IMPORTANT:
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see pages 22 & 23 for more details.

2024-25 Employee Benefits Enrollment Guide

Plan Year: July 1, 2024 – June 30, 2025

BOYS & GIRLS CLUBS
OF KING COUNTY

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A Message from HR at Boys & Girls Clubs of King County

At Boys & Girls Clubs of King County we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

In addition to this brochure, you can also view a Summary of Benefits and Coverage (SBC) for each medical plan and other important documents about our benefit program by accessing the Paycom Employee Self Service (ESS) benefit portal.

Sincerely,

Your Boys & Girls Club of King County HR Team

Eligibility

Eligible Employees:

You may enroll in the Boys & Girls Clubs of King County's (BGCKC) Employee Benefits Program if you are a full-time employee working 30 hours or more per week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your legal spouse, domestic partner with signed affidavit, and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided.

When Coverage Begins:

Newly hired employees and dependents will be eligible for BGCKC's benefits programs on the first of the month coinciding with or following thirty (30) days from date of hire. All elections are in effect for the entire 12-month plan year and can only be changed during Open Enrollment unless you experience a life status change event mid-year. Submission of your enrollment is considered timely, within 30 days after becoming eligible.

What is Open Enrollment?

Open Enrollment is a once-a-year opportunity to make voluntary changes to your benefit elections and to review which dependents you will be covering during the new 12-month plan year. Each year, BGCKC conducts Open Enrollment during the month of June and changes you request will take effect July 1.

Benefit Elections – How to Enroll?

Employees will be invited to go through the Paycom ESS portal to submit initial benefit selections, dependent enrollment and pre-tax payroll elections.

With a few exceptions, Open Enrollment is the only time of the year when you can make voluntary changes to your benefits plan, due to the IRS code section 125. During Open Enrollment, you can:

- Add, change, or delete coverage.
- Add, or drop dependents from coverage.
- Enroll, or re-enroll in the health care, dependent care or transportation flexible spending accounts. To continue your pre-tax FSA elections, you must re-enroll each plan year.

Mid-Year Life Status Change:

A change in life status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some life status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age, court judgment)
- Change in coverage eligibility (i.e. loss or significant change in coverage, ceasing to be enrolled in Medicaid or CHIP)
- Change in employment or job status (i.e. spouse loses job, FT to PT, etc.)

If you have a qualified change in status, you can make changes to your benefits by logging into the Paycom ESS portal to update your benefits within 30 days of the change. The change to your benefits must be consistent with the qualified change in status. Failure to request a change of status timely may result in your having to wait until the next open enrollment period to make your change.

Monthly Premiums and Contributions

The amount you pay depends upon which plans you elect and which dependents you choose to cover. This table shows how benefit costs are shared. All premiums will automatically be deducted on a pre-tax basis except for premiums paid for domestic partner coverage. Employees will pay income tax and Social Security payroll tax on the portion of the insurance premium that BGCKC contributes towards a domestic partner's policy.

MEDICAL INSURANCE – CIGNA OPEN ACCESS PLUS				
OAP $1,600 HDHP (Base Plan)	**Monthly Rate**	**Employer Cost**	**Employee Cost**	**Per Pay Period**
Employee	$761.31	$666.08	$95.24	$43.95
Employee & Spouse/DP*	$1,598.80	$1,198.81	$399.99	$184.61
Employee & Child(ren)	$1,446.58	$1,084.69	$361.89	$167.03
Employee & Spouse/DP* & Child(ren) (Family)	$2,284.02	$1,712.61	$571.41	$263.73
OAP $1,000 Choice PPO (Buy-up Plan)				
Employee	$934.64	$669.51	$265.13	$122.37
Employee & Spouse/DP*	$1,963.13	$1,220.78	$742.35	$342.62
Employee & Child(ren)	$1,776.42	$1,104.75	$671.67	$310.00
Employee & Spouse/DP* & Child(ren) (Family)	$2,805.04	$1,744.52	$1,060.52	$489.47
DENTAL INSURANCE				
Willamette Dental EPO	**Monthly Rate**	**Employer Cost**	**Employee Cost**	**Per Pay Period**
Employee	$47.40	$47.40	$0.00	$0.00
Employee & Spouse/DP*	$95.95	$70.73	$25.22	$11.64
Employee & Child(ren)	$89.35	$67.57	$21.78	$10.05
Employee & Spouse/DP* & Child(ren) (Family)	$145.60	$94.59	$51.01	$23.54
MetLife Dental PPO				
Employee	$53.58	$45.18	$8.40	$3.88
Employee & Spouse/DP*	$108.49	$69.38	$39.11	$18.05
Employee & Child(ren)	$101.01	$66.01	$35.00	$16.15
Employee & Spouse/DP* & Child(ren) (Family)	$164.70	$94.68	$70.02	$32.32
VISION INSURANCE				
VSP Vision - Choice	**Monthly Rate**	**Employer Cost**	**Employee Cost**	**Per Pay Period**
Employee	$7.69	$7.69	$0.00	$0.00
Employee & Spouse/DP*	$12.31	$4.31	$8.00	$3.70
Employee & Child(ren)	$12.56	$4.56	$8.00	$3.70
Employee & Spouse/DP* & Child(ren) (Family)	$20.25	$12.25	$8.00	$3.70

*For domestic partners who do not qualify as dependents under Section 152 of the Internal Revenue Code, premium associated with domestic partner coverage will be paid by the employee with after-tax dollars and the fair market value of any employer contributions made on behalf of your domestic partner will be imputed as income to the employee.

