2023
Benefits Information Guide

KENAI
The Best Place To ALASKA

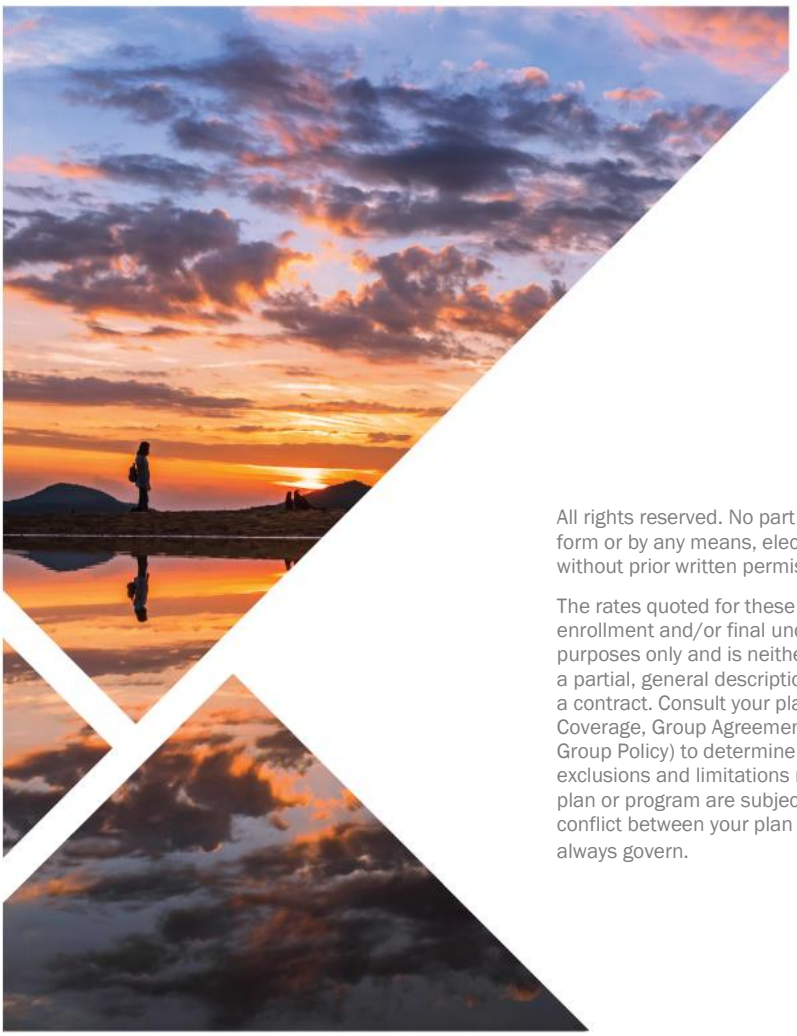
Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in a PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

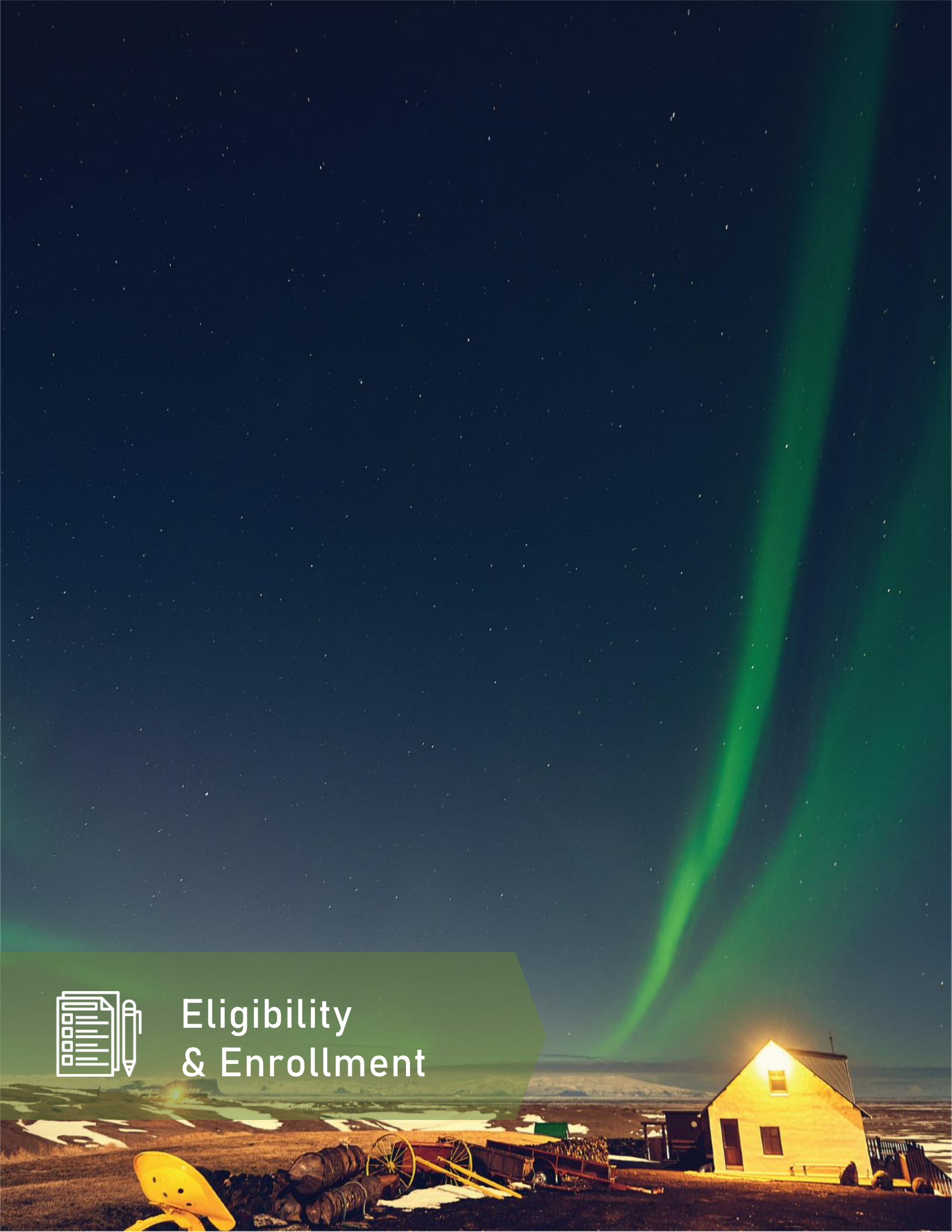
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 37 for more details.



