If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 18 for more details.
Your Benefit Choices

Welcome to the University of Puget Sound! We are pleased to offer you a comprehensive benefits package. Eligible faculty and staff may choose to participate in the following benefit plans and programs:

» Medical and Prescription Drugs
» Dental
» Vision
» Health Reimbursement Arrangement
» Flexible Spending Accounts – healthcare and dependent care
» Short and Long Term Disability Plans
» Employee Assistance Program (EAP)
» Life and Accidental Death and Dismemberment (AD&D) Insurance
» Retirement Benefits

The Puget Sound benefits program gives you choices of benefits and coverage amounts that are right for you. We provide every eligible faculty and staff member with medical, annual vision exam, prescription drug and life/AD&D coverage. This summary highlights some of the main features of your benefit package so that you can make informed decisions about what coverage is right for you.

BENEFIT ENROLLMENT INSTRUCTIONS:

1) Review this Benefit Guide for a summary of the benefits offered.

2) Use our Benefits Election worksheet to determine which benefits you intend to select and their cost.

3) Complete your Benefit Enrollment/Change Form. Make sure to sign and date your forms.

4) Submit your Benefit Enrollment/Change Form to human resources by:
   a. delivering in person to Howarth Hall 016
   b. sending through campus mail to CMB #1064 OR
   c. Scanning and emailing to benefits@pugetsound.edu

5) Include an Affidavit of Marriage or Domestic Partnership Form if you plan to enroll a spouse or domestic partner for the first time.

6) Include a UNUM Beneficiary Designation Form to appoint a beneficiary for your life insurance.

This guide briefly summarizes the benefit choices provided by the University of Puget Sound and is based on current university programs, policies, and practices. This guide does not contain detailed information regarding the various benefits described. For detailed information, consult the plan documents and insurance booklets. If the text of this guide is inconsistent with the plan document or insurance booklets, the language in the plan document or insurance booklet controls. The university reserves the right, whether in an individual case or more generally, to alter, reduce, or eliminate any pay practice, policy, or benefit, in whole or in part, without notice.
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Eligibility

To be eligible for benefits at Puget Sound, you must be a faculty or staff member with at least a half-time appointment, or be a full-time, one-semester visiting faculty member. Eligible faculty and staff are those who meet the following hours or teaching requirements:

   **STAFF MEMBERS** who are regularly scheduled to work 1,040 hours per year or .50 FTE over the course of the year.

   **FACULTY MEMBERS** who teach four units of course work, or meet an equivalent set of responsibilities during the academic year.

   **VISITING FACULTY MEMBERS** scheduled to teach three units of course work in one semester.

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Effective Dates

The effective date of most benefits occurs on the first of the month coinciding with or next following your date of eligibility. For example, if you are eligible on the 5th of the month, your benefits will begin on the 1st of the next month. If you are eligible on the 1st of the month, your coverage will begin on that day.

Benefit coverage, including access to your HRA, ends on the last day of the month in which you separate from employment, or if your employment status changes to an ineligible level. You or your eligible dependents may be eligible for COBRA coverage. Please contact human resources for details.

Claims may be submitted against your Flexible Spending Account through the date you separate from employment unless you elect COBRA.

---

Enrolling In Coverage

If you are a faculty or staff member who is newly eligible for our benefit plans, you have 30 days from your hire date (or date of appointment to an eligible position) to enroll in benefits.
Changing Your Choices During The Year

The benefit choices you make are in effect from January 1 through December 31, or from the effective date of your coverage, through December 31. You may change your elections only during the open enrollment period, which occurs during the month of November each year for a January 1 effective date. The only exception is if you have a qualified family status change during the year. Qualified family status changes may include:

- Marriage or divorce
- Death of a spouse/partner or dependent
- Birth or adoption of a child or addition of a dependent
- Loss of eligibility of a dependent
- Change in employment status for you or your spouse/partner or dependent
- Reduction in hours

Note: your elections in our retirement plan may be changed more often; see the Retirement Plan section for details.

**COST OF COVERAGE**

Puget Sound pays 100% of the premium cost for medical and prescription drug coverage for you. We help cover the premium cost for your eligible family members by paying 50% of the cost for you to cover your children, and 25% of the cost for you to cover your spouse/domestic partner. Monthly premiums for your spouse and children are taken out of your paycheck pre-tax. Monthly premiums for your domestic partner or partner’s children will be deducted after taxes and any premiums paid by Puget Sound on behalf of your partner or partner’s children will be taxable income to you. Contact human resources for additional information. Current monthly rates for our medical and prescription drug plan are listed on the Benefits Election Worksheet.

**WAIVING MEDICAL BENEFITS**

You may elect not to enroll in our medical plan, but only if you have adequate medical coverage for yourself through another plan, such as through your spouse’s or domestic partner’s employer. To waive our medical benefits, you must attest that you have such coverage by completing the waiver on the Benefit Enrollment/Change Form. Otherwise, you must enroll in our medical plan.

**REMEMBER:** You must notify human resources **within 30 days** of a qualified change in family status. You have 60 days to enroll if the change is due to birth, adoption, placement for adoption or entitlement to Medicaid.

Note: If you miss this deadline, you will have to wait until the next open enrollment to make changes.
The medical and prescription drug plan for Puget Sound is a preferred provider organization (PPO) plan in the Premera Heritage Prime network, with a Health Reimbursement Arrangement (HRA). Our medical and prescription drug plan is insured by Premera Blue Cross. Puget Sound funds half of your medical deductible each year through our contribution into your HRA. See page 6 for more details. Below is a summary of our medical benefits:

### Medical Benefits

The Premera PPO Heritage Prime Network is a narrow network with a limited provider list that is subject to changes. Providers in the Heritage Prime network have agreed to deeper discounts than those who are merely contracted with Premera. Both types of providers agree to bill Premera directly and to accept a discounted fee as payment in full.

