WELCOME TO YOUR BENEFITS

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Kitsap County supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

The benefits in this summary are effective January 1, 2024 through December 31, 2024.

2024 BENEFITS GUIDE

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

ELIGIBILITY

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you were hired into a position budgeted at .50 FTE or above.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Eligible dependents

- Legally married spouse or WA state registered domestic partner
- Natural, adopted or step children up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

For additional information, please refer to the benefit booklets for each benefit.

The contents of this guide may be applicable to All County employees, Deputies and/or MPOA. Please review the notes at the top of each page to know if these benefits apply to you.

ENROLLING IN BENEFITS

WORKDAY

Workday is an online system that enables you to make all your benefit decisions in one place. If you don't have access to a computer, you can access Workday from a tablet.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover
- Review your enrollment materials to understand your benefit options and costs for the coming year

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the 1st of the month following employment as long as you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll be defaulted into the lowest Medical & Dental options available. You will be able to change your benefit elections during the next open enrollment (one time each year that you can make changes to your benefits for any reason). Kitsap County's open enrollment is November 1 through 15. Changes take place on January 1.

CHANGING YOUR BENEFITS

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

Life Happens

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

HAVE QUESTIONS ABOUT YOUR BENEFITS?

GET HELP FROM A BENEFIT ADVOCATE

Are you getting married and not sure how and when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HSA and an FSA? A Benefit Advocate can help answer these questions and more.

Benefit Advocates are trained benefits expert available at no cost to you who can help you understand and use your healthcare and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Health care claim or billing issues, when warranted
- Coverage changes due to life events (marriage, new child, divorce, etc.)

CLAIMS ASSISTANCE

If you need claims assistance, you'll need to complete a HIPAA Authorization Form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed.

Contact Your Alliant Benefit Advocate

Email: benefitsupport@alliant.com
Phone: 800.489.1390
Hours: Monday - Friday,
5 a.m. to 5 p.m. PST, 8 a.m. to 8 p.m. ET

This is a FREE service, providing Kitsap County benefit specific assistance.

MEDICAL BENEFITS

MAKE TIME FOR HEALTH

We offer 6 medical plans. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs. This can help you choose the best fit for your health concerns and budget, as well as to understand how the plan works.

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors and hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

Our Medical Plans

Most County Benefits only. To view Deputy Benefits visit (URL pending)

- Aetna Classic
- Aetna Value
- Aetna HDHP/HSA
- Kaiser Classic
- Kaiser Value
- Kaiser HDHP/HSA

Play the Health Lingo Game!

AETNA MEDICAL PLANS

aetna

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible. Out-of-network coverage may acquire additional costs, please refer to the Plan Summary Booklets for more information.

HDHP/HSA plans are only available during Open Enrollment for a January 1st start date

	AETNA VALUE PLAN In-Network	AETNA CLASSIC PLAN In-Network	AETNA HDHP/HSA PLAN In-Network
Annual Deductible (aggregate)	$500/person $1,500/family	$300/person $900/family	$1,600/person* $3,200/family*
Annual Out-of-Pocket Maximum	$3,000/person $9,000/family	$2,500/person $7,500/family	$3,000/person $6,000/family
Office Visit Primary Care Provider Specialist Virtual Visit	 $25 copay $25 copay $25 copay	 $25 copay $25 copay $25 copay	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Preventive Services	No charge	No charge	No charge
Lab and X-ray	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Urgent Care	$25 copay	$25 copay	20% coinsurance after deductible
Emergency Room	20% coinsurance after $125 copay	10% coinsurance after $125 copay	20% coinsurance after deductible
Inpatient Hospitalization	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Hearing Instruments	$3,000 per ear with hearing loss every 36 months	$3,000 per ear with hearing loss every 36 months	$3,000 per ear with hearing loss every 36 months
Retail Prescription Generic Preferred Brand Non-preferred Brand	30-day supply limit $20 copay $40 copay $60 copay	30-day supply limit $10 copay $30 copay $50 copay	30-day supply limit 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Mail Order Prescription Generic Preferred Brand Non-preferred Brand	31-90-day supply limit $40 copay $80 copay $120 copay	31-90-day supply limit $20 copay $60 copay $100 copay	31-90-day supply limit 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible

*Offset by Employer HSA of $1,200 for emplyee only or $2,400 for employee plus dependent(s). See page 21 for more details.

MONTHLY AETNA BENEFIT COSTS

Most County Rates Only. To view Corrections Rates visit kitsapgov.com/hr/Pages/Health%20Benefits.aspx.

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

AETNA VALUE PLAN	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$910.00	$878.40	**$31.60**
Employee + Child(ren)	$1,868.00	$1,750.63	**$117.37**
Employee + Spouse	$1,579.00	$1,425.80	**$153.20**
Employee + Family	$2,535.00	$2,297.56	**$237.44**

AETNA CLASSIC PLAN	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$994.00	$896.31	**$97.69**
Employee + Child(ren)	$2,038.00	$1,804.97	**$233.03**
Employee + Spouse	$1,723.00	$1,434.32	**$288.68**
Employee + Family	$2,767.00	$2,344.55	**$422.45**

AETNA HDHP W/ HSA PLAN	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$850.00	$837.62	**$12.38**
Employee + Child(ren)	$1,740.00	$1,681.19	**$58.81**
Employee + Spouse	$1,495.00	$1,417.62	**$77.39**
Employee + Family	$2,296.00	$2,172.16	**$123.84**

Medical Waiver Credit

Full-time employees (.75 to 1.0 FTE) may waive medical coverage through Kitsap County and will receive a $150.00 per month waiver- incentive payment.

Part-time employees (.50 to less than .75 FTE) may waive medical coverage through Kitsap County and will receive a $100.00 per month waiver- incentive payment.

Full-time employees who waive coverage to participate in Medicare are not eligible to receive the waiver-incentive premium pursuant to 42 CFR Section 411.103.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Kitsap County if your domestic partner is your tax dependent.

KAISER MEDICAL PLANS

KAISER PERMANENTE®

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible. Out-of-network coverage may acquire additional costs, please refer to the Plan Summary Booklets for more information.