SPOUSAL CERTIFICATION FORM

If you are covering a spouse/domestic partner, you must complete the Spousal Certification Form. This form certifies that your spouse/domestic partner does not have affordable and minimum value coverage elsewhere (i.e. their own employer). If they do have access to affordable and minimum value coverage elsewhere and choose to stay on Boys & Girls Club's medical plan, you will not receive the employer contribution towards spouse/domestic partner's coverage and therefore will be responsible for the full spousal premium.

See HR for questions or more details. The form can be found on the online enrollment platform. If your spouse's/DP's benefits status changes mid-year, please see HR and complete a new form.

Medical Definitions – Know the basics of health insurance

WHAT IS A DEDUCTIBLE?

A deductible is a fixed amount of money that you must pay for health care expenses before your insurance coverage starts paying, each calendar year. This does not include the premium amount that is taken out of your paycheck each month. For example, if the **base plan** has a $1,600 deductible, you pay the first $1,600 of medical and/or prescription expenses. After that, the plan will pay a percentage of the expenses.

WHAT IS COINSURANCE?

Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount. You pay coinsurance after you have met your deductibles. For example, if the coinsurance percentage is 20% and the plan's allowed amount for an office visit is $100. Once you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance plan pays the rest of the allowed amount.

WHAT IS A COPAY?

A copay is a fixed or flat dollar amount you must pay each time you visit the doctor or purchase medicine. This amount will vary depending on where you go for care, the type of doctor you see and the kind of medicine you need. Not all plans have the same copays.

WHAT IS AN OUT-OF-POCKET MAXIMUM?

This is the most you could pay in deductible, copay and coinsurance in a calendar year. Once the in-network maximum-out-of-pocket limit is reached, the plan covers 100% of all eligible expenses in-network.

What is a High Deductible Health Plan (HDHP)?

This is a qualified plan as defined by the IRS. No first dollar benefits (i.e., copays), all services are subject to the deductible before the plan will pay. Exception is Routine Preventive Care as defined by the IRS. The full family deductible applies, if enrolled with a dependent.

What is a Health Savings Account (HSA)?

This is a Tax-Free account, with triple tax advantages, established and owned by the employee. The funds are meant to pay for qualified health care expenses, typically subject to the High Deductible Health Plan (HDHP).

WHAT COUNTS AS A PREVENTIVE CARE VISIT?

In general, a preventive care visit is one where you are going for a general checkup and don't have a specific concern. If you have a specific ailment for the doctor to check on, this is typically considered a diagnostic visit. Be aware, however, if you go to the doctor for a yearly check-up and bring up ailments to the doctor, part of the visit might be billed as preventive ***and*** part as diagnostic.

WHAT IS A NETWORK?

A network is a group of doctors, hospitals and other health care providers. This group has worked with Cigna to get special prices just for you, the employee. When a health care provider is in your network, it's called "In-network."

WHY GO IN-NETWORK?

Each provider has agreed to accept our plan's contracted rate as payment for services. Their costs are usually lower than out-of-network providers, and they also agree to file claims for you and not bill you for charges beyond the set price.

WHAT IS AN EXPLANATION OF BENEFITS (EOB)?

An EOB is a statement that comes in the mail and explains details about a submitted insurance claim. The EOB shows the portion that was paid by the insurance carrier and what payment, if any, will be the patient's responsibility. Even though it resembles a bill, it is not. The bill for your portion will come from the health care provider and should be paid to the provider.

OPEN ACCESS PLUS FEATURES:

- **Primary care physician (PCP)** selection is recommended to manage your healthcare journey.
- **Referrals** are not required to see a specialist.
- **Direct Access to OBGYN** no prior authorization required.
- **Out-of-network coverage** is included at a higher out-of-pocket cost.
- **Pre-certification** may be required for hospitalizations and some types of outpatient care.

HAVE QUESTIONS? NEED HELP?

The Benefit Specialists at the USI Benefit Resource Center (BRC) are available Monday through Friday 8:00am to 5:00pm Pacific Time at 866-468-7272 or via e-mail at BRCWest@usi.com. Simply provide the **Boys & Girls Clubs of King County's** name to get started.

BOYS & GIRLS CLUBS
OF KING COUNTY

Medical Options –

Boys & Girls Clubs of King County offers employees two medical plan options to choose from. Both plans are administered by CIGNA and the following chart is a brief outline of the Base and Buy-up plans. To locate an Open Access Plus provider, please visit www.cigna.com or www.mycigna.com. Please refer to the summary plan description for complete plan details.

