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 20 for more details.
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 if you haven’t already.

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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**ELIGIBLE DEPENDENTS ARE YOUR:**

- Legal Spouse or Domestic Partner*
- Your children until they turn age 26

*An eligible domestic partner must meet all requirements included in the Puget Sound Affidavit of Marriage or Domestic Partnership form. Eligible partners are extended the same rights and benefits of a spouse. Coverage also includes the eligible children of the partner. Any premiums paid by Puget Sound on behalf of the partner or partner’s children will be taxable income to the faculty or staff member.

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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.

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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.

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.

Medical And Prescription Drug Benefits

COST OF COVERAGE

Puget Sound pays 100% of the premium cost for medical, vision, 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.
Medical Benefits

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 administered 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:

### HERITAGE PRIME PPO NETWORK

<table>
<thead>
<tr>
<th>Medical Service</th>
<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>$1,500 Individual</td>
<td>$3,000 Individual</td>
</tr>
<tr>
<td></td>
<td>$3,000 Family</td>
<td>$6,000 Family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>Calendar Year</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Includes deductible, copays and coinsurance</td>
<td>$4,000 Individual</td>
<td>$8,500 Individual</td>
</tr>
<tr>
<td></td>
<td>$8,000 Family</td>
<td>$17,000 Family</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>Paid at 100% no deductible</td>
<td>Paid at 100% no deductible</td>
</tr>
<tr>
<td>Routine Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory Services and screenings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>including colonoscopy, mammograms</td>
<td>Paid at 100% no deductible</td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Paid at 80% after deductible</td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td>Office Visits, surgery and inpatient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-Ray and Laboratory Services</td>
<td>Paid at 80% after deductible</td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td>Inpatient and Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td></td>
<td>Paid at 80% after $150 copay</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td>Paid at 80% after deductible</td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td>Inpatient and Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Paid at 80% after deductible</td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td>Physical, occupational and speech therapy</td>
<td><em>Limited to 60 visits per calendar year</em></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Paid at 80% after deductible</td>
<td>Paid at 60% after deductible</td>
</tr>
<tr>
<td>Inpatient and Outpatient</td>
<td><em>Limited to 12 visits per calendar year</em></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>Paid at 80% after deductible</td>
<td>Paid at 60% after deductible</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/.

Premera’s 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.

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 or call customer service at 1.800.722.1471.

**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.
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**.

Our pharmacy benefit is based on preferred drugs (generic, brand and specialty), and covers medications that are effective and lower cost, and require a prescription to purchase. Following is our prescription drug benefit:

<table>
<thead>
<tr>
<th></th>
<th>MEDICATIONS PURCHASED AT A RETAIL PHARMACY</th>
<th>MEDICATIONS PURCHASED THROUGH MAIL ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Days Supply</strong></td>
<td>Up to 30 days</td>
<td>90 days</td>
</tr>
<tr>
<td><strong>Tier 1: Preferred Generics</strong></td>
<td>$10 copay per script</td>
<td>$25 copay per script</td>
</tr>
<tr>
<td><strong>Tier 2: Preferred Brands</strong></td>
<td>$30 copay per script</td>
<td>$75 copay per script</td>
</tr>
<tr>
<td><strong>Tier 3: Preferred Specialty</strong></td>
<td>$50 copay per script, limited to 30 day supply</td>
<td>You pay 30% of the cost of the medication</td>
</tr>
<tr>
<td><strong>Tier 4: Non-Preferred</strong>*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*includes generics, brands and specialty medications.

To find out what drugs are preferred and in our Essentials Formulary:
- Visit [www.premera.com](http://www.premera.com)
- From the landing page, select the “Pharmacy” tab
- Use the “Drug Search” option, then "Rx Search"
- Type in the name of the medication and select the "E4 Formulary" from the drop down menu
- If a drug is excluded from the preferred Essentials drug list, “EX” will appear next to the drug name
- If not excluded, you will see coverage tier 1, 2, 3 or 4

Note: If you fail to show your Plan ID card at the pharmacy, or you use a pharmacy that is not part of the Express Scripts network, you must pay the full cost of the medication and file a claim with Premera for reimbursement. The plan will pay 60% after the applicable copay.

**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](http://Premera.com) for more information about how to get started receiving your medications by mail.

**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.
TELADOC

If you are at home or on the road, Teladoc can be your go-to resource for convenient, quality medical care through virtual physician visits.