Allowable charges for out-of-network providers are paid based on “Usual Customary & Reasonable” amounts, as determined by Premera. To determine if your provider is part of the Premera Heritage Prime network visit [Premera.com](http://premera.com) or call customer service at 1.800.722.1471.

---

<table>
<thead>
<tr>
<th>HERITAGE PRIME PPO NETWORK</th>
<th>CONTRACTED OR OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>$1,500 Individual</td>
<td>$3,000 Individual</td>
</tr>
<tr>
<td>$3,000 Family</td>
<td>$6,000 Family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Includes deductible, copays and coinsurance</td>
<td>Calendar Year $4,000 Individual $8,000 Family</td>
</tr>
<tr>
<td></td>
<td>$3,000 Individual</td>
</tr>
<tr>
<td></td>
<td>$6,000 Family</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td><em>Routine Exam</em></td>
<td>Paid at 100% no deductible</td>
</tr>
<tr>
<td>Laboratory Services and screenings including colonoscopy, mammograms</td>
<td>Paid at 100% no deductible</td>
</tr>
<tr>
<td></td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits, surgery and inpatient care</td>
<td>Paid at 80% after deductible</td>
</tr>
<tr>
<td></td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td><strong>X-Ray and Laboratory Services</strong></td>
<td>Paid at 80% after deductible</td>
</tr>
<tr>
<td><em>Inpatient and Outpatient</em></td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Paid at 80% after $150 copay</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td><em>Inpatient and Outpatient</em></td>
<td>Paid at 80% after deductible</td>
</tr>
<tr>
<td></td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitation</strong></td>
<td>Paid at 80% after deductible</td>
</tr>
<tr>
<td><em>Physical, occupational and speech therapy</em></td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td><strong>Limited to 60 visits per calendar year</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
</tr>
<tr>
<td><em>Inpatient and Outpatient</em></td>
<td>Paid at 80% after deductible</td>
</tr>
<tr>
<td></td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td><strong>Spinal Manipulations</strong></td>
<td></td>
</tr>
<tr>
<td><em>Limited to 12 visits per calendar year</em></td>
<td></td>
</tr>
</tbody>
</table>

*Preventive care services require no cost share from the participant (not subject to deductible or copay). The list of preventive care services covered includes annual exams, mammograms, some birth control, well-baby and newborn exams, and many other services. For specific information about what is included in preventive care services, log in to your Premera account or visit premera.com/wa/member/stay-healthy/preventive-health/.

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**OUT-OF-AREA BENEFITS:** Your Premera plan travels with you throughout the U.S. and around the world through the Blue Card PPO network. To find a provider outside Washington State, simply call the Blue Card Access Line at 1.800.810.BLUE (2583) or visit their website at [provider.bcbs.com](http://provider.bcbs.com).
Identification Cards

You will receive an identification card (for yourself and each of your covered family members) in the mail. If you have misplaced your card you can order a new one by logging into your account at Premera.com. There is also a smartphone app that contains a virtual ID card that you can use when you need care. You will need to set up your account with Premera by signing on with your medical plan ID number (which is on your ID card).

Prescription Drugs

Prescription drug benefits are included in our medical plan through Premera, and are managed by Express Scripts, Inc. This plan is designed to help you and your family use clinically appropriate medications and manage the cost of prescription drugs.

RETAIL PHARMACY

You have access to a comprehensive retail pharmacy network administered by Express Scripts. For a 30-day supply of prescriptions filled at a participating retail pharmacy, you will pay a copay based on the type of prescription being filled. Use the Premera provider directory to find participating pharmacies, or call the toll-free pharmacy locator line at 1.800.391.9701.

MAIL ORDER

If you have prescription medications that you take on an ongoing basis, using the Express Scripts mail order service may save you money and offers you the convenience of delivery at home through the mail. Visit Premera.com for more information about how to get started receiving your medications by mail.

Below is a summary of our prescription drug benefit:

<table>
<thead>
<tr>
<th>Medications Purchased at a Retail Pharmacy* (Up to a 30 day supply)</th>
<th>Medications Purchased through Mail Order (Up to a 90 day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generics</td>
<td>$10 copay per script</td>
</tr>
<tr>
<td>Preferred or Formulary Brand</td>
<td>$20 copay per script</td>
</tr>
<tr>
<td>$30 copay per script</td>
<td></td>
</tr>
<tr>
<td>$60 copay per script</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred or Non-Formulary Brand</td>
<td>$120 copay per script</td>
</tr>
</tbody>
</table>

*If you fail to show your Plan ID card at the pharmacy or if you use a pharmacy that is not part of the Express Scripts network, you must pay the full cost of the medication and file your claim with Premera for reimbursement. The plan will pay 60% after the applicable copay.
PRIMEPLUS CARE – PREFERRED CENTERS OF CARE
Healthcare can be difficult to navigate, particularly when you are experiencing the need for cancer treatment or a joint replacement. With PrimePlus Care, Premera will provide a patient advocate who will support the patient and coordinate with the provider, customer service and case management. These preferred centers of care provide additional support and care from local, world class providers. The oncology program is through the Seattle Cancer Care Alliance or Northwest Medical Specialists in Tacoma. The hip and knee replacement program is through Proliance Surgeons. If you use these providers for your cancer treatment or joint replacement, there will be no cost to you – your deductible and coinsurance are waived. To access this valuable program, call Premera customer service.

24-HOUR NURSELINE – 800.722.1471
Did you know you have access to a registered nurse 24/7? Through our Premera medical plan you can call a nurse to ask any type of medical or care questions you may have any time of the day or night. Nurseline staff can help you decide whether to go to the doctor or ER, address issues when your doctor’s office is closed, and answer any other questions you may have.