PCY – Per Calendar Year, PT – Physical Therapy

CIGNA Group # 0609270	BASE PLAN – HDHP OAP w/HSA		BUY-UP PLAN – OAP Choice	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Calendar Year Deductible – *plan deductible applies unless noted as "dw", meaning deductible waived*				
Individual / Family	$1,600 / $3,200[1]	$3,000 / $6,000(1)	$1,000 / $2,000	$4,500 / $9,000
Coinsurance	Plan pays 80% **You pay 20%**	Plan pays 60% **You pay 40%**	Plan pays 90% **You pay 10%**	Plan pays 50% **You pay 50%**
Calendar Year Maximum Out-of-Pocket – *includes deductible, copays, coinsurance*				
Individual / Family	$4,500 / $9,000 (1)	$9,000 / $18,000	$5,000 / $10,000	Unlimited
Physician Office Visit				
Preventive Adult/Well-Child Visit	100%, dw	40% after deductible	$0 copay, dw	50% after Deductible
MDLIVE Telehealth	20%, dw	Not Covered	$25 copay, dw	Not Covered
Primary Care Visit	20% after deductible	40% after deductible	$25 copay, dw	50% after deductible
Specialty Care Visit	20% after deductible	40% after deductible	$25 copay, dw	50% after deductible
Outpatient Mental Health & Substance Abuse Visit	20% after deductible	40% after deductible	$25 copay, dw	50% after deductible
Outpatient Diagnostic & Facility Services				
X-ray and Lab Tests	20% after deductible	40% after deductible	10%, dw	50% after deductible
Inpatient Facility Charges	20% after deductible	40% after deductible	10% after deductible	$500 copay; 50%, dw
Outpatient Facility and Surgical Charges	20% after deductible	40% after deductible	10% after deductible	$500 copay; 50%, dw
Urgent Care Facility	20% after deductible	40% after deductible	$50 copay, dw	50% after deductible
Emergency Room Facility Charges*	20% after deductible		$200 copay, dw (*copay waived if admitted)	
Other Services				
Chiropractic - 20 visits PCY	20% after deductible	40% after deductible	$25 copay, dw	50% after deductible
Acupuncture - 12 visits PCY	20% after deductible	40% after deductible	10% after deductible	50% after deductible
Massage Therapy – Visits combined with Physical Therapy	20% after deductible	40% after deductible	10% after deductible	50% after deductible
Retail Pharmacy (30-day Supply noted)				
Generic Drugs	20% after deductible	Not Covered	$15 copay	50%
Preferred Brand Drugs	20% after deductible	Not Covered	$25 copay	50%
Non-Preferred Brand Drugs	20% after deductible	Not Covered	$45 copay	50%
Home Delivery (90 Day Supply noted; Specialty 34 Day Supply or less)				
Generic Drugs	20% after deductible	Not Covered	$30 copay	Not Covered
Preferred Brand Drugs	20% after deductible	Not Covered	$50 copay	Not Covered
Non-Preferred Brand Drugs	20% after deductible	Not Covered	$90 copay	Not Covered
Specialty Drugs	Included	Not Covered	Included	Not Covered

[1] Non-Embedded Deductible and Out-of-Pocket Maximum: When enrolled with one or more dependents, there is no individual deductible, and the family deductible must be met before the plan will pay coinsurance. Additionally, the overall family out-of-pocket maximum must be met before the plan will pay 100% of in-network eligible expenses.

Preventive Medications: Covered 100%, dw; to view the Preventive Drug List, visit www.Cigna.com/PDL | **Members should use the Price a Medication tool to see how much a medication may cost at the different pharmacies in the plan's network.**

Specialty Medications: Used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.

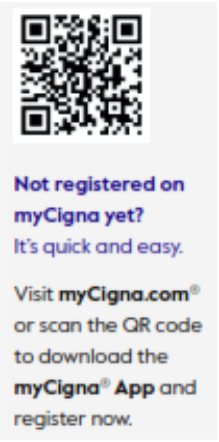
Exclusive Specialty Home Delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.

CIGNA Member Resources –

Member Portal Access - www.mycigna.com

Getting started is easy. Go to mycigna.com, click "Customer Login" and then follow the prompts to create your account. You'll need your member ID number, which is on your Cigna ID card, to complete registration.

- Track your care and your spending, including your deductible.
- Find in-network doctors, hospitals, and pharmacies.
- Refill prescriptions and get dose reminders.
- Find the forms you need.
- Learn more about your benefits.



Cigna Diabetes Prevention Program

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

MDLive Telehealth Connection – mycigna.com or MDLIVEforCigna.com - 888.726.3171

Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options such as **Primary Care, Urgent Care, Behavioral Care and Dermatology*** — available by phone or video whenever it works for you. MDLIVE doctors can diagnose, treat and prescribe most medications via secure video chat or phone. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits. (*Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care.)

3 Easy Steps to Connect to Care

Virtual care visits are convenient and easy. To schedule an appointment:

- Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)
- Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE.
- Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care.