The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Discover Your Benefits

Let's explore your benefit plan options, programs and resources.



Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

If you are an employee that is expected to regularly work a minimum of 25 hours per week, you are eligible to participate in the medical/dental/vision program. Eligible employees may also choose to enroll family members, including a legal spouse and/or eligible children.

When does coverage begin?

Regular, full-time and part-time employees: You are eligible to enroll on your date of hire, but your coverage will not be effective until 30 days from your date of hire.

Your enrollment choices remain in effect through the end of the benefits plan year, (December 31, 2023). If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status event during the plan year.

How do I get started with my enrollment?

- Enrollment and waiver forms will be distributed to you through Human Resources.
- Please return all forms to Human Resources.
- You must complete a waiver form to waive coverage and provide proof of other coverage to qualify for Cash-in-Lieu.

What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a change in status event as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the status change event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's loss or gain of coverage through our organization or another employer.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days.

Do I have to enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates (Alaska does not have a state-specific individual mandate). To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov.

All full-time employees will receive Group Life and AD&D coverage. You may waive medical/dental/embedded vision coverage through Premera Blue Cross and the Supplemental Products through Unum.

If you are eligible to participate in our Premera health coverage, and you elect to decline the City's coverage (Medical/Dental/Embedded Vision/) for yourself or yourself and family, the City will offer you cash-in-lieu of coverage in the amount of $300/month for full-time employees and $150/month for part-time (benefit-eligible) employees through the year.

In order to participate in the Cash-in-Lieu option, eligible employees must provide the city with reasonable evidence that the employee has or will have minimal essential coverage under a separate plan during the period of coverage to which the opt-out arrangement applies.

To waive coverage, please complete a waiver form. It is important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be during Open Enrollment for 2024 unless a change in status event occurs.


Medical/Rx

Medical

Premera Blue Cross Blue Shield of Alaska Yukon-Network PPO

A Preferred Provider Organization (PPO) Plan contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Using providers that belong in the plan's network will provide a higher benefit, but you have the flexibility to see a provider outside the network, generally for an additional cost.

PPO Advantages

- Broader choice of providers.
- No referrals required for specialists.

Preferred and Participating Providers

Services received by Preferred and Participating Providers are considered "In-Network" under both medical plan options. Your deductible is lower and services are covered at the highest benefit with Preferred and Participating Providers.

Note:

You may choose in or out-of-network care. However, in-network care provides you a higher level of benefit.

For a detailed view of your medical plan summaries, visit www.premera.com and login to your account.

How do I find a provider?

To find an in-network PPO provider:

Premera Blue Cross Yukon Network

- Go to www.premera.com and select "Find Care".
- Search by location, physician name, medical specialty, or advanced search.
- It is recommended you create a login and search from your portal.
- Physician profiles and locations available will appear.

Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug's tier.

Preferred Generics (Tier 1): Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.

Preferred Brand name medications (Tier 2): A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.

Preferred Specialty prescriptions (Tier 3): Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

All Non-Preferred prescriptions (Tier 4): Although you may be prescribed non-preferred prescriptions, these types of drugs are not on the insurance company's Essentials formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.

Why pay more for prescriptions?

Use Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply from a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. Call ahead to determine which pharmacy provides the most competitive price.

Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive alternative that serves the same purpose as prescription medications.

Need to see a doctor on demand?

Telemedicine Services

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet, video chat or telephone. By leveraging these virtual visits, you can avoid emergency rooms or urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

Start today at Premera.com or through the Premera app

dr. on demand

Doctor on Demand allows employees to access medical care through a board certified physician conveniently via internet connection or by phone. General services are Covered in Full! You do not need to meet your deductible first.

myCare Alaska provided by Premera

Text-based virtual care program that allows you to securely message, send photos or video chat with a doctor instantly. General services are Covered in Full! You do not need to meet your deductible first.

talkspace

Premera's expanded behavioral health network includes Talkspace, a virtual provider of therapy services. Services are covered at the Specialty Office-Visit copay.

Boulder

Achieve recovery wherever you are with virtual care. Get the care you need from the comfort of home.

Treatment for opioid use disorder and alcohol use disorder.

Workit Health

Live chat, video visits available with Workit Health. Video visits and text messaging available with Boulder. Services are covered at the Specialty Office-Visit copay.

Start your eVisit today!