TELADOC
Do you need to visit the doctor when you have the flu, bronchitis, ear or sinus infections, rashes, etc.? Is it hard to leave work, or maybe you don’t discover you need the visit until after normal office hours? You can save time and money by visiting a board certified physician by phone, skype or facetime through Teladoc. Phone visits are available 24/7 and video consultations from 7am to 9pm PST, 7 days a week.

HERE’S HOW IT WORKS:
1) Call 855.332.4059
2) Have your ID card ready. They’ll verify your plan.
3) Then, usually within 20 minutes, you’ll be contacted by a doctor – by your choice of phone or video chat.

There’s no time limit to your Virtual Care visit. When appropriate, the doctor will send an electronic prescription to the pharmacy of your choice. They can also send treatment notes to your primary care physician to complete your medical record.

You can also access Teladoc through their smartphone app or online through Premera.com. The visit will cost $40, which will go towards your deductible or will be paid at 80% if you have already satisfied your deductible. That’s much less than a regular office visit which costs about $165 or an emergency room visit which costs about $1,200.

PREMERA DISCOUNT PROGRAMS
As a Premera member, you have access to discounts for many types of services including alternative care services, hearing aids/screenings, fitness clubs and gyms, diet and nutrition, eye care services and hardware and more. To access these discounts visit Premera.com under Member Discounts.

ESTIMATE MEDICAL COSTS AND EXPLORE PROVIDER QUALITY (BLUE DISTINCTIONS)
This tool helps you evaluate costs and quality of providers in your area for common medical conditions and services. You can look for lower cost options, evaluate your provider choices, and shop for care. Visit Premera.com and log in.

Under “My Account” you can click on “Compare Treatment Costs”. Then click on the “$ Find a Cost” tile. Select from a list of common treatments or services. You will see a list of in-network providers in your area who perform this procedure and the cost for each. You will receive a range of prices – from lowest to highest – you can expect to pay based on our coverage and amount remaining to meet your deductible. There will also be indications of quality, awards and the Blue Distinction designation.
HEALTHCARE NAVIGATORS

Need some help? When a health crisis occurs it’s easy to get overwhelmed. Premera can work with you to identify the things that make it challenging to get through complex medical events. Their licensed professionals work with you and your providers as a single point of contact who will advocate on your behalf. Premera can help you navigate the health system, understand your health situation to help you make informed decisions, and locate additional community resources. To connect with a healthcare navigator call 888.742.1469 or email healthhelp@premera.com.

MAIL ORDER MEDICATION – EXTENDED PAY PROGRAM

Your prescription drug program encourages you to use mail order when purchasing any maintenance medications, meaning those you take regularly. This allows you to purchase up to a 90-day supply and the medication is delivered to your home. There may be times when your portion of the cost for your mail order medication is too much for you to handle. Premera offers you the Extended Pay Program (EPP) which removes the barrier of the 90-day supply copay by giving you the option to spread out the copayments over three installments using a debit or credit card. There is no minimum dollar amount required, no service fee and no interest charged.

OUTPATIENT REHABILITATION – PRIOR AUTHORIZATION REQUIRED

For members needing outpatient rehabilitation services, Premera has partnered with eviCore healthcare to review and authorize these services. This approach ensures members will receive cost effective and appropriate care. This is for occupational, physical, massage therapy and rehabilitation services provided by chiropractors. After an initial visit for these services, your provider will outreach to eviCore to evaluate your treatment needs and determine the amount of approved visits going forward.

For more information regarding services included in our medical plan refer to your Premera plan booklet. You can also get more information by calling Premera customer service at 1.800.722.1471.
Health Reimbursement Arrangement (HRA)

Puget Sound establishes an HRA for every faculty and staff member who is enrolled in our medical benefits plan. Your account will be funded on January 1 of each year and you will be allowed to roll over your unused funds. HRA funding for faculty and staff hired after January 1 will be pro-rated based on the number of months coverage is effective. Following are the annual funding amounts and roll over maximums:

<table>
<thead>
<tr>
<th>IF YOU ARE COVERING</th>
<th>CALENDAR YEAR FUNDING</th>
<th>MAXIMUM ROLL OVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yourself</td>
<td>$750</td>
<td>Up to $750</td>
</tr>
<tr>
<td>Yourself and any family members</td>
<td>$1,500</td>
<td>Up to $1,500</td>
</tr>
</tbody>
</table>

*Should you terminate coverage, access to the HRA funds will end as of the date your coverage terminates, unless you elect COBRA.*

Our HRA plan is administered by Navia Benefit Solutions. Access to your HRA account is easy. Here’s how it works:

1) You receive medical care

2) Your provider sends the bill to Premera

3) Premera applies the PPO discount and processes the claim based on where you are in your deductible, then applies the coinsurance

4) Premera sends the information about what you are required to pay to Navia and an explanation of benefits to you

5) Navia takes funds out of your HRA to pay for your deductible, coinsurance or copayments and pays you – this will either be as a check sent to your home, or you can visit [www.naviabenefits.com](http://www.naviabenefits.com) to sign up for direct deposit into your bank account

6) You pay your provider

If there are not enough funds in your HRA, Navia will automatically process the claim through your healthcare flexible spending account (FSA) if you have one. If you don’t have funds in either account, Navia will not process a payment.

**WHAT CAN I USE MY HRA FUNDS FOR?**

Your Puget Sound medical plan deductible, coinsurance or copayments based on what is reported on the Premera explanation of benefits that you receive each time you receive care.

**EXCEPTIONS**

*Double Coverage*

If you have dual coverage (coverage under both your Puget Sound and a spouse/partner’s plan or Medicare) you will need to submit a claim to Navia for reimbursement of any out of pocket plan expenses once both plans have paid.