HDHP/HSA plans are only available during Open Enrollment for a January 1st start date

	KAISER VALUE PLAN In-Network	KAISER CLASSIC PLAN In-Network	KAISER HDHP/HSA PLAN In-Network
Annual Deductible (aggregate)	$350/person $1,050/family	$250/person $750/family	$1,600/person* $3,200/family*
Annual Out-of-Pocket Maximum	$2,000/person $6,000/family	$1,000/person $3,000/family	$3,000/person $6,000/family
Office Visit Primary Care Provider Specialist Virtual Visit	 $30 copay after deductible $30 copay after deductible $30 copay after deductible	(first 4 visits not subject to deductible) $25 copay after deductible $25 copay after deductible $25 copay after deductible	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Preventive Services	No charge	No charge	No charge
Lab and X-ray	No charge	No charge	20% coinsurance after deductible
Urgent Care	$30 copay after deductible	$25 copay after deductible	20% coinsurance after deductible
Emergency Room	$75 copay after deductible	$75 copay after deductible	20% coinsurance after deductible
Inpatient Hospitalization	$350/day up to $1,050/admission	$200/day up to $600/admission	20% coinsurance after deductible
Outpatient Surgery	$100 copay after deductible	$100 copay after deductible	20% coinsurance after deductible
Hearing Instruments	$3,000 per ear with hearing loss every 36 months	$3,000 per ear with hearing loss every 36 months	$3,000 per ear with hearing loss every 36 months
Retail Prescription Generic Preferred Brand Non-preferred Brand	30-day supply limit $0 copay $20 copay $40 copay	30-day supply limit $15 copay $15 copay $30 copay	30-day supply limit $0 copay 20% coinsurance after deductible 20% coinsurance after deductible
Mail Order Prescription Generic Preferred Brand Non-preferred Brand	90-day supply limit $20 copay $40 copay $80 copay	90-day supply limit $30 copay $30 copay $60 copay	90-day supply limit 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible

*Offset by Employer HSA of $1,200 for emplyee only or $2,400 for employee plus dependent(s). See page 21 for more details.

MONTHLY KAISER BENEFIT COSTS

KAISER PERMANENTE®

Most County Rates Only. To view Corrections Rates visit kitsapgov.com/hr/Pages/Health%20Benefits.aspx.

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

KAISER VALUE PLAN	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$672.00	$672.00	**$0.00**
Employee + Child(ren)	$1,160.00	$1,097.95	**$62.05**
Employee + Spouse	$1,377.00	$1,287.83	**$89.17**
Employee + Family	$1,866.00	$1,716.84	**$149.16**

KAISER CLASSIC PLAN	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$718.00	$673.09	**$44.91**
Employee + Child(ren)	$1,243.00	$1,103.55	**$139.45**
Employee + Spouse	$1,474.00	$1,294.19	**$179.81**
Employee + Family	$1,998.00	$1,725.03	**$272.97**

KAISER HDHP W/ HSA PLAN	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$601.00	$601.00	**$0.00**
Employee + Child(ren)	$1,053.00	$1,014.19	**$38.81**
Employee + Spouse	$1,228.00	$1,173.85	**$54.15**
Employee + Family	$1,614.00	$1,521.55	**$92.45**

Medical Waiver Credit

Full-time employees (.75 to 1.0 FTE) may waive medical coverage through Kitsap County and will receive a $150.00 per month waiver- incentive payment.

Part-time employees (.50 to less than .75 FTE) may waive medical coverage through Kitsap County and will receive a $100.00 per month waiver- incentive payment.

Full-time employees who waive coverage to participate in Medicare are not eligible to receive the waiver-incentive premium pursuant to 42 CFR Section 411.103.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Kitsap County if your domestic partner is your tax dependent.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

TYPE	APPROPRIATE FOR	EXAMPLES	ACCESS	COST
Nurseline 	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7	FREE
Online Visit 	Many non-emergency health conditions	• Cold, flu, allergies • Headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns	24/7	$
Office Visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours	$$
Urgent Care, Walk-In Clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Office hours, up to 24/7	$$$
Emergency Room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7	$$$$$

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

NEED	ALTERNATIVE	FEATURES	SAVINGS
Surgery 	Ambulatory Surgery Center (ASC)	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	**Up to 50% over hospital stay** (in-network)
Physical Therapy 	Free-standing physical therapy center	• Important part of the recovery process after an injury or surgery	**40 to 60% over a hospital setting** (in-network)
Sleep Study 	Home testing	• Diagnoses sleep apnea and other conditions • Cost is often covered by insurance if considered medically necessary	**Approximately $4,500** (in-network)
Infusion Therapy 	Home or outpatient infusion therapy	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	**Up to 90% over hospital stay** (in-network)

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance. Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE SCREENING BENEFITS

YOU TAKE YOUR CAR IN FOR MAINTENANCE. WHY NOT DO THE SAME FOR YOURSELF?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

Preventive care is covered in full only when obtained from an IN-NETWORK provider!

WHAT IS PREVENTIVE CARE?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit cdc.gov/prevention for recommended guidelines.

NOT ALL EXAMS AND TESTS ARE CONSIDERED PREVENTIVE

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

PRESCRIPTIONS BREAKING YOUR BUDGET?

UNDERSTANDING THE FORMULARY CAN SAVE YOU MONEY

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

WHAT IS A FORMULARY?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

GET THE MOST FROM YOUR COVERAGE

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

The Formulary Drug Tiers Determine Your Cost

Generic Drug	$
Brand Name Drug	$$
Specialty Drug	$$$

HEALTH SAVINGS ACCOUNT

Only available during open enrollment for a January 1st start date. Must be paired with one of our HDHP medical plans

A PERSONAL SAVINGS ACCOUNT FOR HEALTHCARE

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today, and save for expenses you may have in the future.

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

- Enrolled in the **Kaiser HDHP** or **Aetna HDHP**.
- Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
- Not a tax dependent.

FOUR REASONS TO LOVE AN HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

HOW THE HSA PLANS WORK

- The HSA is only available during open enrollment for a January 1st start date
- You will need to create your HSA account prior to funds being deposited
- Kitsap County makes an annual lump sum contribution to your HSA: **Individual:** $1,200 | **Family:** $2,400
- You can contribute up to the limit set by the IRS (includes company amount): **Individual:** $4,150 | **Family:** $8,300 (2024 annual limits)
- **Are you age 55+?** You can contribute an additional $1,000/year
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Find out more

Eligible Expenses

Ineligible Expenses

FLEXIBLE SPENDING ACCOUNTS

SET ASIDE TAX-FREE DOLLARS FOR THE COMING YEAR

A flexible spending account allows you to set aside tax-free money to pay for certain expenses. There are two types of flexible spending accounts

Healthcare FSA

A healthcare FSA or HCFSA allows you to set aside tax-free money to pay for qualified healthcare expenses you expect to have over the coming year.

Dependent Care FSA

A dependent care FSA or DCFSA allows you to set aside tax-free money to pay for work-related day care expenses. Eligible expenses include not only child care, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for an adult dependent who lives with you and is physically or mentally incapable of self-care.

ARE YOU ELIGIBLE?

All benefit eligible employees can participate in either the Healthcare or Dependent care FSA. You can participate in an FSA regardless of your medical plan coverage with Kitsap County.

