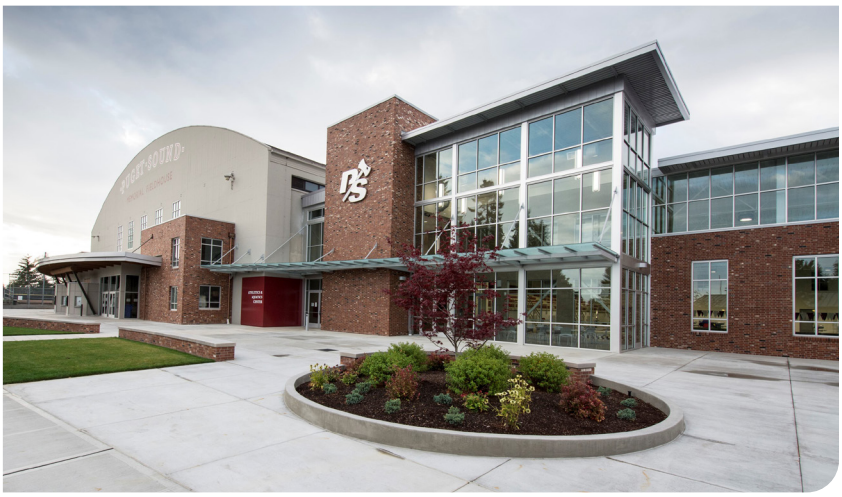
2024

OPEN ENROLLMENT BENEFITS GUIDE

Est. 1888
UNIVERSITY of PUGET SOUND



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 24 for more details.

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UNIVERSITY of PUGET SOUND

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

Open Enrollment 2024

Welcome to Open Enrollment 2024! Our health care plan renews on January 1, 2024, and every year we review our benefits plan offering, consider our levels of benefits, our insurance company performance, and the cost to both you and the University.

Based on this review, we have made the following decisions for our benefits offering effective January 1, 2024:

- Premera Blue Cross will continue to administer our medical, HRA, and dental benefits
- Vision Service Plan (VSP) will continue to provide our vision benefits
- You continue to have a choice of base and buy-up dental and vision plans
- Life and disability benefits will continue to be offered through Lincoln Financial Group
- You will continue to be able to set aside pre-tax dollars into a Flexible Spending Account (FSA) for healthcare or dependent care expenses administered by WEX
- **No changes to medical, dental or vision premiums!**

The following guide provides the information needed to assist you and your family to make decisions about your benefits during this year's open enrollment, which runs from October 30 - November 10, 2023. Please take a few minutes to review the important information in this Guide in order to make the best healthcare coverage decisions for you and your family.

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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*

- 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 may also include 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.

Enrolling In Coverage

If you are a faculty or staff member who is newly eligible for our benefits plans, you have 30 days from your hire date (or date of appointment to an eligible position) to enroll yourself and your eligible dependents.

If you don't enroll, or you waive coverage, you'll automatically be enrolled in the benefits shown below at no cost to you:

- Basic Life Insurance and AD&D
- Employee Assistance Program

Once you're enrolled in benefits, you generally aren't allowed to make changes until the next annual Open Enrollment. Open Enrollment is your one chance each year to review your coverage and make changes to your benefits. It's also your chance to enroll if you declined coverage when you first became eligible. Open Enrollment changes take effect on January 1st each year.

Other than during Open Enrollment, you can make changes to your benefits during the year only if you experience a Qualifying Life Event. Please refer to the Special Enrollment section later in this document (**page 5**).

Open Enrollment

This is the time of year to add or drop coverage for any eligible family members. If you do not enroll an eligible spouse or child now because they have coverage through another employer, you may only add that person on our plan during next year's Open Enrollment period, unless you experience a Qualifying Life Event. Please refer to the Special Enrollment section later in this document (**page 5**). Any changes you make will be effective January 1, 2024.