With your Premera health plan, you and your covered family members can get virtual care by phone or video, from a board certified doctor for common conditions like cold or flu symptoms, ear infections, urinary tract infections, rashes, or eye irritation. The Teladoc physicians can consult, diagnose and prescribe appropriate medications – saving you a trip to the doctor, urgent care center or emergency room.

To get started you must register. Here’s how:

1) **Online:**
   - Visit teladoc.com/Premera
   - Click “Set-up Account”
   - Enter required information, including fields on the My Medical History tab

2) **Use the Teladoc smartphone App** and follow the instruction for registration

3) **Call** Teladoc at **855.332.4059** and register by phone

Once your account is set up, a doctor visit is just a call or click away! Call Teladoc at 855-332-4059. Register now so you (or your family member) is ready when you need care. Add the Teladoc phone number to your cell phone or download their smartphone app so care is always at your fingertips!

The visit will cost $45, which will go towards your deductible or will be paid at 80% if you have already satisfied your deductible. That is much less than a regular office visit which costs about $165 or an emergency room visit which costs about $1,200.

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.

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**.
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.

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.

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).
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 for out-of-pocket medical care 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 (the 20% you pay), and emergency room copay based on what is reported on your Premera explanation of benefits that you receive each time you receive care. You can also use the funds for your pharmacy copayments, but you will be required to submit your pharmacy receipts (retail or mail order) to Navia for reimbursement. See the instructions on page 9 for filing Flexible Spending Account claims – the HRA submission works the same, but be sure to indicate an HRA reimbursement if you are submitting through their smartphone App.

### 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 up to $500 will be rolled over to be used in the following calendar year. Anything over $500 will be forfeited. Only enroll in the plan for expenses you know you will incur between January 1 and December 31 each year, but know that if it looks like you will have funds left over, up to $500 will roll over.

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 not funded by your HRA
- Out of pocket medical expenses

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

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, coinsurance, copays and pharmacy expenses), 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, or manually via email, fax or mail. Claim forms can be found on the HR webpage if submitting manually. 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>Benefits</th>
<th>DENTAL OPTIMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$50 Individual</td>
</tr>
<tr>
<td></td>
<td>$150 Family</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>(Oral Exams, X-rays, Fluoride treatment)</td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>80% after the deductible</td>
</tr>
<tr>
<td>(Fillings Extractions, oral surgery, periodontics)</td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>50% after the deductible</td>
</tr>
<tr>
<td>(Crowns, Bridges, Dentures, Repairs)</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum per Individual</td>
<td>$1,500</td>
</tr>
<tr>
<td>Orthodontia Services, per Individual</td>
<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 may be responsible for any additional amounts (also called balance billing) if you use an out-of-network provider.
Vision

Puget Sound will provide base plan benefits to all benefits-eligible faculty and staff through Vision Service Plan (VSP). This coverage provides an annual routine eye exam at no cost to you (so long as you use a VSP provider). You can choose the base plan only, or you can elect to purchase full vision coverage through the buy-up plan, which covers vision hardware including lenses, frames and contact lenses.

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 or call customer service at 1.800.877.7195.

COST OF VISION COVERAGE

The base plan (exam only) is provided by Puget Sound. If you do not elect a vision plan, you will be enrolled in the base plan by default. The buy-up plan is voluntary. If you choose the buy-up plan, premiums for you, your spouse and/or your eligible children will be deducted from your paycheck before taxes. Premiums for domestic partners or children of domestic partners will be deducted after taxes. 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>Vision Exam</td>
<td>$0 copay, covered at 100%</td>
<td>Plan pays up to a $50 allowance</td>
</tr>
<tr>
<td>1 exam every calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BUY-UP (MATERIALS) PLAN</th>
<th>Everyone Who Enrolls for Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copay</td>
<td>Limited to One Set Every calendar year</td>
</tr>
<tr>
<td>Eyeglass Lenses</td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>100%</td>
</tr>
<tr>
<td>Bifocals</td>
<td>100%</td>
</tr>
<tr>
<td>Trifocals</td>
<td>100% after $50 copay</td>
</tr>
<tr>
<td>Standard Progressives</td>
<td>100% after $80 to $90 copay</td>
</tr>
<tr>
<td>Premium Progressives</td>
<td>100% after $120 to $160 copay</td>
</tr>
<tr>
<td>Custom Progressives</td>
<td>100% for children</td>
</tr>
<tr>
<td>Polycarbonate Lenses</td>
<td>35 to 40% discount</td>
</tr>
<tr>
<td>Other lens enhancements</td>
<td></td>
</tr>
</tbody>
</table>

| Eyeglass Frames         | 100% up to $150, $170 for featured frame brands, $80 at Costco |
| 1 pair every other calendar year |                      |

| Contact Lenses (Instead of Glasses) | 100% up to $150 allowance |
| Every calendar year               | Contact lens fitting: 100% after $60 copay |

| Additional Pairs of Glasses and Sunglasses | 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 |
|                                          | No benefit for fitting |

<table>
<thead>
<tr>
<th>Laser Vision Correction</th>
<th>Average 15% off regular price or 5% off promotional price; only available from VSP contracted providers</th>
</tr>
</thead>
</table>
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.