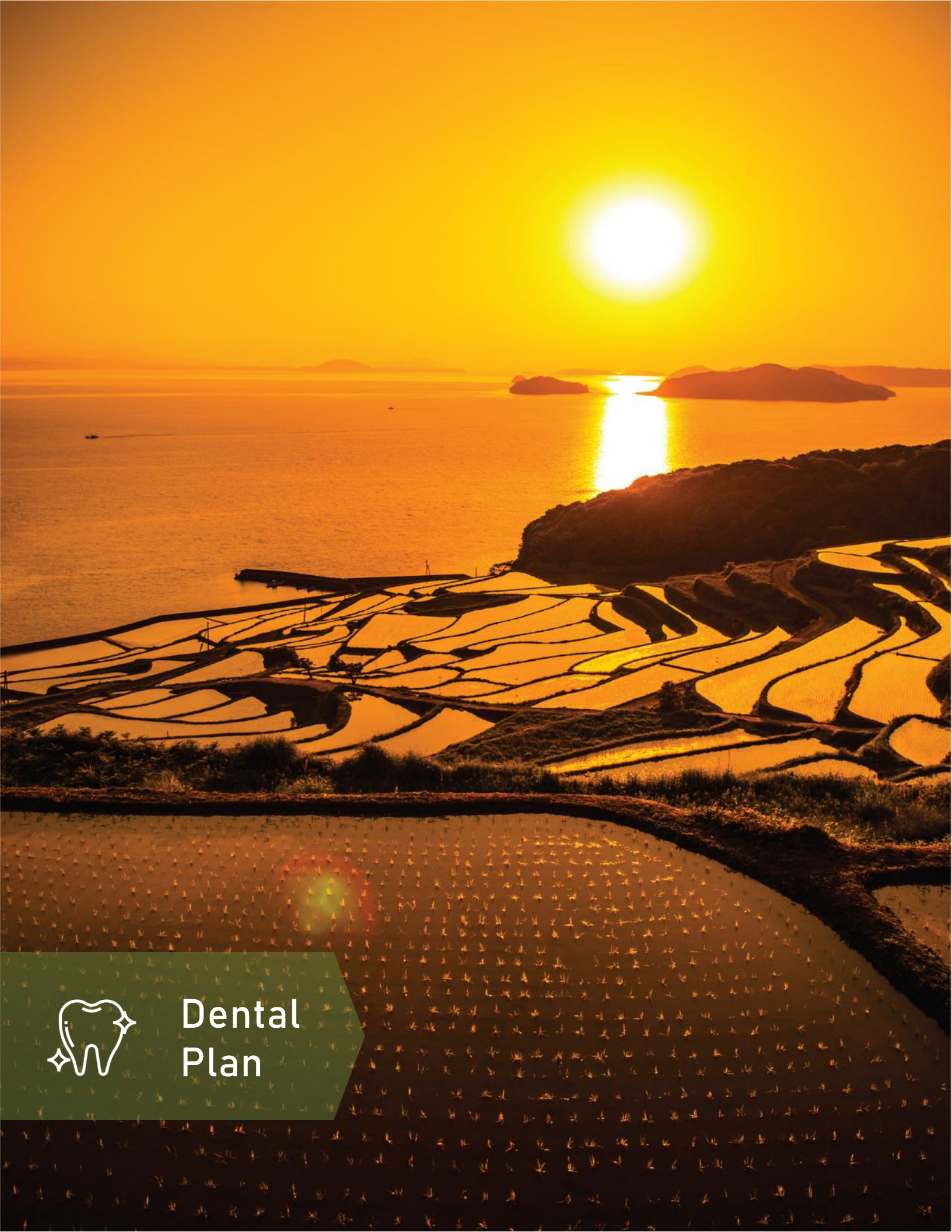
- General Services received by Dr. on Demand and myCare Alaska are Covered in Full!
- Login to your Premera portal to get started.

"I need specific medical care! How much does it cost?"

Plan Highlights	$2,000 Deductible Plan		$3,000 Deductible Plan	
	In-network	Out-of-network	In-network	Out-of-network
Annual Deductible				
Individual	$2,000	$4,000	$3,000	$6,000
Family	$4,000	$4,000 per person	$6,000	$6,000 per person
Maximum Calendar Year Out-of-pocket [1]				
Individual	$4,500	$45,000	$6,000	$45,000
Family	$9,000	$90,000	$12,000	$90,000
Coinsurance	20% Preferred 40% Participating	60%	20% Preferred 40% Participating	60%
Professional Services				
Preventive Care Exam	Covered in Full	Subject to Ded and Coinsurance	Covered in Full	Subject to Ded and Coinsurance
Premera App-Based Telehealth Visit (General Services)				
Primary Care Physician (PCP)	$25 copay		$30 copay	
Specialist	$65 copay		$65 copay	
Chiropractic Services	$25 copay		$25 copay	
Diagnostic X-ray and Lab	Subject to Ded and Coinsurance		Subject to Ded and Coinsurance	
Complex Diagnostics (MRI/CT Scan)				
Hospital Services				
Urgent Care	$40 copay	Subject to Ded and Coinsurance	$40 copay	Subject to Ded and Coinsurance
Inpatient	Subject to Ded and Coinsurance		Subject to Ded and Coinsurance	
Outpatient Surgery				
Emergency Room	$100 copay, then subject to Ded and Coinsurance		$100 copay, then subject to Ded and Coinsurance	
Mental Health & Substance Abuse				
Inpatient	$25 copay	Subject to Ded and Coinsurance	$30 copay	Subject to Ded and Coinsurance
Outpatient	Subject to Ded and Coinsurance		Subject to Ded and Coinsurance	
Retail Prescription Drugs(30-day supply)				
Deductible	$150 individual $300 family (combined with mail order) Waived for Generics		$150 individual $300 family (combined with mail order) Waived for Generics	
Preferred Generics	$15 copay		$15 copay	
Preferred Brands	$60 copay		$60 copay	
Preferred Specialty	$100 copay		$100 copay	
All Non-Preferred medications	50%		50%	
Mail Order Prescription Drugs (90-day supply)				
Deductible	$150 individual $300 family (combined with retail) Waived for Generics		$150 individual $300 family (combined with retail) Waived for Generics	
Preferred Generics	$37.50 copay		$37.50 copay	
Preferred Brands	$150 copay		$150 copay	
Preferred Specialty	$100 copay		$100 copay	
All Non-Preferred medications	50%		50%	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.



Dental Plan

Dental Plan

A smile is the nicest thing you can wear.

Using the PPO Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. To determine whether your dentist is in or out of your insurance network, go to www.premera.com.

You must be enrolled in the Medical plan to receive Dental benefits.

"I need specific dental care! How much does it cost?"

Plan Highlights	Premera Blue Cross Blue Shield of Alaska
	All Dentists
Calendar Year Deductible	
Individual	$50
Family	$100
Annual Maximum	$2,000
Preventive	Covered in Full
Basic Services	20%
Major Services	50%

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Vision Plan

Vision Plan

Keep a clear focus on your sight.