Remember, your telehealth services are only available for minor, non-life-threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

Additional CIGNA Resources

Behavioral Health / Mental Health Digital Tools

Cigna provides access to behavioral and mental health virtual care through national telehealth providers as part of your plan, however this service is separate from your health plan's network. For more information, visit mycigna.com.

ginger created the world's first integrated mental healthcare system where coaches, therapists, and psychiatrists work as a team to coordinate the best, personalized care right from your smartphone, whenever you need it. It's like a virtual clinic without the waiting room. Ginger's mental health services are in-network and accessible through your behavioral health benefits. Visit **ginger.com/cigna** or view the **Ginger Sign-up Guide** to learn more.

talkspace is an online therapy platform that makes it easy and convenient for you to hold sessions with a licensed behavioral therapist from anywhere, at any time. With Talkspace, you can send private messages to, or hold live video sessions with, your dedicated therapist through a secure digital app platform. Visit talkspace.com/cigna to get started.

iPrevail offered through Cigna is a digital therapeutics program designed to help you take control of the stresses of everyday life. You will have access to interactive video lessons and one-on-one coaching to help with depression and anxiety. To log in, visit https://my.cigna.com/web/public/iprevail.

happify offered through Cigna is a self-directed program with activities, science-based games and guided meditations, designed to help reduce stress and anxiety, increase confidence, defeat negative thoughts and boost overall health. Visit https://cigna.happify.com/ to start your journey.

Cigna Healthy Rewards Discount Program

Start saving today with Cigna Healthy Rewards. Just use your Cigna ID wallet card when you pay and let the savings begin. Get discounts on the health products and programs you use every day for:

- Nutritional Meal Delivery Service
- Fitness Memberships and Devices*
- Vision Care, Lasik Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts*

*Fitness Membership and Devices along with Yoga Products and Virtual Workouts can only be accessed by logging into myCigna.com and navigating to Healthy Rewards Discount Program.

For Cigna customers who don't have access to **myCigna.com** and want an Active&Fit Direct™ gym membership:

- Call **800.870.3470**; and
- Press 3 to be transferred to a customer service agent.

Dental Options

Boys & Girls Clubs of King County offers two dental programs to choose from. The plan an employee signs-up for is the plan available to eligible dependents. The dental plan, administered by Willamette Dental Group (WDG), requires members to see a WDG dentist and receive care at a WDG facility; and does not offer out-of-network coverage. Visit www.willamettedental.com to locate a WDG dental office and provider.

The dental PPO plan, administered by MetLife, allows members the freedom to select any dentist. However, members will receive a higher level of coverage and pay less out of pocket when accessing an in-network provider. Visit www.metlife.com to locate an in-network provider. If you receive out-of-network services, you will be responsible for any charges in excess of the negotiated fee schedule amount or R&C Fee, and charges for non-covered services. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

WDG #: WA571 **MetLife #: 5384749**	**Willamette Dental Group EPO**	**MetLife DPPO – PDP Plus**	
	Schedule of Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
Calendar Year Deductible			
Individual	$0	$50	$50
Family	$0	$150	$150
Waived for Preventive Care	N/A	Yes	Yes
Diagnostic & Preventive Benefits			
Calendar Year Benefit Maximum Per Person	Unlimited	$3,000	$3,000
(Type A) – Preventive: Exams, cleaning, x-rays, Periodontal Scaling & Root Planning	$15 copay per visit	No Charge	No Charge
(Type B) – Basic: Fillings, Root Canal, Oral Surgery (Simple & Surgical)	Various copays apply	You pay 20%	You pay 20%
(Type C) – Major: Crown, Bridges, Dentures, Implant Services, TMJ	Various copays apply	You pay 50%	You pay 50%
Miscellaneous Treatment	Dental Implants Surgery: $1,500 benefit maximum per year	N/A	
Orthodontia			
(Type D) - Benefit: Adult & Child	Pre-Treatment: $150 copay* Treatment: $2,000 copay (*copay is deducted from treatment)	You pay 50%; $1,500 lifetime maximum	
Late entrant waiting periods	No waiting period	No waiting period	
Network Reimbursement	N/A – You pay charges in excess of $100 for out of area Emergency Care	Reasonable & Customary (R&C)	

Dental Pre-Determination: In the event you need to have dental work estimated to cost $300 or more, we recommend you have your dentist submit the charges to Willamette or MetLife for pre-authorization. Each carrier will review the intended treatment plan and let your dentist know how much of the bill they will cover. We recommend this to avoid billing surprises.

Vision Insurance

BGCKC provides vision insurance through Vision Service Plan (VSP) and the Choice Network. Sight, it's a beautiful thing and not to be taken for granted. Whether you want to be incognito and wear contact lenses or stand out in the crowd with the latest stylish frames, this vision plan has you covered. Visit www.vsp.com to locate a provider near you.

