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Puget Sound Educational Service District

Benefits Overview 2022

What's Inside

This Benefits Guide provides benefit plan highlights and is intended for summary purposes only. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail.

Important: 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 pages 39 & 40 for more details.

Non-Union

Who is Eligible

Non-Union employees working 32-40 hours per week and Regular employees working 18-32 hours per week.

Dependents are covered to age 26 regardless of student status.

Your spouse or domestic partner may also enroll. Must be a registered domestic partner for Kaiser Permanente.

How to Enroll

Review all information in this summary.

To make changes, complete an enrollment/change form and send to HR. If no changes are being made, no action is required.

If enrolling or continuing participation in FSA, DCAP or HSA you must complete enrollment online.

Contact HR for assistance.

When to Enroll

Open enrollment begins **October 25th and ends November 22nd** .

The benefits you choose during open enrollment will become effective on **January 1, 2022**.

New Hires hired on or before the 15th of the month are eligible on the 1st of the following month. You have 30 days to enroll.

How to make a change

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Change in residence (in some cases)
- Birth or adoption of a child
- Marriage, divorce or legal separation
- Death of a spouse, child or other qualified dependent
- Change in child's dependent status
- Change in employment status or a change in coverage under another employer-sponsored plan

Affordable Care Act (ACA)

The Affordable Care Act (ACA) imposes rules governing offers of group health plan coverage by employers for their full-time employees. For this purpose, we have chosen to determine which employees are full-time employees under the “look-back measurement method.” These rules are explained at some length in our plan’s summary plan description (SPD), which is available through Human Resources.

Domestic Partnership

If you have a domestic partner, they/them are eligible to enroll in these plans as a dependent. Note: Kaiser Permanente allows only registered domestic partners.

- Your domestic partner may be the same or opposite gender as yourself.
- You must live together and meet all criteria outlined in the domestic partner affidavit.
- If your domestic partner is not your tax dependent, the IRS requires that the portion of the premium you pay toward his/her coverage be deducted from your paychecks on a post-tax basis.
- Any amount your employer pays toward his/her coverage must also be added (imputed) to your taxable wages. As a result, your taxable income will be higher than the cash wages you actually receive through each paycheck.

Please contact your HR department for more information.

Cost of Coverage: Non-Union
Premera Blue Cross Dental & Vision

Puget Sound ESD provides a monthly benefit allocation toward the purchase of employee benefits. The benefit allocation for fiscal year 2022 is $920 for full-time employees (.80 – 1.0 FTE) and pro-rated for part-time employees (.45 - .79 FTE). Family dental and vision insurance is mandatory for all employees (the allocation goes towards dental and vision before medical).

The total premiums are listed below on monthly basis. Your contribution is deducted automatically from your paycheck on a pre-tax basis for you and your covered tax dependents. Domestic Partners and their children are post-tax.

Premera Blue Cross Dental Plan C	Total Premium
Composite Rate	$89.70

Premera Blue Cross Dental Plan A with Ortho Plan A	Total Premium
Composite Rate	$127.46

Premera Blue Cross Vision Plan C	Total Premium
Composite Rate	$25.65

Cost of Coverage: Non-Union
Kaiser Permanente - Medical

Kaiser Permanente HMO $1000 Base Plan	Total Premium
Employee Only	$702.44
Employee + Spouse	$1,189.43
Employee + Spouse & Child(ren)	$1,432.41
Employee + Child(ren)	$855.71

Kaiser Permanente HMO $100 Buy-Up Plan	Total Premium
Employee Only	$809.25
Employee + Spouse	$1,370.30
Employee + Spouse & Child(ren)	$1,650.22
Employee + Child(ren)	$985.83

Cost of Coverage: Non-Union
Premera Blue Cross – Medical

Premera Blue Cross EasyChoice A Plan	Total Premium
Employee Only	$835.81
Employee + Spouse	$1,523.13
Employee + Spouse & Child(ren)	$1,826.20
Employee + Child(ren)	$1,110.76