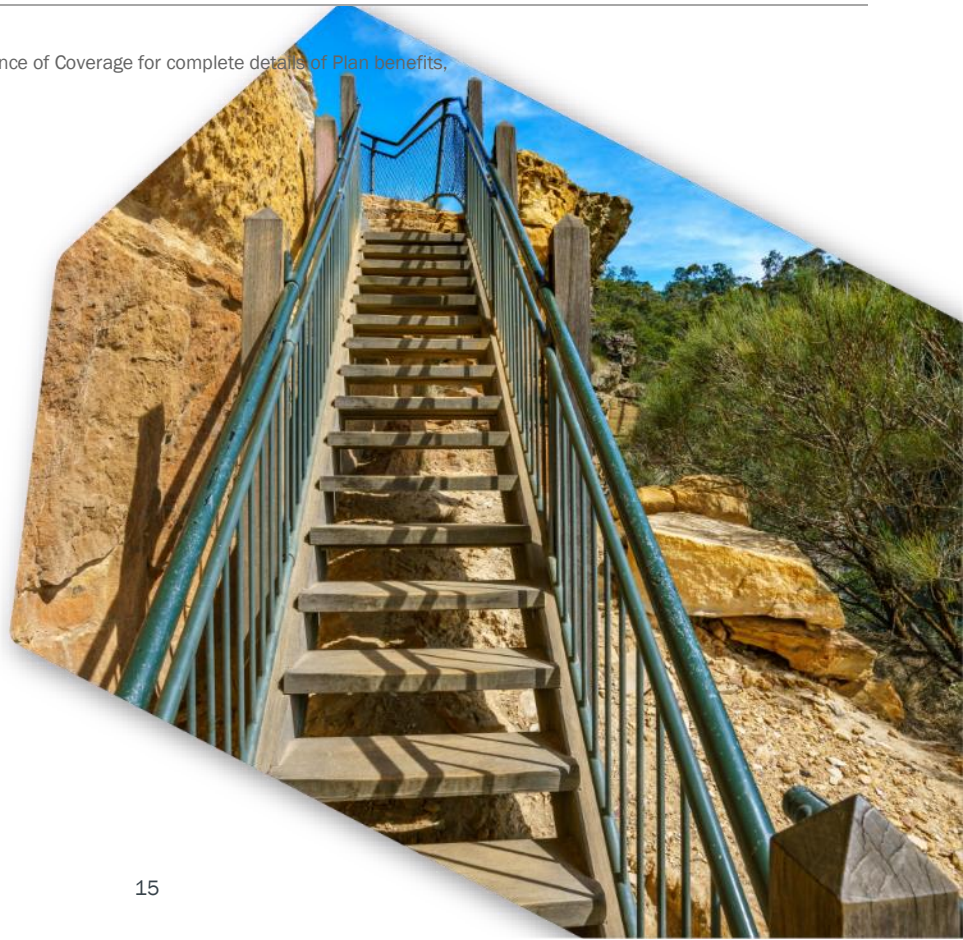
Vision coverage is offered by Premera as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.premera.com.

This Vision coverage is embedded in the Medical plan. You must be enrolled in the Medical plan to receive vision benefits.

"I need specific vision care! How much does it cost?"

Plan Highlights	Premera Blue Cross Blue Shield of Alaska
	All Vision Providers
Adults age 19 and over	
Exam – One per Calendar Year	10%
Vision Hardware	
Frames – Every two Calendar Years	Covered in full, max $90
Lenses – One pair per Calendar Year	Covered in Full
Contacts – 12 month supply	Covered in Full, max $170 (contacts in lieu of glasses)
Calendar Year Maximum All Services Combined	$350
Pediatric Services age 19 and under	
Exam – One per Calendar Year	Subject to your medical office visit copay - either $25 or $30 depending on which medical plan you choose
Vision Hardware	
Frames and Lenses – One per Calendar Year	Covered in Full
Contacts – 12 month supply	Covered in Full

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.



Spending Accounts

Spending Accounts

Make your money work for you.

Health Reimbursement Account (HRA)

What is it?

Your Health Reimbursement Account (HRA) is an employer-funded, tax advantaged health fund to help reimburse you for your eligible deductible and vision expenses. Contributions are made by The City of Kenai and can be used to pay for qualified healthcare costs.

How do I use it?

The City of Kenai will provide an HRA where you will have the ability to have your qualified deductible and vision expenses reimbursed by the health plan, subject to a limit. The HRA provides up to schedule on the following page. When seeking reimbursement for your incurred healthcare expenses, submit a reimbursement claim to Navia or use your HRA debit card, and, assuming it is a qualified expense and you have adequate funds in your HRA, the incurred healthcare expense will be reimbursed to you through your HRA. To manage your HRA, visit www.navia.com.

Review the chart on the following page. The HRA benefit you are eligible for depends on the medical plan option you are enrolled in and at what enrollment level.

The Vision HRA applies to both medical plan options and does not vary based your medical plan choice.

A few rules you need to know:

- If incurred expenses exceed the funds available in your HRA, you will be paying for any incurred out-of-pocket healthcare expenses above your HRA limit.
- HRA funds are no longer available to you to reimburse your healthcare expenses after you are no longer employed by the company. However, you may still be eligible to seek reimbursement from any remaining HRA funds if you enroll in COBRA coverage.
- You are not permitted to contribute to your HRA.

You must be enrolled in a medical plan to receive HRA benefits.

For more details about using an HRA, contact Navia at 1-866-897-1996 or visit their website at naviabenefits.com.