Open enrollment also provides you an opportunity to change your existing voluntary life coverage with Lincoln. You may increase voluntary life insurance coverage for yourself by $10,000 with no questions asked (no Evidence of Insurability application is needed) during open enrollment if you haven't been previously declined for coverage. You may increase existing voluntary life coverage for your spouse or domestic partner by $5,000 with no questions asked as long as they haven't previously been declined for coverage. If your total election exceeds the guaranteed issue amount (You: $180,000, Sp/DP: $50,000), then you will need to submit an Evidence of Insurability application when you request to increase your election.

If you wish to increase your voluntary life benefit amount by more than $10,000 for yourself and/or $5,000 for your spouse or domestic partner, you will be required to complete an Evidence of Insurability application to prove your good health, and the additional coverage would not be effective until approved by Lincoln.

You may also change your voluntary AD&D election at open enrollment. AD&D coverage is not subject to evidence of insurability.

This is also the one time of year when you can choose to participate in our healthcare and dependent care flexible spending accounts for 2024.

Online Enrollment

The enrollment election process is done online through Employee Navigator. Each employee must create an account and sign in to make and review benefits elections or submit benefits changes due to a Qualifying Life Event.

How do I create an account and sign into Employee Navigator?

- You can access Employee Navigator two different ways
  - Visit **www.employeenavigator.com**; or
  - Log into your My Apps Dashboard – University of Puget Sound and choose the Employee Navigator – HR Benefits Portal.
- Select "Login" in the upper right corner of the webpage and then "Register as a new user."
  - When you register for the first time, please enter your Social Security Number
  - Company Identifier: **University of Puget Sound**
  - Note: A unique code will be sent to your Puget Sound email address each time you sign into Employee Navigator as part of the multi-factor authentication process
- Create a username/password of your choice and finalize account creation
- The first time you log in, you will be provided with a notice regarding use of personal data and security information
- After signing in, you will see a message indicating that you have a benefits enrollment to complete.

Whom can I contact with questions about account creation or if I experience login issues?

Synergy provides technical support for Employee Navigator and they may be contacted at **enrollment@synergyenrollment.com** or by phone at 858-282-0660 and are available Monday through Friday 8:00 a.m. to 5:00 p.m. (except on holidays).

Whom do I contact if I notice a discrepancy in my benefits elections, dependents, or beneficiaries in my Employee Navigator account, or if I have other benefits related questions?

Please contact Puget Sound Benefits at **benefits@pugetsound.edu** for questions about benefits elections, listed dependents, or any other benefits related items.

What Do I Have To Do?

- ❑ Review this Open Enrollment Benefits Guide for a summary of the benefits offered.
- ❑ Visit **www.employeenavigator.com** to complete your open enrollment elections.
- ❑ Add coverage for your spouse or partner and children who were previously eligible but not enrolled, if desired.
- ❑ Switch from the Base Plans to the Buy-up Plans, or vice versa, if desired. Please note that any family members you cover will be enrolled on the same plan as you.
- ❑ Drop coverage for yourself or any dependents, if desired. You must provide details of other coverage if you drop medical coverage for yourself.
- ❑ Elect to participate in the Health FSA or Dependent Care FSA, if desired.

i OPEN ENROLLMENT ELECTIONS MUST BE COMPLETED IN EMPLOYEE NAVIGATOR BY **NOVEMBER 10, 2023**.

WHAT HAPPENS IF I DO NOT COMPLETE MY OPEN ENROLLMENT ELECTIONS?

It is best practice for everyone to log into **www.employeenavigator.com** during open enrollment and confirm and update their benefits election. If you do not complete Open Enrollment in Employee Navigator, your benefits will default to your 2023 elections, and you will not have a flexible spending account (FSA) in 2024. If you had a flexible spending account in 2023, that election will not carry over; you must elect the FSA in the Open Enrollment module in Employee Navigator in order have an FSA in 2024.

HELPFUL TIPS:

Keep your ID card! Premera will only issue you a new ID card if you make a change at open enrollment that requires a new card, such as changing plans.

If you participate in the FSA, keep your debit card! Any new FSA elections will be loaded onto your debit card. WEX will automatically mail you a new debit card when it is close to its expiration date.

How Much Do I Have To Pay?

The following contributions are effective January 1, 2024.