	Vision Service Plan (VSP) Vision Plan
Vision Exams	
Well Vision Exam Contact Lens Exam (fitting and evaluation)	$10 copay, every 12 months Up to $60 copay, every 12 months
Vision Materials	
Materials Copay	$20 copay
Frames	Covered at 100%, after material copay, every 24 months Up to $200 allowance for wide selection for frames Up to $220 allowance for featured brands 20% savings on amounts over allowance Up to $200 Walmart*/Sam's Club; $110 Costco*
Lenses: Impact-resistant for dependent children, Single vision, Lined bifocal and Lined trifocal	Covered 100% after material copay, every 12 months
Enhancements: Standard progressive lenses Premium progressive lenses Custom progressive lenses	$0 $95 - $105 $150 - $175
Contact Lens (In lieu of glasses)	
Medically necessary Elective contacts	Covered 100%, materials copay does not apply $200 allowance, every 12 months
LIGHTCARE ™	
Non-Prescription Sunglasses	After a $20 copay, receive a $200 allowance, every 24 months Ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts.
EXTRA SAVINGS & DISCOUNTS	
Glasses and Sunglasses	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.
Routine Retinal Screening	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and may vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Health Savings Account (HSA)

When you are enrolled in the Base Plan, a qualified High Deductible Health Plan (HDHP), and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account. BGCKC partners with AccrueCMS and once enrollment in the Base plan is complete, AccrueCMS will send a *Welcome* email with instructions to login and sign the banking agreements. This step must be completed to receive the BGCKC HSA contributions and activate the HSA debit card.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses, for you and/or your eligible dependents, for current or future healthcare expenses. The HSA is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year-to-year. Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes.
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the QHDHP medical plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare, TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months, except for service related injury or disability.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA or a carryover FSA balance available to you. (Enrollment in a limited purpose health care FSA is allowed).

2024 HSA Contributions

BGCKC will contribute to your HSA on your behalf, making a lump sum contribution, upon enrollment in the Base HDHP plan. You can also contribute to your HSA on a pre-tax basis, through payroll deductions, up to the IRS statutory maximums. The below table illustrates your allowable maximum tax-free contributions, including the BGCKC HSA funding.

Enrollment Tier	2024 Tax Year Maximum	BGCKC Total Contribution
Single Employee	$4,150	$500
Employee + Dependent(s)	$8,300	$500
*Age 55 or older you may make additional "catch up" contributions up to $1,000 per year ($83 per month).		

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. You can manage your HSA member portal through www.Accruesolutions.com 24 hours a day, seven days a week.

AccrueCMS: How Do I Access my HSA online? - *Account Holder pays monthly account fee of $3.00*

Members can access the HSA portal in two ways. You can log into the member portal or download the mobile app to manage your account, view alerts, make payments, withdrawals, deposits and more! You can use our My HSA Planner https://myhsaplanner.com/ASL to not only learn more about HSAs, but to get a personalized recommendation on how to contribute to it!

Employer-Paid Group Insurance

BGCKC provides Basic Life and Accidental Death and Dismemberment (AD&D) and Long-Term Disability (LTD), to eligible employees through MetLife at no cost. The **life insurance** benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The **AD&D** benefit will be paid in the event of a loss of life or limb by accident while covered under the plan. **LTD insurance** protects your ability to earn an income and pay bills in the event you become unable to work due to an illness or injury.

Important Reminder! Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.

	MetLife Basic Life / AD&D and Long-Term Disability
Basic Life/AD&D	
Life Benefit Maximum	Lesser of 1.5x basic annual earnings up to $175,000
Taxation	IRS regulations require taxation on the value of employer provided Life benefits above $50,000 to the employee. This imputed income will be reflected on your paycheck statement.
AD&D Benefits	100% paid due to loss of life; see schedule of benefits for additional details
Benefit Reduction	The above benefits will begin to decrease at age 70.
Long-Term Disability	
Benefit Maximum	60% of your monthly salary (up to $6,000)
Elimination Period	Benefits begin to pay after 90 days of disability
Duration of Benefits	24 months own occupation, then to age 65 or Social Security Retirement Age
Pre-existing Condition	If you receive treatment within the 3 months leading up to your coverage start date, no benefits will be covered for that condition by the plan for 12 months.

Employee-Paid Voluntary and Supplemental Insurance

Through MetLife, you have the option to purchase additional voluntary life and AD&D insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability (EOI).

	Voluntary Life / AD&D
You	
Life Benefit Maximum	Increments of $10,000; 5x earnings to $300,000
AD&D Benefit Maximum	Equal to life insurance amount chosen
Guaranteed Issue	$100,000
Your Spouse/Domestic Partner	
Life Benefit Maximum	Increments of $5,000; 50% of employee amount to $150,000
AD&D Benefit Maximum	Equal to life insurance amount chosen
Guaranteed Issue	$20,000
Your Child	
Benefit Maximum	Flat $1,000, $2,000, $4,000, $5,000, or $10,000 15 days - 6 months: $100
Guaranteed Issue	Full benefit amount, up to $10,000

SINGLE LIFE/AD&D RATES	
Monthly Rates per $1,000	
Under 30	$0.094
30 - 34	$0.102
35 - 39	$0.125
40 - 44	$0.162
45 - 49	$0.246
50 - 54	$0.374
55 - 59	$0.616
60 - 64	$0.955
65 - 69	$1.55
70 +	$2.71
CHILD RATE	**Rate per $1,000**
	$0.294

- No Benefit Reduction due to age.
- Spouse age-banded rates are based on the employee's age.

