Letter of Agreement
by and between
City of Tacoma
and
Tacoma Police Union Local 6, I.U.P.A.
Commissioned Bargaining Unit

Subject: Agreement to Modify Appendix C of the Collective Bargaining Agreement

Effective Date: January 1, 2025

This Letter of Agreement ("LOA") is entered into between the City of Tacoma and the Tacoma Police Union Local 6 ("Union") on behalf of its Commissioned bargaining unit (collectively "the Parties").

The Parties hereby enter into a Letter of Agreement to modify Article 10.8.A.5 and Appendix C of the Parties' Collective Bargaining Agreement (CBA) effective January 1, 2025, as follows:

1. The Parties agree to implement carrier-directed plan design changes to the Kaiser Permanente HMO health plan in response to carrier requirements and state mandates, as set forth in Attachment A.
2. The benefit levels for the Kaiser Permanente HMO plan are set forth in Attachment B.
3. The benefit levels for the Regence PPO and HDHP plans are set forth in Attachment C.
4. The Parties agree to adjust the deductible and employer Health Savings Account (HSA) contributions to the Regence High Deductible Health Plan as follows:
    - 2025 HDHP deductible will change to $2,000 individual / $4,000 family.
    - 2025 Health Savings Account contribution with Wellness Credit: $1,650/$3,300.
    - 2025 Health Savings Account contribution without Wellness Credit: $825/$1,650.
5. Effective January 1, 2025, Article 10.8.A.5 of the CBA is amended to read:
   Contributions to HSA Accounts. Employees who select the Regence HDHP/HSA option will receive an annual contribution to a health savings account in the amount of $500 per year for employees selecting employee-only coverage and $1,000 per year for employees insuring one or more dependents; provided that for employees participating in wellness as described in Section 10.5.C below, the contributions will be $1,250 per year for employees selecting employee-only coverage and $2,500 per year for employees insuring one or more dependents. *Effective January 1, 2025, employees who select the Regence HDHP/HSA option will receive an annual contribution to a health savings account in the amount of $825 per year for employees selecting employee- only coverage and $1,650 per year for employees insuring one or more dependents; provided that for employees participating in wellness as described in Section 10.8.B below, the contributions will be $1,650 per year for employees selecting employee-only coverage and $3,300 per year for employees insuring one or more dependents.* Contributions will be deposited on a biweekly basis. Employees may contribute to their own accounts up to the maximum dollar value permitted by applicable law.

This agreement will become effective upon the final signature of all Parties.

CITY OF TACOMA

City Manager Date

Tacoma Police Chief Date

Human Resources Director Date

Finance Director Date

LOCAL 6, I.U.P.A.

President Date

APPROVED AS TO FORM:

City Attorney Date

Attest:

City Clerk

ATTACHMENT A

Kaiser Standard Contract Changes

Required

Benefit	Explanation
Advanced Care at Home Program	• Advanced Care at Home Program will end 12/31/24

Dialysis (Home and Outpatient)	• During the 90-day waiting period, benefits will continue to be covered at current benefit (outpatient services cost shares). After the 90-day waiting period, if the member chooses to enroll in Original Medicare Part B, the group will cover the Part B premiums. KP is determining the possibility to perform the reimbursement and then allocate/bill the group the associated costs as we do for other claim expenses
	• Once a member chooses to enroll in Original Medicare Part B:
	  • Part B Premiums – covered by the group
	  • ESRD claims expenses – paid by Original Medicare Part B

Drugs – Outpatient Prescription S622HB 1979	• Member will not pay more than $35 for a 30-day supply of at least one inhaled corticosteroid or at least one two pack of epinephrine autoinjectors
Drugs – Outpatient Prescription ESSB 6127 HIV PEP drugs	• One regimen of HIV postexposure prophylaxis will be covered at no member cost share
Balance Billing: Ground Ambulance State Mandate: WA SSB 5986	• In 2024 balance billing applied to out-of-network ambulance providers • In 2025, balance billing will no longer apply, and provide s will be required to write off any amounts billed above the allowed amount
Ambulance	• Emergency ambulance services are covered when transport is to the nearest facility including behavioral health emergency services providers

ATTACHMENT B

KAISER PERMANENTE	
Medical Benefit	**HMO**
	In Network
Deductible (Amount the employee pays)	$100 - Individual $200 - Family 4th Quarter Carryover
Coinsurance (Employee share of the cost of a covered service - unless specified otherwise)	N/A
Copay (Amount the employee pays)	$10 Primary/ $20 Specialist copay + Deductible
Telehealth (Amount the employee pays)	$0
Out-of-Pocket Maximum: Includes deductible, Coinsurance and Copays (Amounts the employee pays)	$1,500 Individual
	$3,000 Family
Preventive Care (Amount the employee pays)	$0
	Not subject to Deductible
Professional (Amount the employee pays)	$10 Primary, $20 Specialist copay + Deductible
Emergency Room Copay (Amount the employee pays)	$150 copay + Deductible Note: only ER services are available out of network for HMO plan
Hospital Stay (Amount the employee pays)	$100 copay x 3 days + Deductible
Outpatient Surgery (Amount the employee pays)	$100 copay + Deductible
Lab/X-Ray (Amount the employee pays)	Inpatient: covered under Hospital Services Outpatient: $0 + Deductible
Vision Exam/Schedule (Amount the employee pays)	Annual Exam: (1 visit every 12 months) $10 copay, Deductible Waived
(Amount the plan pays)	$150 Hardware Allowance (Every 12 months) - Deductible Waived
Pharmacy (Amount the employee pays)	Group Health (30 day supply): Generic $5/ Preferred Brand $25/ Non-Preferred Brand $50 Mail order: 2x for 90 day supply
Monthly Employee Premium Contributions (Single/Family)	$50/$100

