2025 City of Yakima Benefits Guide

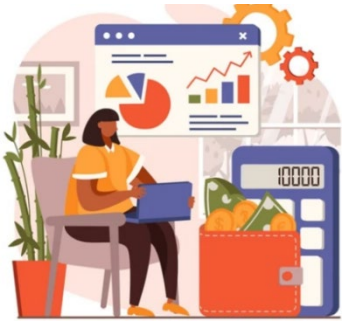
~Common Good, what is achieved by citizenship, collective action, and active participation in the realm of politics and public service. One understanding of the common good rooted in Aristotle's philosophy remains in common usage today, referring to what one contemporary scholar calls the "good proper to, and attainable only by, the community, yet individually shared by its members."[2]

What's New in 2025

Prudent Rx

Offerings

November 2025 is Open Enrollment for Plan Year 2026



Who Is Eligible?

All permanent regular full-time and part-time employees who have worked an average of at least 20 hours per week over the past 12 months are eligible for benefits on the first of the month following the initial month of employment. You may also enroll your eligible dependents for medical, dental and vision during open enrollment or in the event of a qualified change in status.

Your eligible dependents include:

- Your legal spouse or domestic partner. Domestic partner coverage requires that you complete an Affidavit of Domestic Partnership and you will be charged the appropriate rate on a post-tax basis, unless you elect pre-tax basis.
- Your children up to age 26.
- Any dependent child who is incapable of self-support because of a physical or mental disability.

Special Enrollment Rights "Qualified Change in status"

- Because many of your benefits are available on a pre-tax basis the IRS requires you to have a qualified change in status during the year to make changes. Otherwise, all the coverages you select will be effective for a full calendar year, unless you leave employment or have a "qualified change in status"
- If you are declining enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this plan if you or your dependents lose eligibility from other coverage (or if the employer stops contributing towards your dependents other coverage). However, you must request enrollment within 30 days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage) or within 60 days of the birth, adoption or placement for adoption of a new child.
- You may also be able to enroll your dependents in the future if your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.
- In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents. However, you must request enrollment within 60 days after the change (birth, adoption or placement for adoption of a child). Applications for coverage must be made on the plan's enrollment form by this applicable deadline. To request special enrollment or obtain more information, contact your Human Resources Department.

The Total Worker Health (TWH) approach prioritizes a hazard-free work environment for all workers. It also brings together all aspects of work in integrated interventions that collectively address worker safety, health, and well-being.

The City of Yakima offers a Total Worker Health (TWH) approach to enhance worker health, safety and wellbeing. COY's 1st step and best step is offering free and easy access to primary care.

Why? A primary care physician is your first line of defense to ensure a healthy lifestyle. For many, they are the first point of contact within the healthcare system. That means they are often the first to see depression, early signs of cancer or chronic disease, and other health concerns. They ensure patients get the right care, in the right setting, by the most appropriate provider, and in a manner consistent with the patient's desires and values.

What Are the Benefits of Primary Care? There is strong evidence of the benefits of primary care for personal health. Studies show that robust systems of primary care can improve health. As a result, adults in the U.S. who have a primary care provider have 19% lower odds of premature death than those who only see specialists for their care.

The benefits of having a primary care physician include:

Continuity of Care. When you have a primary care physician, he or she is responsible for providing a patient's comprehensive care. Routine checkups with the same doctor will build a relationship that is beneficial to the patient. "The collaboration between physician and patient is associated with better quality of life and better health outcomes."

Prevention. The more a doctor is aware of your overall health, the more likely they will be able to identify health problems before they happen.

Time Savings. When a patient has an established relationship with a primary care doctor, issues that come up in between annual checkups can often be addressed quickly.

Medication Management. Oftentimes, different medications are prescribed by different doctors and there's always a chance of side effects when the drugs interact with each other. A primary care physician can serve as a monitor by keeping track of all medications a patient takes.

Comprehensive Wellness Exam includes gathering your health history, collecting complete lab work, and ordering the appropriate screenings. The physician is your partner in navigating through "Preventive Care" and the difficulties of any new health problems. This can lead to lesser incidence of cancer, heart disease, diabetes or stroke." And if prolonged life were not enough, primary care is important because it lowers costs. Catching and treating problems early during annual checkups is cheaper than treating severe or advanced illnesses.

COY pays you an incentive to complete your annual biometric screening see the health & wellness incentive rules: **RULES**

No cost to plan members

The employee primary care clinic is an amazing benefit. You can save thousands of dollars in medical expenses and time loss. No charge to members, no co-pays and no deductibles. The Clinic provides quick free primary care; screenings, routine, episodic and chronic conditions, provided by a physician and or nurse practitioner. Many medications are dispensed onsite. Lab results are faster than a conventional clinic setting. The primary care clinic is available to employees and their dependents on COY's insurance plan. Online and telephonic scheduling for appointments are available.

miCare providers partner with plan members to develop personalized wellness plans that encourage lifestyle changes necessary to lead a healthy and productive life style.

miCare Benefits Schedule **Maximum Benefit Amount**	UNLIMITED
Deductible	NONE
Maximum out of pocket	NONE
COVERED CHARGES	COVERED PERSON PAYS
Routine Well Care	$0
Office visits/minor office visit procedures	$0
Laboratory Services	$0
***Select* Prescription Drugs**	$0
All other covered miCare Services	$0

Note: miCare can provide an initial 30-day supply for Select Prescription Drugs. These drugs may include but are not limited to; antibiotic medicines, maintenance supply medications, and women's contraceptives.