You are guaranteed group pricing and "Guaranteed" amounts with no medical questions, when you enroll in this voluntary benefit when first eligible to enroll in our benefits programs. Medical questions are required for all amounts you elect above the guaranteed issue amounts.

Voluntary and Supplemental Insurance (continued)

The following chart outlines additional employee-paid insurance options available through MetLife. Please see the certificate of coverage for complete plan details.

Short-Term Disability (STD)	STD is income protection, in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 60% of your weekly base salary up to $1,500 per week, benefit payments begin after 14 days of injury or illness and last up to 11 weeks. This coverage coordinates with the state WA PFML. Age-banded rates can be found on Paycom.
Accident & Injury	Voluntary accident policy is meant to help fill in the gaps of care, provide cash to cover your out-of-pocket expenses and offers peace of mind when an accidental injury occurs. Coverage options and rates can be found on Paycom.
Critical Illness	Voluntary critical illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness such as Cancer, heart attack, major organ failure or stroke. Coverage options and rates can be found on Paycom.

MetLife Value-Added Programs

BGCKC cares about the well-being of our employees both on and off the job. The following programs are available to employees that purchase Supplemental Life and AD&D coverage with MetLife, at no cost. These affiliate services are not considered Insurance.

- **Grief Counseling** - You, your dependents, and your beneficiaries have access to grief counseling sessions and funeral related concierge services to help cope with a loss. Call the 24/7 support line at 1-866-307-1405 or log on to https://metlifebene.lifeworks.com/ (Username: metlifebene; Password: support).
- **Funeral Discounts and Planning Services** – to support and help honor your loved one's life with Dignity Memorial Network at www.finalwishesplanning.com or by phone 1-866-853-0954.
- **Will Preparation** – Access MetLife Legal Plan's network of 18,000+ participating attorneys for preparing or updating a will, living will and power of attorney. Visit: www.willscenter.com or call Metlife Legal Plans at 1-800-821-6400.
- **Digital Estate Planning** – to ensure final wishes are clear, employees can complete wills and other important estate planning document quickly, with access to online notary services.
- **MetLife Estate Resolution Services** – a MetLife Legal Plan attorney will consult with your beneficiaries by phone or in-person regarding the probate process for your estate. Call Metlife Legal Plans at 800-821-6400.
- **Travel Assistance** - AXA administers emergency medical assistance services when you or a family member becomes ill or injured while traveling 100 miles or more away from home. Visit: www.metlife.com/travelassist or 1-800-454-3679.

Employee Assistance Program (EAP) - Cigna

As an employee of BGCKC, you have access to the valuable Cigna Employee Assistance Program (EAP) at no cost to you. EAP personal advocates will work with you and your household family members to help you resolve issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more. Call 1-877-622-4327 or log into myCigna.com, enter Employer ID: **bgckc**, for initial registration only. Some features of the EAP include:

- 3 face-to-face counseling sessions with a counselor in your area, as well as video-based sessions.
- Legal assistance: 30-minute consultation with an attorney, face-to-face or by phone. (*Employment-related legal issues are not covered)
- Financial: 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- Parenting: Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- Eldercare: Resources and referrals for home health agencies, assisted living facilities, social and recreational programs, and long-distance caregiving.
- Pet care: Resources and referrals for pet sitting, obedience training, veterinarians, and pet stores.
- Identity theft: 60-minute consultation with a fraud resolution specialist.

Pet Insurance Options

BGCKC is pleased to offer employees two options to purchase discounted pet Insurance directly though **Pets Best** and **FIGO**. The amount you pay depends upon the plan you elect and how many pets you enroll. The below chart outlines general benefit features, however final benefits and rates are determined by your direct selection. Pre-existing conditions are generally not covered. Pre-existing conditions are any illness or injury a pet had prior to the start of the policy.

	PETS BEST	FIGO
	BENEFIT FEATURES	**BENEFIT FEATURES**
Benefit Features		
Pets Available for Coverage	Dogs and cats only	Dogs and cats only
Group Discount	5%; multi-pet discount (additional 5% if more than one pet)	Up to 10%
Wellness Plans	Yes - Routine Wellness rider available (3 different plan options)	Yes - Wellness plan add-on available
General	Accidents, illness, cancer, hereditary conditions, ER surgeries & Rx Meds	Accidents, illness, cancer, hereditary conditions, ER surgeries & Rx Meds
Alternate Care	Rehabilitation, acupuncture & chiropractic available through ELITE option	Acupuncture & chiropractic offered Rehabilitation available option
Direct Employee Access		
Employee Enrollment Weblink	www.petsbest.com/bgckc	*https://bit.ly/3uH9S48*
Toll-Free Phone Number	888.984.8700	844.738.3446

CONTINUATION OF COVERAGE

Pet insurance is an individual policy. You will be able to continue pet insurance so long as premiums are paid, regardless of your employment status.