*Sensitive Diagnosis*

If your claim is deemed a “sensitive diagnosis” by Premera (mental health, substance abuse, male or female specific health issues), these claims are not sent directly to Navia due to HIPAA privacy concerns. You will need to submit a claim to Navia for such services.
Flexible Spending Accounts

Healthcare and dependent care Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family’s health care and dependent care costs for the next year, you can lower your taxable income. Upon becoming eligible for benefits, and each year during open enrollment, you may elect to set aside a certain amount of money pre-tax to cover medical and dependent care expenses for the calendar year.

You may submit claims for reimbursement against your FSA for expenses incurred between January 1 and December 31. If you do not spend all of your FSA funds within this period, the remaining balance in your account will be forfeited. Because of this “use it or lose it” rule, you should only enroll in the plan if you expect to incur those expenses between January 1 and December 31 each year. Do not treat it as a “rainy day fund” by setting money aside just in case you need it.

HEALTH CARE FSA
You can set aside up to $2,650 per year pre-tax to pay for certain IRS-approved medical care expenses not covered by the insurance plan or HRA. Some examples include:

- Orthodontia
- Out of pocket dental expenses
- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Chiropractic services
- Acupuncture
- Prescription copays
- Out of pocket medical expenses

For a complete list of eligible and non-eligible FSA expenses, visit Navia’s website at www.naviabenefits.com.

You or your family members do not have to be enrolled in the Puget Sound medical plan to take advantage of the FSA. You can use your FSA dollars to pay for any eligible out of pocket medical expense for any of your eligible family members. Due to IRS regulations, domestic partners and their children are not eligible for reimbursements from a FSA.

HOW DOES THE HRA COORDINATE WITH MY HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)?

The HRA and Health Care FSA, while separate accounts, provide reimbursement of qualified medical expenses as defined by the university for the HRA (qualified medical deductible, co-insurance and co-pays only), and by the IRS for the Health Care FSA (i.e., deductibles, coinsurance, and prescription expenses). Should you have both accounts, qualified expenses eligible under both plans will be reimbursed through the HRA first, and then applied to the Health Care FSA.

DEPENDENT CARE FSA
Similar to the Health Care FSA, you may also use pre-tax dollars to pay for qualified dependent care needed to allow you or your spouse/partner to work or go to school. The maximum amount you may contribute into the Dependent Care FSA is $5,000 per calendar year (or $2,500 if married and filing separately). Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

CAN I CHANGE HOW MUCH I PUT INTO MY ACCOUNT DURING THE YEAR?
Only if you experience a change in family status (marriage, birth/adoption, divorce, etc).
Flexible Spending Accounts (continued)

IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment status.

HOW DO I GET THE FUNDS OUT OF MY FSA?

You can submit claims online, through Navia’s smartphone app for Android and iPhone, email, fax or mail. Claims are typically processed within a few days and reimbursements are issued either by check or direct deposit (if elected through Navia’s site at www.naviabenefits.com). The full balance of your Healthcare FSA is available to you as of your enrollment date or January 1 each year. Dependent care elections can only be claimed as they are deducted from your paycheck.

If you are no longer employed by the university all pre-tax contributions to your flexible spending account will end. Expenses incurred after your termination date will not be eligible for reimbursement unless you elect to continue your FSA contributions on an after-tax basis through COBRA.

Dental

Our dental plan is voluntary and helps pay the cost of dental expenses for you and your eligible family members. It is designed to promote and encourage preventive dental care. Like our medical plan, our dental plan has a list of participating dentists who have agreed to a discounted fee, to bill Premera directly, and to accept the discounted fee as payment in full. Allowable charges for out-of-network providers are paid based on “Usual Customary & Reasonable” amounts, as determined by Premera. To determine if your provider is part of the Premera Optima network, visit Premera.com or call customer service at 1.800.722.1471.

Below is a summary of our dental plan benefits:

<table>
<thead>
<tr>
<th>DENTAL OPTIMA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
</tr>
<tr>
<td>$50 Individual</td>
</tr>
<tr>
<td>$150 Family</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
</tr>
<tr>
<td>(Oral Exams, X-rays, Fluoride treatment)</td>
</tr>
<tr>
<td>100%, no deductible</td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
</tr>
<tr>
<td>(Fillings Extractions, oral surgery, periodontics)</td>
</tr>
<tr>
<td>80% after the deductible</td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
</tr>
<tr>
<td>(Crowns, Bridges, Dentures, Repairs)</td>
</tr>
<tr>
<td>50% after the deductible</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum per Individual</strong></td>
</tr>
<tr>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Orthodontia Services, per Individual</strong></td>
</tr>
<tr>
<td>Covered up to $1,000 lifetime</td>
</tr>
</tbody>
</table>

COST OF DENTAL COVERAGE

Dental coverage is voluntary, meaning you have a choice to purchase dental coverage for yourself, your spouse/partner and your eligible children. If you choose dental coverage, premiums for you, your spouse, and/or your dependent children will be deducted pre-tax. Monthly premiums for your domestic partner or partner’s children will be deducted after taxes. Current monthly rates for our dental plan are listed in the Benefits Election Worksheet.

You can enroll yourself or your family members in our dental plan, even if not enrolled in our medical plan.
With enrollment in Puget Sound’s medical plan, you will also be enrolled in a **base plan** with Vision Service Plan (VSP). This coverage provides an annual vision exam at no additional cost to you. If you enrolled in medical coverage for your partner/spouse, children or family, all enrollees will be covered for one vision exam every 12 months. With the base plan, if you need to purchase lenses and frames you will receive a 20% discount if you purchase them from a VSP provider. If you have additional vision care needs, you can purchase the vision **buy-up plan** to cover hardware including lenses, frames and contact lenses.

**COST OF VISION COVERAGE**

The base plan (vision exam only) is included when you enroll in the medical plan. The buy-up plan is voluntary and is based on the coverage you have elected for the medical plan. If you choose the buy-up, premiums for you, your spouse, and/or your eligible children will be deducted before taxes. Monthly premiums for your domestic partner or partner’s children will be deducted after taxes. Current monthly rates for our vision buy-up plan are listed in the Benefits Election Worksheet.

