

2022 BENEFIT GUIDE



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.



**Contact
human resources
regarding any
questions you
may have about
the information
contained in this
booklet. We will be
happy to assist you.**

**We can be
reached at:
Howarth Hall 016
253.879.3369
benefits@pugetsound.edu**

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 (HRA)**
- » **Flexible Spending Accounts – healthcare and dependent care**
- » **Long Term Disability**
- » **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 (including an HRA), prescription drug, basic dental, basic vision, 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 the Benefit Enrollment/Change Form. All benefit elections, including medical, dental, vision, voluntary life/voluntary AD&D and flexible spending accounts are included on this form.
- 4)** Electronically submit the online Benefit Enrollment/Change Form to Human Resources.
- 5)** Submit an Affidavit of Marriage or Domestic Partnership Form if you plan to enroll a spouse or domestic partner for the first time.
- 6)** Submit a Lincoln 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.



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.

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 for service dates 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 for 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



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.

For those who are participating in our dependent care flexible spending account, in addition to the reasons, above, you may also change your dependent care elections mid-year if you experience closure of your daycare center, if you change daycare providers and there is a significant cost change, if your children no longer need before or after school care, etc. Contact WEX for more information.

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

Medical And Prescription Drug Benefits

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.

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, prescription drug and HRA plans are 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	CONTRACTED OR OUT-OF-NETWORK
Calendar Year Deductible	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
Out-of-Pocket Maximum Includes deductible, copays and coinsurance	Calendar Year \$4,000 Individual \$8,000 Family	Calendar Year \$8,500 Individual \$17,000 Family
Preventive Care* <i>Routine Exam</i>	Paid at 100% no deductible	Paid at 100% no deductible
<i>Laboratory Services and screenings including colonoscopy, mammograms</i>	Paid at 100% no deductible	Paid at 60% after deductible
Physician Services <i>Office Visits, surgery and inpatient care Includes Virtual Care</i>	Paid at 80% after deductible	Paid at 60% after deductible
X-Ray and Laboratory Services <i>Inpatient and Outpatient</i>	Paid at 80% after deductible	Paid at 60% after deductible
Emergency Room	Paid at 80% after \$150 copay and deductible	
Hospital Services <i>Inpatient and Outpatient</i>	Paid at 80% after deductible	Paid at 60% after deductible
Outpatient Rehabilitation <i>Physical, occupational and speech therapy Includes Virtual Care</i>	Paid at 80% after deductible	Paid at 60% after deductible <i>Limited to 60 visits per calendar year</i>
Mental Health <i>Inpatient and Outpatient and virtual care</i>	Paid at 80% after deductible	Paid at 60% after deductible
Spinal Manipulations	Paid at 80% after deductible	Paid at 60% after deductible <i>Limited to 12 visits per calendar year</i>

*Preventive care services from PPO network providers 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 <https://www.premera.com/visitor/care-essentials/preventive-care>.

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](https://www.premera.com) or call customer service at 1.800.722.1471.**

i 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](https://www.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 medication 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 of up to a 90 day supply of medications to your home through the mail. Visit **Premera.com** for more information about how to get started receiving your medications by mail.

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:

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

*includes generics, brands and specialty medications.

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.

SPECIALTY MEDICATION PROGRAM WITH SAVEONSP

For those who use specialty medications, our plan includes the services of SaveonSP. This program allows you and our health plan to take advantage of discounts that the drug manufacturer gives through their payment coupon programs. This program will benefit both the patient and the plan, lowering your cost share and helping to keep our healthcare costs more affordable.

If you take a specialty medication it must be purchased through Accredo Specialty pharmacy. During the set up process, they will advise you if your medication is part of the SaveonSP program. If you choose to participate, the cost of your medication will be zero. If you don't enroll with SaveonSP, your cost share will be significantly more – equal to 30% of the cost of the drug. This program only applies to certain specialty medications, so if you take a medication not part of this program, regular cost shares will apply.

To find out what drug are preferred and in our Essentials Formulary:

- Visit **www.premera.com** and log in as a member
- Under “Prescriptions” at the top of the page, select “Manage Prescriptions”
- Select “Search drug prices” to access the Express Scripts interactive cost and coverage tool

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.