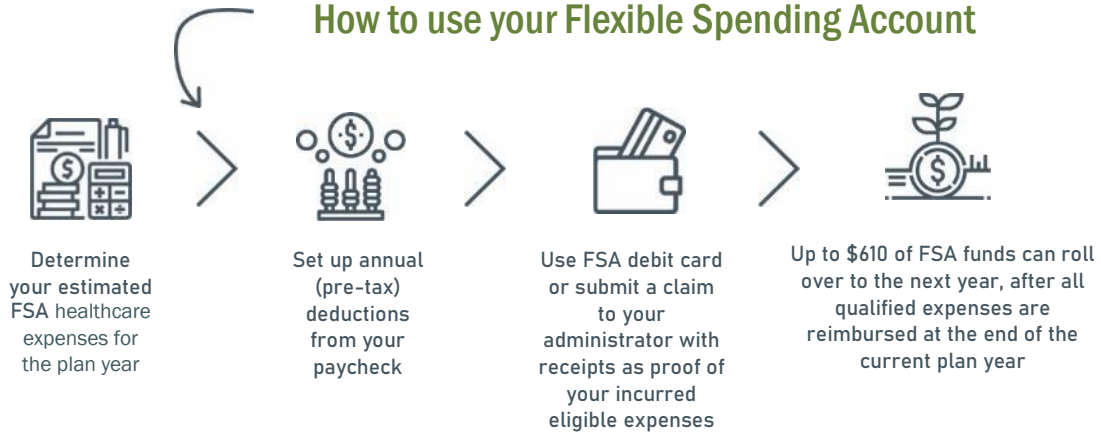
Medical Plan Election	HRA Benefit	
	Single Coverage (Employee-Only Medical Coverage)	**Family Coverage** (Employee plus one or more dependents)
$2,000 Medical Deductible Plan	$2,000 Medical Deductible $150 Rx Deductible $2,150 Total Deductible You Pay: The first $500 of deductible expenses HRA Pays: $1,650 of remaining deductible expenses Total You and HRA: $2,150	$4,000 Family Medical Deductible $300 Rx Deductible $4,300 Total Deductible You Pay: The first $500 of deductible expenses HRA Pays: the next $1,650 of deductible expenses You Pay: the next $500 of deductible expenses HRA Pays: the last $1,650 of deductible expenses Total You and HRA: $4,300
$3,000 Medical Deductible Plan	$3,000 Medical Deductible $150 Rx Deductible $3,150 Total Deductible You Pay: The first $500 of deductible expenses HRA Pays: $2,650 of remaining deductible expenses Total You and HRA: $3,150	$6,000 Family Medical Deductible $300 Rx Deductible $6,300 Total Deductible You Pay: The first $500 of deductible expenses HRA Pays: the next $2,650 of deductible expenses You Pay: the next $500 of deductible expenses HRA Pays: the last $2,650 of deductible expenses Total You and HRA: $6,300
Vision HRA – Applies to both medical plan options	100% up to $150	100% up to $300
	The Vision HRA will reimburse vision services covered under the Premera vision plan which exceed the plan's dollar maximums, up to the limits reflected above. The existing Premera frequency limits apply; services not covered under the Premera vision plan are not eligible. To file for Vision reimbursement, submit an itemized statement outlining your vision service and cost. The statement must include the date of service, type of service and cost.	

Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible healthcare and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2023 is $3,050.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Maximum contribution for 2023 is $5,000.

For more details about using an FSA, contact Navia at 1-800-669-3539.




Life &
Disability

Life & Disability

Protection for your loved ones.

Basic Life and AD&D

In the event of your passing, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your accidental death & dismemberment (AD&D) coverage may apply.

Paid for in full by The City of Kenai, the benefits outlined below are provided by Unum:

- Basic Life and AD&D Insurance of 1.5 x annual earnings up to $100,000.
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional life and AD&D coverage for you and/or your dependents is available on a voluntary basis through payroll deductions from Unum.

For employees:	Increments of $10,000 up to a $500,000 maximum, not to exceed 5 times your annual earnings, with a guarantee issue benefit of $100,000 if you enroll in the plan within 30 days of your initial eligibility.
For your spouse:	Increments of $5,000 up to a 100% of the employee's amount, with a guarantee issue benefit of $25,000 if you enroll in the plan within 30 days of your initial eligibility. You must be enrolled to cover your spouse.
For your child(ren):	Ages 6 months and older, increments of $2,000 up to $10,000, with all amounts approved. You must be enrolled to cover your children.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

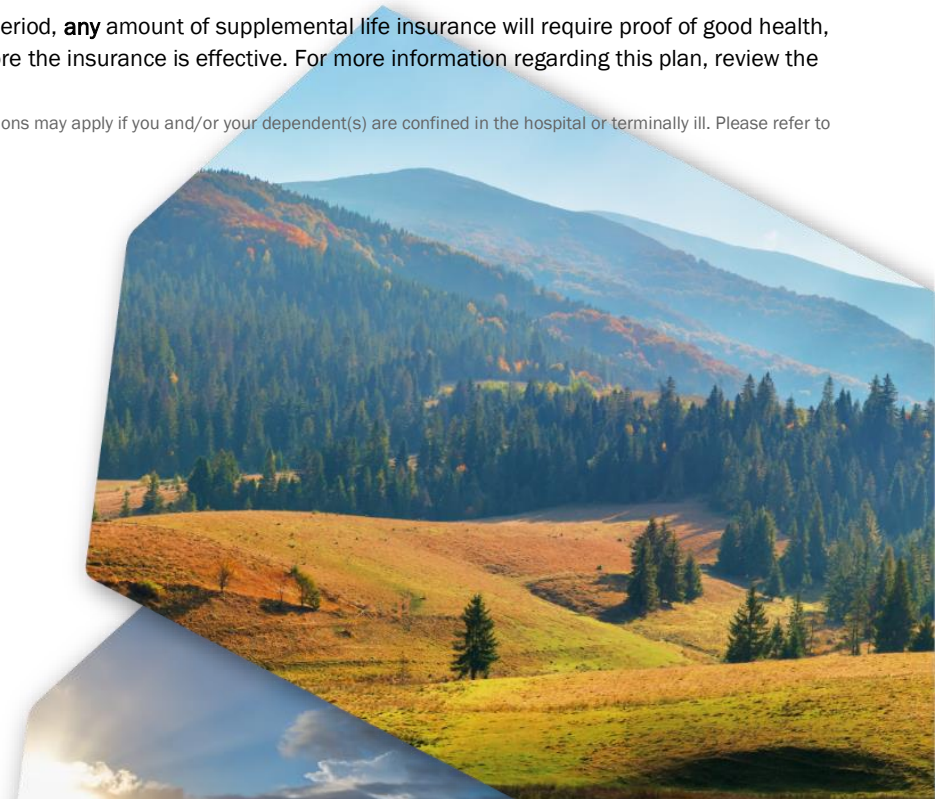
If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Required! Are your beneficiaries up to date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time.
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.
- To select or change your beneficiary, contact Human Resources.



Supplemental Health Plans

Supplemental Health Plans

Be prepared for the unexpected.