Annual FSA Carryover

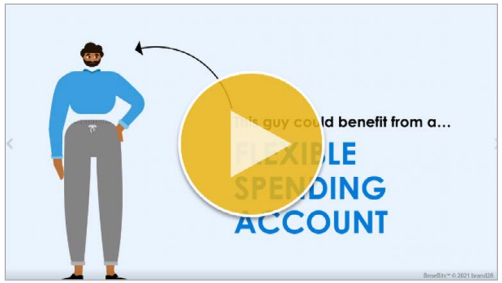
If you don't spend all the money in your account, you can carry over up to $640 into 2025.

HOW THE FSA PLANS WORK

- You estimate what you and your family's out-of-pocket costs will be for the coming year.
- You make your contribution election up to the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
  - HCFSA 2024 contribution limit: $3,200
  - DCFSA 2024 contribution limit: $5,000 per household
- During the year, you can use your FSA funds to pay for qualified services and products. Withdrawals are tax-free as long as they're for eligible expenses.

LIMITED PURPOSE FSA

If you have an existing Flexible Spending Account and enroll in a Health Savings Account, your FSA money will transition into a "Limited Purpose" FSA. Limited Purpose FSA will operate the same but excludes medical eligible expenses, only dental and vision expenses will qualify. Any medical related expense will then be eligible through the HSA funds.



ENHANCED SERVICES

MENTAL HEALTH SERVICES THROUGH AETNA AND KAISER

These are challenging times, and we understand that you or people close to you may also be faced with additional work and family stresses. Feelings of isolation, depression or despair should never be taken lightly. This is a reminder that our medical plans include coverage for mental health care. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

Sometimes the hardest part about addressing a mental health issue is taking the first step. Now it's a bit easier through our telemedicine services from Aetna and Kaiser. You can schedule an immediate video or phone consult with a provider anywhere, any time. To learn more and set up your account, go to teledoc.com/Aetna or kp.org/wa.

	IN-NETWORK MENTAL HEALTH SERVICES	
	Outpatient	Inpatient
Aetna Classic	Office: $25 copay; Other outpatient services: no charge	10% coinsurance
Aetna Value	Office: $25 copay; Other outpatient services: no charge	20% coinsurance
Aetna HDHP/HSA	20% coinsurance	20% coinsurance
Kaiser Classic	$25/visit	$200/day up to $600/admission
Kaiser Value	$30/visit	$35 /day up to $1,050 admission
Kaiser HDHP/HSA	20% coinsurance	20% coinsurance

The EAP is here to help

If you're dealing with stress or anxiety; a relationship or substance abuse issue; financial worries; or the responsibility of caring for others; the Employee Assistance Program from Supportlinc can help.

(888) 881-5462 | supportlinc.com
EAP website password: Kitsap County

AETNA'S ENHANCED NETWORK

ONLINE DIRECTORY

Find network doctors, right at your fingertips. Need a doctor? Simply search by specialty and location in our online directory. You'll also find maps, directions and more. You can also look for doctors who speak different languages. Just visit aetna.com and select "Find a doctor" to get started.

24-HOUR NURSE LINE

For free, you can talk to a registered nurse for information about tests, procedures and treatment options, 24 hours a day, 7 days a week. Have questions about upcoming medical visits and choices? A simple call can make all the difference.

To find the phone number, just visit aetna.com and log in to your member website.

TELADOC® GENERAL MEDICINE SERVICES

24/7 access to quality care

After hours? Can't get to the doctor's office? Teladoc connects you with board-certified doctors anytime. They can treat many non-emergency medical issues by phone or video. This may help you avoid urgent care and emergency room visits, which can be costly and time-consuming.

And it's easy to use — you can speak to a doctor "on demand" in minutes. Or just schedule a time that's more convenient for you.

You can request visits by either:

- Going to teladoc.com/aetna
- Downloading the Teladoc app

Visit teladoc.com/aetna to find out more and set up your account.

PARTICIPATING URGENT CARE CENTERS

Say goodbye to ER visits and hello to savings. If you have an urgent but not life-threatening medical issue, think about going to an urgent care center, walk-in clinic or MinuteClinic®. These centers can treat sprains, the flu, minor cuts and more.

There are over 8,000 participating locations. Many are open seven days a week, with no appointments needed. You'll typically pay less — and cut your waiting time, too. Look up the nearest urgent care center or walk-in clinic on aetna.com. Select "Find a doctor" to use our directory. Or use the mobile app.

NATIONAL MEDICAL EXCELLENCE PROGRAM® TRANSPLANT CARE

Our program puts your needs first

You may never need an organ transplant, bone marrow treatment or CAR-T therapy. But you can rest a little easier if you do, because you have access to this special program. It helps you get the care and resources you need — when you need them most.

You and your family get one-on-one support from:

- Dedicated medical directors
- Nurse care managers with special experience
- Dedicated claims and Member Services staff

AETNA'S PROGRAMS & RESOURCES

AETNA MATERNITY PROGRAM

Giving you and your baby a healthy start

By participating in this program, you'll learn more about:

- What to expect before and after delivery
- Early labor symptoms
- Newborn care
- Breastfeeding, and more

And if you have certain risk factors, you'll also get special support to help towards a safe and healthy delivery.

Plus, this program is part of your plan — there's no extra cost to you. You'll have access to the Maternity Support Center on your member website. On the site, you'll get helpful tools and resources, information about pregnancy stages, personalized benefit details and more.

SIMPLE STEPS TO A HEALTHIER LIFE®

This interactive online health and wellness program can help enhance your health.

With its health assessment and online health coaching programs, this program helps lower health risks. It can help you stay healthy, productive and connected with Aetna® care management support services. It also provides a personalized health risk score and easy-to-find health information.

Access these resources by visiting aetna.com.

AETNA IN TOUCH CARE℠ PREMIER

Helping you find your way through current health challenges

This program is an industry-leading care management program. Our focus is to help you and your family work through the health system, which we know can be confusing. This lets you focus on what really matters —your health and well-being.

Your dedicated team will be right there to help you with short- and long-term care management. And they'll provide support based on what you want and need.

Dedicated nurse support to help you improve your health

This program combines digital and nurse support to help you get or stay healthy. And a single nurse is responsible for supporting you and your family.

The program also:

- Helps you use your benefits wisely and stay motivated
- Finds health hurdles and helps you decide which health goals are most important
- Provides support and focuses on real-time care
- Helps you take care of continuing health issues

Your dedicated team supports everything from clinical preapproval and help during your care, to short and long-term care management. And they'll provide support based on what you want and need.