Tools To Manage Your Health - Premera



VIRTUAL CARE

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

You have two options for virtual care: **98point6** and **Doctor on Demand**. You also have access to **TalkSpace** for virtual behavioral health visits. Following is what each provider offers:

Services	98point6	Doctor on Demand	TalkSpace
24/7 Access	Yes	Yes	Yes – emergencies only
Care delivered by phone	No	Yes	Yes
Care delivered by video chat	No	Yes	Yes
Care delivered by text messaging	Yes	No	No
Primary or Urgent Care Provider	Yes	Yes	No
Dermatology Care	Yes	Yes	No
Mental Health Provider	No	Yes	Yes
Prescribe Medications?	Yes	Yes	Yes
Order Medical Tests	Yes	Yes	No

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

The cost of the visit will vary by provider type, and will go towards your deductible or will be paid at 80% if you have already satisfied your deductible. Virtual urgent or primary care is much less expensive than a regular office visit, which costs about \$165 or an emergency room visit which costs about \$1200 per visit. Behavioral health care visits are based on Premera’s regular fee schedule, so the cost will be about the same as an in person visit, but will be much more convenient. Here is a summary of the cost of visits by provider:

Visit Type	98point6	Doctor on Demand	TalkSpace
Urgent or Primary Care	Less than 10 minute visit: \$19 10 to 20 minute visit: \$39 21+ minute visit: \$62	\$60 per visit	Not offered
Behavioral Health Counseling	Not offered	Follows regular Premera behavioral health fee schedule which varies by provider and service type. Most therapy is around \$100 per visit.	Follows regular Premera behavioral health fee schedule which varies by provider and service type. Most therapy is around \$100 per visit.

Here is additional information about each option and how to access care from each:

98point6

You will access services at your convenience from the 98point6 App by text messaging. You will be immediately connected with an “automated assistant” that will ask questions and collect information about the purpose of the visit and background on the patient. These are shared with the attending physician who will join the conversation to provide the needed medical care. The average wait time for a physician is 3 minutes. The 98point6 physician can provide both primary and urgent care, and they can order medical tests. Contact 98point6 by downloading their smart phone App and following the instruction to register before your first visit. Have your Premera ID card handy.


Tools To Manage Your Health - Premera (*continued*)

Doctor on Demand

Different from 98point6, the Doctor on Demand visit is done through their technology platform (desktop, tablet, app) by video chat. You can request an immediate visit and you will be contacted within an average of 4 to 7 minutes. Or you can make an appointment and select the provider you would like to see from the Doctor on Demand website. Their physicians can provide both primary and urgent care, and they can order medical tests. Contact Doctor on Demand at www.doctorondemand.com/premera or download their mobile app. You will need to follow the instructions to register prior to your first visit. Have your Premera ID card handy.

Doctor on Demand Behavioral Health Care

In addition to medical care issues, you can also receive behavioral health counseling through Doctor on Demand. Just as with in-person visits, you can select your provider and have regularly scheduled virtual sessions by video. They have a variety of provider types available who can provide talk therapy or medication management, or both! It usually takes between 1 and 3 days to schedule an appointment, and while this care is not available 24/7, there are expanded hours. You can go on the Doctor on Demand site or app and select the provider that best fits your care criteria prior to making your appointment. Contact Doctor on Demand at www.doctorondemand.com/premera or download their mobile app.

 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**, visit their website at www.premera.com, or download their smartphone app.

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.

TalkSpace Behavioral Health Care

You can receive behavioral health counseling through TalkSpace. Just as with in-person visits, you can select your provider and have regularly scheduled virtual sessions by video, phone or text message. They have a variety of provider types available who can provide talk therapy or medication management, or both! It usually takes between 1 and 3 days to schedule an appointment, and while this care is not available 24/7, there are expanded hours. Once you have established a relationship with your provider, you have access to unlimited text messaging. You can go on the TalkSpace site or mobile app and select the provider that best fits your care criteria prior to making your appointment. You will need to register prior to your first visit, so have your Premera ID card handy.

Virtual Physical Therapy – Through Physera

You also have access to physical therapy through virtual visits. Has your doctor recommended physical therapy, or are you having some back, shoulder or knee pain that could benefit from some care? Now you can do your physical therapy from the comfort and convenience of your home. This saves you time and money, since you can have the visits before work, after work, or whenever it is convenient for you. Just as with in-person visits, there will be an initial consultation and assessment, which costs \$100 and will be processed as any other claim. If a course of treatment is needed, you will then be charged additional \$225 for 3 weeks of unlimited visits. Your physical therapist will work with you to create a treatment plan, make sure you know what you are supposed to do and how frequently, and make sure you are doing it correctly. If you need equipment, it will be sent to you. If after 3 weeks you need ongoing care, you will be charged an addition \$225 for 4 additional weeks of care.