<table>
<thead>
<tr>
<th>BASE (EXAM ONLY) PLAN</th>
<th>VSP Providers</th>
<th>All Other Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Exam</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 exam every 12 months</td>
<td>$0 copay, covered at 100%</td>
<td>Plan pays up to a $50 allowance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BUY-UP (MATERIALS) PLAN</th>
<th>VSP Providers</th>
<th>All Other Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10 copay</td>
<td>Limited to One Set Every 12 Months</td>
<td></td>
</tr>
<tr>
<td><strong>Eyeglass Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>100%</td>
<td>100% up to $50 allowance</td>
</tr>
<tr>
<td>Bifocals</td>
<td>100%</td>
<td>100% up to $75 allowance</td>
</tr>
<tr>
<td>Trifocals</td>
<td>100%</td>
<td>100% up to $100 allowance</td>
</tr>
<tr>
<td>Standard Progressives</td>
<td>100% after $50 copay</td>
<td>100% up to $75 allowance</td>
</tr>
<tr>
<td>Premium Progressives</td>
<td>100% after $80 to $90 copay</td>
<td>100% up to $75 allowance</td>
</tr>
<tr>
<td>Custom Progressives</td>
<td>100% after $120 to $160 copay</td>
<td>100% up to $75 allowance</td>
</tr>
<tr>
<td>Polycarbonate Lenses</td>
<td>100% for children</td>
<td>No additional benefit</td>
</tr>
<tr>
<td>Other lens enhancements</td>
<td>35 to 40% discount</td>
<td>No additional benefit</td>
</tr>
<tr>
<td><strong>Eyeglass Frames</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 pair every 24 months</td>
<td>100% up to $150, $170 for featured frame brands, $80 at Costco</td>
<td>100% up to $70 allowance</td>
</tr>
<tr>
<td><strong>Contact Lenses (Instead of Glasses)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every 12 months</td>
<td>100% up to $150 allowance</td>
<td>100% up to $105 allowance</td>
</tr>
<tr>
<td>Contact lens fitting:</td>
<td>100% after $60 copay</td>
<td>No benefit for fitting</td>
</tr>
<tr>
<td><strong>Additional Pairs of Glasses and Sunglasses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30% discount if purchased from the same VSP provider on the same day as your well vision exam. OR 20% from any VSP provider within 12 months of your last well vision exam</td>
<td>No benefit</td>
<td></td>
</tr>
<tr>
<td><strong>Laser Vision Correction</strong></td>
<td>Average 15% off regular price or 5% off promotional price; only available from VSP contracted providers</td>
<td>No benefit</td>
</tr>
</tbody>
</table>

Similar to our medical and dental plan, our vision plan has a list of participating providers who have agreed to bill VSP directly and to accept a negotiated fee as payment in full. If you use a non-VSP provider, you will need to submit a claim to VSP and you will be reimbursed up to the scheduled amounts. To find a provider in the VSP network, visit [vsp.com](http://vsp.com) or call customer service at **1.800.877.7195**.
Life And Accidental Death And Dismemberment (AD&D)

UNIVERSITY PAID
The university provides $25,000 of life insurance and $25,000 of accidental death and dismemberment (AD&D) insurance coverage, both at no cost to you. AD&D insurance provides benefits to your beneficiary in the event of your accidental death, or to you in the event of accidental dismemberment (loss of limbs, sight, hearing, etc.)

VOLUNTARY LIFE INSURANCE
Voluntary life insurance is available if you want more insurance than what Puget Sound provides. You may purchase additional group term life coverage of:

<table>
<thead>
<tr>
<th>OPTION 1</th>
<th>OPTION 2</th>
<th>OPTION 3</th>
<th>OPTION 4</th>
<th>OPTION 5</th>
<th>OPTION 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$25,000</td>
<td>$50,000</td>
<td>$100,000</td>
<td>$150,000</td>
<td>$175,000</td>
</tr>
</tbody>
</table>

Voluntary Life premiums are based on your age on January 1 of each year. Current rates are listed on the Benefits Election Worksheet.

As long as you enroll within 31 days of eligibility, you can purchase up to $175,000 without having to complete an evidence of insurability form. If you don’t enroll within 31 days of eligibility, you will have to complete an evidence of insurability form and be approved by UNUM.

Note: If you are age 70, your life benefits will be reduced to 65% of your original amount and at age 75 will reduce to 50% of the original amount. Voluntary life coverage cannot be increased after a reduction due to age.

CHANGES TO VOLUNTARY LIFE:
You may increase your coverage by one level each year at open enrollment. If you are electing voluntary life more than 31 days after your date of eligibility, or increasing your current coverage by more than one level, you will need to complete an evidence of insurability form.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
In addition to the voluntary life insurance, you may purchase AD&D coverage for yourself, your spouse/partner and your children (up to age 19, or 26 if a full time student).

<table>
<thead>
<tr>
<th>COVERED INDIVIDUAL</th>
<th>MINIMUM BENEFIT</th>
<th>MAXIMUM BENEFIT</th>
<th>PURCHASED IN INCREMENTS OF</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>$10,000</td>
<td>$300,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Spouse/Partner</td>
<td>$10,000</td>
<td>$300,000, but not more than your own election</td>
<td>$10,000</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$10,000</td>
<td>$20,000, but not more than your own election</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Voluntary AD&D coverage is not based on your good health, so if you do not enroll now you may add any level of coverage during open enrollment.
Long Term Disability

Puget Sound pays for long term disability benefits for faculty and staff members who are at least .75 FTE when you meet one of the following:

1. You have completed 12 consecutive months of service at Puget Sound; OR
2. You attest that you had LTD coverage within 3 months prior to your employment with Puget Sound, and the plan you had provided benefits for 5 or more years of disability.