COST PER MONTH	Medical		
	Faculty/Staff Share	Puget Sound Share	Total
Subscriber	$0	$695	$695
Subscriber and Spouse/Partner*	$687	$877	$1,564
Subscriber and Child(ren)	$274	$941	$1,215
Subscriber & Family	$961	$1,123	$2,084

COST PER MONTH	Base Dental		
	Faculty/Staff Share	Puget Sound Share	Total
Subscriber	$0.00	$17.00	$17.00
Subscriber and Spouse/Partner*	$17.00	$16.50	$33.50
Subscriber and Child(ren)	$21.00	$17.50	$38.50
Subscriber & Family	$38.00	$17.00	$55.00

COST PER MONTH	Buy-Up Dental		
	Faculty/Staff Share	Puget Sound Share	Total
Subscriber	$27.00	$17.50	$44.50
Subscriber and Spouse/Partner*	$71.00	$18.00	$89.00
Subscriber and Child(ren)	$83.00	$18.50	$101.50
Subscriber & Family	$126.50	$19.00	$145.50

COST PER MONTH	Base Vision		
	Faculty/Staff Share	Puget Sound Share	Total
Subscriber	$0.00	$1.17	$1.17
Subscriber and Spouse/Partner*	$0.00	$2.33	$2.33
Subscriber and Child(ren)	$0.00	$2.49	$2.49
Subscriber & Family	$0.00	$3.98	$3.98

COST PER MONTH	Buy-Up Vision		
	Faculty/Staff Share	Puget Sound Share	Total
Subscriber	$7.71	$1.17	$8.88
Subscriber and Spouse/Partner*	$15.88	$2.33	$18.21
Subscriber and Child(ren)	$16.99	$2.49	$19.48
Subscriber & Family	$27.15	$3.98	$31.13

*An eligible domestic partner must meet all requirements included in the Puget Sound Affidavit of Marriage or Domestic Partnership. 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. Premiums paid by faculty or staff members for a partner or partner's children will be deducted after taxes.

Contributions Pre-Tax

Please note that the amount you pay for medical and dental coverage will be taken out of your paycheck before taxes, as allowed by Section 125 of the Internal Revenue Code. 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 Qualifying Life Event, such as marriage, divorce, birth of a child, or change in employment status. This means you may not add or drop coverage during the year unless there is a Qualifying Life Event.

What's Changing for 2024

Hearing aids are now covered under the Premera medical plan. The plan will pay in full the first $3,000 of hearing aid cost, every three years.

The plan now has a travel support benefit for abortion and gender affirming care when services are restricted in your state of residence.

Primary care received at Kinwell clinics is covered 100%.

The support program hosted by Livongo has been expanded to include a weight management program which is free of charge to those enrolled on Premera who qualify to participate.

When filling a prescription at the pharmacy, the Premera system will automatically look for offers from discount cards that are available. If the discount card price is lower than your regular copay, the discount card price will apply.

The lifetime orthodontia maximum on the buy-up dental plan is increasing to $2,000.

The frame allowance on the buy-up vision plan is increasing to $180.

The IRS increases the amount of money you can set aside pre-tax in your Health Care FSA annually. The current maximum is $3,050 and the rollover is $610. The indexed amounts have yet to be released for 2024 but you will be able to elect up to the new maximum once available.

There are no other material changes to the plans as of January 1, 2024.

These benefits are fully described in the Plan Booklet you will receive later. This summary does not reflect all of the changes.

Note: This is not a complete explanation of covered services, exclusions, limitations, reductions, or the terms under which the program may be continued in force. The summary of benefits is not a contract. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, please refer to your benefit booklet.

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 Qualifying Life Event during the year. Qualifying Life Events may include:

- Marriage or divorce (once finalized)
- 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

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.