Premera Blue Cross EasyChoice B Plan	Total Premium
Employee Only	$872.75
Employee + Spouse	$1,592.18
Employee + Spouse & Child(ren)	$1,909.09
Employee + Child(ren)	$1,160.96

Premera Blue Cross Plan 2	Total Premium
Employee Only	$1,295.11
Employee + Spouse	$2,390.90
Employee + Spouse & Child(ren)	$2,869.44
Employee + Child(ren)	$1,736.17

Premera Blue Cross QHDHP Plan	Total Premium
Employee Only	$686.01
Employee + Spouse	$1,249.89
Employee + Spouse & Child(ren)	$1,477.95
Employee + Child(ren)	$911.60

Glossary

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.

Copay

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Out-of-Pocket Limit/Max

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount.

Allowed Amount

The maximum amount upon which our Medical Plan bases payments for covered services. This may also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

In-Network

The doctors, hospitals, laboratories, pharmacies, etc., that are members of the plan’s provider network. When you see an in-network provider, the plan pays a higher benefit.

Medical: Non-Union Kaiser Permanente

We offer two plans through Kaiser Permanente.

- HMO $1,000 Base Plan
- HMO $100 Buy-Up Plan

Go to kp.org/wa to find an In-Network provider or view your claim status online.

	Kaiser Permanente HMO $1,000 Base Plan	Kaiser Permanente HMO $100 Buy-Up Plan
	In-Network Only *	In-Network Only *
Network	**Core/Kaiser**	**Core/Kaiser**
Annual Deductible	$1,000/Individual	$100/Individual
	$3,000/Family	$300/Family
Annual Out- of- Pocket Limit (Includes Deductible & Coinsurance)	$4,000/Individual	$2,000/Individual
	$12,000/Family	$6,000/Family
Office Visits (Primary Provider, Specialist & Urgent Care)	$40 copay, deductible waived	1st 4 visits per calendar year $35 copay, deductible waived; then $35 copay, after deductible
Virtual Care	Covered in full	Covered in full
Chiropractic & Acupuncture Care	$40 copay, deductible waived (Chiro 20/Acup 8 Visits per cal year)	1st 4 visits per calendar year $35 copay, deductible waived; then $35 copay, after deductible (Chiro 10/Acup 12 Visits per cal year)
Preventive Services	Covered in full	Covered in full
Diagnostic Lab & X- Ray Services	20% after deductible	1st $500 per calendar year covered in full, then; 0% after deductible
Inpatient Hospital Services	20% after deductible	$100 copay, after deductible per day up to 3 days per admit ($300)
Outpatient Surgery	20% after deductible	$50 copay, after deductible
Emergency Room	$100 copay, then 20% after deductible (Includes Out-of-Network)	$100 copay, after deductible (Includes Out-of-Network)

