

Employee Benefits

REQUIRED LEGAL NOTICES



King County

Each year, King County provides you with important benefit notices so you are aware of your rights under federal law. Please carefully review the following notices. If you have questions or would like more information, contact Benefits, Payroll and Retirement Operations at 206-684-1556 or kc.benefits@kingcounty.gov.

Plan Documents

Summary of Benefits and Coverage and Uniform Glossary: A short, easy-to-understand summary of each plan's benefits and coverage, and a glossary of standard terms, is provided for each benefit plan at kingcounty.gov/benefits.

Summary Plan Description: A Summary Plan Description (also referred to as plan Booklet or Plan Document) that describes the important benefit features, rights, and obligations of your plan is provided for each benefit plan at kingcounty.gov/benefits.

Outbreak Period Notice

Timing extensions expiring for HIPAA Special Enrollment events, COBRA coverage, and ERISA claims and appeals

The U.S. Department of Labor and IRS announced temporary extensions of certain plan deadlines during the COVID-19 pandemic. Under these extensions, plan participants and dependents were given extra time to make HIPAA Special Enrollment election changes, file ERISA claims and appeals, receive notifications about COBRA elections, and make COBRA premium payments. This temporary extension became effective March 1, 2020, and created individual extension deadlines.

What this means for you and your family

During the period that began March 1, 2020, to present, individual timing extensions can only be extended for a maximum of 12 months. If the original deadline would have been on or after March 1, 2020, your new deadline will now be one-year from your original deadline. For example, if you would have been required to notify the plan of a HIPAA Special Enrollment event (e.g., the birth of a child) by July 1, 2021, your deadline to request an election change under the HIPAA rules will now be June 30, 2022.

Your deadline could end sooner than one year once the National Emergency declaration ends. At the time of this notice, the National Emergency declaration remains ongoing. However, the extensions described here will only last for the *shorter* of the following two periods: one year from your original deadline, or the period between your deadline (if after March 1, 2020) and 60 days following the end of the National Emergency declaration.

If you delayed any of the following due to your timing extension, **you should act quickly or you may lose your ability to exercise your rights under the plan for:**

- Requesting enrollment under the plan due to a HIPAA Special Enrollment event;
- Filing an ERISA claim or appeal; or
- Enrolling in or making premium payment(s) for your COBRA continuation coverage

If you did not experience a HIPAA Special Enrollment or COBRA qualifying event, or did not have the need to file an ERISA claim or appeal, you do not need to take any action.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services: If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance-billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center: When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may not ask you to give up your protections not to be balance-billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).

- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may you may file a complaint with the federal government at www.cms.gov/nosurprises/consumers or by calling 800-985-3059; or file a complaint with the Washington State Office of the Insurance Commissioner at their website or by calling 800-562- 6900.

Patient Protection Disclosure

SmartCare and KingCare Select plans require the designation of a primary care provider. Employees in all King County medical plans have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your medical plan at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your medical plan or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, such as obtaining prior authorization for certain services, following a pre-approved treatment plan, and using referral procedures. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical plan at the number on the back of your ID card.

Premium Assistance Under Medicaid and Children's Health Insurance Program

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (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 healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Washington, contact the Medicaid office to find out if premium assistance is available hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program or 800-562-3022, ext. 15473.

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 call 877-KIDS NOW or 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 askebsa.dol.gov or call 866-444-EBSA (3272).

Your Prescription Drug Coverage and Medicare

This notice explains the options you may have under Medicare prescription drug coverage and can help you decide whether you want to enroll. 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.

Medicare prescription drug coverage became available to everyone with Medicare in 2006. 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 prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

King County has determined that prescription drug coverage through our medical plans is, on average for all plan participants, expected to pay out as much as the 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.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, you will need to discontinue your King County medical plan, which includes coverage for other health expenses in addition to prescription drug coverage. Be aware that you may not be able to get this coverage back.

If you drop or lose your King County coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay more to join a Medicare drug plan later. If you go 63 days or longer without creditable prescription drug coverage, your monthly premium may go up by at least one percent per month for every month you did not have that coverage. For example, if you go 19 months without 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.

More 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 [medicare.gov](https://www.medicare.gov).
- Call your state Health Insurance Assistance Program at the number in your Medicare & You handbook.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, go to [socialsecurity.gov](https://www.socialsecurity.gov) or call 800-772-1213 (TTY 800-325-0778).

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).

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed by King County and how you can get access to this information.

Your Rights

When it comes to your health information, you have the following rights.

- Get a copy of health and claims records: You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records: You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
- Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- Get a list of those with whom we’ve shared information: You can ask for a list of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting per year for free but will charge a reasonable, cost-based fee for another one within 12 months.
- Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- If you believe your privacy rights have been violated, you may file a complaint in writing with King County Benefits, Payroll and Retirement Operations at The Chinook Building CNK-ES-0240, 401 Fifth Avenue, Seattle, WA 98104. You can also 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 [hhs.gov/ocr/privacy/hipaa/complaints/](https://www.hhs.gov/ocr/privacy/hipaa/complaints/). We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We *never* share your information unless you give us written permission for marketing purposes, or the sale of your information.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

- Help manage the health care treatment you receive: We can use your health information and share it with professionals who are treating you.
- Run our organization: We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- Pay for your health services: We can use and disclose your health information as we pay for your health services.
- Administer your plan: We may disclose your health information to your health plan sponsor for plan administration.

We are allowed or required to share your information in other ways, as follows – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

<https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>.

- Help with public health and safety issues: We can share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety.
- Do research: We can use or share your information for health research.
- Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director: We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you or workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; for special government functions such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change

your mind. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. For more information see: hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Women’s Health and Cancer Rights Act Notice

As required by the Women’s Health and Cancer Rights Act of 1998, King County’s health plans provide benefits for mastectomy-related services, including all stages of reconstruction; surgery to achieve symmetry between the breasts; prostheses; and treatment of complications resulting from a mastectomy, including lymphedema.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

Notice of Special Enrollment Rights

If you have declined enrollment in King County’s health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under the plan[s] without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

King County will also allow a special enrollment opportunity if you or your eligible dependents either: 1) Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible, or, 2) Become eligible for a state’s premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in a King County group health plan. Note that this 60-day extension doesn’t apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Employee Rights Under the Family and Medical Leave Act

Leave entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care
- To bond with a child (leave must be taken within 1 year of the child’s birth or placement)
- To care for the employee’s spouse, child, or parent who has a qualifying serious health condition
- For the employee’s own qualifying serious health condition that makes the employee unable to perform the employee’s job
- For qualifying exigencies related to the foreign deployment of a military member who is the employee’s spouse, child, or parent

An eligible employee who is a covered service member’s spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious

injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule. Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures. Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified. Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility. Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights. For additional information or to file a complaint, contact U.S. Department of Labor Wage and Hour Division at dol.gov/whd, 866-487-9243, or TTY: 1-877-889-5627.