Critical Illness Coverage

Critical illness coverage offered on a voluntary basis through Unum pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

What can critical illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance.
- Lost income.
- Everyday expenses such as groceries and utilities.
- Alternative treatments.
- Lodging and travel to a specialist

What are examples of covered illnesses or conditions?

- Cancer.
- Heart Attack.
- Stroke
- Alzheimer's.
- Kidney Failure.
- Organ Transplant.

100% Employee-paid

If you elect the voluntary critical illness plan, 100% of the cost is deducted through payroll deductions.

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$10,000 or $20,000 (All Guaranteed Issue)
Spouse	Up to 50% of Employee benefit election (All Guaranteed Issue)
Child(ren)	Children are automatically covered at 50% of employee
Important:	**Not all diagnoses are covered at the full benefit amounts shown. Some covered diagonses are covered at a percentage of your full election amount. Typcially less severe conditions may be covered at a lower amount.** **This coverage contains a pre-existing exclusion and your services may not be covered as a result. For more information, please contact Unum with any questions.**

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information on this coverage, contact Unum.

Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital insurance offered on a voluntary basis through Unum pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

How can hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments.
- Deductibles.
- Transportation expenses.
- Child care.
- Lodging expenses for a companion.
- Lost income.

Here's an example of how Hospital Insurance works

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5 day hospital stay. Through his primary medical insurance, Trevor owed a $500 deductible and $3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a $1,500 admission benefit plus $200 for each additional day, he was only out of pocket $1,200 instead of $3,500.

Out-of-Pocket Expenses	Hospital Indemnity Plan Benefits
$500 deductible	$1,500 admission benefit
$3,000 co-insurance	$200/day x 4 additional days = $800
Total: $3,500	**Total benefits paid to Trevor: $2,300**

100% Employee-paid

If you elect the voluntary hospital insurance plan, 100% of the cost is deducted through payroll deductions.

Important: **This coverage contains a pre-existing exclusion and your services may not be covered as a result. For more information, we recommend you contact Unum with any questions.**

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information on this coverage, contact Unum.

Accident Insurance Plan

Accident insurance offered on a voluntary basis through Unum provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

How can accident insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses. What are some common covered benefits?

- Emergency room visit.
- Ambulance
- Doctor visits.
- Hospital admission.
- Surgery.
- Medical equipment.
- Outpatient therapy.
- Diagnostic imaging.

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$400
Emergency room care	$150
Physician follow-up ($75 x 2)	$150
Medical Imaging Test	$200
Concussion	$150
Total benefit paid by Accident Plan	**$1,050**

100% Employee-paid

If you elect the voluntary accident insurance plan, 100% of the cost is deducted through payroll deductions.

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information on this coverage, contact Unum.

Short Term Disability

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD)	• Administered by Unum, STD coverage provides a benefit equal to 60% of your weekly earnings, up to $1,500 per week for a period up to 12 weeks. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days.
Important:	• **This coverage contains a pre-existing exclusion and your services may not be covered as a result. For more information, we recommend you contact Unum with any questions.**

Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.

Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

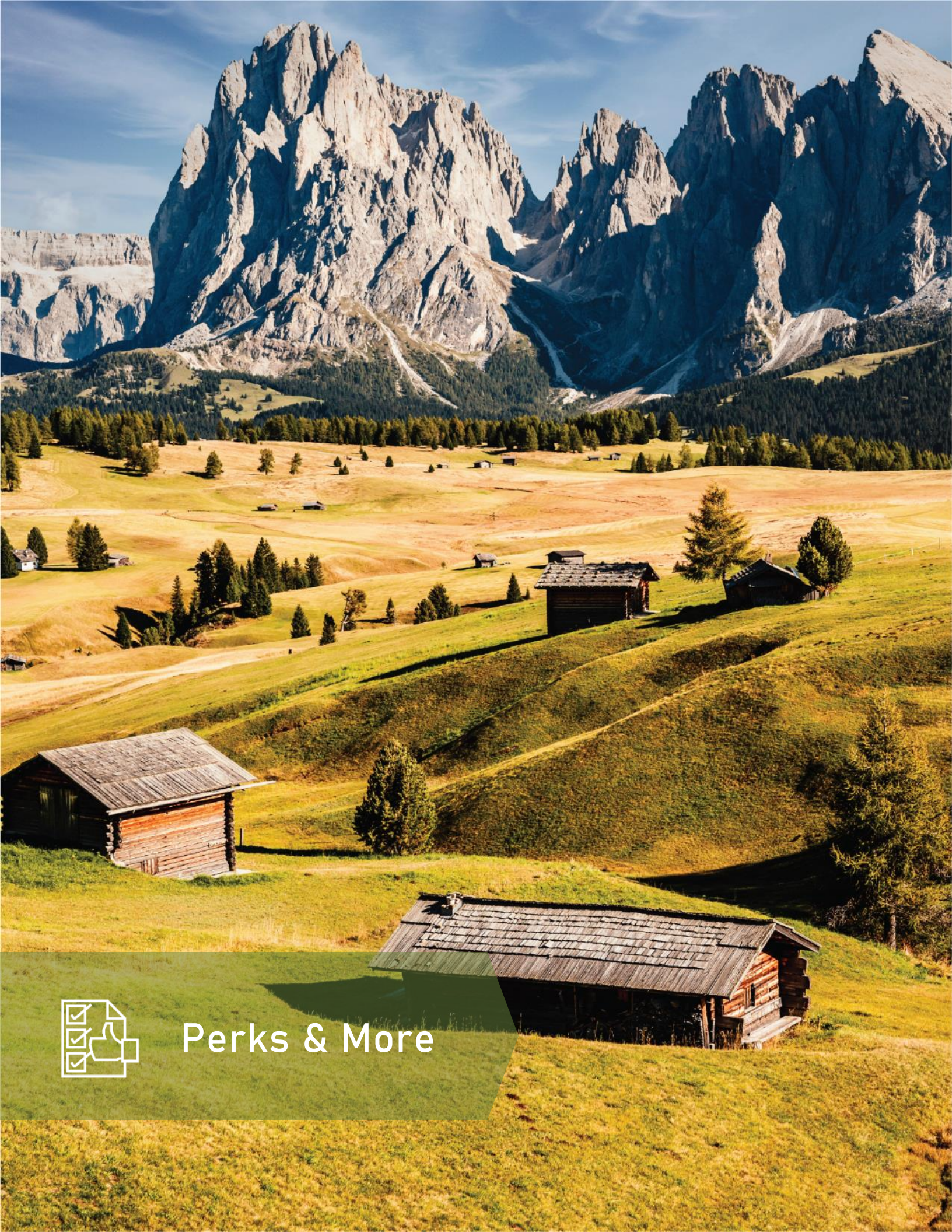
Your free and confidential go-to resource.