AETNA'S PROGRAMS & RESOURCES

AETNA® BEHAVIORAL HEALTH

Feeling your best

From time to time, we all feel a bit down or stressed —but sometimes these feelings can persist and get in the way of daily life. They could be brought on by something related to physical health. It's important to know that these feelings are common and, most of all, treatable. But the condition must be diagnosed first. Your medical plan includes behavioral health benefits. So you'll get the help and resources you may need to work toward feeling your best.

These resources include:

- 24/7 support to help you find the right care
- Face-to-face counseling in the provider's office or through telehealth
- Online resources and tools, and more

AETNA® BEHAVIORAL HEALTH CONDITION MANAGEMENT PROGRAM

We'll get to know you with personalized support

Everyone occasionally feels sad or anxious. But when these feelings interfere the way you think, sleep and engage in daily activities, it might be time to seek help to feel better. With our confidential program, you'll work side by side with your care team. They'll help you find your way through the health care system, so you can get care earlier and feel better sooner. And our care managers can connect you with the right support at the right time — and help you set realistic goals.

You'll also get:

- Early screening for early help
- Online tools to check your risk for a condition
- Strategies and tips for everyday living

AETNA BEHAVIORAL HEALTH SUPPORT

Focusing on health conditions and life changes

When you're managing chronic pain or going through major life changes, it's common to feel overwhelmed. And you may not know where to go for support. That's why we've teamed up with AbleTo, a leading behavioral health provider to help.

Through the AbleTo emotional support program, you'll get help with issues that can make life more challenging. This eight-week program offers you emotional support after a medical diagnosis or life transition — for example, becoming a caregiver or giving birth.

It combines counseling and coaching to help you:

- Work through the normal emotions you're having
- Understand the types of changes you need to make
- Feel like you're in control of your health and life

Once you connect with an Aetna® or AbleTo representative, they'll explain more about the program and how it can help. They'll also answer any questions you have. Aetna® does not recommend the self-management of health problems. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional.

AETNA CONCIERGE

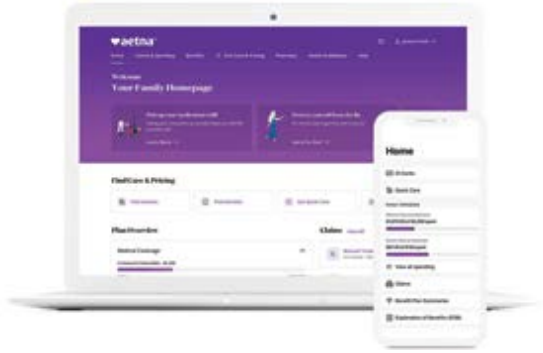
Your personal assistant for health care

Have questions about your benefits? Need solutions that fit your needs? Just ask your Aetna® Concierge to help you:

- Get answers about a diagnosis
- Find a doctor in your network based on your medical needs
- Learn about your coverage or plan for upcoming treatment
- Use our online tools
- Schedule appointments, and more

AETNA MEMBER WEBSITE AND AETNA HEALTH℠ APP

MANAGE YOUR BENEFITS, CONNECT TO CARE, HANDLE CLAIMS – FROM ANYWHERE.



As a member, you can:

- View your health plan summary and get information about what's covered
- Track spending and progress toward your deductible for you and your family
- View and pay claims, even see the breakdown of your costs, like what's covered by your plan and what you're responsible for
- Use tools to help you choose quality in-network providers including those offering telemedicine services
- Estimate and compare costs
- Get personalized reminders to help improve your health

Once you're a member, here's how you can connect:

Your Aetna member website

Go to aetna.com to create an account and log in to your member website.

The Aetna Health app

Get the Aetna Health app by texting "GETAPP" to 90156 for a link to download the app and create an account. Message and data rates may apply.

Available on the App Store

GET IT ON Google Play

KAISER'S ENHANCED NETWORK

KAISER PERMANENTE®

YOUR CARE, YOUR WAY. CONNECT TO CARE ANYTIME, ANYWHERE.

Get the care you need, the way you want it. No matter which option you choose, your providers can see your health history, update your medical record, and give you personalized care that fits your life.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider.

In-person visit

Same-day appointments are often available. Sign on to kp.org/waanytime, or call us to schedule a visit.

Email

Message your doctor's office with non-urgent questions anytime. Sign on to kp.org or use our mobile app.

Phone appointment

Save yourself a trip to the doctor's office for minor conditions or follow-up care.

Video visit

Meet face-to-face online with a doctor on your computer, smartphone, or tablet for minor conditions or follow-up care.

E-visit

Get quick online care for common health problems. Fill out a short questionnaire about your symptoms, and a physician will get back to you with a care plan and prescriptions (if appropriate) – usually within 2 hours.

Need care now? Know before you go.

Urgent care

An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition. This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating.

Emergency care

Emergency care is for medical or mental health conditions that require immediate medical attention to prevent serious jeopardy to your health. Examples include chest pain or pressure, severe stomach pain that comes on suddenly, severe shortness of breath, and decrease in or loss of consciousness.

Visit Kaiser Permanente anytime at **healthy.kaiserpermanente.org/washington/get-care** to make an appointment or to get care advice."

KAISER'S ENHANCED NETWORK

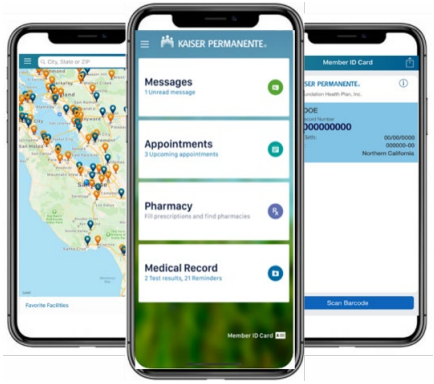
KAISER PERMANENTE®

KAISER PERMANENTE MOBILE APP

It's convenient and easy to use

Not sure if you need an appointment? Get advice, then schedule an appointment from the quick service menu.

- View and cancel appointments easily
- Tap on the quick service menu to view your prescription list, then order refills or check the status of an order
- See detailed medical record updates at a glance
- Review your latest test results in an easy-to-read format
- Send messages to your doctor or Member Services
- Find a facility near you and get directions on the way



DIGITAL SELF CARE TOOLS

Everyone needs support for total health — mind, body, and spirit. Digital tools can help you navigate life's challenges, make small changes that improve sleep, mood, and more, or simply support an overall sense of well-being.