Tools To Manage Your Health - Premera (*continued*)

CHRONIC CONDITION SUPPORT WITH LIVONGO

Six in ten adults in the United States are living with a chronic condition. Of those, 91% say they need more help managing their condition. Premera provides a comprehensive chronic condition support program through Livongo to help anyone managing diabetes or hypertension, or who may be at risk for developing diabetes through their diabetes prevention program.

If you qualify, you will get:

- Personal health support from expert coaches
- Help with strategies for living with diabetes or high blood pressure
- Help with weight loss and other strategies for those at risk for becoming diabetic
- Connected technology that delivers real-time results and remote monitoring (like blood sugar, blood pressure and weight), with outreach if your numbers are outside norms
- Continuing education and push notifications

Participation is completely voluntary and you can opt out at any time. Livongo will reach out to anyone who meets the criteria to participate in the program.

PREMERA CENTERS OF EXCELLENCE – NO COST SURGERY FOR HIP AND KNEE REPLACEMENTS

Premera has contracted with Centers of Excellence for the replacement of knees and hips. The selection of providers is based on high quality metrics and discounted rates. Valley Medical Center in Renton is the designated center of excellence for this type of care for Puget Sound plan members. If you choose to have your surgery through the Premera Centers of Excellence program, your out-of-pocket costs for the surgery will be waived. You must work with Premera's care coordinator who will arrange your care and help you through the process. Call Premera to access this program.

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](https://www.premera.com) and log in.

Under "Find a Doctor" tool you can look for providers in your Heritage Prime network. Physicians and hospitals will have both patient review data and the "Blue Distinction" or "Blue Distinction Plus" designation of quality.

You can also compare prices for many treatments. In the "Find a Doctor" tab:

Put in your criteria – location and miles you are willing to travel

- In the "Browse by Category" (top left) drop down select the "Medical Procedure Costs" tab
 - Select which service you would like to cost compare
 - The results will have the lowest cost first and will show your cost based on your coverage and the amount remaining to meet your deductible
 - To determine the total cost of care (yours and the provider's) click on the "view profile" for each provider.

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 and work through 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](https://www.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:

IF YOU ARE COVERING	CALENDAR YEAR FUNDING	MAXIMUM ROLL OVER
Yourself	\$750	Up to \$750
Yourself and any family members	\$1,500	Up to \$1,500

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 Premera. Access to your HRA account for out-of-pocket medical care is easy and automatic. 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 then applies any unused HRA funds towards your out-of-pocket costs and adjusts your responsibility accordingly
- 5) Premera issues payment to the provider which includes any HRA funds that are applied to your out-of-pocket costs
- 6) You pay your provider any remaining balance due

Premera will track the amount remaining in your HRA. Your available balance will be indicated on your Explanation of Benefits statement. You can also call Premera Customer Service for updates on your HRA balance, especially after using your funds towards prescription drugs which do not generate an EOB.

All HRA claims are processed within the Premera claim system. There are no claim forms. If you have coverage through another medical plan that is secondary to the Puget Sound plan, the HRA funding is now part of the primary payment from the Puget Sound plan.

When your HRA balance equals zero, Premera will continue to process claims as they come in and pay providers after applying your deductible and coinsurance. The EOB will indicate your member responsibility and you will pay your provider once you receive your invoice.



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 pharmacy copayments. HRA funds will automatically apply to your pharmacy copayments when your pharmacist processes your prescription.

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.

HEALTH CARE FSA

You can set aside up to \$2,850 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 like your deductible and coinsurance

For a complete list of eligible and non-eligible FSA expenses, visit WEX's website at www.wexinc.com.

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 Health Care FSA funds within this period, the remaining balance in your account up to \$570 will be rolled over to be used in the following calendar year. Anything over \$570 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 \$570 will roll over.



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, expenses of 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, 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 paid through the HRA first, and then you can claim any remaining balance from your 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). For the dependent care account you can also change if there is a change in your childcare needs or costs.

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?

WEX will issue each participant a debit card that can be used to pay for qualified medical expenses. You can also submit claims online, through WEX'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 WEX's site at www.wexinc.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



Puget Sound will provide base dental plan benefits to all benefits-eligible faculty and staff through Premera. This coverage provides diagnostic and preventive care services paid at 100% when using in-network providers. The base plan will pay a maximum of \$500 in care for the calendar year. You can choose the base plan only, or you can elect to purchase full dental coverage through the buy-up plan which includes benefits for basic, major and orthodontia services.