The following services are not available at the miCare Clinic:

- Before Covered Care: treatment or supplies incurred before a person was covered under this Plan
- Chronic Pain Management Services: for pain that lasts beyond the term of an injury or painful stimulus including but not limited to; pain from a chronic or degenerative disease, and pain from an unidentified cause
- Excluded Charges: Charges excluded or limited by the Plan design
- Excluded under Medical: Services that are excluded under Medical Plan Exclusions, unless specified in the miCare, LLC Employer Agreement
- Obstetrics: to include all services typically provided during pregnancy (prenatal period), childbirth and the postnatal period
- Occupational illness or injury: Services related to the management of work related injuries or conditions, including an independent medical evaluation, a return to work status determination, or a determination of whether an injury or condition relates to and or arose from the individual's employment.
- Radiology and X-ray procedures
- Services outside the scope of the license for a family practice physician, general practitioner, or mid-level provider, as determined by the laws of the State in which the services are provided
- Services provided for Dental, Hearing or Vision Care
- Emergency Services

*Note, the primary care clinic may not be able to manage all your special medical needs. You will need to make yourself aware of what insurance does cover and what cost you may incur going outside the clinic. If you have questions or concerns, please consult your Human Resources office, they will be happy to provide you with more information.

Caremark RxBenefits mail order pharmacy

Brochure and Website are available to ebms client organizations throughout the U.S. Clients that offer this mail-order prescription benefit achieve lower costs for their health plan and members experience additional savings and convenience for their maintenance medications.

RxBenefits is a fast, convenient way to save time and money by having maintenance medications delivered to your home or office. By choosing RxBenefits pharmacy, you are able to receive up to a 90-day supply at a lower cost, FDA-approved prescription drugs. Every prescription is evaluated for accuracy and filled by highly trained, registered pharmacists who ensure the quality, quantity and potency of the medication is accurate before it is mailed. To make certain there are no adverse interactions with other prescriptions you are taking make sure your RxBenefits profile is up to date. When necessary, the pharmacists will contact your doctor with any questions or concerns.

What prescriptions are covered?

The program covers any drug for which Federal law requires a doctor's prescription and is covered by your employer's benefit plan. Please refer to your plan document for specific drug inclusions and exclusions. Due to specific handling requirements, some prescriptions will not be available through RxBenefits Pharmacy. These prescriptions include insulin and most specialty pharmacy drugs.

To identify whether RxBenefits will carry your maintenance prescription, please contact one of our friendly customer service representatives at 800-334.8134.

How to get started

If this is your first order with RxBenefits, you must fill out the Patient Profile on CVS Caremark.

It is important to make sure that you update your patient profile form each time you have a change to your prescription/medical history

ebms
The Benefit of Balance

One call, that's all!

When you or your loved ones have questions about your benefit plan or a specific claim, the last thing you want to hear is that you'll have to make additional calls to your provider or other organizations. When you call us, we provide answers to all your questions and make the necessary calls for you to resolve your problems. A commitment to service is a guarantee, not an option. We also provide:

- Nurse support for inpatient admission or critical illness
- Health coaches and medical staff support for chronic conditions and/or to develop a healthy lifestyle
- 24/7 online access to all benefits, claims and healthcare resource information to help you learn what your health plan will cover, identify whether a claim was paid, view accumulators for deductibles, Flex accounts, or perform simple tasks such as request an ID card, submit requested documentation to EBMS in order to process a claim, etc.
- Benefits and heath resource communications (available in your personal miBenefits account and through your Health Plan or employer)
- Online chat with knowledgeable, friendly Client Service Representatives (when you login to miBenefits)

RECURO HEALTH

info@recurohealth.com | 855.6RECURO | www.recurohealth.com | Scan QR Code

When you are, or a family member is sick, how can you get expert help and guidance? Virtual care is available at the touch of a button. Access board-certified physicians 24/7, 365 days for urgent medical needs. Doctors will discuss your symptoms, confirm a diagnosis, and prescribe any needed medication.

Our virtual care solution connects members with tools and services for a smoother, more cost-effective healthcare experience. In only 10 minutes members can connect to board-certified physician wherever they are, whenever they need it for treatment of common medical concerns or comprehensive behavioral health care from therapy and counseling to psychiatry and medication management. Video and telephone-based visits are available.

**Registering your account is not required to use the service, you can call 855.6RECURO anytime for 24/7 access to doctors.*

RECURO Health, Virtual 24/7 Care Access ONLY$25 co-pay for Acute & Mental Health Visits

Examples of Conditions Treated

- Acid Reflux
- Allergies
- Asthma
- Bladder Infection
- Bronchitis
- Cold or Flu
- Constipation
- Depression
- Diarrhea
- Diabetes
- Fungal Infections
- Gout
- Headache
- Heartburn
- Hemorrhoids
- High Blood Pressure
- Infections
- Joint Aches
- Nausea
- Pneumonia (mild)
- Rashes
- Sinus Infections
- Sore Throat
- Thyroid Conditions
- Urinary Tract Infections
- Respiratory Infections

Common Medications Prescribed

- Albuterol
- Allegra
- Amoxicillin
- Augmentin
- Azithromycin
- Bactrim
- Biaxin
- Cipro
- Diflucan
- Flonase
- HCTZ
- Ibuprofen 800 mg
- Keflex
- Levaquin
- Lipitor
- Lisinopril
- Macrobid
- Metformin
- Nasonex
- Prednisone
- Pyridium
- Tamiflu
- Zithromax (Z-Pack)