- Thoroughly evaluated by Kaiser Permanente clinicians
- Easy to use and proven effective
- Safe and confidential

Calm

Calm is the #1 app for meditation and sleep — designed to help lower stress, reduce anxiety, and more. Kaiser Permanente members can access all the great features of Calm at no cost, including:

- The Daily Calm, exploring a fresh mindful theme each day
- More than 100 guided meditations
- Sleep Stories to soothe you into deeper and better sleep
- Video lessons on mindful movement and gentle stretching

MyStrength

MyStrength is a personalized program that helps you improve your awareness and change behaviors. Kaiser Permanente members can explore interactive activities, in-the-moment coping tools, community support, and more at no cost.

- Mindfulness and meditation activities
- Tailored programs for managing depression, stress, anxiety, and more
- Tools for setting goals and preferences, tracking current emotional states and ongoing life events, and viewing your progress

Adult Kaiser members can download these popular apps at kp.org/selfcareapps.

DENTAL BENEFITS

WHY SIGN UP FOR DENTAL COVERAGE?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

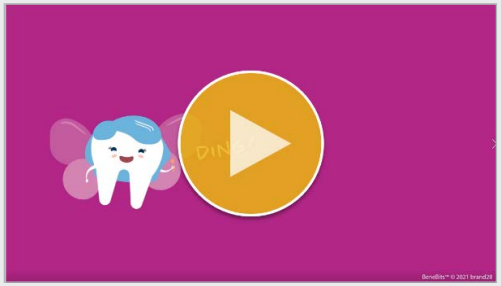
That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health. At Kitsap County, an employee must enroll in a dental plan (waiving coverage is not an option) but there is a zero premium dental plan for election.

Dental insurance covers three types of treatments:

- **Preventive care** includes exams, cleanings and x-rays
- **Basic care** focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major care** goes further than basic and includes bridges, crowns and dentures

Our Dental Plans

- Willamette Dental Plan
- Delta Dental Plan C
- Delta Dental Plan D



DENTAL PLANS

Delta Dental of Washington

Willamette Dental Group

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay/the plan pays after the deductible.

	DELTA DENTAL PLAN C*		DELTA DENTAL PLAN D		WILLAMETTE DENTAL	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$0/person $0/family		$0/person $0/family		$0/person $0 per family	
Annual Plan Maximum (per year, per dependent)	$1,000		$2,000		No annual maximum	
Waiting Period	None		None		None	
Diagnostic & Preventive	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	$10 copay	$10 copay
Basic Services Fillings Root Canals Periodontics	 Plan pays 90% Plan pays 90% Plan pays 90%	 Plan pays 80% Plan pays 80% Plan pays 80%	 Plan pays 90% Plan pays 90% Plan pays 90%	 Plan pays 80% Plan pays 80% Plan pays 80%	 $10 copay $10 copay $10 copay	 $10 copay $10 copay $10 copay
Major Services	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%	$10 copay	$10 copay
Orthodontic Services Adults Dependent Children Full-time Students	Plan pays 50% Covered Covered Covered	Plan pays 50% Covered Covered Covered	Plan pays 50% Covered Covered Covered	Plan pays 50% Covered Covered Covered	$150** Covered Covered Covered	$150** Covered Covered Covered
Orthodontia Lifetime Maximum	$2,000/person		$2,000/person		$1,800 copay	

*Corrections Officers are ineligible for Delta Dental Plan C

**Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

MONTHLY DENTAL BENEFIT COSTS

Delta Dental of Washington

Willamette Dental Group

Most County Rates Only. To view Corrections and Deputy Rates visit kitsapgov.com/hr/Pages/Health%20Benefits.aspx.

The total amount that you pay for your benefits coverage depends on the plans you choose, and how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

DELTA DENTAL PLAN C*	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$55.24	$55.24	**$0.00**
Employee + Child(ren)	$98.42	$80.24	**$18.18**
Employee + Spouse	$98.42	$80.24	**$18.18**
Employee + Family	$177.61	$116.43	**$61.18**

DELTA DENTAL PLAN D	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$58.43	$55.25	**$3.18**
Employee + Child(ren)	$103.53	$80.25	**$26.46**
Employee + Spouse	$103.53	$80.25	**$26.46**
Employee + Family	$186.69	$117.79	**$68.90**

WILLAMETTE DENTAL PLAN	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$61.24	$55.24	**$6.00**
Employee + Child(ren)	$101.86	$74.24	**$27.62**
Employee + Spouse	$101.86	$74.24	**$27.62**
Employee + Family	$162.69	$103.13	**$59.86**

*Corrections Officers are ineligible for Delta Dental Plan C

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Kitsap County if your domestic partner is your tax dependent.