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 Choice network, visit Premera.com or call customer service at **1.800.722.1471**.

COST OF DENTAL COVERAGE

The base plan (diagnostic and preventive services only) is provided by Puget Sound. If you do not elect a dental plan, you will be enrolled on the base plan by default. You can choose to enroll dependents on the base plan and you will pay for the cost for their coverage. 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. Current monthly rates for our dental base and buy-up plan are listed in the Benefits Election Worksheet.

i You may be responsible for any additional amounts (also called balance billing) if you use an out-of-network provider.

Below is a summary of our dental plan benefits:

	Base Plan	Buy-Up Plan
	Dental Choice Providers	
Calendar Year Deductible	None	\$50 Individual \$150 Family
Preventive Care (Oral Exams, X-rays, Fluoride treatment)	100%	100%, no deductible
Basic Services (Fillings Extractions, oral surgery, periodontics)	Not covered	80% after the deductible
Major Services (Crowns, Bridges, Dentures, Repairs)	Not covered	50% after the deductible
Calendar Year Maximum per Individual	\$500	\$1,500
Orthodontia Services, per Individual	Not covered	Covered up to \$1,000 lifetime



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 pay upfront and submit a claim to VSP who will reimburse you 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.

	VSP Providers	All Other Providers
BASE (EXAM ONLY) PLAN	Everyone Who Enrolls for Medical	
Vision Exam 1 exam every calendar year	\$0 copay, covered at 100%	Plan pays up to a \$50 allowance
BUY-UP (MATERIALS) PLAN	For those who choose to Buy-up	
Copay	\$10 copay	\$10 copay
Eyeglass Lenses	Limited to One Set Every calendar year	
<i>Single Vision</i>	100%	100% up to \$50 allowance
<i>Bifocals</i>	100%	100% up to \$75 allowance
<i>Trifocals</i>	100%	100% up to \$100 allowance
<i>Standard Progressives</i>	100% after \$50 copay	100% up to \$75 allowance
<i>Premium Progressives</i>	100% after \$80 to \$90 copay	100% up to \$75 allowance
<i>Custom Progressives</i>	100% after \$120 to \$160 copay	100% up to \$75 allowance
<i>Polycarbonate Lenses</i>	100% for children	No additional benefit
<i>Other lens enhancements</i>	35 to 40% discount	No additional benefit
Eyeglass Frames 1 pair every other calendar year	100% up to \$150, \$170 for featured frame brands, \$80 at Costco or Walmart	100% up to \$70 allowance
Contact Lenses (Instead of Glasses) Every calendar year	100% up to \$150 allowance Contact lens fitting: 100% after \$60 copay	100% up to \$105 allowance No benefit for fitting
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
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; only available from VSP contracted providers	No benefit

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 can purchase term life insurance for yourself, your spouse and your children. Here is what our plan offers:

COVERED INDIVIDUAL	MINIMUM BENEFIT	MAXIMUM BENEFIT	PURCHASED IN INCREMENTS OF	GUARANTEED ISSUE AMOUNT
You	\$10,000	The lesser of 5x salary or \$500,000	\$10,000	\$180,000
Spouse/Partner	\$5,000	The lesser of 50% of the employee election or \$150,000	\$5,000	\$50,000
Child(ren)* over 6 months	\$5,000	\$20,000	\$5,000	Full amount

*Children are covered up to age 26. There is no child benefit from birth – 14 days. The maximum benefit for 14 days to 6 months is \$2,500.

As long as you enroll within 31 days of eligibility, you can purchase up to the guaranteed issue amount noted above 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 Lincoln.

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.

i **CHANGES TO VOLUNTARY LIFE:** You may increase your coverage by one increment 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 increment, you will need to complete an evidence of insurability form and be approved by Lincoln.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

In addition to voluntary life insurance, you may purchase AD&D coverage for yourself, your spouse/partner and your children (up to age 26). The coverage levels available match the voluntary life amounts listed above.

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 90 days of disability.

How long will I receive benefits?

As long as you meet Lincoln'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 90 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, a 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.



For more information about our LTD plan, or to file a claim, contact Lincoln at **1.800.320.7585**

Employee Assistance Program (EAP) – ComPsych

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 eligible for benefits, 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.GuidanceResources.com

Username: LFGsupport

Password: LFGsupport1

Or call **1.888.628.4824**

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** 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?