ATTACHMENT C

REGENCE MEDICAL	2025	
Medical Benefit	**PPO** **Preferred Network/Participating Network/ Out of Network**	**HDHP/HSA** **Preferred Network/Participating Network/ Out of Network**
Deductible (Amount the employee pays)	$250 Individual (waived for office visits) $500 Family (waived for office visits)	$2,000 Individual $4,000 Family
Coinsurance (Employee share of the cost of a covered service unless specified otherwise)	10%/ 40%/ 50%	20%/40%/50%
Office Visits – Illness or Injury (Amount the employee pays)	$20 office visit copay/ 40% after $20 copay / 50% after $20 copay	After deductible 20% / 40% / 50%
Telemedicine (through MD Live)	$10 copay	After Deductible 20%
Out-of-Pocket Maximum: Includes deductible, Coinsurance and Copays (Amounts the employee pays)	$1,500 Individual	$3,000 Individual
	$3,000 Family	$6,000 Family
Preventive Care (Amount the employee pays)	0% / 0%/ 50% Not Subject to Deductible	0% / 0%/ 50% - Not Subject to Deductible
Professional (Amount the employee pays)	After Deductible 0% / After Deductible 40% / 50%	After Deductible 20% / After Deductible 40%/ After Deductible 50%
Emergency Room Copay (Amount the employee pays)	After $150 copay and Deductible 10% / 10% / 10% (Facility) After Deductible 0% / 0% /0% (Professional)	After Deductible 20%/20%/20% (Facility) After Deductible 20%/20%/20% (Professional)
Hospital Stay (Amount the employee pays)	After Deductible 10% /40%/ 50% (Facility) After Deductible 0% / 40%/ 50% (Professional)	After Deductible 20% / 40%/ 50% (Facility) After Deductible 20%/ 40%/ 50% (Professional)
Outpatient Surgery (Amount the employee pays)	After Deductible 10% / 40%/ 50% (Facility) After Deductible 0% /40%/ 50% (Professional)	After Deductible 20% / 40%/ 50% (Facility) After Deductible 20%/ 40%/ 50% (Professional)
Lab/X-Ray (Amount the employee pays)	After Deductible 0% / 40%/ 50%	After Deductible 20% / 40%/ 50%
Vision Exam/Schedule	No hardware	No hardware

REGENCE MEDICAL	2025		
Medical Benefit	**PPO** **Preferred Network/Participating Network/ Out of Network**	**HDHP/HSA** **Preferred Network/Participating Network/ Out of Network**	
Pharmacy (Amount the employee pays)	100% coinsurance up to the following for a (30 day) supply: Generic: $5 Max Brand - Formulary: $35 Max Brand - Non-Formulary: $60 Max Specialty - Formulary: $75 Max Specialty - Non-Formulary: $150 Max Mail Order: 90 days for 2 copays *Low Value Drug Exclusion List added to exclude high-cost drugs that have a lower cost alternative	Retail or Mail Order – Up to 90-day supply and up to 30-day supply for covered self-administrable injectable medication. After Deductible 20% - member may be balance billed when non-participating pharmacy is used. *Rx list includes drugs in certain categories that will not be subject to the plan deductible. It includes generic medications and formulary brand-name medications specifically designated for treatment of chronic diseases. *Low Value Drug Exclusion List added to exclude high-cost drugs that have a lower cost alternative	
HSA IRS Annual Contribution Limits* (~~2023~~ 2025 limits shown)	N/A	**$4,300/$8,550*** **(Employee Family)**	
City Annual Contributions to Health Savings Account **(prorated per pay period)**		EE Only	EE+Family
		$825 w/o Wellness **$1,650 with Wellness**	**$1,650 w/o Wellness** **$3,300 with Wellness**
Monthly Employee Premium Contributions (Single/Family)	$50/$100	$50/$100	

***Annual limits are subject to change by the IRS.**

Kaiser Permanente	2025
Medical Benefit	**HMO**
	In Network
Deductible (Amount the employee pays)	$100 - Individual $200 - Family
Coinsurance (Employee share of the cost of a covered service - unless specified otherwise)	N/A
Copay (Amount the employee pays)	$10 Primary/ $20 Specialist copay + Deductible
Out-of-Pocket Maximum: Includes deductible,	$1,500 Individual
Coinsurance and Copays (Amounts the employee pays)	$3,000 Family
Preventive Care (Amount the employee pays)	$0 Not subject to Deductible
Professional (Amount the employee pays)	$10 Primary, $20 Specialist copay + Deductible
Emergency Room Copay (Amount the employee pays)	$150 copay + Deductible Note: only ER services are available out of network for HMO plan
Hospital Stay (Amount the employee pays)	$100 copay x 3 days + Deductible
Outpatient Surgery (Amount the employee pays)	$100 copay + Deductible
Lab/X-Ray (Amount the employee pays)	Inpatient: covered under Hospital Services Outpatient: $0 + Deductible

Kaiser Permanente	2025
Medical Benefit	**HMO**
	In Network
Vision Exam/Schedule (Amount the employee pays) (Amount the plan pays)	Annual Exam (1 visit every 12 months) $10 copay, Deductible Waived $150 Hardware Allowance (Every 12 months) - Deductible Waived
Pharmacy (Amount the employee pays)	Kaiser Permanente (30 day supply): Generic $5/ Preferred Brand $25/ Non-Preferred Brand $50 Mail order: 2x for 90 day supply
Monthly Employee Premium Contributions (Single/Family)	$50/$100