Human Resources
Address 190 Queen Anne Ave N
Seattle, WA 98109
Telephone 206–615-3300
TDD 1-800-833-6388
Website www.seattlehousing.org

January 27, 2022

These notices are for your information only. No immediate action is required.

Dear Seattle Housing Authority Employee:

SHA is pleased to provide employees with several health care plans for their personal needs. The following pages contain annual notices about your City health care coverage; not all of them may apply to you. These notices (summarized below) are for your information only; no immediate action is required. **Please keep this information with your other important papers** to refer to them later.

Women's 1998 Health and Cancer Rights Act (page 2)
→ This notice applies to employees and family members with medical coverage.

Grandfathered Plan Notice (page 2)
→ This notice applies to employees and family members with medical coverage.

Medicare Part D (Creditable Coverage) (pages 3-5)
→ This notice applies to employees and family members enrolled in a City of Seattle-sponsored Aetna or Kaiser Permanente medical plan and confirms your prescription drug coverage is at least as good as Medicare Part D coverage.

Initial Notice of COBRA Continuation Coverage Rights (pages 6-10)
→ This notice applies to employees and family members with medical/dental/vision coverage.

Notices of Privacy Practices (pages 11-15)
→ This notice applies to employees and family members with medical/dental/vision coverage; describes your health information rights.

Medicaid and the Children's Health Insurance Program (CHIP) Notification (page 16)
→ This notification describes premium assistance through the State.

Privacy Notice (pages 17-18)
→ This notice describes the protection of your data.

Health Care Exchange Notice (pages 19-21)
→ This notice describes the medical coverage options through the Health Care Exchange.

If you have questions about these notices, please call Benefits at (206) 615-3328.

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Women's 1998 Health and Cancer Rights Act

Annual Notice

As required by the Women's Health and Cancer Rights Act of 1998, the group health plans offered by the City of Seattle provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

A group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles, copays, and coinsurance amounts consistent with those that apply to other benefits under the plan. Contact your health plan for more information.

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Health Care Reform Notice -- Grandfathered Plan Status Disclosure

The City of Seattle's Aetna and Kaiser Permanente medical plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As the Affordable Care Act permits, a grandfathered health plan can preserve specific basic health coverage that was already in effect when Congress enacted that law. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as eliminating lifetime limits on benefits. Questions? Contact Benefits at (206) 615-3328.

Important Notice from the City of Seattle About Your Prescription Drug Coverage and Medicare for Plan Year 2022

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 Seattle 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 critical 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 Seattle has determined that the prescription drug coverage offered by Aetna, Kaiser Permanente, and UnitedHealth Care is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. It 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 during their annual enrollment period.

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Seattle coverage will be affected. Your current prescription drug coverage is part of a City of Seattle medical plan. You cannot drop your City of Seattle prescription drug coverage unless you also drop your City of Seattle medical coverage. If you enroll in an individual Medicare Part D prescription drug plan and drop your creditable coverage with the City of Seattle, you and your dependents will not be able to return to the City of Seattle plan. Suppose you or your dependents enroll in a different employer active employee or retiree group medical plan with creditable Part D coverage and drop your creditable coverage with the City of Seattle. In that case, you and your dependents will be able to return if you involuntarily lose coverage on the employer group plan. It is essential you compare your current plan, including which drugs are covered, with the coverage and costs of Medicare part D plans.

If you decide to join a Medicare drug plan and drop your current City of Seattle 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 Seattle 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 November to join.

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

Contact your medical plan for further information. **NOTE:** You'll receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through the City of Seattle 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 guide 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 whether or not you are required to pay a higher premium (a penalty).

Date:	10/29/2021
Name of Entity/Sender:	Seattle Housing Authority
Contact--Position/Office:	Human Resources Benefits

Address: P.O. Box 19028
Seattle, WA 98109
Phone Number: (206) 615-3328

CMS Form 10182-CC

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
It is important that all covered individuals (employee, spouse/domestic partner, and eligible dependent children, if able) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent not living at your address, please provide written notification to SHA's Benefits Team so SHA can send a notice to that dependent as well.