IMPORTANT NOTES

Premium Payment: Please note you will be billed directly from the carrier you choose for your elected coverage – premiums are not payroll deducted.

File a Claim

Use your mobile app or file a claim online, there is no need to send us medical records unless we request them.

Pets Best
PET HEALTH INSURANCE

FIGO

Flexible Spending Accounts (FSA)

The Flexible Spending Account (FSA) plan with AccrueCMS allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period to one or all accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your debit card to pay OR submit the appropriate paperwork to be reimbursed by the plan.

Healthcare FSA:

- The full amount of your election is available immediately, no waiting for money to be withheld.
- The funds may be used to pay for qualified medical, dental or vision expenses (i.e., deductibles, copays, OTC).
- Limited Purpose FSA funds may only be used to pay for qualified dental and vision expenses (i.e., HSA members)
- The funds may be used to pay for any tax-dependent's expenses.
- Use-it or lose-it applies, however up to **$640** of unused funds may be rolled over to the next plan year.

Dependent Care FSA:

- The funds are only available as money is deducted per pay period.
- The funds may be used to pay for qualified day care expenses (i.e., before & after school care, summer camps, etc.)
- You must submit a claim for reimbursement with caregiver taxpayer identification.

Transit Commuter FSA:

- The funds may be used to pay for parking expenses and public transit expenses.
- The funds not used at the end of the month will roll-over to following month.

Important rules to keep in mind:

- You must submit a new FSA election form each year to participate in pre-tax savings.
- You cannot transfer funds from one FSA to another.

Pre-Tax Maximum Limits	
Health Care FSA (125)	$3,200 per account
Dependent Care FSA (129)	$5,000 Household max / $2,500 Married filing separately
Transit Commuter Account (132)	$315 per month

The BGCKC 401K Retirement Plan

TRANSITION

Effective July 1, 2024, Fidelity Investments will become the new provider of recordkeeping, trustee services, and investment options for the Boys & Girls Clubs of King County (BGCKC) Retirement Plan.

PLAN PROVISIONS

- **Eligibility:** Regular full-time employees and regular part-time employees who work 1,000 hours or more each year are eligible.
- **Enrollment:** Once you attain age 18 and have completed 1 month of service you are eligible to enroll in the plan on the first day of each month.
- **Contributions:** You may contribute up to 100% of your eligible compensation, inclusive of pre-tax and/or Roth after-tax deferrals. You cannot exceed the annual IRS dollar limit. For 2024 the limit is $23,000 or $30,500 if you are age 50 or older.
- **Company Match:** You will receive a match from BGCKC in the amount of 100% on the first 4% in eligible compensation you defer. View the vesting schedule in the employee handbook.
- **Withdrawals:** Generally permitted in the event of termination of employment, retirement, disability, or death. Your plan also offers a loan feature.

ENROLLMENT INSTRUCTIONS

Before enrolling please carefully read all enrollment materials provided by your Human Resource Department. To sign up for the BGCKC Plan, you must first register your account then enroll in the plan.

Registration Process

- **Log on to** www.401k.com
- **Verify your identity:** Enter your full name, date of birth, last four digits of Social Security number.
- **Provide your contact information:** Enter your personal email, phone type, personal information, read electronic disclosers.
- **Set up your username:** Use 8-15 characters, including at least two letters.
- **Create a password:** Use 6-20 characters, including at least one number.
- **Confirm registration:** You should receive a message that says you have successfully registered. Now you can login with your new username and password and complete the enrollment process.

Enrollment Process

- **Select contribution amount:** From the top page of sub-navigations go to the heading "Contributions" and select "Manage your Contribution Amount". Select whether you want Pre-Tax deferrals or Roth deferrals and select either a percentage of your salary or a dollar amount. You can split your contribution between the two types. *Please note these amounts will be taken out per pay period.*
- **Select investment options:** From the top page of sub-navigations go to the heading "Investments" and select "Change Investments". Go to "Future Investments" to select your investment options. The selections you enter will be applied to all contributions that are submitted. Once you make your selection you can always change it anytime. If you click on the fund name, you will be taken to a fund fact sheet to learn more about each fund option. If you need assistance with selecting funds go to the heading "Investments" and select "Investment Guidance". This will take you to an interactive tool that can make investment decisions for you or provide guidance to help you decide.
- **Assign beneficiaries:** From the main menu bar go to the heading "Profile" and select "Beneficiaries". It is recommended that you assign primary and contingent beneficiaries. If you are married and would like to assign someone other than your spouse as primary beneficiary, you will need to complete a form manually. Please contact the BGCKC Human Resources Department.
- **Additional guidance:** To learn about more about the tools available to help you save and invest for retirement, please view the pre-recorded tutorial Brainshark - Guided Tour. NetBenefits provides the resources you need to help achieve financial wellness and feel confident about where you stand.