Key Terms You Should Know

- **Calendar Year Out-of- Pocket Maximum.** This is the total amount of money you have to pay in medical expenses each plan year before the medical plan begins to cover you at 100% for most covered services for the remainder of the year. This helps protect you from the financial impact of significant medical expenses occurring within a single calendar year.
- **Coinsurance.** The percentage the plan pays for covered services after you meet the deductible.
- **Copay.** A fixed dollar amount that you pay for a doctor's office visit, a prescription drug or other health care services. You usually pay the copay at the time you receive the service.
- **Deductible.** The amount you pay each plan year before the plan begins to pay benefits. The deductible does not apply to preventive care visits or services that have a copay.
- **Generic drug.** Prescription medications with identical active ingredients as brand-name drugs. They generally cost far less than their brand-name equivalents, and so you pay the lowest copay when you use generic drugs.
- **Formulary drugs.** Prescription drugs that are on your medical plan's list of approved medications. Formulary drugs are your middle copay option.
- **In-Network vs. Out-of-Network.** When you see a network provider, the amount you will be responsible for paying will almost always be less than if you go to an out-of-network provider. In-network providers contract with your medical plan to provide services for pre-negotiated rates.
- **Non-formulary drugs.** Prescription drugs that are not on your medical plan's list of approved medications. Non-Formulary drugs are your highest copay option

Prescription Drug Benefits Schedule

Administered by RxBenefits + CVS Caremark 800.334.8134

Prescription Drug Out-of-Pocket	Maximum Per Covered Person ... $1,000	Per Family Unit ... $2,000

Prescription Drug copayments will apply to the Prescription Drug out-of-pocket maximum until the amount shown below has been met. Then, covered Prescription Drugs incurred by a Covered Person will be payable at 100% for the remainder of the Calendar Year. Prescription Drug copayments and Prescription Drug out-of-pocket maximum amounts do not contribute to the medical maximum out-of-pocket amounts.

If you need drugs to treat your illness or condition	Tiers
Formulary Generic	$10 copay (34-day retail) $0 copay (90-day mail order)
Formulary Brand	$20 copay (34-day retail) $40 copay (90-day mail order)
Non-preferred Formulary	$40 copay (34-day retail) $80 copay (90-day mail order)

Retail prescriptions are limited to a 34-day supply. Mail Order prescriptions are limited to a 90-day supply.

At select participating pharmacies, a 90-day supply may be available at 2x the retail copay amount.

Diabetic supplies and medications are available through RxBenefits at $0 copay (generic or brand with no generic equivalent).

RxBenefits® + PrudentRx

A reminder on your specialty Rx benefit

A specialty program to help you save

Your specialty prescription benefit plan will look a little different.

Here's what's new

PrudentRx has collaborated with CVS Caremark® to offer a third-party (manufacturer) copay assistance program* that may help save you money on your specialty prescription.

How it works

You'll pay nothing out of pocket† – that's right, $0! – for medications on your plan's specialty drug list dispensed by CVS Specialty®, as well as select high-cost limited distribution drugs (LDDs) as outlined within the PrudentRx Copay Program drug list. We will work with you to obtain third-party copay assistance for your medication, if available.** **For PrudentRx HDHP with HSA, members must fulfill their deductible before $0 copay applies.**

How to get started

Your enrollment in the program will be started automatically, but you must speak with a PrudentRx advocate to finalize enrollment.** You can choose to opt out at any time.

We'll send more information before we make this plan change. In the meantime, you can continue to fill your prescriptions as usual.

*Not all specialty prescriptions offer assistance. Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change.

**Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must call PrudentRx to participate in the copay assistance for that medication. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for 30 percent of the cost of your specialty medications.

†Out-of-pocket maximum is the amount you must pay each policy year before the policy starts paying the full benefits. This may be for the whole family and/or one person alone.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

 106-56566B 010322

Aetna

Your medical plan is a PPO style, discounted by Aetna: which means you can see any doctor or go to any facility you want; however, you will pay less if you stay within the preferred physician network. If you choose to see a provider or use a facility outside of the network, you will pay a higher percentage of billed charges. Our plan also includes a deductible. That's the amount you pay for care before the plan starts sharing costs with you. Our plan gives you access, at a discount, to a network of high-quality doctors and facilities. It also comes with free preventive care, like checkups and vaccines, and caps on the amount you'll pay for care over the course of a year, they cover prescription drugs. The plan shares costs with you through copays or coinsurance. Copays are flat fees that you pay each time you receive treatment or visit a doctor. Coinsurance, is the percentage of the bill you pay for professional services. Once you've reached your out-of- pocket maximum in net-work, the plan covers 100% percent of your costs for the rest of the plan year.