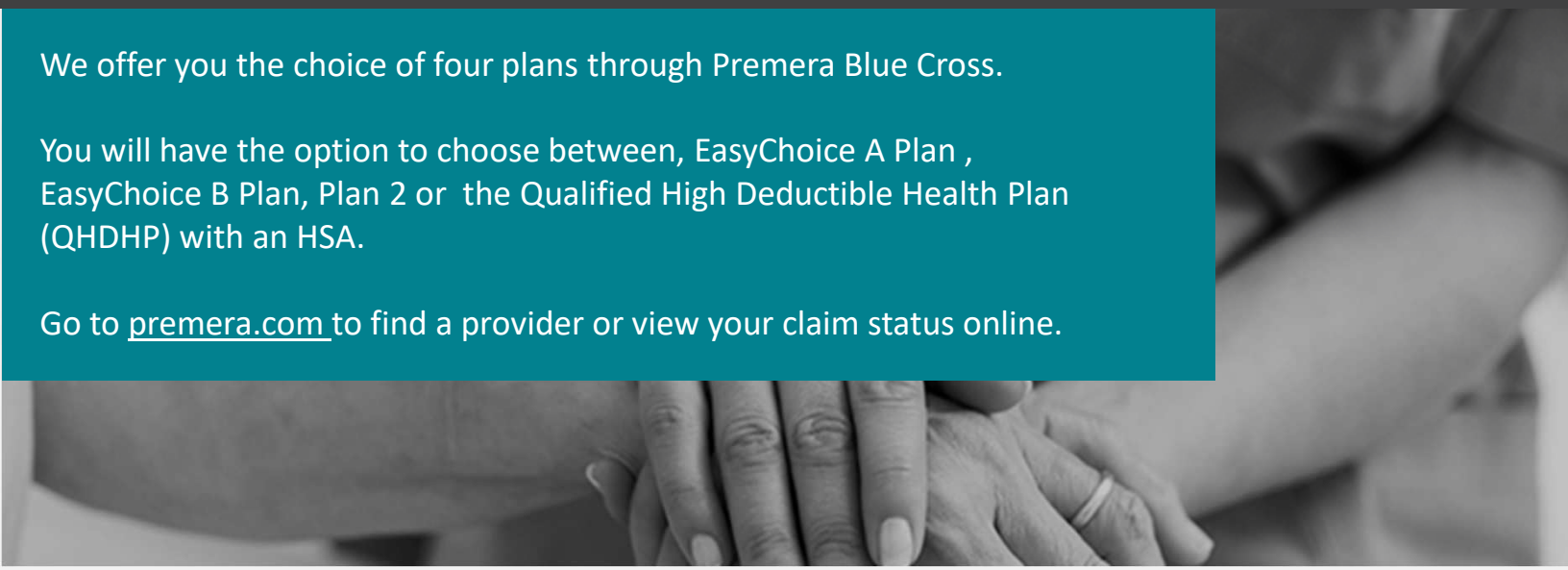
*** When you use an Out-Of-Network provider, your benefits will not be paid except Emergency Care. (You will be responsible for the entire balance)**

Medical: Non-Union
Premera Blue Cross

We offer you the choice of four plans through Premera Blue Cross.

You will have the option to choose between, EasyChoice A Plan , EasyChoice B Plan, Plan 2 or the Qualified High Deductible Health Plan (QHDHP) with an HSA.

Go to premera.com to find a provider or view your claim status online.



EasyChoice A & B / Plan 2	QHDHP w/HSA
Higher Premiums	**Lower** Premiums
Lower Deductible	**Higher** Deductible
Embedded Deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. **Embedded Out-of-Pocket Limit:** Each covered family member only needs to satisfy his or her individual out-of-pocket maximum.	**Aggregate Family Deductible:** The total family deductible must be met before insurance starts to pay for any one individual family member; when there is 1 or more dependent enrolled. **Embedded Out-of-Pocket Limit:** Each covered family member only needs to satisfy his or her individual out-of-pocket maximum.
Prescription drugs: Copays/Coinsurance apply (deductible waived)	**Prescription drugs:** Subject to deductible/coinsurance
Preventive Care: Covered in full	**Preventive Care:** Covered in full
Office Visits: Copay applies (deductible waived)	**Office Visits:** Subject to deductible/coinsurance

Medical: Non-Union Premera Blue Cross

We offer four plans through Premera Blue Cross.

- EasyChoice A
- EasyChoice B

Go to premera.com to find an In-Network provider or view your claim status online.