We can all use an extra helping hand from time to time. Whether you need support with a personal relationship or professional challenge, or you're seeking guidance on a particular subject, the Employee Assistance Program (EAP) provides the tools you need to thrive. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Number of sessions	Unlimited telephonic and online support with up to three in-person visits
How to access	Phone or face-to-face sessions
Topics may include	Mental Health Support: • Marital, relationship or family problems. • Bereavement or grief counseling. • Substance abuse and recovery. Community Support: • Childcare and eldercare. • Legal services and Identity theft. • Financial support. • Educational materials.
Who can utilize	All employees, dependents of employees, and members of your household

Get in touch:

- By phone: 1.800.854.1446
- Online: unum.com/lifebalance



Perks & More

Perks & More

Let's cover the fun stuff.

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

Holidays

The following paid holidays will be observed:

- New Year's Day.
- President's Day.
- Memorial Day.
- Independence Day.
- Labor Day.
- Alaska Day.
- Veteran's Day.
- Thanksgiving Day and the day after.
- Christmas Day.
- A floating holiday subject to individual choice.

Paid Time Off (PTO)

A combination of paid sick, vacation and other time off is available to support your work-life balance.

Annual Leave is available for full-time and part-time employees working more than 15 hours per week in proportion to hours worked and accrues as follows:

- First 2 years of service 7.38 hours bi-weekly/equivalent to approximately 24 days/year.
- 3.-5 years 8.30 hours bi-weekly/equivalent to approximately 27 days/per.
- 6.-10 years 9.23 hours bi-weekly/equivalent to approximately 30 days/per.
- 10+ years 10.15 hours bi-weekly/equivalent to approximately 33 days/per.

Bereavement leave is provided in the following amounts:

- 3 paid working day(s) up to 24 hours maximum for funeral attendance or to handle matters arising due to the death of an immediate family member (parent, spouse, child, sibling, parent-in-law).

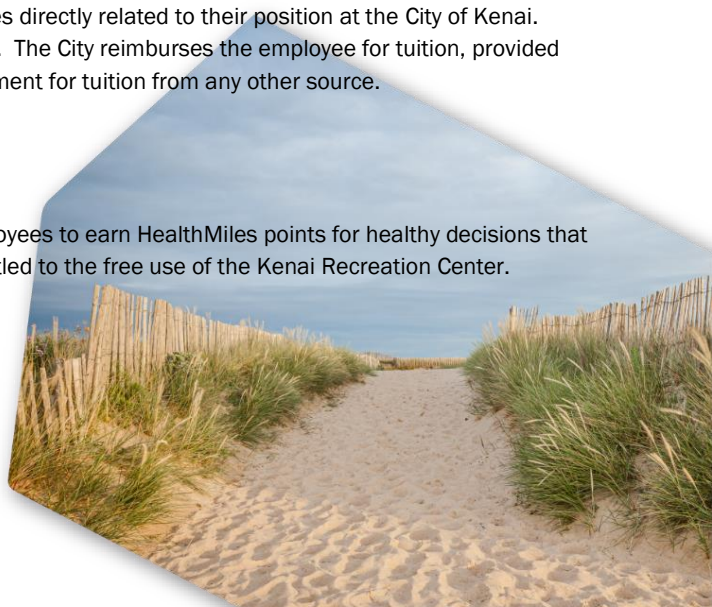
Other time off such as for family or medical reasons may be honored based on state and federal law and employees may participate in a bona fide employer-sponsored medical leave sharing arrangement.

Educational Opportunities

The City of Kenai will reimburse employees for the full amount of tuition for classes directly related to their position at the City of Kenai. Classes must be budgeted and approved in advanced through Human Resources. The City reimburses the employee for tuition, provided courses are completed successfully and the employee is not receiving reimbursement for tuition from any other source.

Wellness Program

The City of Kenai offers a wellness program through Virgin Pulse that allows employees to earn HealthMiles points for healthy decisions that may be redeemed for cash rewards. Additionally, City of Kenai employee are entitled to the free use of the Kenai Recreation Center.



Costs, Directory, & Required Notices

Cost Breakdown

All of your rates in one place.

KENAI
The Best Place To ALASKA

The rates below are effective January 1, 2023 – December 31, 2023.

Coverage Level	Total Cost	Contribution	Payroll Deduction
	Monthly	The City of Kenai	Employee
Full – Time Employees			
$2,000 Medical Deductible plan			
Medical / Dental / embedded Vision			
Employee Only	$1,182	$1,028	$154
Employee and Spouse	$2,369	$2,061	$308
Employee and Child(ren)	$2,148	$1,869	$279
Employee and Family	$3,260	$2,836	$424
$3,000 Medical Deductible plan			
Medical / Dental / embedded Vision			
Employee Only	$1,167	$1,015	$152
Employee and Spouse	$2,335	$2,031	$304
Employee and Child(ren)	$2,127	$1,850	$277
Employee and Family	$3,187	$2,765	$413
Part – Time Employees			
$2,000 Medical Deductible plan			
Medical / Dental / embedded Vision			
Employee Only	$1,104	$514	$590
Employee and Spouse	$2,215	$514	$1,701
Employee and Child(ren)	$1,995	$514	$1,481
Employee and Family	$3,107	$514	$2,593
$3,000 Medical Deductible plan			
Medical / Dental / embedded Vision			
Employee Only	$1,047	$508	$539
Employee and Spouse	$2,098	$508	$1,590
Employee and Child(ren)	$1,890	$508	$1,382
Employee and Family	$2,942	$508	$2,434
Unum - Group Life & AD&D	Varies	100%	0%
Unum Accident / Cancer / Hospital / STD	Varies– see next page	0%	100%
Unum Voluntary Life and AD&D	Varies – see next page	0%	100%