	Deductibles per Calendar Year			***Out-of-Pocket Maximums***	
Deductible per Calendar Year Per Covered Person | Per Family	Police	All Others	Medical Maximum Out-of-Pocket, Per Calendar Year	Police	All Others In-Network Out-of- Network
	$200 $400	$400 $800		$1400 $2800	$4400|$8800 In-Network $8800|$17600 Out-of-Network

The Plan will pay the designated percentage of Covered Charges until the medical maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the Covered Charges for the rest of the Calendar Year

Medical Benefits Schedule MAXIMUM BENEFIT AMOUT PER CALENDAR YR		**OUT-OF- POCKET**
The following charges do not apply toward the medical maximum out-of-pocket amounts and are never paid at 100%		
▪ **Expenses that exceed the Allowable Charge**	▪ **Non-covered services** ▪ **Prescription Drug charges**	▪ **Out of Network Providers**
	Participating Providers	**Non-participating providers**
Note: The maximums listed below are the total for Network Provider and Non-Network Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network Providers.		
Hospital Services		
ROOM AND BOARD	80% after deductible Semiprivate room rate	60% after deductible
INTENSIVE CARE UNIT	80% after deductible Hospital ICU Charge	60% after deductible
Emergency Room Services	80% after deductible and $200 copayment **Note:** The emergency room copayment will be waived if admitted or if services are deemed a Medical Emergency as defined by the Plan	
OUTPATIENT SERVICES	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible Semiprivate room rate 60 DAYS PER Calendar Year maximum	60% after deductible Semiprivate room rate 60 DAYS PER Calendar Year maximum
Physician Services		
INPATIENT VISITS	80% after deductible	60% after deductible
OFFICE VISITS	100% after copay no deductible applies	60% after deductible
Note the Office visit copayment will apply toward the office visit and any services rendered and billed by the Physician on the same day in the office setting.		
SURGERY (other than an office visit setting)	80% after deductible	60% after deductible
ANESTHESIA SERVICES	80% after deductible	

Other Covered Charges	Participating Providers	Non-participating providers
Ambulance Service	80% after deductible	
Alternative Care Benefit *Massage Therapy/Acupressure*	*100% after Copayment,* *no deductible applies* *20 (combined) visits per Calendar Year maximum*	*60% after deductible applies 20 (combined) visits per Calendar Year maximum*
Alternative Care Benefit *Acupuncture*	*100% after copayment, no deductible applies* *12 visits per Calendar Year maximum* *(Unlimited if treatment is for substance abuse)*	*60% after deductible applies* *12 visits per Calendar Year maximum* *(Unlimited if treatment is for substance abuse)*
Colonoscopy (Diagnostic)	100% no copayment or deductible applies	60% after deductible
Diagnostic Testing (x-Ray & Lab)	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Home Infusion Therapy	80% after deductible	60% after deductible
Hospice Care	80% after deductible	60% after deductible
Impatient Rehab Therapy	80% after deductible	60% after deductible
Kidney Dialysis	First 42 treatments:80% after deductible thereafter: 100% payable at 150% of the Medicare allowable, no deductible applies	First 42 treatments:60% after deductible thereafter: 100% payable at 150% of the Medicare allowable, no deductible applies
Mental disorders and Substance Abuse Treatment		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Office	*100% After copayment, no deductible applies*	60% after deductible
Neurodevelopmental Therapy	*Same as any other Covered Charges* *for covered Dependent children under 7 years of age*	
Obesity	80% after deductible	60% after deductible
Organ Transplants	80% after deductible	60% after deductible
Orthotics	80% after deductible	60% after deductible
Outpatient Rehabilitation Includes: Occupational, Speech and Physical Therapy	80% after deductible	60% after deductible
Pre-Admission Testing	*100% After copayment, no deductible applies*	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Routine Well Newborn Care	*Same as any other Covered Charges*	
Spinal Manipulations Chiropractic (includes exams and x-rays)	*100% after Copayment,* *no deductible applies* *20 visits per Calendar Year maximum*	*60% after deductible applies* *20 visits per Calendar Year maximum*
Wigs after Chemotherapy or Radiation Treatment	*100% deductible applies* *$300 per Lifetime maximum*	*60% after deductible* *$300 per Lifetime maximum*
All other Covered Charges	80% after deductible	60% after deductible

Routine well Care	**100%, no copayment or deductible applies**

Routine Well Care services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), unless otherwise specifically stated in the Schedule of Benefits and which can be located using the following website:

http://www.healthcare.gov/what-are-my-preventive-care-benefits/;
http:/www.hrsa.gov/womensguidelines/;
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Routine Well Care Services will include, but will not be limited to. The following routine services:
Office visits, routine physical exams, prostate screening, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examination.

Women's Preventive Services, will include, but will not be limited to, the following routine services:
Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immunodeficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity (this does not include birthing classes), preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

Influenza Vaccinations 100% no Copayment or deductible applies

Diabetes Educations 100%, no copayment or deductible applies, 4 visits per Calendar Year Maximum

Nutrition Education (other than for diabetic instruction) 100%, no copayment or deductible applies, 4 visits per Calendar Year Maximum

Tobacco Cessation Counseling 100%, no copayment or deductible applies, 4 visits per Calendar Year Maximum

Hearing Screening Benefits 100% no copayment or deductible applies, 1 exam per Calendar Year Maximum

Pregnancy *(Covered Employee or Spouse)*	*Same as any other Covered Charges*	
Routine prenatal office visits	*100% no deductible applies; If global maternity fee:40% of Covered Charges will be payable at 100% deductible waived; thereafter; the same as any other covered Charge*	60% after deductible
*Routine prenatal office visits **only** (covered dependent daughters)*	*100% no deductible applies; If global maternity fee: 40% of Covered Charges will be payable at 100% deductible waived; thereafter; the same as any other covered Charge. Thereafter, not covered.*	Not Covered
Note: Pregnancy of Dependent daughters (including complications) is not covered except as specified in the routine Well Care benefits of this Plan or as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)		