You are receiving this notice because you may have recently become covered under one or more of the following group health plans: Aetna, Kaiser Permanente, Delta Dental of Washington, Dental Health Services, VSP, UnitedHealthCare, and the Health Flexible Spending Account (Health FSA). This notice contains important information about your right to COBRA continuation coverage, a temporary extension of group health coverage under a plan under certain circumstances when coverage would otherwise end due to a qualifying event. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plans listed above (medical, dental, vision, and the Health FSA) and not to any other benefits offered by the City of Seattle (such as life insurance, long term disability, or accidental death and dismemberment insurance). **Should an actual qualifying event occur in the future, the Seattle Housing Authority will send you additional information and an election notice at that time.**

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available when you would otherwise lose your group health coverage under a plan. It can also become available to your spouse/domestic partner and dependent children, if they are covered under a plan, when they would otherwise lose their group health coverage under the plan. This notice does not fully describe COBRA coverage or other rights under a plan. For additional information about your rights and obligations under a plan and federal law, you should review the plan booklet or contact the Seattle Housing Authority Benefits Team, which is the COBRA Plan Administrator. A plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are in this notice. After a qualifying event occurs and any required notice of that event is correctly provided to SHA's Benefits Team, COBRA coverage must be offered to each person losing plan coverage who is a "qualified beneficiary." You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under a plan is lost because of the qualifying event. Under a plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage.

Who is entitled to elect COBRA Continuation Coverage?

If you are an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason.

If you are the spouse/domestic partner, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because any of the following qualifying events happens:

- your spouse/domestic partner dies;
- your spouse's/domestic partner's hours of employment are reduced;
- your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse, or you terminate your domestic partnership. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation occurs within three months of the reduction or elimination of coverage, then the divorce or legal separation will be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if they lose group health coverage under a plan because any of the following qualifying events happen:

- 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 child stops being eligible for coverage under a plan as a "dependent child."

When is COBRA Continuation Coverage Available?

When the qualifying event is the end of employment, reduction of hours of work, or death of the employee, a COBRA election notice will be made available to qualified beneficiaries. You do not need to notify the Benefits Representative in your department of the occurrence of any of these three qualifying events. However, notice must be provided to your department's Benefits Representative for other qualifying events, as explained below in the section entitled "You Must Give Notice of Some Qualifying Events."

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, termination of domestic partnership, or a dependent child's loss of eligibility for coverage as a dependent child), a COBRA election notice will be available to you only if you complete and submit a *Health Care Benefits Change Form* to the SHA Benefits Team within 60 days after the date on which the qualified beneficiary loses or would lose coverage under the terms of the plan as a result of the qualifying event. If this procedure is not followed during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE. (A *Health Care Benefits Change Form* is available from SHA's Benefits Team.)

Electing COBRA Coverage

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses/domestic partners (if the spouse/domestic partner is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA coverage is

not elected within the 60-day election period specified in the COBRA election notice WILL LOSE THEIR RIGHT TO ELECT COBRA COVERAGE.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

How Long Does COBRA Coverage Last?
COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce, legal separation or termination of domestic partnership; or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months BEFORE the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse/domestic partner and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

Extension of Maximum Coverage Period
If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

Disability extension of 18-month period of continuation coverage
If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a

total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above.)

The disability extension is available only if you complete and submit a *Notice of Disability* and a copy of the Social Security Administration's determination of disability to the COBRA Plan Administrator: (a) during the 18 months after the covered employee's termination of employment or reduction of hours, and (b) within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of a plan as a result of the covered employee's termination of employment or reduction of hours.

If these procedures are not followed or if the notice is not provided to the COBRA Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. You can obtain a copy of a *Notice of Disability* from the COBRA Plan Administrator.

Second qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse/domestic partner and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Plan Administrator. This extension may be available to the spouse/domestic partner and any dependent children receiving COBRA coverage if the employee or former employee dies, gets divorced or legally separated, or terminates a domestic partnership; or if the dependent child stops being eligible under a plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under a plan had the first qualifying event not occurred. (This extension is not available to the spouse/domestic partner and any dependent children under a plan when a covered employee becomes entitled to Medicare after electing COBRA coverage .)

This extension due to a second qualifying event is available only if you notify the COBRA Plan Administrator by completing and submitting a *Notice of Second Qualifying Event* within 60 days after the date of the second qualifying event. You can obtain a copy of a *Notice of Second Qualifying Event* from the COBRA Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the COBRA Plan Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Health Care FSA Component

COBRA coverage under the Health Care FSA will be offered to qualified beneficiaries. Health Care FSA COBRA coverage will consist of the Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. Health Care FSA COBRA coverage will consist of the Health FSA

coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and Health Care FSA COBRA coverage will terminate at the end of the plan year.