VISION BENEFITS

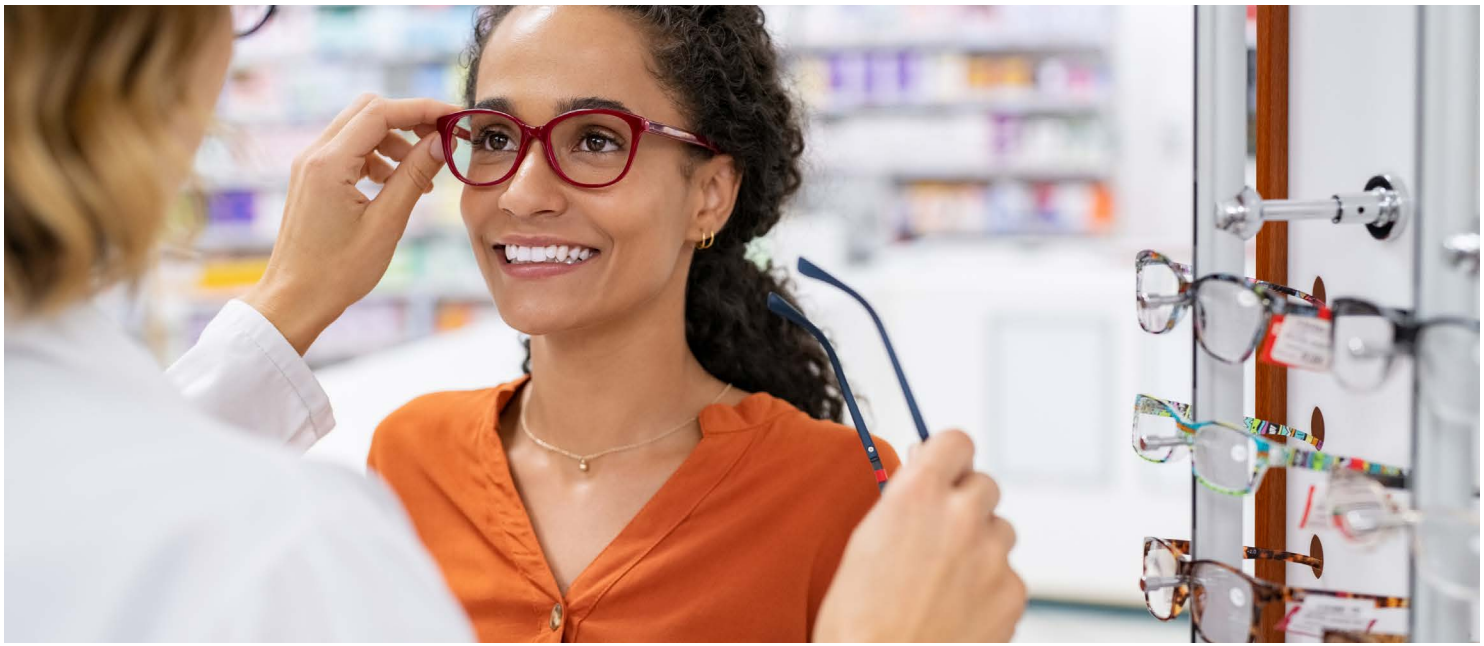
THE BENEFITS OF HAVING VISION COVERAGE

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease. Our vision plan help cover the cost of eye exams, eyeglasses, and contact lenses to ensure you're seeing and feeling your best.

At Kitsap County, an employee must enroll in the free Vision plan (waiving coverage is not an option). The vision plan is offered with $0 premium for you and your covered family members. That includes children up to age 26, regardless of work or student status.

Our Vision Plan

- VSP Vision Plan



VISION BENEFITS

	VSP VISION PLAN (IN-NETWORK)		
Benefit	Description	Copay	Frequency
Wellvision Exam	Focuses on your eyes and overall wellness	$0	Every 12 months
Prescription Glasses		$15	See frame and lenses
Frame	• $175 allowance for a wide selection of frames • $195 allowance for featured frame brands • 20% savings on the amount over your allowance • $95 Costco®/Walmart/Sam's Club® frame allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Anti-glare coating • Scratch-resistant coating • UV protection • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $0 $0 $0 $95 - $105 $150 - $175	Every 12 months
Contacts (Instead of Glasses)	• $155 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eyecare Plus Programsm	• Retinal screening for members with diabetes • Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor details.	$0 $20 per exam	As needed
Additional Eyewear			
Frame	• $175 allowance for a wide selection of frames • $195 allowance for featured frame brands • 20% savings on the amount over your allowance • $95 Costco®/Walmart/Sam's Club® frame allowance	$20 for frame and lenses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with Frame	Every 12 months
Contacts (Instead of Glasses)	• $155 allowance for additional contacts • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months

VISION BENEFITS

VSP SPECIAL OFFERS

VSP members have immediate access to special offers and discounts, in addition to vision insurance.

- **Vision Correction:** Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.
- **Glasses & Sunglasses:** Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.
- **Contacts:** Access coupons for contact lens care items.
- **Routine Retinal Screening:** No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam Laser
- **LASIK:** Take advantage of member only discounts at participating vision centers.
- **VSP Simple Values:** Log in to your VSP member portal to access the VSP Simple Values program. The program is not insurance, rather gives you access to savings and discounts on a variety of services (both vision and non vision related).
- **TruHearing:** Access savings on hearing aids, batteries and online hearing screening.

Offers can change periodically throughout the year. To stay up to date on the most recent offers, visit www.vsp.com/offers/special-offers.

MONTHLY VISION BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

VSP VISION PLAN	MONTHLY RATE	COUNTY CONTRIBUTION	EMPLOYEE MONTHLY COST
Employee Only	$19.64	$19.64	**$0.00**
Employee + Child(ren)	$19.64	$19.64	**$0.00**
Employee + Spouse	$19.64	$19.64	**$0.00**
Employee + Family	$19.64	$19.64	**$0.00**

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Kitsap County if your domestic partner is your tax dependent.

LIFE, AD&D, AND DISABILITY INSURANCE

IS YOUR FAMILY PROTECTED?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

Your Beneficiary = Who Gets Paid

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes. You can make these changes in Workday.

LIFE AND AD&D INSURANCE

BASIC LIFE INSURANCE

Basic Life Insurance pays your beneficiary a lump sum if you pass away. The cost of coverage is paid in full by Kitsap County.

	BASIC LIFE INSURANCE
Employee Amount	$24,000
Eligible Dependents Amount	$1,000 each

Make sure that you have named a beneficiary for your life insurance benefit, and update it if your family or marital status changes.

A Note About Taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

VOLUNTARY AD&D INSURANCE

Voluntary Accidental Death & Dismemberment (AD&D) Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

AD&D coverage is available for election at any time throughout the year, with no Medical Underwriting required.

If an employee elects AD&D coverage & also elects Spouse AD&D, the coverage amounts MUST be equal.

	VOLUNTARY AD&D
Employee	Increments of $10,000 up to $500,000.
Spouse	Coverage must equal the amount of the employee coverage (Example: Employee elects $100,000 coverage – Spouse coverage must also be for $100,000)

Monthly Costs

Your cost for voluntary AD&D coverage depends on how much coverage is elected. To calculate your cost for voluntary AD&D, determine how much coverage you would like to purchase.

Cost of coverage can be calculated by following this equation:
[coverage amount] / 10,000 = B
B x [rate shown on table] = your monthly cost

Example:
Shaun elects $100,000 for himself
100,000 / 10,000 = 10
10 x $0.025 = $0.25 per month

	RATE PER $10,000 OF COVERAGE
Employee Only	$0.025
Spouse	$0.025
Children	$0.030

LIFE AND AD&D INSURANCE

VOLUNTARY TERM LIFE INSURANCE

Voluntary Term Life Insurance (VTL) allows you to purchase additional life insurance to protect your family's financial security.

You may enroll in VTL coverage with a guaranteed issue coverage value, within your first 31 days of benefit eligibility. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself. Medical Underwriting is not required for coverage values within the guaranteed issue values.

VTL policies may be elected or increased at any time beyond your first 31 days of eligibility. However, any requested coverages will be subject to the vendor's Medical Underwriting process.

VOLUNTARY TERM LIFE	
Employee	Maximum coverage value up to $500,000 but not to exceed 6 times an employee's annual earnings Guaranteed issue: Increments of $10,000 up to $200,000
Spouse	Maximum coverage value up to $250,000 Guaranteed issue: Increments of $10,000 up to $50,000
Child	Guaranteed issue: Up to $10,000

Guaranteed Issue

If you purchase life insurance coverage after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Monthly Costs

Your cost for VTL depends on how much coverage is elected, and your age at the time you elect coverage. As your age changes, your cost of coverage will also change based on the table below.To calculate your cost for voluntary term life insurance coverage first determine how much coverage you would like to purchase. Then, find your current age bracket.