	Premera Blue Cross EasyChoice A Plan		Premera Blue Cross EasyChoice B Plan	
	In-Network	Out-Of-Network *	In-Network	Out-Of-Network *
Network	Heritage		Heritage	
Annual Deductible	$1,250/Individual	$2,000/Individual	$750/Individual	$1,500/Individual
	$3,750/Family	$6,000/Family	$2,250/Family	$4,500/Family
Annual Out- of- Pocket Limit (Includes Deductible & Coinsurance)	$4,000/Individual	Unlimited/Indvidual	$3,500/Individual	Unlimited/Individual
	$8,000/Family	Unlimited/Family	$7,000/Family	Unlimited/Family
Primary Care Provider (PCP) Office Visit	$25 copay, deductible waived	50% after deductible	$30 copay, deductible waived	50% after deductible
Specialist Provider Office Visit	$35 copay, deductible waived	50% after deductible	$40 copay, deductible waived	50% after deductible
Urgent Care	$35 copay, deductible waived	50% after deductible	$40 copay, deductible waived	50% after deductible
Virtual Care General Medical	$10 copay, deductible waived	Not covered	$10 copay, deductible waived	Not covered
Virtual Care Mental Health & Substance Abuse	$25 copay, deductible waived	Not covered	$30 copay, deductible waived	Not covered
Chiropractic & Acupunture Care	$25 copay, deductible waived (12 visits each)	50% after deductible (12 visits each)	$30 copay, deductible waived (12 visits each)	50% after deductible (12 visits each)
Preventive Services	Covered in full	Not covered	Covered in full	Not covered
Diagnostic Lab & X- Ray Services	First $1,000 paid in full; then		25% after deductible	50% after deductible
	20% after deductible	50% after deductible		
Inpatient Hospital Services	20% after deductible	50% after deductible	25% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	25% after deductible	50% after deductible
Emergency Room	$100 copay, then 20% after in-network deductible		$150 copay, then 25% after in-network deductible	

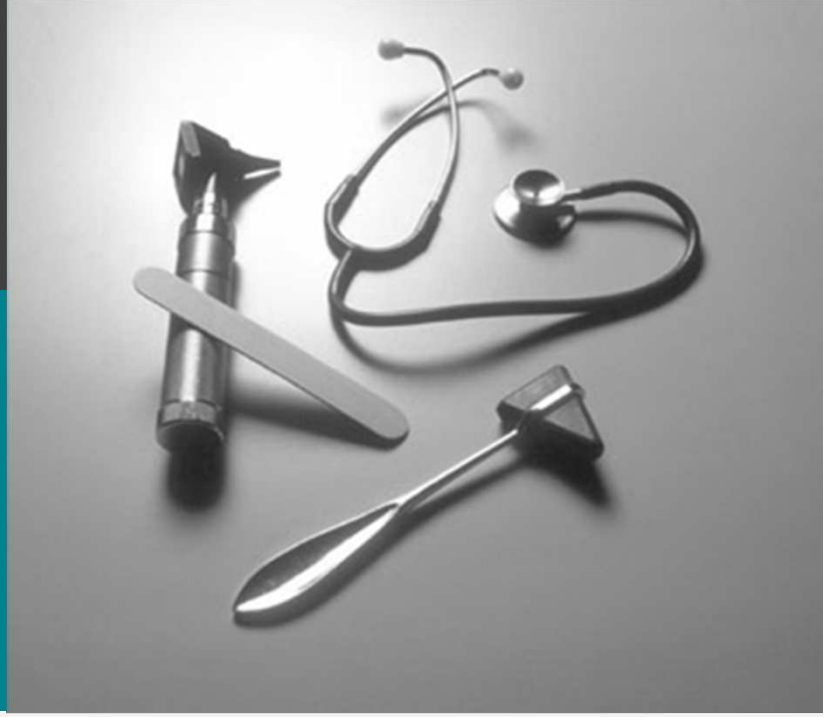
*** If you seek the service of an Out-of-Network provider balance billing may apply, members are responsible for the amounts in excess of the allowable charge.**

Medical: Non-Union Premera Blue Cross

We offer four plans through Premera Blue Cross.

- Plan 2
- QHDHP

Go to premera.com to find an In-Network provider or view your claim status online.