REMEMBER: You must notify Human Resources **within 30 days** of a Qualifying Life Event. 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 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 11** 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* *Routine Exam*	Paid at 100% no deductible	Paid at 100% no deductible
Laboratory Services and screenings including colonoscopy, mammograms	Paid at 100% no deductible	Paid at 60% after deductible
Physician Services *Office Visits, surgery and inpatient care Includes Virtual Care*	Paid at 80% after deductible	Paid at 60% after deductible
X-Ray and Laboratory Services *Inpatient and Outpatient*	Paid at 80% after deductible	Paid at 60% after deductible
Emergency Room	Paid at 80% after $150 copay and deductible	
Hospital Services *Inpatient and Outpatient*	Paid at 80% after deductible	Paid at 60% after deductible
Outpatient Rehabilitation *Physical, occupational and speech therapy Includes Virtual Care*	Paid at 80% after deductible	Paid at 60% after deductible
	Limited to 60 visits per calendar year	
Mental Health *Inpatient and Outpatient and virtual care*	Paid at 80% after deductible	Paid at 60% after deductible
Spinal Manipulations	Paid at 80% after deductible	Paid at 60% after deductible
	Limited to 12 visits per calendar year	

*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 into 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 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 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.

Your drug cost may be less than the above stated copays as the plan will automatically apply any available drug discount cards if it reduces your out-of-pocket cost.

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 pay at once. 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 drugs 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	Yes
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. 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 mobile 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 instructions 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, 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 mobile 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.

i 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.

KINWELL PRIMARY CARE

You have access to $0 cost primary care at Kinwell Clinics. To schedule a virtual or in-person appointment, visit **kinwellhealth.com**.

GOING PAPERLESS

Please notify Premera to communicate with you electronically to support the University's sustainability initiative, reduce your clutter, and help protect your privacy. Log in at **www.premera.com** and under "My Account" select "Account Settings" to turn on paperless explanation of benefits (EOB).

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, 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 Omada

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 care? Now you can do your physical therapy from the comfort and convenience of your home. 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 additional $225 for 4 additional weeks of care.

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.

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

CHRONIC CONDITION SUPPORT WITH LIVONGO

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. Livongo also provides a weight management program for those who qualify.

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

Premera has contracted with Centers of Excellence for the replacement of knees and hips, spine surgery, gene therapy, cellular immunotherapy, and transplants. The selection of providers is based on high quality metrics and discounted rates. 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** 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, or 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 number of approved visits going forward.

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. Dental and vision expenses are not eligible to be reimbursed through the HRA.

Flexible Spending Accounts

Health care 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 $3,050 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 $610 will be rolled over to be used in the following calendar year. Anything over $610 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 $610 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 an FSA.*

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

The HRA and Health Care FSA, while separate accounts, both 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)

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 Qualifying Life Event or you experience a change in your childcare needs or costs.

CAN I CHANGE HOW MUCH I PUT INTO MY ACCOUNT DURING THE YEAR?

The Health Care FSA and Dependent Care FSA only allow changes to your election amount mid-year if you experience a Qualfying Life Event. In addition, you can change your Dependent Care FSA election if there is a change in your childcare needs or cost.

Flexible Spending Accounts *(continued)*

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 for reimbursement 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 for reimbursement as they are deducted from your paycheck.

When you use your debit card, WEX will need proof that what you used your debit card for is allowed by the IRS. This is called substantiation. Auto-substantiation technology is used to attempt to electronically verify that the transaction meets the IRS rules. If the transaction cannot be auto-substantiated, a paper follow-up will be required. In these instances, you will receive notification from WEX that you need to submit a receipt.

Keep your receipts, explanation of benefits or paperwork from your provider so you have them handy. They need to include:

- The name of the patient
- The name of the provider
- A description of the service or items purchased
- The date the services were provided or items were purchased
- The charge and/or out-of-pocket expense that was not paid by the Plan or other insurance

Please note: if you do not submit the requested receipt in a timely manner, your WEX debit card will be turned off until your previous usage can be substantiated. Any amounts not substantiated before the end of the calendar year will be reported to the IRS as taxable income.

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.

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 $2,000 lifetime

i 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 pay up front 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**.