Cost of coverage can be calculated by following this equation:
[coverage amount]/10,000 = A
A x [rate shown on table] = your monthly cost

Example:
Jeanne is 47 years old, and elects $50,000 of coverage.
50,000 / 10,000 = 8
8 x 2.35 = $11.75 per month

	RATE PER $10,000 OF COVERAGE	
Age	Employee	Spouse
<20	$0.56	$0.60
20-24	$0.66	$0.70
25-29	$0.71	$0.75
30-34	$0.82	$0.90
35-39	$0.98	$1.05
40-44	$1.45	$1.55
45-49	$2.35	$2.45
50-54	$3.91	$4.09
55-59	$5.81	$5.87
60-64	$8.74	$9.57
65+	$12.53	$13.53
Child Rate	$0.44 per $2,000	

DISABILITY BENEFITS

WASHINGTON PAID FAMILY & MEDICAL LEAVE (WA PFML)

Workers that have worked a minimum of 820 hours in Washington, in the last year, qualify for WA PFML. Coverage is paid for by employers and employees through payroll withholding. To learn more or to file a claim visit https://paidleave.wa.gov/individuals-and-families/.

	WASHINGTON PAID FAMILY & MEDICAL LEAVE
Weekly benefit amount	up to 90% of your weekly pay - up to a maximum of $1,327 in 2024
Benefits begin	After one week
Maximum payment period	up to 12 weeks for medical leave 16-18 weeks of combined medical and family leave depending on your situation

SHORT-TERM DISABILITY INSURANCE

Excluding AFSCME Union

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as: Pregnancy issues and childbirth recovery; Prolonged illness or injury; Surgery and recovery time.

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability.

	90-DAY BENEFIT PERIOD STD POLICY
Weekly benefit amount	60% of covered salary up to a maximum of $1,000 per week
Benefits begin	After 30 days of disability due to accident or sickness
Maximum payment period	90 days (based on first day you are disabled, not when benefits begin)

	180-DAY BENEFIT PERIOD STD POLICY
Weekly benefit amount	60% of covered salary up to a maximum of $1,000 per week
Benefits begin	After 30 days of disability due to accident or sickness
Maximum payment period	180 days (based on first day you are disabled, not when benefits begin)

Expect The Unexpected

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

DISABILITY BENEFITS

LONG-TERM DISABILITY INSURANCE

Excluding AFSCME Union

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

LTD benefit payments may be reduced by state, federal, or private disability benefits you receive while disabled.

COMPANY PAID BASE LTD	
Monthly benefit amount	40% of covered monthly earnings up to a maximum of $4,000
Benefits begin	After 180 days of disability
Maximum payment period	Social Security normal retirement age

Within your first 31 days of benefit eligibility, you may enroll in LTD Buy-Up coverage with a guaranteed issue. Enrollment beyond the first eligibility period, will require Medical Underwriting for consideration of the benefit approval.

VOLUNTARY BUY-UP LTD	
Monthly benefit amount	60% of covered monthly earnings up to a maximum of $6,000
Benefits begin	After 90 days of disability
Maximum payment period	Social Security normal retirement age

3 Things To Know About LTD Insurance

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

AFSCME Union Benefits

Metlife Long Term Disability is mandatory elected benefit coverage for all AFSCME employees. Both the County and AFSCME employees pay for this coverage. County Contribution is $8 / month. Employee Cost is $20 / month.

	AFSCME UNION LTD
Monthly benefit amount	60% of covered monthly earnings up to a maximum of $5,000
Benefits begin	After 180 days of disability

VOYA FINANCIAL VOLUNTARY HEALTH BENEFITS

VOYA ACCIDENT INSURANCE

Accident insurance pays cash benefits for treatments associated with an accidental injury such as fractures, dislocations, burns, emergency room or urgent care visit, and physical therapy. If you or a covered family member suffers an accident, the plan will pay a lump sum benefit based on a predetermined schedule of benefits. By enrolling in the Accident plan, you and your enrolled dependents are also eligible to receive an annual $50 Wellness Benefit ($25 for children) for keeping up with your preventive care. Coverage is provided by Voya.

	MONTHLY PREMIUM
Employee Only	$13.14
Employee + Spouse	$21.88
Employee + Children	$25.72
Employee + Family	$34.46

Sample Benefit Amount

Kyle injured himself while playing in the yard and suffered a serious concussion. Although Christine, his mom, had good medical coverage, the out-of-pocket costs kept adding up. Thankfully, she and her family were enrolled the Accident plan. She was able to use the $1,050 she received under the plan to offset her medical deductible and applicable copays. (Benefit amount based on an ambulance ride, emergency room visit, major diagnostic test, and a concussion diagnosis.)

COVERED SERVICE	BENEFIT AMOUNT
Ambulance	$360
Emergency room treatment	$225
Major diagnostic exam	$240
Concussion diagnosis	$225

For more information about Voya Accident Insurance visit presents.voya.com/EBRC/Product/Kitsap/Accident2.

VOYA FINANCIAL VOLUNTARY HEALTH BENEFITS

CRITICAL ILLNESS INSURANCE

Critical Illness insurance can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum benefit is paid directly to you. By enrolling in the Critical Illness plan, you and your enrolled dependents are also eligible to receive an annual $50 Wellness Benefit ($25 for children) for keeping up with your preventive care. Coverage is provided by Voya.

You select a benefit amount of $10,000, $20,000 or $30,000. Your cost depends on your age and amount of coverage selected.

	EMPLOYEE AND SPOUSE MONTHLY RATES	
Attained Age	EMPLOYEE ($10,000 benefit)	SPOUSE ($5,000 benefit)
0 – 29	$2.60	$1.40
30 – 39	$4.80	$2.60
40 – 49	$10.30	$5.35
50 – 59	$20.40	$10.45
60 – 69	$36.00	$18.20
70+	$71.70	$36.25

CHILDREN COVERAGE SEMI-MONTHLY RATES (24 pay periods) Includes Wellness Benefit Rider	
Coverage Amount	Rate
$2,500	$0.21
$5,000	$0.43
$7,500	$0.64

Sample Benefit Amount

Cindy has a history of cancer in her family, so she enrolled in the Critical Illness plan and elected $20,000 in benefits. A few months later, Cindy was diagnosed with invasive breast cancer. After filing a claim, Cindy was able to use her $20,000 benefit to help cover her medical costs, pay for additional childcare and cover some of her lost income. (Benefit amount based on a $20,000 election and cancer diagnosis.)

COVERED CONDITION	% OF ELECTED BENEFIT
Cancer	100%

For more information about Voya Critical Illness Insurance visit https://presents.voya.com/EBRC/Product/Kitsap/CriticalIllness2.