When do I receive benefits?
Long term disability benefits begin after 180 days of disability.

How long will I receive benefits?
As long as you meet UNUM’s definition of disability, the maximum duration of your LTD is the earlier of: 1) your normal social security retirement age, or 2) your ability to return to work.

What does Long Term Disability insurance cover?
You will receive a monthly benefit if you are totally disabled due to injury or sickness that lasts longer than 180 days, whether the disability occurs on or off the job.

How much is my monthly benefit?
You can receive 60% of your monthly earnings to a maximum of $15,000 per month. Your payment may be reduced by other sources of income.

What is the limitation for a pre-existing health condition?
You will not be eligible for long term disability benefits until you have been covered for 12 months if you have received medical treatment, consultation, care or services (including diagnosis and/or medications) for any sickness or injury during the 3 months just prior to your coverage effective date.

What other benefits are included with your LTD plan?
This plan also offers return to work incentives, retirement premium waiver (which provides continuing contributions to your retirement account), dependent care benefits, rehabilitation and return to work assistance. Please refer to the Long Term Disability benefit booklet for more details.

Voluntary Short Term Disability

Puget Sound offers you the opportunity to purchase short term disability coverage. This valuable benefit pays you a portion of your salary if you become disabled due to pregnancy, injury or illness.

You can choose to purchase this coverage within 30 days of hire, or change to a benefits-eligible position, with no health questions asked. If you choose not to purchase when you are hired, you can apply for coverage during open enrollment. You will have to complete an evidence of insurability form and be approved by Unum. Because you pay the premiums for this plan, when you become disabled your weekly benefits are not taxed.

When do I receive benefits?
Short term disability benefits begin after 14 days of disability.

How long will I receive benefits?
As long as you meet UNUM’s definition of disability, the maximum duration of the short term disability benefit is the earlier of: 1) 24 weeks, or 2) your ability to return to work.

What does Short Term Disability insurance cover?
You will receive a weekly benefit if you are totally disabled off the job due to injury or sickness that lasts longer than 14 days. This includes pregnancy.

How much is my weekly benefit?
You can receive 60% of your weekly earnings to a maximum of $2,000 per week.

What is the limitation for a pre-existing health condition?
You will not be eligible for short term disability benefits until you have been covered for 12 months if you have received medical treatment, consultation, care or services (including diagnosis and/or medications) for any sickness or injury during the 3 months just prior to your coverage effective date.

Premiums – This is a group plan benefit, which means the premiums are more affordable. The monthly cost of the plan is per $10 of benefit, which is based on your salary. Premiums are also based on your age on January first of each year. Current rates are listed on the Benefits Election Worksheet.

For more information about our LTD plan, or to file a claim, contact UNUM at 1.877.851.7637

For more information about our Short Term Disability plan, or to file a claim, contact UNUM at 1.800.633.7479
Employee Assistance Program (EAP) – Unum/Ceridian

ONLY AVAILABLE TO THOSE COVERED ON OUR LONG TERM DISABILITY PLAN

The EAP is a completely free and confidential program that helps you and/or your family members address life issues, big or small. Benefits are offered to all faculty and staff members enrolled in the long-term disability plan, and can help with:

- Marital and family concerns
- Difficult relationships
- Depression
- Substance abuse
- Grief and loss
- Financial entanglements
- Other personal stressors
- Elder and child care needs

ACCESSING THE EAP IS EASY:
Visit their website at lifebalance.net
Website username and password are both: lifebalance
Call 1.800.854.1446

Travel Assistance – Assist America

ONLY AVAILABLE TO THOSE COVERED ON OUR LONG TERM DISABILITY PLAN

You and your family have access to worldwide medical emergency assistance whenever you travel 100+ miles from home. Travel assistance does NOT replace your medical insurance – it is there to help you access health care, such as:

- Prescription replacement assistance
- Medical referrals to Western-trained, English-speaking medical providers
- Hospital admission assistance
- Emergency medical evacuation
- Care and transport of unattended minor children
- Critical care monitoring
- Emergency message service
- Transportation for friend/family member to join the hospitalized patient
- Legal and interpreter referrals

Ask human resources for a brochure if you would like more information about this service.

Retirement Savings Plan - TIAA

To help you prepare for the future, Puget Sound sponsors a 403(b) plan as part of our benefits package. As an eligible faculty or staff member, Puget Sound will begin contributing to your retirement account after a defined waiting period. See the Summary Plan Description for a definition of the waiting period. This waiting period may be waived if you have worked for an eligible employer such as another nonprofit or public institution of higher learning for at least one year immediately preceding your employment at Puget Sound.

You may make voluntary pre-tax or after-tax (Roth) contributions to the plan on the first day of the pay period following your first date of employment.

Contributions may be invested in one or more of the available investment funds. You can change your investment allocations and your contribution amounts at any time. You may also make additional catch-up contributions if you are age 50 or older. Visit www.tiaa.org for more information on choice of funds and maximum contribution levels.

How much can I contribute?
You can have money deducted from your paycheck pre-tax or after-tax (Roth) up to the IRS limits for elective deferrals to a 403(b) plan.