More Information About Individuals Who May Be Qualified Beneficiaries

- *Children born to or placed for adoption with the covered employee during COBRA coverage period*
  A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in a plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in a plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

- *Alternate recipients under QMCSOs*
  A child of the covered employee who is receiving benefits under a plan pursuant to a qualified medical child support order (QMSCO) received by the COBRA Plan Administrator during the covered employee's period of employment with the City of Seattle is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep SHA Human Resources staff informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to SHA's Human Resources staff.

If You Have Questions

Questions concerning your Plan or COBRA coverage should be addressed to the:

HR Benefits Administrator
Seattle Housing Authority
190 Queen Anne Avenue N.
PO Box 19028
Seattle, WA 98109 **Phone**: (206) 615-3328

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.

Safeguarding Your Protected Health Information

The City of Seattle self-insured group health plans administered by Aetna, Inc., Kaiser Permanente, Delta Dental of Washington, VSP and the Health Care Flexible Spending Account Plan administered by Navia Benefits Solution (the "Plans") are designed to protect the privacy of your health information. The Plans are required by applicable federal and State laws to maintain the privacy of your Protected Health Information. This notice explains the Plans' privacy practices, their legal duties, and your rights concerning your Protected Health Information (referred to in this notice as "PHI"). The term "PHI" includes any information that is personally identifiable to you and that is transmitted or maintained by the Plans, regardless of form (oral, written, electronic). This includes information regarding your health care and treatment, and identifiable factors such as your name, age, and address. The Plans will follow the privacy practices described in this notice while it is in effect.

Why do the Plans collect Protected Health Information?

The Plans collect PHI for a number of reasons, including to determine the appropriate benefits to offer individuals, to pay claims, to provide case management services, and to provide quality improvement services.

How do the Plans collect Protected Health Information?

The Plans collect PHI through covered members, their health care providers, and the Plans' Business Associates. For example, the Plans' claims administrators, which are Business Associates, receive PHI from health care providers, such as through the submission of a claim for reimbursement of covered benefits.

How do the Plans safeguard your Protected Health Information?

The Plans protect your PHI by:

- Treating all of your PHI that is collected as confidential;
- Stating confidentiality policies and practices in the Plans' group health plan administrative procedure manual, as well as disciplinary measures for privacy violations;
- Restricting access to your PHI to those individuals who need to know your personal information in order to provide services to you, such as paying a claim for a covered benefit;
- Only disclosing your PHI that is necessary for a service company to perform its function on the Plans' behalf, and the company agrees to protect and maintain the confidentiality of your PHI; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and State regulations to guard your PHI.

How do the Plans use and disclose your Protected Health Information?
The Plans will not disclose your PHI unless they are allowed or required by law to make the disclosure, or if you (or your authorized representative) give the Plans permission. Uses and disclosures, other than those listed below, require your authorization. If you authorize a Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use your PHI for the reasons covered by the written authorization. If there are other legal requirements under applicable state laws that further restrict a Plan's use or disclosure of your PHI, it will comply with those legal requirements as well. Following are the types of disclosure the Plans may make as allowed or required by law:

> **Treatment**: They may use and disclose your PHI for the treatment activities of a health care provider. It also includes consultations and referrals between one or more of your providers. Treatment activities include disclosing your PHI to a provider in order for that provider to treat you.

Payment: They may use and disclose your medical information for their payment activities, including the payment of claims from physicians, hospitals and other providers for services delivered to you. Payment also includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, utilization review and preauthorizations).

For example, a Plan may tell a physician whether you are eligible for benefits or what percentage of the bill will be paid by the Plan.

Health Care Operations: They may use and disclose your medical information for their internal operations, including their customer service activities. Health care operations include but are not limited to quality assessment and improvement, disease and case management, medical review, auditing functions including fraud and abuse compliance programs and general administrative activities.

Business Associates: They may also share PHI with third party "business associates" who perform certain activities for the Plans. They require these business associates to afford your PHI the same protections afforded by themselves.

Plan Sponsor: They may disclose your PHI to the Plans' sponsor with your authorization or when required by law to permit it to perform administrative activities.

To You or Your Authorized Representative: Upon your request, a Plan will disclose your PHI to you or your authorized representative. If you authorize a Plan to do so, it may use your PHI or disclose it to the person or entity you name on your signed authorization. After you provide a Plan with an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. In certain situations when disclosure of your information could be harmful to you or another person, a Plan may limit the information available to you, or use an alternative means of meeting your request.

To Your Parents, if You are a Minor: Some state laws concerning minors permit or require disclosure of PHI to parents, guardians, and persons acting in a similar legal status. The Plans will act consistently with the laws of the State where the treatment is provided, and will make disclosures consistent with such laws

Your Family and Friends: If you are unable to consent to the disclosure of your PHI, such as in a medical emergency, a Plan may disclose your PHI to a family member or friend to the extent necessary to help with your health care or with payment for your health care. A Plan will only do so if it determines that the disclosure is in your best interest.