Questions: Call 1-800-777-3575 or visit us at www.ebms.com. This SBC is not the Plan Document and does not provide, nor is it intended to provide complete details of the benefits. If this SBC and the Plan Documents do not agree, the Plan Documents will prevail. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Delta Dental of Washington	DDWA PPO Dentist	Any Licensed Dentist
Calendar Year Deductible	**No Deductible**	
Calendar Year Maximum Benefit	$1250 Police / $1,500 (General Plan Only)	
Preventive and Diagnostic Services *Includes* exams, cleanings, X-rays, sealants, space maintainers and topical fluoride treatments	Class 1 In-Network or Out-of-Network Constant 100% (no deductible)	
Basic Services *Includes* fillings, endodontics, periodontics, oral surgery and simple extractions	Constant 90%In network/Constant 80% out of Network 80%	
Major Services *Includes* bridges, dentures, crowns, prosthodontics and implants	50%	
Orthodontia | Benefit Maximum	50% (no deductible) | $2000 Lifetime Orthodontic Benefits per person	
Temporomandibular Joint Disorders (TMJ)	Constant 50%	

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to usual and customary frequencies, age limitations, terms and conditions of the contract.

NOTE: *You may seek care from any dentist, in or out of the PPO network; however, if you use a Delta Dental of WA PPO participating dentist,* some *benefits will be paid at a higher level and your out-of-pocket expenses may be lower. All Delta Dental dentists will file your claims and you are responsible only for your stated deductible, copay and/or amounts in excess of the program maximums.*

VSP Vision Care — Vision Benefits	Benefits through a VSP Provider	Out-Of-Network
Retinal Scan (General plan Only)	**Covered in full Every calendar year**	
Well Vision Eye Exam Frame *Additional Pairs of Glasses Within 12 months of exam: 20% off unlimited additional pairs of prescription and or non-prescription sunglasses from any VSP doctor	• $200 allowance for a wide selection of frames • $220 allowance for featured frame brands • 20% savings on the amount over your allowance • $110 Walmart*/Costco* frame allowance **Every calendar year** **Included in Prescription Glasses**	$60 Up to $96
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children **Every calendar year** **Included in Prescription Glasses**	Up to $30 Lined Bifocal Up to $50 Trifocal Up to $65
Lens Enhancements	• Progressive lenses • Anti-reflective coating • Avg. savings of 20-25% on other lens enhances **Every calendar year $30 Co-pay**	Up to $50
Contacts (instead of glasses)	• $200 allowance for contacts: copay does not apply • Contact lens exam (fitting and evaluation) **Every calendar year Up to $60 Co-pay**	Up to $185
TLC Laser Eye Centers &LASIK Vision Inst.	• $500 per eye **Once per lifetime**	

Sun Life Basic Life Insurance

Basic Life and Accidental Death & Dismemberment
All Full-Time, Part-Time, Seasonal Employees and Elected City Council Members scheduled to work at least 20 hours per week

Class

1. Management
2. Confidential
3. Judges
4. Supervisory
5. AFSCME Transit
6. Corrections SGT
7. Police OFF/SGT
8. Police MGMT
9. Fire Shift
10. Fire Days
11. Fire PERS
12. AFSCME Municipal
13. Public Safety Communications
14. Fire Battalion Chief
15. PW Supervisors & Admin Unit
16. PW Division Managers
17. Council Members

Sun Life Financial, Inc. is a Canada-based financial services company known primarily as a life insurance company. It is one of the largest life insurance companies in the world and also one of the oldest with history spanning back to 1865.

Class	Life	AD&D
1 thru 4	1x the Employee's Basic Annual Earnings Max Benefit $150,000	An Amount equal to the Employee's amount of Life Insurance in force
5 thru 6	$100,000	$100,000
7	$150,000	$150,000
8	$150,000	$150,000
9 thru 16	$100,000	$100,000
17	$5,000	$5,000
Benefits Reduce	65% at age 65; 50% at age 70; 35% at age 75;	**An Employee's Life, Accidental Death & Dismemberment Insurance terminates on the Employee's termination date or last day in a pay status.**

Other valuable services offered by Sun Life

Emergency Travel Assistance

If you have a medical emergency while you are more than 100 miles away from home, you don't have to face it alone. With one simple phone call, you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24/7. No matter where you are in the world, they will help you access or receive services available for you or your immediate family (whether traveling together or separately) you can activate Assist America's emergency services with one call to the number on your Assist America ID Card, whether you are on vacation or on a business trip (spouse business travel excluded). Assist America pays for 100% of the services it arranges for and provides. Pick up a reference card so you can take advantage of these services if or when you need to.

Identity Theft Protection

Identity theft is a serious crime. Each year, millions of Americans have their personal financial information stolen and must spend a significant amount of time and money to restore their records. If you ever become a victim of identity theft, you don't have to face it alone. You have support of a comprehensive Identity Theft Protection program through Assist America's SecuAssist Identity Protection program. Pick up a reference card so you can take advantage of these services if or when you need to.

Aflac Supplemental Benefits

Better rates & more robust benefits! Health insurance pays doctors and hospitals. Aflac pays you. That means you can use your benefits any way you like, whether it's to help pay leftover health care costs or any other expense you may have. The benefits are yours, so you can use them your way.

City of Yakima makes the following Aflac insurance policies available to its employees:

Accident
Accidents happen. When a covered accident happens to you, our accident insurance policy pays you cash benefits to help with the unexpected health care costs and everyday expenses that begin to add up almost immediately.

Hospital confinement indemnity
Hospital stays are expensive. An Aflac hospital confinement indemnity insurance policy can help ease the financial burden of hospital stays by providing cash benefits.