How much does Puget Sound contribute?
For eligible faculty and exempt staff members: 12% of regular salary. For eligible non-exempt staff members: 10% of regular salary. You are not required to contribute any money to receive the Puget Sound contributions.
# Important Phone Numbers And Websites

<table>
<thead>
<tr>
<th>CONTACT</th>
<th>CARRIER</th>
<th>LOCATION / PHONE NUMBER</th>
<th>EMAIL OR WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources</td>
<td></td>
<td>Howarth 016 (M-F 8 a.m. to noon, and 1 – 5 p.m.) Phone: 253.879.3369 Fax: 253.879.2839</td>
<td><a href="mailto:benefits@pugetsound.edu">benefits@pugetsound.edu</a></td>
</tr>
<tr>
<td>Medical and Dental Insurance</td>
<td>Premera</td>
<td>Customer Service: 1.800.722.1471 Out-of-State Care: 1.800.810.BLUE (2583)</td>
<td><a href="http://www.premera.com">www.premera.com</a></td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>Express Scripts</td>
<td>Phone: 1.800.391.9701 Fax: 1.888.327.9791</td>
<td><a href="http://www.premera.com">www.premera.com</a></td>
</tr>
<tr>
<td>Vision Insurance</td>
<td>Vision Service Plan (VSP)</td>
<td>Phone: 1.800.877.7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>Health Reimbursement Arrangement (HRA)</td>
<td>Navia Benefit Solutions</td>
<td>Phone: 1.866.897.1996 Fax: 1.866.831.6222</td>
<td><a href="mailto:105@naviabenefits.com">105@naviabenefits.com</a></td>
</tr>
<tr>
<td>Flexible Spending Account (FSA)</td>
<td>Navia Benefit Solutions</td>
<td>Phone: 1.800.669.3539 Fax claims: 1.866.535.9227</td>
<td><a href="http://www.naviabenefits.com">www.naviabenefits.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Company ID: UPD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:customerservice@naviabenefits.com">customerservice@naviabenefits.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>email claims: <a href="mailto:claims@naviabenefits.com">claims@naviabenefits.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>UNUM / Ceridian</td>
<td>1.800.854.1446</td>
<td><a href="http://www.Lifebalance.net">www.Lifebalance.net</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>User ID and password: lifebalance</td>
</tr>
<tr>
<td>Travel Assistance</td>
<td>Assist America</td>
<td>1.800.872.1414 OR Outside the US: +(US access code) 609.986.1234</td>
<td><a href="http://www.assistamerica.com">www.assistamerica.com</a></td>
</tr>
<tr>
<td>Retirement Savings</td>
<td>TIAA</td>
<td>1.800.842.2252</td>
<td><a href="http://www.tiaa.org/pugetsound">www.tiaa.org/pugetsound</a></td>
</tr>
<tr>
<td>Washington Health Benefit Exchange</td>
<td></td>
<td>1.855.923.4633</td>
<td><a href="http://www.wahealthplanfinder.org">www.wahealthplanfinder.org</a></td>
</tr>
</tbody>
</table>
Special Enrollment
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), allows a special enrollment period in addition to the regular open enrollment period. Only the following individuals may enroll outside the open enrollment period:

- Individuals who previously waived coverage under this program because they had other coverage and then involuntarily lost the other coverage. Enrollment must occur within 30 days of the loss of other coverage;
- New dependents due to marriage, birth, adoption or placement for adoption. The eligible employee and other dependents who previously did not elect to be covered under the employer’s health care plan may also enroll at the time the new dependent is enrolled. Enrollment must occur within 60 days of date of marriage, or 60 days of a birth, adoption or placement for adoption;
- A court has ordered coverage be provided for a spouse or minor child under this plan and request for enrollment is made within 60 days after issuance of such court order;
- If employee and/or dependent(s) become ineligible for Medicaid or the Children’s Health Insurance program and request coverage under our plan within 60 days of termination (Please read the Medicaid and the Children’s Health Insurance Program notice for more information); or
- If employee and/or dependent(s) become eligible for the state premium assistance program and request coverage under our plan within 60 days after eligibility is determined.

Notice Regarding the Women’s Health and Cancer Rights Act of 1998
As required by the Women’s Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

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. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact human resources for more information.
**HIPAA Privacy Practices**

The Health Insurance Portability and Accountability Act (HIPAA) requires employers to adhere to strict privacy guidelines and establishes your rights with regard to your personal health information. This notice describes how medical information about you may be used and disclosed, and how you can access that information. Please contact human resources or the hr benefits webpage for a copy of our HIPAA Privacy Notice.

If you have any questions regarding the HIPAA Privacy Notice, or would like another copy, please contact human resources.

**COBRA**

COBRA continuation coverage is a temporary continuation of coverage under our employee benefit plan. Please contact human resources for a copy of the General Notice of COBRA Continuation Rights. This notice explains your rights and obligations to receive COBRA benefits.

We are not always aware when a COBRA event takes place, unless notified by you. The most common examples are divorce, or when a child exceeds the maximum age. When such an event occurs, the Notice of Qualifying Event must be postmarked within 60 days of the qualifying event for the affected person to be eligible for COBRA continuation. If you have questions about COBRA please contact human resources.

**Maternity Hospital Stay**

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

Healthcare Reform – Individual Mandate
The Affordable Care Act is complicated and you may have questions about how it impacts you, your family and your benefits. There are two things you should know.

First, most Americans are required to have health insurance (this requirement started on January 1, 2014). In 2018, individuals who do not purchase coverage and do not qualify for an exemption will pay the greater of 2.5% of your annual household income or $695 per person ($347.50 per child). The Health Insurance Marketplace was created for individuals who have no access to affordable coverage to purchase health insurance.

Second, since Puget Sound pays the full cost of your employee medical premium, the medical plan is considered affordable coverage and neither you nor any family members are eligible for the federal subsidies available in the Health Insurance Marketplace, even if you choose not to enroll in Puget Sound’s plan.