Research; Death; Organ Donation: They may use or disclose your PHI for research purposes in limited circumstances. They may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: They may disclose your PHI if they believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. They may disclose your PHI to appropriate authorities if they reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: They must disclose your PHI when they are required to do so by law, including workers' compensation laws.

Process and Proceedings: They may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement: They may disclose limited information to law enforcement officials.

Military and National Security: They may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. They may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities.

What rights do you have as an individual regarding a Plan's use and disclosure of your Protected Health Information?

You have the right to request all of the following:

Access to your PHI: You have the right to review and receive a copy of your PHI. Your request must be in writing. A Plan may charge you a nominal fee for providing you with copies of your PHI. This right does not include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to other state or federal laws that prohibit a Plan from releasing such information. A Plan may also limit your access to your PHI if they determine that providing the information could possibly harm you or another person; you have the right to request a review of that decision.

Amendment: You have the right to request that a Plan amend your PHI. Your request must be in writing, and it must identify the information that you think is incorrect and explain why the information should be amended. A Plan may decline your request for certain reasons, including if you ask it to change information that it did not create. If a Plan declines your request to amend your records, it will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If a Plan accepts your request to amend the information, it will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in any future disclosures of that information.

Accounting of Disclosures: You have the right to receive a report of instances in which a Plan or its business associates disclosed your PHI for purposes other than for treatment, payment, health care operations, and certain other activities. You are entitled to such an accounting for the 6 years prior to

your request, though not for disclosure made prior to April 14, 2003. A Plan will provide you with the date on which it made a disclosure, the name of the person or entity to whom it disclosed your PHI, a description of the PHI it disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a 12-month period, a Plan may charge you a reasonable fee for creating and sending these additional reports.

Restriction Requests: You have the right to request that a Plan place additional restrictions on its use or disclosure of your PHI for treatment, payment, health care operations or to persons you identify. It may be unable to agree to your requested restrictions. If the Plan does, it will abide by its agreement (except in an emergency).

Confidential Communication: You have the right to request that a Plan communicate with you in confidence about your PHI by alternative means or to an alternative location. If you advise a Plan that disclosure of all or any part of your PHI could endanger you, it will comply with any reasonable request provided you specify an alternative means of communication.

Electronic Notice: If you receive this notice on the Plan sponsor's Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact the Plans using the information listed at the end of this notice to obtain this notice in written form.

Can I "opt out" of certain disclosures?
You may have received notices from other organizations that allow you to "opt out" of certain disclosures. The most common type of disclosure that applies to "opt outs" is the disclosure of personal information to a non-affiliated company so that company can market its products or services to you. Self-insured group health plans must follow many federal and State laws that prohibit them from making these types of disclosures. Because they do not make disclosures that apply to "opt outs," it is not necessary for you to complete an "opt out" form or take any action to restrict such disclosures.

When is this notice effective?
This notice takes effect April 14, 2003, and will remain in effect until the Plans revise it.

What if the Plans change their notice of privacy practices?

The Plans reserve the right to change their privacy practices and the terms of this notice at any time and to make the revised or changed notice effective for PHI they already have about you, as well as any information they receive in the future, provided such changes are permitted by applicable law. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your individual rights, the Plans' duties or other privacy practices stated in this notice. For your convenience, a copy of the Plans' current notice of privacy practices is always available on the Plans' sponsor's Web site at http://inweb/personnel/benefits/docs/NoticeofPrivacyPractices.DOC, and you may request a copy at any time by contacting the Plans' Privacy Officer at the number listed below.

How can you reach us?
If you want additional information regarding the Plan's Privacy Practices, or if you believe the Plans have violated any of your rights listed in this notice, please contact the Seattle Housing Authority Benefits Administrator, Human Resources, 190 Queen Anne Avenue N., PO Box 19028, Seattle, WA 98109; 206-615-3328. If you have a complaint, you also may submit a written complaint to the U.S. Department of Health and Human Services, 2201 6th Ave., Suite 900, Seattle, WA 98121-1831 or by e-mail to OCRComplaint@hhs.gov. Your privacy is one of the Plan's greatest concerns and there is

never any penalty to you if you choose to file a complaint with SHA's Benefit Administator or with the U.S. Department of Health and Human Services.

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

You may be eligible for assistance paying your employer health plan premiums. Contact the Medicaid office for Washington for further information on eligibility.