Critical illness
An Aflac critical illness insurance policy is designed to help with the costs of treatment if you experience a covered health event such as cancer, heart attack, or stroke.

Short-term disability
How would you pay your bills if you're disabled and can't work? An Aflac Short-Term Disability Insurance policy can help provide you with a source of income so you can focus on getting better.

For more information about applying and policy benefits,
Please contact our Aflac insurance agent:

Tricia Charles
509.833.1215 | tricia_charles@us.aflac.com

Employee's Whole Life Insurance - from New York Life

Haddia Nazer | habbasnazer@ft.newyorklife.com |509-494-7819

Peace of mind, death benefit protection, cash value accumulation and fixed premiums. These are just some of the advantages of a whole life policy with New York Life Insurance Company.

Section 125 Accounts

Save money with Flexible Spending Accounts. Take home more money by decreasing your payroll taxes on health care, child care expenses and medical premiums. To qualify you must elect an amount during open enrollment each year. For tax free premiums select section 125 on your enrollment form.

COY offers three Accounts:

Health Care: You can choose annual pre-tax payroll deductions of up to the IRS yearly maximum. This pre-tax money can be used to pay for qualified **healthcare** expenses not covered by your medical plan.

Dependent Care: You can choose annual pre-tax payroll deductions of up to $5,000 per household. (If you are married and filing separately, your limit is $2,500). This pre-tax money can be used to pay for qualified daycare expenses for your children, disabled spouse or other dependents who qualify as your dependents under IRS rules and are mentally or physically incapable of self-care.

The total amount you choose to pay into these accounts will be taken out of your paycheck in even portions during the year. Once you have made an election, you cannot make a mid-year change to the election unless there is a qualifying event. Examples of qualifying events are marriage, divorce or the birth of a child.

Keep in mind that money cannot be transferred between accounts. For example, you cannot use your Dependent Care FSA to reimburse your healthcare expenses.

Premium Only Plan (POP): The Premium Only Plan allows employees to pay for their portion of benefit plan costs on a before tax basis.

CAUTION

You must use the entire balance in your Flexible Spending Accounts for 2025 by March 15, 2026. You may request reimbursement for expenses incurred in 2025 until March 31, 2026 with a paper claim. ***Note** any claims submitted after the March 31st deadline for the prior year will be ineligible for reimbursement and any unspent prior year funds will be forfeited.

Note your Flex Incentive is applied to your Flexible Spending Account.

If you did not do payroll deduction for flex spending and you earned your Flex Incentive, you will have up to $500 awarded to your flexible spending debit card. If you did elect Flexible Spending, you will have the incentive you earned plus the amount you elected. Loaded onto your flexible spending debit card to spend on qualified medical expenses. SAVE THE BENEFIT CARD! The card is reloaded each year with your new benefit elections and incentive.

How to Pay for Expenses with Your FSA and Request Reimbursements

Pay at Time of Service with an FSA Debit Card

1. Elect the FSA debit card when you enroll and use it to pay for qualified expenses.
2. Hold on to your receipts. You may be asked to send a copy of a receipt to support your claim.
3. If you do not send the receipt or if you used the card to pay for an expense that is not qualified, you will be asked to pay back the amount of the expense.
4. Request Reimbursement without an FSA Debit Card.
5. Complete a claim form (available on the ICE intranet) and mail, fax or submit online along with a copy of the receipt to EBMS. See Your Benefit Contacts for details.
6. From the mibenefits member portal, you will have the option to request reimburse for yourself for any medical expenses via direct deposit or to schedule a payment to be sent directly to your provider.
7. Either way, you will typically receive your reimbursement within 5-7 business days. EBMS also offers direct deposit reimbursement options, see your enrollment form for details.

TO LEARN MORE ABOUT THE FSA OR TO MANAGE YOUR ACCOUNTS, GO TO: ebms.com

Examples of expenses reimbursed through the Health Care FSA (not an all-inclusive list)

Allergy Medications (Rx only)
Alternative Healers
Ambulance
Prescribed Antacids
Appliances for Hearing Impaired
Artificial Limbs and Teeth
Bandages, Gauze Pads and Band-Aids
Blood Sugar Test Kit
Childbirth or Lamaze Classes
Chiropractors
Co-Insurance Amounts
Contact Lenses and Supplies
Deductible Medical Coverage
Crutches/Wheelchairs
Dental Care, Dentures and Denture Adhesives Diagnostic Fees
Eye Exams and Prescription Lenses
Fertility Treatments
First Aid Kits
Fluoridation
Hearing Devices and Batteries
Hospital Bills
Hypnosis for Treatment of an Illness
Insulin
Laboratory Fees
Language Training for Child
Medical Monitoring & Testing Devices
Medical Records Charges
Naturopath Fees if Legal in Resident State (Does not Include Herbs or Other Remedies)
Nursing Services
Obstetrical Expenses
Occlusal Guards
Orthodontics
Orthopedic Shoes (only with a note from your doctor when needed to treat a specific medical condition)
Osteopathy Oxygen
Patterning Exercises for the Mentally Handicapped
Patient Transportation to Medical Services and Lodging, if Necessary
Physical Therapy
Physician Fees
Prescription Contraceptives
Birth Control Pills
Prescription Drugs
Prescription Sunglasses
Psychiatrist and Psychologist
Repair and Maintenance (Medically Necessary Items)
Routine Physicals
Other Diagnostic Services or Treatments
Seeing Eye Dog
Sterilization Fees if a Legal Operation
Surgery and Surgical Fees
Therapy Treatments (if Prescribed)
Vaccines,Immunizations & FluShots