	Premera Blue Cross Plan 2		Premera Blue Cross QHDHP Plan	
	In-Network	Out-Of-Network *	In-Network	Out-Of-Network *
Network	Heritage		Heritage	
Annual Deductible	$300/Individual		$1,750/Individual	$3,000/Indvidual
	$900/Family		$3,500/Family	$6,000/Family
Annual Out- of- Pocket Limit (Includes Deductible & Coinsurance)	$2,000/Individual	$3,400/Individual	$5,000/Individual	Unlimited/Individual
	$6,000/Family	$10,200/Family	$10,000/Family	Unlimited/Family
Primary Care Provider (PCP) Office Visit	$25 copay, deductible waived	$30 copay, deductible waived	20% after deductible	50% after deductible
Specialist Provider Office Visit	$35 copay, deductible waived	$40 copay, deductible waived	20% after deductible	50% after deductible
Urgent Care	$35 copay, deductible waived	$30/$40 copay, deductible waived	20% after deductible	50% after deductible
Virtual Care General Medical	$10 copay, deductible waived	Not covered	20% after deductible	Not covered
Virtual Care Mental Health & Substance Abuse	$25 copay, deductible waived	Not covered	20% after deductible	Not covered
Chiropractic & Acupunture Care	$25 copay, deductible waived (Chiro Unlimited/Acup 12 visits)	$30 copay, deductible waived (Chiro Unlimited/Acup 12 visits)	20% after deductible (12 visits each)	50% after deductible (12 visits each)
Preventive Services	Covered in full	20% deductible waived	Covered in full	Not covered
Diagnostic Lab & X- Ray Services	20% after deductible	40% after deductible	20% after deductible	50% after deductible
Inpatient Hospital Services	$150 copay per day up to $450 per calendar year; then 20% after deductible	$150 copay per day up to $450 per calendar year; then 40% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	$100 copay, then 20% after deductible	$100 copay, then 40% after deductible	20% after deductible	50% after deductible
Emergency Room	$75 copay, then 20% after deductible		20% after in-network deductible	

*** If you seek the service of an Out-of-Network provider balance billing may apply, members are responsible for the amounts in excess of the allowable charge.**

Prescription Drugs: Non-Union Kaiser Permanente

Your Kaiser Permanente medical plans also include prescription drug coverage.

- HMO $100
- HMO $1,000

Go to kp.org/wa to find a pharmacy, review the Kaiser Large Group formulary or review claims online.

	Kaiser Permanente HMO $1,000 Base Plan	Kaiser Permanente HMO $100 Buy-Up Plan
	In-Network Only *	In-Network Only *
Formulary	Kaiser Large Group 4-Tier	Kaiser Large Group 2-Tier
Deductible	$0	$0
Out-of-Pocket Maximum	Applies to medical out-of-pocket maximum	Applies to medical out-of-pocket maximum
Retail Pharmacy	Up to 30-day supply; at participating pharmacy	Up to 30-day supply; at participating pharmacy
Preferred Generic	$15 copay	$15 copay
Preferred Brand	$40 copay	$40 copay
Non-Preferred Generic & Brand	$60 copay	Not covered
Specialty	$150 copay	Applicable cost share may apply
Mail Order	Up to 90-day supply	Up to 90-day supply
Generic	$30 copay	$30 copay
Preferred Brand	$80 copay	$80 copay
Non-Preferred Generic & Brand	$120 copay	Not covered

*** When you use a Out-Of-Network provider, you will be responsible for the entire balance.**

Prescription Drugs: Non-Union Premera Blue Cross

Your Premera Blue Cross medical plans also includes prescription drug coverage.

- EasyChoice A
- EasyChoice B

Go to premera.com to find a pharmacy, review the formulary or review claims online.

	Premera Blue Cross EasyChoice A Plan	Premera Blue Cross EasyChoice B Plan
	In-Network Only *	In-Network Only *
Formulary	Preferred A2 2-Tier	Preferred B-4 4-Tier
Deductible	$500 per member / per cal year	$250 per member / per cal year
Out-of-Pocket Maximum	Applies to the medical out-of-pocket maximum	Applies to medical out-of-pocket maximum
Retail Pharmacy	Up to 30-day supply; at participating pharmacy	Up to 30-day supply; at participating pharmacy
Generic	$10 copay, deductible waived	$5 copay, deductible waived
Preferred Brand	30% after deductible	$30 copay, after deductible
Non-Preferred Brands	30% after deductible	$45 copay, after deductible
Specialty	30% after deductible	30% after deductible
Mail Order	Up to 90-day supply	Up to 90-day supply
Generic	$20 copay, deductible waived	$10 copay, deductible waived
Preferred Brand	30% after deductible	$75 copay, after deductible
Non-Preferred Brands	30% after deductible	$112 copay, after deductible
Specialty	30% after deductible	30% after deductible

*** When you use an Out-of-Network pharmacy, you will be responsible for the entire balance.**

Prescription Drugs: Non-Union Premera Blue Cross

Your Premera Blue Cross medical plans also includes prescription drug coverage.