Unum Supplemental Costs

Critical Illness

Monthly costs		
Age	Employee coverage: $10,000 Spouse coverage: $5,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$3.58	$2.73
25 - 29	$4.38	$3.13
30 - 34	$5.58	$3.73
35 - 39	$7.08	$4.48
40 - 44	$9.58	$5.73
45 - 49	$13.48	$7.68
50 - 54	$19.28	$10.58
55 - 59	$26.68	$14.28
60 - 64	$38.18	$20.03
65 - 69	$55.78	$28.83
70 - 74	$83.68	$42.78
75 - 79	$117.78	$59.83
80 - 84	$164.08	$82.98
85+	$258.68	$130.28

Monthly costs		
Age	Employee coverage: $20,000 Spouse coverage: $10,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$5.28	$3.58
25 - 29	$6.88	$4.38
30 - 34	$9.28	$5.58
35 - 39	$12.28	$7.08
40 - 44	$17.28	$9.58
45 - 49	$25.08	$13.48
50 - 54	$36.68	$19.28
55 - 59	$51.48	$26.68
60 - 64	$74.48	$38.18
65 - 69	$109.68	$55.78
70 - 74	$165.48	$83.68
75 - 79	$233.68	$117.78
80 - 84	$326.28	$164.08
85+	$515.48	$258.68

Hospital Coverage

Hospital Insurance monthly rates	
Age	Employee
17-49	$30.62
50-59	$39.80
60-64	$55.03
65+	$82.16

Accident Coverage

Monthly Premium	
You	$16.14
You and your spouse	$26.67
You and your child(ren)	$29.03
You, your spouse and child(ren)	$39.56

Short-Term Disability

Disability worksheet

1 Calculate your weekly disability benefit.

$_____ ÷ 52 = $_____ x 60% = $_____

Your annual earnings | Your weekly earnings | (Max % of income covered) | Max weekly benefit available (if the amount exceeds the plan max of $1,500, enter $1,500.

2 Calculate your cost per paycheck.

$_____ ÷ 10 = $_____ x $_____ = $_____ x 12 = $_____ ÷ 12 = $_____

Your weekly benefit amount | Your rate | Your monthly cost | Your annual cost | Number of paychecks per year | Your cost per paycheck

Age	Rates
15-24	$0.250
25-29	$0.570
30-34	$0.890
35-39	$0.680
40-44	$0.480
45-49	$0.660
50-54	$0.800
55-59	$1.090
60-64	$1.330
65+	$1.330

Voluntary Life and AD&D

	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $_____	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $_____	= $_____
Child	$_____,000	÷ $2,000 = $_____	X $_____	= $_____
			Total cost	

AD&D	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $0.500	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $0.250	= $_____
Child	$_____,000	÷ $2,000 = $_____	X $0.100	= $_____
			Total cost	

Employee monthly rate	
Age	Per $10,000 of coverage
	Cost
15-24	$0.620
25-29	$0.620
30-34	$0.740
35-39	$1.240
40-44	$1.800
45-49	$2.790
50-54	$4.220
55-59	$6.010
60-64	$18.680
65-69	$19.220
70-74	$36.520
75+	$36.520

Spouse monthly rate
Per $5,000 of coverage
Cost
$0.310
$0.310
$0.370
$0.620
$0.900
$1.400
$2.110
$3.000
$9.340
$9.610
$18.260
$18.260

Child monthly rate
$0.240 per $2,000 of coverage

AD&D monthly rates		
	Coverage amount	Rate
Employee	per $10,000 of coverage	$0.500
Spouse	per $5,000 of coverage	$0.250
Child	per $2,000 of coverage	$0.100

Directory & Resources

Below, please find important contact information and resources for The City of Kenai.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources		907.283.8223	
Medical / Dental / Vision			
Premera Blue Cross Blue Shield of Alaska	4001919	800.508.4722	www.premera.com
Flexible Spending Accounts			
Navia	KNI	1-800-669-3539	www.naviabenefits.com
Health Reimbursement Arrangement			
Navia	KNI	1-866-897-1996	www.naviabenefits.com
Life / Voluntary Life/ Supplemental			
Unum	612660	1.866.679.3054	www.unum.com
Employee Assistance Plan			
Unum		800.584.1446	www.unum.com/lifebalance

The City of Kenai Health and Welfare Benefits Annual Notice Packet

For the January 1, 2023 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact us at 907.283.8223

Medicare Part D
Creditable Coverage Notice
Important Notice from The City of Kenai
About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to 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 while enrolled in The City of Kenai coverage as an active employee, please note that your The City of Kenai coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare

prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in The City of Kenai coverage as a former employee.

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

[When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with [The City of Kenai] 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 at 907-283-7535. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The City of Kenai 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).

Name of Entity/Sender: The City of Kenai
Contact--Position/Office: Human Resources

Address: 210 Fidalgo Ave, Kenai, AK 99611
Phone Number: 907-283-7535

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in The City of Kenai group health coverage 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

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

The City of Kenai sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of The City of Kenai, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by The City of Kenai, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact The City of Kenai HIPAA Privacy Officer:

City of Kenai
Attention: HIPAA Privacy Officer
210 Fidaldo Ave
Kenai, AK 99611

Effective Date

This Notice as revised is effective January 1, 2023.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental,

investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

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

GEORGIA – 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

INDIANA – Medicaid

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)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

KENTUCKY – 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://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

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

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa

Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid

Website:
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

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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	SOUTH DAKOTA – 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: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone:1-800-432-5924 CHIP Phone:1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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 July 31, 2022, 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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a 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. If you would like more information on WHCRA benefits, contact your plan administrator at 907.283.7535.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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 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).

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed

later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resource, 210 Fidalgo Ave, Kenai, AK 99661.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect

COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

City of Kenai, Human Resources, 210 Fidalgo Ave, Kenai, AK 99611.

Notes

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www.MarshMMA.com | CA Insurance Lic: 0H18131