Wellness

COY is here to support your Well-being

- Wellness Fair
- Flu Shots
- Employee Picnic or Sporting Event
- Blood Draws "Know your Numbers!"
- In Facility Gyms
- Walking Paths
- Bicycles
- Employee Clinic
- Stop Smoking Consultation
- Weight Loss Consultation
- Preventive Care
- Discounted Gym Memberships

The City of Yakima Wellness Incentive

"Know your numbers" is a national best practice to help increase the wellness of employees and their families. It is a great first step in changing the way we look at our health and catching serious health conditions through the completion of a Blood Draw and a Health Risk Assessment. The City Manager and Insurance Board offer a similar program for Yakima employees, spouses and retirees on the plan. To qualify, employees and retirees must meet the wellness incentive requirements to earn $300. If qualified spouses participate and meet the requirements an additional $200 of flexible spending benefit can be earned.

For complete rules see CityICE:

https://cityice.yakimawa.gov/hr/files/2023/09/2024-Wellness-Health-Incentive-Rules.pdf

To Earn the City of Yakima Wellness Incentive

(Flex Credit is added to your Flexible Spending Benefit Card)

1. Complete a **BLOOD DRAW** by **June 30, 2025**
2. Attend a **FOLLOW-UP APPOINTMENT** at miCare to review your lab work soon after your blood draw
3. Complete **YOUR ONLINE HEALTH ASSESSMENT** (HRA) at: www.ebms.com no later than October 31, 2025
4. **DENTIST** visit anytime between November 1, 2024 and October 31, 2025
5. Complete Attestation on **CityICE:** City of Yakima Health Screening Attestation – Human Resources (yakimawa.gov) no later than October 31, 2025. Attest as soon as requirements are completed. Don't wait until the last minute!

NOTICE REGARDING WELLNESS PROGRAM

Wellness Incentive is a voluntary wellness program available to all eligible employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and

whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a full Lipid Panel (cholesterol, LDL, HDL, triglycerides), Blood glucose, Body Composition (height, weight, BMI, body fat percentage, waist circumference), A1c, PSA, TSH, cotinine, and other lab tests for annual health risk assessments supported by biometric testing.

Biometric testing obtains a baseline of the membership's overall health to be used as a benchmark going forward to help gauge the improved clinical health of the population. The results of the HRA, combined with information from disease management programs, help identify potential areas for targeted communication.

However, employees who choose to participate in the wellness program will receive an incentive of flexible spending for $300. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the Flexible Spending Incentive.

An additional incentive of $200 may be available for employees whose spouse is on the City of Yakima Benefits Plan, completes the HRA and participates in the biometric screening. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your benefits board representative at the City of Yakima.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and The City of Yakima may use aggregate information it collects to design a program based on identified health risks in the workplace, the Flexible Wellness Incentive will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you, provided in connection with the wellness program, will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are employees of EBMS in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at (509) 575-6090.

Workers Compensation

An injured worker is entitled to no-fault accident and disability coverage. This "workers compensation" covers medical expenses and pays a portion of wages lost while a worker recovers from a workplace injury or occupational disease.

The City of Yakima is self-insured. This means we must cover the costs of an on-the-job injury or occupational disease. Washington Department of Labor & Industries (L&I) regulates self-insurance programs.

For more information on workers compensation or self-insurance, ask your supervisor, or contact Human Resources at (509)575-6090.

Employee Assistance Program (EAP)

The City of Yakima through Northwest Employee Assistance Program provides an Employee Assistance Program (EAP). The EAP offers free and confidential counseling and assistance in resolving situations that are affecting your life and your work. All employees and their eligible family members are covered by the EAP. The EAP provides short-term counseling and referrals to help you deal with a variety of issues that can affect you at work or at home, such as:

- Parenting Concerns
- Child/Adolescent Issues
- Drug and Alcohol Use
- Communication Difficulty
- Work-Related Issues
- Aging Parents
- Stress Management
- Grief & Loss
- Emotional Concerns
- Depression, Anxiety
- Marriage & Family

Appointments with an EAP counselor can be made by contacting NEAP

[Yakima Area] 509-575-4313 or [All other areas] 800-321-3498 or eap@cwcmh.com

You and dependent members of your family will be able to schedule an appointment without charge and utilize time off from work to attend your appointments (up to 4x). Please check with your supervisor or Human Resources for requirements. (There may be a $30 charge for "no shows".) When you contact NEAP, please identify yourself as a City of Yakima employee to ensure coverage under your EAP benefit.

The receptionist will ask for a general description of the problem you wish to discuss. This helps to determine which counselor will be the best fit for you.

Your use of NEAP services is entirely confidential. Only information specifically authorized by you or your family members, through a signed release of information, may be shared by or with anyone else.

For Comprehensive's **24-hour Crisis Open Line**, call: **(509) 575-4200** or **(800) 572-8122**

Legal Notices

You have the right to request and receive (free of charge) paper copies of any of the enrollment materials, including the legal notices. Send your request to Abbi Rhoads at 509-576-6609 or abigail.rhoads@yakimawa.gov.

Disclaimer

The City of Yakima is self-Insured and follows WA State requirements for local government self-insurance health and welfare programs. Washington State Legislature sets the standard for operations and claims management for Individual and joint self-insured local government employee health/welfare (medical) benefit programs as provided in RCW 48.62 and WAC 200-110. The State Risk Management Office reviews and approves new programs and continues review of approved programs, collection of financial, membership and key data annually allows continuous monitoring of the programs between reviews.