Puget Sound contributes 6% of regular salary for eligible faculty and staff members. You are not required to contribute any money to receive the Puget Sound contributions.




Important Phone Numbers And Websites

CONTACT	CARRIER	LOCATION / PHONE NUMBER	EMAIL OR WEBSITE
Human Resources		Howarth 016 (M-F 8 a.m. to noon, and 1 – 5 p.m.) Phone: 253.879.3369 Fax: 253.879.2839	benefits@pugetsound.edu
Medical and Dental Insurance	Premera	Customer Service: 1.800.722.1471 Out-of-State Care: 1.800.810.BLUE (2583)	www.premera.com
Prescription Drug	Express Scripts	Phone: 1.800.391.9701 Fax: 1.888.327.9791	www.premera.com
Vision Insurance	Vision Service Plan (VSP)	Phone: 1.800.877.7195	www.vsp.com
Health Reimbursement Arrangement (HRA)	Premera	Phone: 1.800.722.1471	www.premera.com
Flexible Spending Account (FSA)	WEX	Phone: 866.451.3399	www.wexinc.com customerservice@wexhealth.com
Life/AD&D	Lincoln	800.423.2765	www.lfg.com
LTD and FMLA Leave Administration	Lincoln	Claim: 800.320.7585 Leave: 866.277.5276	Mylincolnportal.com
Employee Assistance Program	ComPsych	1.888.628.4824	www.GuidanceResources.com Username: LFGsupport Password: LFGsupport1
Retirement Savings	TIAA	1.800.842.2252	www.tiaa.org/pugetsound
Washington Health Benefit Exchange		1.855.923.4633	www.wahealthplanfinder.org

The resources you need to meet life's challenges



*EmployeeConnect*SM offers professional, confidential services to help you and your loved ones improve your quality of life.

 In-person guidance	 Unlimited 24/7 assistance	 Online resources
<p>Some matters are best resolved by meeting with a professional in person. With <i>EmployeeConnect</i>, you and your family get:</p> <ul style="list-style-type: none"> ▪ In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year) ▪ In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings 	<p>You and your family can access the following services any time – online, on the mobile app, or with a toll-free call:</p> <ul style="list-style-type: none"> ▪ Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more ▪ Legal information and referrals for family law, estate planning, and consumer and civil law ▪ Financial guidance on household budgeting and short- and long-term planning 	<p><i>EmployeeConnect</i> offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNowSM mobile app. You'll find:</p> <ul style="list-style-type: none"> ▪ Articles and tutorials ▪ Videos ▪ Interactive tools, including financial calculators, budgeting worksheets, and more

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress





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.

Washington State
Health Care Authority



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

Legal Notices

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.

Legal Notices

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).

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, 2021, 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**.

Legal Notices

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.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current 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.

Legal Notices

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, 2022
Name of Entity/Sender:	University of Puget Sound
Contact-Position/Office:	Erin Ruff
Address:	1500 N. Warner St. #1064 Tacoma, WA 98416-1064
Phone Number:	253-879-3640

Legal Notices

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 July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: 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/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
CALIFORNIA – Medicaid	IOWA – Medicaid and CHIP (Hawki)
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
COLORADO Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	KANSAS – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884

Legal Notices

<p style="text-align: center;">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p style="text-align: center;">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p style="text-align: center;">LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p style="text-align: center;">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p style="text-align: center;">MAINE – Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 TTY: Maine relay 711</p>	<p style="text-align: center;">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p style="text-align: center;">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840</p>	<p style="text-align: center;">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>
<p style="text-align: center;">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p style="text-align: center;">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
<p style="text-align: center;">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p style="text-align: center;">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p style="text-align: center;">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>	<p style="text-align: center;">OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>
<p style="text-align: center;">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>	<p style="text-align: center;">PENNSYLVANIA – Medicaid</p> <p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462</p>
<p style="text-align: center;">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p style="text-align: center;">RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItte Share Line)</p>
<p style="text-align: center;">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>	<p style="text-align: center;">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>
<p style="text-align: center;">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p style="text-align: center;">SOUTH DAKOTA – Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p style="text-align: center;">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p style="text-align: center;">TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>

Legal Notices

UTAH – Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	WEST VIRGINIA – Medicaid Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VIRGINIA – Medicaid and CHIP Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924	WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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



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