- Plan 2
- QHDHP

Go to premera.com to find a pharmacy, review the formulary or review claims online.

	Premera Blue Cross Plan 2		Premera Blue Cross QHDHP Plan	
	In-Network	Out-Of-Network *	In-Network	Out-Of-Network *
Formulary	Preferred B4 4-Tier		Open A-1 1-Tier	
Deductible	$0		Applies to medical deductible	
Out-of-Pocket Maximum	Applies to medical out-of-pocket maximum		Applies to medical out-of-pocket maximum	
Retail Pharmacy	Up to 34-day supply; at participating pharmacy Specialty; 30-day supply		Up to 90-day supply; at participating pharmacy	
Generic	$10 copay	$10 copay, then 40%	20% after deductible	20% after deductible
Preferred Brand	$20 copay	$20 copay, then 40%	20% after deductible	20% after deductible
Non-Preferred Brands	$35 copay	$35 copay, then 40%	20% after deductible	20% after deductible
Specialty	$50 copay	Not covered	20% after deductible	Not covered
Mail Order	Up to 100-day supply	N/A	Up to 90-day supply	N/A
Generic	$20 copay	Not covered	20% after deductible	Not covered
Preferred Brand	$40 copay	Not covered	20% after deductible	Not covered
Non-Preferred Brands	$65 copay	Not covered	20% after deductible	Not covered
Specialty	$50 copay	Not covered	20% after deductible	Not covered

*** When you use an Out-of-Network pharmacy, you will be responsible for the balance over the allowable amount. (Balance Billing).**

Generic Drugs

Generic drugs are copies of brand–name drugs with the same effects as the original drug. The Food & Drug Administration requires generic drugs to have the same performance and quality as brand-name counterparts.

Brand–Name Drugs

These are drug for which generic equivalents are not available. There are generally two categories of brand-name drugs:

- Preferred Brand-Name: Been on the market for awhile and are widely accepted.
- Non-Preferred Brand-Name: More expensive than preferred brand-name and newer to the market.

Specialty Medications

Specialty medications are high-cost prescription drugs used to treat complex or chronic conditions. Many health plans have a separate tier or higher contribution requirement depending on your plan. Please contact Kaiser Permanente or Premera Blue Cross to understand how they cover these medications and what your out-of-pocket responsibility may be.

Formulary Information

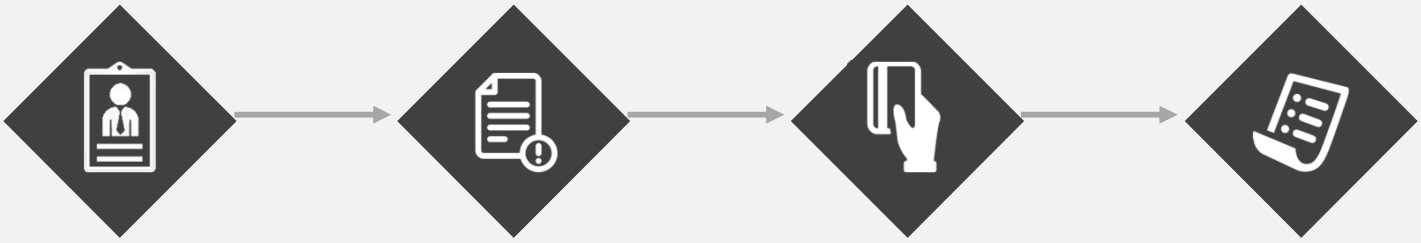
A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners and insurers to identify drugs that offer the greatest overall value. Use Kaiser or Premera's Rx search tool to get information about specific prescription drugs on your plan's formulary, including how a drug may be covered and alternate drugs you can choose from.

