their covered dependents cannot opt-out of the personal data transmission to contracted vendors. Some vendors may offer participants the option of restricting the use of personal data or limit the use of addresses for communications and notifications on their platforms.

SDHR does not sell individual, personal or aggregate information to third parties for marketing or commercial use.

How do we safeguard your privacy?

We maintain physical, electronic, and procedural safeguards to protect your personal information consistent with the Seattle Information Technology Privacy Program.

All Benefit and Deferred Compensation plan contracted vendors are contractually required to protect and secure the personal information of employees, retirees, and covered dependents provided by SDHR and adhere to the City's procurement and Seattle Information Technology department contracted terms and conditions for data security.

In addition to the Seattle Information Technology Privacy Program, SDHR requires HIPAA Privacy and Security training for appropriate staff and follows best practices for protecting individuals' confidential information. Access to nonpublic personal data is restricted to only those employees who require access to administer benefit plans or programs.

SDHR may amend privacy practices or enter contracts with additional vendors as authorized by Seattle Municipal Code 4.50.010 (D) at any time. A list of all contracted vendors with whom the SHR's Benefits Unit shares personal information is at https://bit.ly/34YIOSW.