Vertically aligning the parentheses

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**

**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 [www.unum.com/lifebalance](http://www.unum.com/lifebalance)
Or 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 as defined in the plan document.

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](http://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> Company ID: UPD <a href="mailto:customerservice@naviabenefits.com">customerservice@naviabenefits.com</a> email claims: <a href="mailto:claims@naviabenefits.com">claims@naviabenefits.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>UNUM</td>
<td>1.800.854.1446</td>
<td><a href="http://www.unum.com/lifebalance">www.unum.com/lifebalance</a></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>
Help, when you need it most

With your Employee Assistance Program and Work/Life Balance services, confidential assistance is as close as your phone or computer.

Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Family and parenting problems
- Anger, grief and loss
- And more

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

Ask our Work/Life Specialists about:

- Child care
- Elder care
- Legal questions
- Identity theft
- Financial services, debt management, credit report issues
- Even reducing your medical/dental bills!
- And more

Help is easy to access:

- Online/phone support: Unlimited, confidential, 24/7.
- In-person: You can get up to 3 visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver™ — helps you save on medical bills

Who is covered?

Unum’s EAP services are available to all eligible employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Employee Assistance Program — Work/Life Balance

Toll-free 24/7 access:

- 1-800-854-1446 (multi-lingual)
- www.unum.com/lifebalance

Turn to us, when you don’t know where to turn.

* The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

Unum’s Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

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Is Apple Health for you?

Find out. Apple Health (Medicaid) is free or low-cost health care coverage based on income.

www.hca.wa.gov/ah4u

At www.hca.wa.gov/ah4u you can:

✔ See if you’re eligible.
✔ Learn how to apply or renew.
✔ Read what’s new and why.

Go to www.hca.wa.gov/ah4u or scan the QR code to get there.
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.
Legal Notices

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 healthcare reform law (or Affordable Care Act (ACA) or Obamacare) is complicated and you may have questions about how it impacts you, your family and your benefits. There are three items you should know.

First, the individual mandate (the requirement that all individuals have health insurance) remains in place. What has changed is the penalty associated with it. As of January 1, 2019, the ACA tax penalty is repealed and you won’t have to pay anything if you don’t enroll.

Second, the Health Insurance Marketplace still exists. You can shop for and enroll in insurance plans through the exchange and still apply for income based subsidies.

Third, for most people the plans we offer are considered affordable 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](http://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](http://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, 2019
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).
## Legal Notices

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
</tr>
</thead>
</table>
| Website: [http://myalhipp.com/](http://myalhipp.com/)  
Phone: 1-855-692-5447 | Website: [http://flmedicaidtplrecovery.com/hipp](http://flmedicaidtplrecovery.com/hipp)  
Phone: 1-877-357-3268 |

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<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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| The AK Health Insurance Premium Payment Program  
Website: [http://myakhipp.com/](http://myakhipp.com/)  
Phone: 1-866-251-4861  
Email: CustomerService@MyAKHIPP.com  
Medicaid Eligibility: [http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx](http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx) | Website: [http://dch.georgia.gov/medicaid](http://dch.georgia.gov/medicaid)  
- Click on Health Insurance Premium Payment (HIPP)  
Phone: 404-656-4507 |

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<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
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| Website: [http://myarhipp.com/](http://myarhipp.com/)  
Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64  
Website: [http://www.in.gov/fssa/hip](http://www.in.gov/fssa/hip)  
Phone: 1-877-438-4479  
All other Medicaid  
Website: [http://www.indianamedicaid.com](http://www.indianamedicaid.com)  
Phone 1-800-403-0864 |

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<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
<th>IOWA – Medicaid</th>
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</table>
| Health First Colorado Website: [https://www.healthfirstcolorado.com/](https://www.healthfirstcolorado.com/)  
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711  
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus  
Phone: 1-800-257-8563 |