	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	
Single Vision	100%	100% up to $50 allowance
Bifocals	100%	100% up to $75 allowance
Trifocals	100%	100% up to $100 allowance
Standard Progressives	100% after $50 copay	100% up to $75 allowance
Premium Progressives	100% after $80 to $90 copay	100% up to $75 allowance
Custom Progressives	100% after $120 to $160 copay	100% up to $75 allowance
Polycarbonate Lenses	100% for children	No additional benefit
Other lens enhancements	35 to 40% discount	No additional benefit
Eyeglass Frames 1 pair every other calendar year	100% up to $180, $200 for featured frame brands, $100 at Costco or Walmart	100% up to $70 allowance
Contact Lenses (Instead of Glasses) Every calendar year	100% up to $180 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/or 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.

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)

Separate from your voluntary life insurance, you may purchase AD&D coverage for yourself, your spouse/partner, and/or 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 you can enroll when you are new, or you may add coverage during open enrollment.

Long Term Disability (LTD)

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.

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

Additional Voluntary Insurance Benefits

Puget Sound offers all benefits eligible faculty and staff the option to purchase voluntary accident and critical illness insurance that pays a cash benefit if you are injured or contract any of the covered conditions. These plans, provided by Lincoln Financial Group, are designed to provide you with an extra source of income to help in the event of an illness or injury.

Some key features of these voluntary plans are:

- You are paid cash quickly
- You can use the money for whatever you would like
- Benefits are not taxed
- You **do not** have to be enrolled on the Puget Sound Premera medical plan to participate

Accident Insurance

Accident insurance is a policy that can help you pay expenses that may follow an accident, including out-of-pocket health care costs. This plan pays benefits if you are injured in an accident, regardless of whether or not you are at work. The amount you receive is based on your injuries, services provided, and treatment.

Accident Monthly Rates	Accident
Employee	$10.43
Employee and spouse	$16.38
Employee and 1 or more children	$17.19
Family* with 1 or more children	$26.33

Additional Voluntary Insurance Benefits *(continued)*

Critical Illness Insurance

Critical Illness insurance is a policy that provides a lump-sum, cash benefit if you are diagnosed with a covered illness (e.g., heart attack, stroke, cancer). These diagnoses can cause significant financial burden, especially if you are unable to work while receiving treatment. You can use the money you receive however you would like, including to help you pay your mortgage, pay your deductible, seek experimental treatment, or for any other expenses.

The benefit amount you receive is based on the level of coverage you purchase. You may also purchase coverage for your spouse. Dependent children automatically receive 50% of your coverage amount up to $10,000 at no extra cost.

	Employee	Spouse	Child
Critical Illness Insurance			
Benefit Available	$10,000, $20,000, or $30,000	$5,000, $10,000 or $15,000 not to exceed 50% of employee election	$10,000, not to exceed 50% of employee election
Guaranteed Issue	$30,000	$15,000	$10,000
Health Screening Benefit	$50 cash for completing an annual wellness exam or other preventive screening		
Pre-existing Exclusion	During the first 6 months of coverage, benefits will not be payable for a pre-existing condition. A "pre-existing" condition is one in which you or an insured dependent receive treatment during the 6 months prior to the effective date of coverage.		

The premiums for these voluntary plans are 100% employee paid and will be deducted post-tax from your paycheck.

Critical Illness Monthly Rates

Age Band	Employee	Spouse	Children
Under 25	$0.194	$0.148	$0.000
25-29	$0.285	$0.239	—
30-34	$0.383	$0.337	—
35-39	$0.507	$0.461	—
40-44	$0.741	$0.696	—
45-49	$1.026	$0.980	—
50-54	$1.473	$1.427	—
55-59	$1.991	$1.944	—
60-64	$2.827	$2.782	—
65-69	$3.923	$3.877	—
70 and over	$7.377	$7.332	—

Note: Spouse rate is based on employee age.

How to Calculate Your Cost:

Employee Critical Illness: _____ (volume) x _____ (rate) /1,000 = _____ Monthly Cost

Spouse Critical Illness: _____ (volume) x _____ (rate) /1,000 = _____ Monthly Cost

Child Critical Illness: _____ (volume) x _____ (rate) /1,000 = $0.000 Monthly Cost

Employee Assistance Program (EAP) – Canopy

The EAP is a completely free and confidential program that helps you and/or your family members address life issues, big or small. The benefit includes 6 free face-to-face, over the phone, or virtual counseling sessions at zero cost. Benefits are offered to all faculty and staff members who are 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

Canopy also provides support for legal issues, identity theft, home ownership, pet parenting, and fertility health. Contact Canopy today to get started.