QUESTIONS

- If you have questions regarding your retirement plan or the participant website, please contact Fidelity at 1-800-835-5907.
- If you have questions regarding your investment options, please contact USI Consulting Group at 866-468-7272 Option 2.

Contact Information

Have Questions? Need Help?

Boys & Girls Clubs of King County is excited to offer access to the USI Benefit Resource Center (BRC), with experienced Benefit Specialists and their primary responsibility is to assist you. The Specialists in the BRC are available Monday through Friday 8:00am to 5:00pm Pacific Time at 866-468-7272 or via e-mail at BRCWest@usi.com.

Additional information regarding benefit plans can be found on the Paycom ESS Portal.

Carrier Contact Information:

	CARRIER	PHONE NUMBER	WEBSITE
Medical/Rx	CIGNA	(866) 494-2111	www.myCigna.com
Home Delivery Pharmacy	Express Scripts	(800) 835-3784	cigna.com/choosehomedelivery
Specialty Pharmacy	Accredo	(800) 351-3606	www.Cigna.com/specialty.com
Telehealth Virtual Care	CIGNA MDLIVE	(888) 726-3171	www.MDLIVEforCigna.com
Dental EPO	Willamette Dental Group	(855) 433-6825	www.willamettedental.com
Dental PPO	MetLife	(800) 438-6388	www.MetLife.com/mybenefits
Vision PPO	VSP Choice	(800) 877-7195	www.vsp.com
Group Life/AD&D, Vol. Life/AD&D and Group Disability	MetLife	(800) 438-6388 (800) 300-4296	www.metlife.com Email: eoi@metlife.com
Beneficiary Grief Counseling	MetLife | LifeWorks Counselor	(866) 307-1405	metlifebene.lifeworks.com
Travel Assistance Program	MetLife | AXA Assistance	(800) 454-3679	www.metlife.com/travelassist
Employee Assistance Program (EAP)	Cigna | **Employer ID: bgckc**	(877) 622-4327	www.mycigna.com
Health Savings Account (HSA), Flexible Spending Accounts (FSA) & Commuter	AccrueCMS	(888) 882-1498	www.accruesolutions.com Email: flex@accruecms.com
Voluntary STD, Accident, Critical Illness	MetLife	(800) 438-6388	www.metlife.com
Pet Insurance options	Pets Best FIGO	(888) 984-8700 (844) 738-3446	www.petsbest.com/bgckc *https://bit.ly/3uH9S48*
BGCKC 401(k) Retirement	Fidelity Investments USI Consulting Group	(800) 835-5907 (866) 468-7272, #2	www.401k.com

USI MyBenefits2Go Mobile App

BGCKC is pleased to offer on-the-go access to key benefit information through the USI Mobile App, **MyBenefits2GO**. Download in the App Store or Google Play Store and enter code **I88754** in the app to access your benefit highlights.

SCAN TO DOWNLOAD!

This brochure summarizes the benefit plans that are available to Boys & Girls Clubs of King County eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. Therefore, the following deductibles and coinsurance apply:

Base Plan: OAP Basic PPO	**In-Network Benefits**	**Buy-up Plan: OAP Choice PPO**	**In-Network Benefits**
Calendar Year Deductible	$1,600 individual | $3,200 family	Calendar Year Deductible	$1,000 Individual (2x family)
Coinsurance	Plan pays 80%	Coinsurance	Plan pays 90%

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within days from the loss of coverage or the date you become eligible for premium assistance.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.

- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Ellie Hooman - Phone: 206-436-1848; Email: ehooman@positiveplace.org

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 will 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.

Important Notice from Boys & Girls Clubs of King County [BGCKC] 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 BGCKC 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. **Boys & Girls Clubs of King County has determined that the prescription drug coverage offered by the BGCKC Health & Welfare Plan through Cigna pharmacy is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered <u>Creditable Coverage</u>. Because your existing coverage is <u>Creditable Coverage</u>, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15thto December 7th.

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

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Boys & Girls Clubs of King County coverage may be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits.

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You

may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through BGCKC 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).

Date:	July 1, 2024
Name of Entity/Sender:	Boys & Girls Clubs of King County
Contact--Position/Office:	Ellie Hooman, Chief Human Resources Officer
Address:	220 W Mercer Street, Ste. #410, Seattle, WA 98119
Phone Number:	206-436-1848

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
Boys & Girls Club of King County	91-0532600	
5. Employer address	6. Employer phone number	
220 W Mercer Street, Ste. #410	206.436.1848	
7. City	8. State	9. ZIP code
Seattle	WA	98119
10. Who can we contact about employee health coverage at this job?		
Ellie Hooman		
11. Phone number (if different from above)	12. Email address	
	ehooman@postiveplaces.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    Full-time eligible employees working 30 or more hours per week
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:

    Legal spouse, Domestic Partners, children up to age 26
  - [ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)