Please refer to your Notice of Health Insurance Marketplace Coverage for general information. For additional information on Marketplace options in your area and subsidy calculators, go to www.healthcare.gov or call 1.800.318.2596.
IMPORTANT NOTICE FROM UNIVERSITY OF PUGET SOUND ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. University of Puget Sound has determined that the prescription drug coverage offered by University of Puget Sound Services Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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 University of Puget Sound coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you or your eligible dependents elects Medicare Part D, can keep this coverage and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current University of Puget Sound coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

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 University of Puget Sound 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 the person listed below for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through University of Puget Sound changes. You also may request a copy of this notice at any time.
For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2018
Name of Entity/Sender: University of Puget Sound
Contact-Position/Office: Kenni Simons
Address: 1500 N. Warner St. #1064
Tacoma, WA 98416-1064
Phone Number: 253.879.3296 U.S.
PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1.877.KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1.866.444.EBSA (3272).
If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Program Details</th>
</tr>
</thead>
</table>
| **ALABAMA** – Medicaid | Website: [http://myalhipp.com/](http://myalhipp.com/)  
                      | Phone: 1-855-692-5447                                                          |
| **FLORIDA** – Medicaid | Website: [http://flmedicaidtplrecovery.com/hipp](http://flmedicaidtplrecovery.com/hipp)  
                      | Phone: 1-877-357-3268                                                          |
| **ALASKA** – Medicaid | Website: [http://myakhipp.com/](http://myakhipp.com/)  
                      | Email: CustomerService@MyAKHIPP.com  
                      | Medicaid Eligibility: [http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx](http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx)  
                      | Phone: 1-866-251-4861                                                          |
| **GEORGIA** – Medicaid | Website: [http://dch.georgia.gov/medicaid](http://dch.georgia.gov/medicaid)  
                      | - Click on Health Insurance Premium Payment (HIPP)  
                      | Phone: 404-656-4507                                                            |
| **ARKANSAS** – Medicaid | Website: [http://myarhipp.com/](http://myarhipp.com/)  
                      | Phone: 1-855-MyARHIPP (855-692-7447)                                          |
| **INDIANA** – Medicaid | Website: [http://www.indianamedicaid.com](http://www.indianamedicaid.com)  
                      | Phone: 1-800-403-0864                                                          |
| **COLORADO** – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) | Website: [https://www.healthfirstcolorado.com/](https://www.healthfirstcolorado.com/)  
                      | Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711  
                      | State Relay 711                                                                |
| **IOWA** – Medicaid | Website: [http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp](http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp)  
                      | Phone: 1-888-346-9562                                                          |
| **KANSAS** – Medicaid | Website: [http://www.kdheks.gov/hcf/](http://www.kdheks.gov/hcf/)  
                      | Phone: 1-785-296-3512                                                          |
| **NEVADA** – Medicaid | Website: [http://www.dhss.nv.gov/](http://www.dhss.nv.gov/)  
                      | Medicaid Phone: 1-800-992-0900                                                |
| **KENTUCKY** – Medicaid | Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
                      | Phone: 1-800-635-2570                                                          |
                      | Phone: 603-271-5218                                                           |
| **LOUISIANA** – Medicaid | Website: [http://dhh.louisiana.gov/index.cfm/subhome/1/n/331](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331)  
                      | Phone: 1-888-695-2447                                                          |
| **NEW JERSEY** – Medicaid and CHIP | Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)  
                      | CHIP Phone: 609-631-2392                                                       |
                      | TTY: Maine relay 711                                                          |
| **NEW YORK** – Medicaid | Website: [https://www.health.ny.gov/health_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)  
<pre><code>                  | Phone: 1-800-541-2831                                                          |
</code></pre>
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid and CHIP Website</th>
<th>Medicaid Phone</th>
<th>CHIP Website</th>
<th>CHIP Phone</th>
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<tr>
<td>MASSACHUSETTS</td>
<td><a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">Website</a></td>
<td>1-800-862-4840</td>
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<td>NORTH CAROLINA</td>
<td><a href="http://www.ncdhhs.gov/">Website</a></td>
<td>919-855-4100</td>
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<td>MINNESOTA</td>
<td><a href="http://mn.gov/dhs/health-care/health-care-programs/medical-assistance.jsp">Website</a></td>
<td>1-800-657-3739</td>
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<td>NORTH DAKOTA</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv-medicaid/">Website</a></td>
<td>1-844-854-4825</td>
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<td>MISSOURI</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">Website</a></td>
<td>573-751-2005</td>
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<td>OKLAHOMA</td>
<td><a href="http://www.oklahoma.gov/DPH/index.html">Website</a></td>
<td>1-800-699-9075</td>
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<td>MONTANA</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">Website</a></td>
<td>1-800-694-3084</td>
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<td>OREGON</td>
<td>[Website](<a href="http://www.oregon.gov/DHS/Provider/Health">http://www.oregon.gov/DHS/Provider/Health</a> Insurance/Free or Low Cost Health Care/CHIP Payment Program)</td>
<td>1-800-562-3022 ext. 15473</td>
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<tr>
<td>RHODE ISLAND</td>
<td><a href="http://www.eohhs.ri.gov/">Website</a></td>
<td>855-697-4347</td>
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<td>SOUTH CAROLINA</td>
<td><a href="http://www.scdhhs.gov">Website</a></td>
<td>1-888-549-0820</td>
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<tr>
<td>SOUTH DAKOTA</td>
<td><a href="http://dss.sd.gov">Website</a></td>
<td>1-888-828-0059</td>
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<tr>
<td>TEXAS</td>
<td><a href="http://gethipptexas.com/">Website</a></td>
<td>1-800-440-0493</td>
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<tr>
<td>VERMONT</td>
<td><a href="http://www.greenmountaincare.org/">Website</a></td>
<td>1-800-250-8427</td>
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<tr>
<td>WISCONSIN</td>
<td>Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a></td>
<td>1-800-362-3002</td>
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<tr>
<td>WISCONSIN</td>
<td><a href="https://www.wyequalitycare.acs-inc.com/">Website</a></td>
<td>307-777-7531</td>
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<tr>
<td>WYOMING</td>
<td><a href="http://www.oregonhealthcare.gov/index-es.html">Website</a></td>
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**Legal Notices**
Legal Notices

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
www.dol.gov/ebsa  
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
www.cms.hhs.gov  
1.877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

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This benefit guide was created by your knowledgeable and friendly benefits professionals at Parker, Smith & Feek!