HSA - How To Navia Benefit Solutions

If enrolled in the Premera Blue Cross QHDHP Plan, you are eligible to enroll in an HSA.

Just follow the steps below to use your HSA (Health Savings Account).

Go to navia.com to view your account balance and review investment options. Navia code: PSE



Present your ID card at the time of service

Wait for the provider to submit the claim to the insurance company

Pay your provider with your HSA card

Save your receipts

What is an HSA?

An HSA, or Health Savings Account is a unique tax-advantaged account that can be used to pay for current or future healthcare expenses. When combined with a Qualified High-Deductible Health Plan (QHDHP), it offers savings and tax advantages that a traditional health plan can't duplicate. With an HSA, you will have:

- A tax-advantaged savings account that you can use to pay for eligible medical expenses as well as deductible, co-insurance, prescriptions, vision and dental care.
- Unused funds that will roll over year to year. There's no "use it or lose it" penalty.
- Potential to build more savings through investing. You can choose from a variety of HSA self-directed investment options (minimum balance requirements apply).
- Additional retirement savings. After age 65, funds can be withdrawn for any purpose without penalty but may be subject to income tax if not used for qualified medical expenses.

The IRS sets limits annually on the amount you can contribute. Below are the amounts you can contribute.

HSA Contribution Limits	
2022	**Total Annual Maximum Contributions**
Individual	$3,650
Family	$7,300
Catch-up (Age 55+)	Additional $1,000

More About HSA's

You are **not** eligible to set up or contribute to an HSA if any of the following situations apply to you:

- You are claimed as a dependent on someone else's tax return
- You are eligible to receive benefits from any plan other than a qualified high deductible health plan, including:
  - ✓ Coverage through your spouse's non-qualified health plan.
  - ✓ Enrollment in a full purpose flexible spending account (FSA) by either you or your spouse.
  - ✓ Coverage through Medicare or Medicaid.
  - ✓ Coverage through a military or veteran's healthcare program (e.g. TRICARE).

You can use your HSA at any time for tax-free reimbursement of qualified health expenses (even if you are later covered under a health plan that is not a qualified high deductible health plan). Please note the following:

- The money must be in your account before you can claim a reimbursement.
- You cannot make claims for services incurred before your HSA becomes active.
- A debit card is typically included (additional cards and checks may be ordered, fees may apply).
- Overdraft fees and other charges may apply if your claims exceed your account balance.
- A 20% penalty applies for a non-qualified related expenses.

HSA Eligibility and Distributions

General

Because this is an actual bank account, your employer will have only the ability to contribute to the account. Just as any other account would be, your HSA is subject to bank fees, along with additional fees that apply for things like NSFs, paper statements, etc. which will be paid by the account holder.

Interest and Investments

Your HSA will accrue a small amount of interest; rates increase with account size.

Filing Your Taxes

Each year you'll receive a IRS Form 1099-SA and IRS Form 5498-SA, which are used to complete IRS Form 8889.

- IRS Form 1099-SA provides you with the distributions made from your Health Savings Account in that tax year. You will receive a separate 1099-SA for each type of distribution made during the tax year.
- IRS Form 5498-SA provides you with all the contributions made to your Health Savings Account in that tax year.
- IRS Form 8889 is attached to your IRS 1040 Form when you file your taxes.