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<tr>
<th>KANSAS – Medicaid</th>
<th>NEW HAMPSHIRE – Medicaid</th>
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| Website: [http://www.kdheks.gov/hcf](http://www.kdheks.gov/hcf)  
Phone: 1-785-296-3512 | Website: [https://www.dhhs.nh.gov/ombp/nhhpp](https://www.dhhs.nh.gov/ombp/nhhpp)  
Phone: 603-271-5218  
Hotline: NH Medicaid Service Center at 1-888-901-4999 |

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<tr>
<th>KENTUCKY – Medicaid</th>
<th>NEW JERSEY – Medicaid</th>
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| Website: [https://chfs.ky.gov](https://chfs.ky.gov)  
Phone: 1-800-635-2570 | Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)  
Medicaid Phone: 609-631-2392  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-541-2392 |

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<tr>
<th>LOUISIANA – Medicaid</th>
<th>NEW YORK – Medicaid</th>
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| Website: [http://dhb.louisiana.gov/index.cfm/subhome/1/n/33](http://dhb.louisiana.gov/index.cfm/subhome/1/n/33)  
Phone: 1-888-695-2447 | Website: [https://www.health.ny.gov/health_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)  
Phone: 1-800-541-2831 |

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<th>MAINE – Medicaid</th>
<th>NORTH CAROLINA – Medicaid</th>
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Phone: 1-800-442-6003  
TTY: Maine relay 711 | Website: [https://dma.ncdhhs.gov/](https://dma.ncdhhs.gov/)  
Phone: 919-855-4100 |

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<th>MASSACHUSETTS – Medicaid and CHIP</th>
<th>NORTH DAKOTA – Medicaid</th>
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Phone: 1-800-862-4840 | Website: [http://www.nd.gov/dhs/services/medicalserv/medicaid/](http://www.nd.gov/dhs/services/medicalserv/medicaid/)  
Phone: 1-844-854-4825 |
## Legal Notices

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<th>MINNESOTA – Medicaid</th>
<th>OKLAHOMA – Medicaid and CHIP</th>
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<tr>
<td>Website: <a href="https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>&lt;br&gt;Phone: 1-800-657-3739</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>&lt;br&gt;Phone: 1-888-365-3742</td>
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<th>MISSOURI – Medicaid</th>
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<th>MONTANA – Medicaid</th>
<th>PENNSYLVANIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>&lt;br&gt;Phone: 1-800-643-3084</td>
<td>Website: <a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a>&lt;br&gt;Phone: 1-800-692-7462</td>
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<th>NEBRASKA – Medicaid</th>
<th>RHODE ISLAND – Medicaid</th>
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<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>&lt;br&gt;Phone: (855) 632-7633&lt;br&gt;Lincoln: (402) 473-7000&lt;br&gt;Omaha: (402) 595-1178</td>
<td>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>&lt;br&gt;Phone: 855-667-4347</td>
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<th>NEVADA – Medicaid</th>
<th>SOUTH CAROLINA – Medicaid</th>
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<tr>
<td>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>&lt;br&gt;Medicaid Phone: 1-800-992-0900</td>
<td>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>&lt;br&gt;Phone: 1-888-549-0820</td>
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<th>SOUTH DAKOTA - Medicaid</th>
<th>WASHINGTON – Medicaid</th>
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<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>&lt;br&gt;Phone: 1-888-828-0059</td>
<td>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a>&lt;br&gt;Phone: 1-800-562-3022 ext. 15473</td>
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<th>TEXAS – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
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<th>VERMONT – Medicaid</th>
<th>WYOMING – Medicaid</th>
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<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>&lt;br&gt;Phone: 1-800-250-8427</td>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a>&lt;br&gt;Phone: 307-777-7531</td>
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<th>VIRGINIA – Medicaid and CHIP</th>
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<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a>&lt;br&gt;Medicaid Phone: 1-800-432-5924&lt;br&gt;CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a>&lt;br&gt;CHIP Phone: 1-855-244-8282</td>
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To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

- **U.S. Department of Labor**<br>Employee Benefits Security Administration<br>www.dol.gov/agencies/ebsa<br>1-866-444-EBSA (3272)
- **U.S. Department of Health and Human Services**<br>Centers for Medicare & Medicaid Services<br>www.cms.hhs.gov<br>1-877-267-2323, Menu Option 4, Ext. 61565

**OMB Control Number 1210-0137 (expires 12/31/2019)**
This benefit guide was created by your knowledgeable and friendly benefits professionals at Parker, Smith & Feek!