ACCESSING THE EAP IS EASY:
Visit their website at
my.canopywell.com
Organization Name:
University of Puget Sound

Call: 800-433-2320
Text: 503-850-7721
Email: **info@canopywell.com**

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.

Notice of Automatic Enrollment

If you are eligible for the Plan but do not enroll within 90 days of becoming eligible, you will be automatically enrolled. This means that pre-tax dollars are contributed to the Plan at a rate of 3% of your eligible compensation. Please contact TIAA if you have any questions or if you would like to adjust your level of contribution.

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/ Voluntary Accident & Critical Illness	Lincoln	**800.423.2765**	**www.lfg.com**
LTD and FMLA Leave Administration	Lincoln	Claim: **800.320.7585** Leave: **866.277.5276**	**MylincolnportaI.com**
Employee Assistance Program	Canopy	Phone: **800-433-2320** Text: **509-850-7721**	**my.canopywell.com** **Organization:** **University of Puget Sound** **info@canopywell.com**
Retirement Savings	TIAA	**1.800.842.2252**	**www.tiaa.org/pugetsound**
Washington Health Benefit Exchange		**1.855.923.4633**	**www.wahealthplanfinder.org**

EAP Summary of Services

A benefit for you and your family members provided by University of Puget Sound

The Employee Assistance Program (EAP) is a **FREE** and **CONFIDENTIAL** benefit that can assist you and your eligible family members with any personal problems, large or small.

Counseling with an EAP Professional

Six (6) counseling sessions face to face, over the phone, or virtually for concerns such as:

- **Relationship conflict**
- **Conflict at work**
- **Depression**
- **Stress management**
- **Family relationships**
- **Anxiety**
- **Alcohol or drug misuse**
- **Grieving a loss**
- **Professional development**

Resources for Life

Canopy will help locate resources and information related to childcare, eldercare, caregiving, and anything else you may need.

Legal Consultations/Mediation

Contact Canopy for a free thirty-minute office or telephone consultation. A 25% discount from the attorney's/mediator's normal hourly rate is available thereafter.

Financial Coaching

Coaches will provide unlimited financial coaching to help develop better spending habits, reduce debt, improve credit, increase savings, and plan for retirement.

Identity Theft

Up to 60-minute free consultation with a Fraud Resolution Specialist™ (FRS) who will conduct emergency response activities and assist with restoring their identity, good credit, and dispute fraudulent debts.

Home Ownership and Housing Support

Assistance and discounts for buying, selling, and refinancing. Resource retrieval for housing assistance.

Coaching

Six (6) phone or video sessions with a Coach to support goal setting, healthy habits, and personal development.

Pet Parent Resources

Free pet information and support, including pet insurance discounts, new pet parent resources, and bereavement support.

Wellbeing Tools

- **Fertility health support**
- **Online legal tools**
- **Will kit questionnaire**
- **Gym membership discounts**

Member Site

Innovative educational tools, chat for support, take self-assessments, view videos and webinars, access courses, download documents and more. Access at **my.canopywell.com**, and register as a new user or log-in. Enter **University of Puget Sound** for company name when you register.

canopy

Crisis Counselors are available by phone **24/7/365**

call: 800-433-2320 **text:** 503-850-7721 **email:** info@canopywell.com

Canopy is committed to creating a safe, inclusive, and equitable society for all.

Washington Apple Health

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.

Washington State Health Care Authority

HCA 19-009 (6/16)

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.

- 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.
- 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.
- 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 on the next page 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.

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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, 2024
Name of Entity/Sender:	University of Puget Sound
Contact-Position/Office:	Ian Dowling
Address:	1500 N. Warner St. #1064 Tacoma, WA 98416-1064
Phone Number:	253-879-3369

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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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

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NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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!

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An AMN Company