Washington – Medicaid

Website: bit.ly/Wamed

Phone: 1-800-562-3022 ext. 15473

For more information on special enrollment rights, you can contact either:

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

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

Privacy Notice – Benefit and Deferred Compensation Plans and Programs

What you should know about our protection of your data

Protecting the personal information of individuals eligible to participate in City of Seattle-sponsored benefit plans and programs is a priority for the Benefits and Deferred Compensation Units of the Seattle Department of Human Resources (SDHR). SDHR is compliant with the City of Seattle Privacy Policy. The Benefits and Deferred Compensation Units and our contracted vendors collect, retain and use personal information about City employees, retirees and their covered dependents for the purpose of offering and providing benefits, services and programs.

This notice outlines how SDHR handles the personal information of employees and retirees and their dependents for whom we administer benefits. It is only informational; no action is required. If you have questions regarding this notice, please email the Benefits Unit at benefits.unit@seattle.gov.

What type of information is collected and stored?

The types of information SDHR may collect to administer the City's Benefit and Deferred Compensation plans and programs include identifying information such as name, address, date of birth, gender, email addresses, mailing addresses, social security number and employee ID. This data is stored in the City's Human Resource Information System (HRIS) and some personnel files. It may be gathered through information the employee provided upon hire, information the employee provided in Employee Self Service (ESS), and information about the employee's benefits elections.

Contracted vendors may collect additional metadata and data voluntarily provided by users from user accounts housed on their own platforms to personalize programs and services or provide aggregate utilization reporting. The City of Seattle does not receive individual personal health information from program vendors.

What information is disclosed and how is it used?

The SDHR Benefits and Deferred Compensation Units may share nonpublic personal information about eligible employees, retirees and covered dependents with contracted vendors and service providers. In doing so, we comply with state and federal laws and follow information security practices to protect both physically and electronically stored and transmitted data.

Contracted vendors may use the nonpublic personal information provided by SDHR, such as mailing addresses, email addresses or phone number to communicate changes, to provide program or service information or perform outreach with the expressed written approval from SDHR. Contracted vendors generally include third-party plan administrators, insurance carriers, program administrators, consultants, technology companies and data analytics companies. A current list of contracted Benefit and Deferred Compensation vendors is available at https://bit.ly/34YIOSW. Contracted vendors are prohibited from distributing the nonpublic personal information provided by

SDHR to affiliated partners or other organizations that do not provide services within the contract.

Due to system limitations, employees, retirees and their covered dependents are not able to opt-out of the personal data transmission to contracted vendors. Some vendors may offer participants the option of restricting the use of personal data or limit the use of addresses for communications and notifications on their platforms.

SDHR does not sell individual, personal or aggregate information to third parties for marketing purposes or for their own commercial use.

How do we safeguard your privacy?

We maintain physical, electronic and procedural safeguards to protect your personal information consistent with the Seattle Information Technology Privacy Program.

All Benefit and Deferred Compensation plan contracted vendors are contractually required to protect and secure the personal information of employees, retirees and covered dependents provided by SDHR and adhere to the City's procurement and Seattle Information Technology department contracted terms and conditions for data security.

In addition to the Seattle Information Technology Privacy Program, SDHR requires HIPAA Privacy and Security training for appropriate staff and follows best practices for protecting individuals' confidential information. Access to nonpublic personal data is restricted to only those employees who require access to administer benefit plans or programs.

SDHR may amend privacy practices or enter contracts with additional vendors as authorized by Seattle Municipal Code 4.50.010 (D) at any time. A list of all contracted vendors with whom the SHR's Benefits Unit shares personal information is at https://bit.ly/34YIOSW.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:
SHA Benefits Administrator
206-615-3328

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Seattle Housing Authority	91-6000977
5. Employer address	**6. Employer phone number**
PO Box 19028	206-615-3328

7. City	8. State	9. ZIP code
Seattle	WA	98109

10. Who can we contact about employee health coverage at this job?

Benefits Administrator

11. Phone number (if different from above)	12. Email address
	Humanresources@seattlehousing.org

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Regular and part-time employees in pay status for 80 hours each month.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal spouse, domestic partner, children under age 26 who meet the City's definition of an eligible child

☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? First of the month after hire date, unless hired on the first day of the month.

☐ **No** (STOP and return this form to employee)

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

14. Does the employer offer a health plan that meets the minimum value standard*?
[x] Yes (Go to question 15) [ ] No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 0.00
b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [x] Monthly [ ] Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
[ ] Employer won't offer health coverage
[ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Year

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