The City of Yakima is required to provide these notices to you each year. Please read them carefully, no other action is required.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

> *The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.*

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- *You ensure that your employer receives advance written or verbal notice of your service;*
- *You have five years or less of cumulative service in the uniformed services while with that particular employer;*
- *You return to work or apply for reemployment in a timely manner after conclusion of service; and*
- *You have not been separated from service with a disqualifying discharge or under other than honorable conditions.*

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free from Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

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 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, 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-KIDSNOW (1-877-543-7669) 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 permit you to enroll in your employer plan if you aren't already enrolled. This is called a "special 1 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, you can contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (1-866-444-3272). *You should contact Washington State Medicaid for further information on eligibility at:* http://www.hca.wa.gov/medicaid/premiumpymt/Pages/index.aspx or 1-800-562-3022, ext. 15473.

Certificate of Creditable Prescription Drug Coverage
Important Notice from the City of Yakima about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Yakima and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. *Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.*

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

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 plan with The City of Yakima coverage will not be affected. The City of Yakima plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; To Medicare Part D

Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current City of Yakima coverage, be aware that you and your dependents will 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 Yakima and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information or call The City of Yakima Human Resources at (509)575-6090. 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 City of Yakima changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: • Visit www.medicare.gov • Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help • Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 if you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Standards for Privacy of individually identifiable health information's (The "Privacy Standards") issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) | Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

1. *In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to: by Law (as defined in the Privacy Standards);*
2. *Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;*
3. *Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;*
4. *Report to the Plan any PHI use ore disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;*
5. *Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);*
6. *Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);*
7. *Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CRF 164.528)6*
8. *Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);*
9. *If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any from and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and*
10. *Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:*
    a) *The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:*

City Manager	*Human Resources*	*Director of Finance and Budget*	*Records Administration*
Assistant City Manager	*City Attorney*	*Financial Services Manager*	*Public Records Officer*

    b) *The access to and use of PHI by the individuals described in subsection a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.*
    c) *In the event any of the individuals described in subsection a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as*

necessary, in its discretion, to ensure that no further noncompliance occurs. Such sanctions shall be imposed progressively (for example, an oral wanting, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that a) the Plan Documents have been amended to incorporate the above provisions and b) the plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(l)(iii) of the Privacy Standards (45 CFR 164.504(f)(l)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has dis-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR 164.504(a)), the Plan Sponsor agrees to:

- *Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;*
- *Ensure that adequate separation between the Plan and Plan Sponsor, as required in 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.*
- *Ensure that any agent, including a subcontractor, to whom the Plan sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and*
- *Report to the Plan any security incident of which it becomes aware.*

Your rights and protections against surprise medical bills

You're protected from balance billing for emergency services

- *State and Federal law protects you from surprise or balance billing if you receive emergency care, including emergency behavioral health services at a medical facility or when you're treated a an in-network hospital or outpatient surgical facility by an out of network provider. If you think you been wrongly billed, contact EBMS 800-888-8735. The City is responsible for enforcing the federal and/or state balance or surprise billing protection laws. Federal number 800-985-3059*

Contact: HR Specialist, Abigail Rhoads | Abigail.Rhoads@yakimawa.gov or HRBenefits@yakimawa.gov (509)576-6609 | 129 N Second Street, Yakima WA 98901

HEALTH BENEFITS CONTACT LIST

AFLAC
Claims: 877-353-9487
Tricia Charles: 509-833-1215

American Health Holdings Nurse Team
Pre-notification for inpatient admissions
Phone: 1-800-641-5566 (or 1-866-894-1505)

DRS
Phone: 800-547-6657

EAP
Northwest Associates
Phone: 509-575-4313

Flexible Spending Account (FSA) Questions about your FSA
Phone: 866-857-8182

Apps for your mobile device are also available through the *iPhone App Store* or *Google Play* for Android phones.

MissionSquare Retirement
Phone: 800-669-7400

LTD Insurance
Richard Miller
Phone: 509.902.1851

VEBA
Phone: 888-659-8828

miBenefits
Click Login, or Register if a first-time user
ID Number can be found on Medical ID Card

EBMS Customer Service
Phone: 866-276-5298
Email 24/7, login to miBenefits (www.ebms.com) to send an email

miCare Employee Health Clinic
To make an appointment: Login to miBenefits (www.ebms.com)
Click Schedule Appointment
Phone for Scheduling Assistance:
866-888-8035 /For same day appointments, call the clinic directly at 509-453-1529 ext.6

Mail Order Pharmacy CVS Caremark
Phone: 866-334-8134
Caremark.com
Email: customercare@rxbenefits.com

New York Life
Agent: Haddia Abbas Nazer
Phone: 509-494-7819

Washington Dental Service / Delta Dental
Phone: 800-554-1907
Group #: 00564
www.deltadentalwa.com

Vision Service Plan Phone: 800-877-7195 Group#: 12328220
www.vsp.com

Please Note:

This overview has been prepared to briefly highlight key features of your plan and is not intended to replace your insurance contract or summary plan description. We have compiled information into summary form to answer questions we most commonly receive. Please refer to the insurance summary plan description for full detailed information and plan limitations, the summary plan description can be viewed on ICE: City of Yakima Health Plans if you would prefer a hard copy, one can be requested from Human Resources. Actual claims paid are subject to the terms and condition of the summary plan description and individual bargaining contract.