VOYA FINANCIAL VOLUNTARY HEALTH BENEFITS

HOSPITAL INDEMNITY INSURANCE

A hospital stay can be costly, even if you have medical coverage. Hospital Indemnity insurance can help cover your medical deductible or coinsurance if you are hospitalized by paying a lump-sum benefit directly to you. Coverage is provided by Voya.

	MONTHLY PREMIUM
Employee Only	$11.18
Employee + Spouse	$22.42
Employee + Children	$18.82
Employee + Family	$30.06

Sample Benefit Amount

Alexis and her husband eagerly awaited the birth of their child. Alexis was enrolled in the Hospital Indemnity plan, which provided benefits for her hospital admission and stay. The $1,200 she received under the plan allowed her to take an extra week of unpaid maternity leave to bond with her little boy. (Benefit amount based on a hospital admission and hospital confinement for two days.)

COVERED SERVICE	BENEFIT AMOUNT
Hospital admission	$1,000
Hospital stay (2 days)	$200

For more information about Voya Hospital Indemnity Insurance visit presents.voya.com/EBRC/Product/Kitsap/HospitalConfinement2.

MEDICARE

Alliant MEDICARE SOLUTIONS

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

If, like most people, you become eligible for Medicare at age 65, you have a seven-month window to enroll, starting three months before you turn age 65 and ending three months after your birthday month.

Introducing Alliant Medicare Solutions

Choosing a Medicare plan – and understanding how it can affect your employer-provided medical coverage – can be confusing. That's why we are offering Alliant Medicare Solutions to help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation. Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.

How does it work?

1. Call Alliant Medicare Solutions to speak to a Licensed Insurance Agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Contact Alliant Medicare Solutions by phone, or book an appointment online.

Phone: 877-203-2728

Online appointments: alliantmedicaresolutions.com

Find out More

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency.
Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

WELLBEING & BALANCE

A HAPPIER, HEALTHIER YOU

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take time to spend with family and friends, take care of personal business, or just have a little extra "me time".

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

WORKINGWELL WELLNESS PROGRAM

Enhance your well-being

Being well involves more than just using your healthcare plans. Wellness is a daily commitment to eating healthy, staying active, managing stress and maintaining balance.

With this in mind, we've created an integrated wellness program — Working Well - to help you create healthy habits and reach your highest level of well-being.

The program consists of support for managing stress, choosing nutritious foods, staying active, maintaining or reaching a healthy weight, avoiding unhealthy habits, and more.

WorkingWell, Kitsap County's employee health & wellness program! This program is designed to provide staff with programs and activities that encourage them to stay healthy, be active, eat well, learn & grow, navigate life events & challenges, and serve our local communities.

WELLBEING & BALANCE

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Supportlinc can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues
- Unlimited web access to helpful articles, resources, and self-assessment tools

Contact The Eap

- Phone: (888) 881-5462
- Website: supportlinc.com
- EAP password: **Kitsap County**

Counseling Benefits

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & Childcare

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial Coaching

- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal Consultation

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare Resources

- Help with finding appropriate resources to care for an elderly or disabled relative

Online Resources

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

PLAN CONTACTS

COVERAGE	PROVIDER	PHONE	WEBSITE
Enrollment	Workday		
Benefit Assistance	Alliant Benefit Advocate	(800) 489-1390	benefitsupport@alliant.com
Medical Benefits	Aetna	(888) 872-3862	aetna.com
	Kaiser Permanente	(888) 901-4636	kp.org/wa
Health Savings Account	Navia	(425) 217-0927	naviabenefits.com
Dental Benefits	Delta Dental	(800) 554-1907	deltadentalwa.com
	Willamette Dental	(855) 433-6825	willamettedental.com
Vision Benefits	Vision Service Plan (VSP)	(800) 877-7195	visionbenefits.vsp.com
Life and AD&D Insurance	The Standard	(866) 695-8622	standard.com
Short-Term and Long-Term Disability	The Standard	(866) 695-8622	standard.com
Employee Assistance Program	Supportlinc by Curalinc	(888) 881-5462	supportlinc.com
Voluntary Health plans	VOYA	(877) 236-7564	presents.voya.com/EBRC/Kitsap

HR Contacts

Human Resources Department
360-337-7185
kitsapbenefits@kitsap.gov
kitsapgov.com/hr/Pages/default.aspx

Rikki Christensen
360-337-4448
rrchristensen@kitsap.gov

Alicia Hartnett
360-307-4342
ahartnet@kitsap.gov

GLOSSARY

-A-

AD&D Insurance: An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount: The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC): A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit: A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing: In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference.

Beneficiary: The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug: A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA: A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim: A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance: Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment: A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible: The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Dental Basic Services: Services such as fillings, routine extractions and some oral surgery procedures. Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services: Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA): An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense: A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service: A service that your health plan doesn't pay for or cover.

-F-

Formulary: A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug: A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered: A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA): An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA): A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP): A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network: In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

-L-

Life Insurance: An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance: Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order: A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment: The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network: Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost: A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum: Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Outpatient Care: Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy: A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year: A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug: Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non- preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services: Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP): The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance: Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc: A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccination: Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit: An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN NOTICES

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located in your benefit packet:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Grandfathered Plan Status:** Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves
- **Notice of Availability of Alternative Standard for Wellness Plans:** Describes right to alternatives ways of participating in employer's wellness program
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available accompanying Annual Notices document. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Summary Plan Descriptions (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Summary Of Benefits And Coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

- Aetna Classic
- Aetna Value
- Aetna HDHP/HSA
- Kaiser Classic
- Kaiser Value
- Kaiser HDHP/HSA

Statement Of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the [ERISA PLAN NAME]. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

DETERMINING ELIGIBILITY

MONTHLY MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Kitsap County uses the monthly measurement method to determine whether an employee meets this eligibility threshold.

DETERMINING ELIGIBILITY

LOOK-BACK MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA). Under the ACA, employers are required to report specific benefits information to IRS on "full-time" employees as defined by the ACA. A "full-time" employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Kitsap County uses the look-back measurement method to determine group health plan eligibility.

New Employees Hired To Work Full-Time

If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of the first of the month following date of hire.

New Employees Hired To Work A Part-Time, Variable Hour Or Seasonal Schedule

If you are hired into a part-time position, a position where your hours vary and Kitsap County is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of December 1 through November 30.

Your IMP will begin on December 1. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage as of the first of the month following this date. Your full-time status will remain in effect during an associated stability period that will last 180 days. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing Employees

An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 180 day period during which Kitsap County counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 180 days. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Kitsap County uses the standard measurement period and associated stability period annual cycle set forth below:
MEASUREMENT PERIOD:
STARTS: December 1. DURATION: November 30.
Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

STABILITY PERIOD:
STARTS: December 1. DURATION: November 30.
Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.