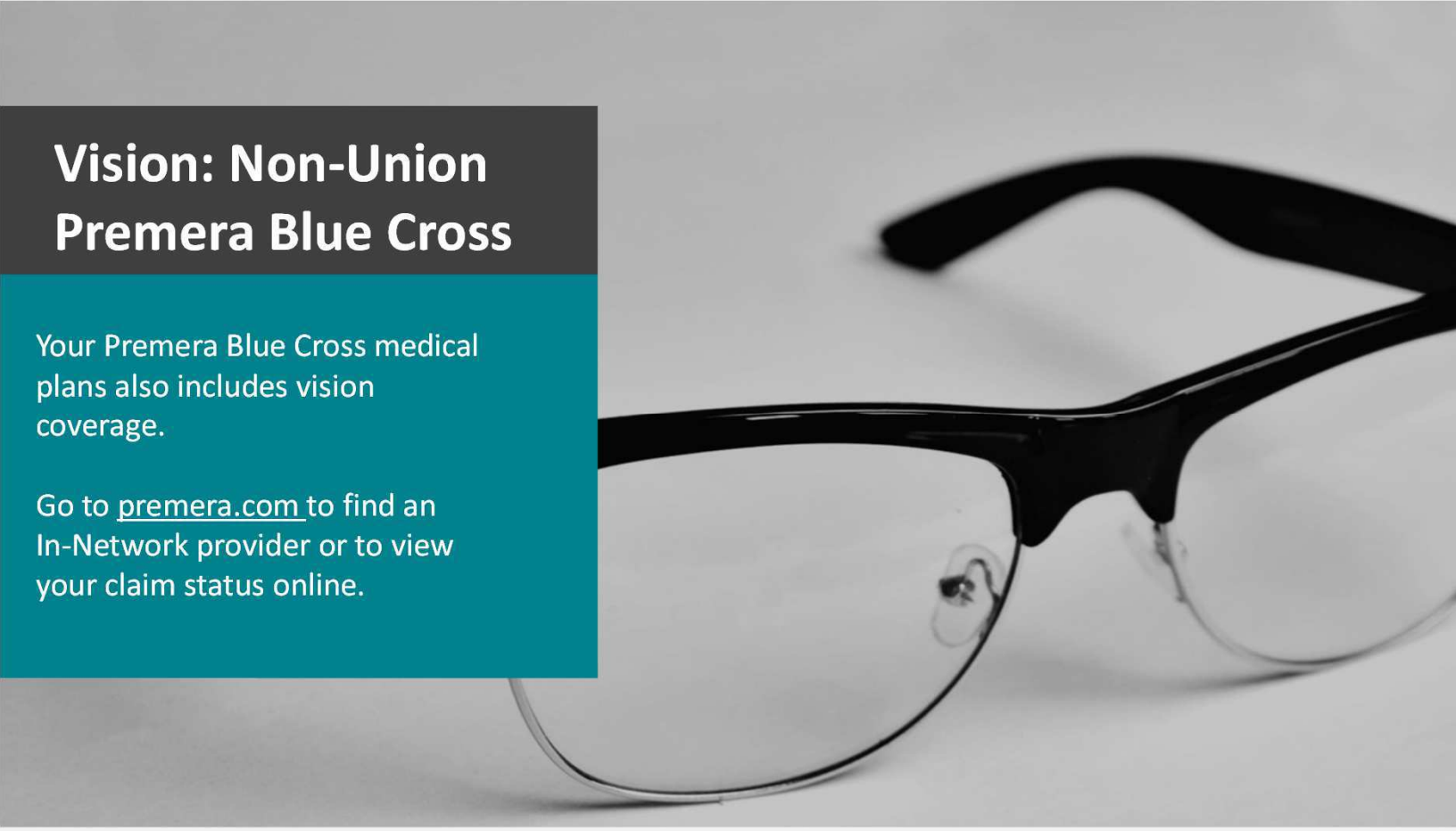
Note: Your employer does not provide tax advice. Please consult your tax advisor!

For a complete list of IRS qualified expenses please visit www.irs.gov

Vision: Non-Union Premera Blue Cross

Your Premera Blue Cross medical plans also includes vision coverage.

Go to premera.com to find an In-Network provider or to view your claim status online.



	Premera Blue Cross Plan C	
	Network	**Out-of-Network ***
Frequencies		
Exam	Once per calendar year	
Lenses	Once per calendar year	
Frames	Once per two calendar years	
Contacts	Once per two calendar years	
Exam	$5 copay	After $5 copay, reimbursed up to $60
Hardware	$15 copay	After $15 copay, reimbursed up to amounts below
Single Vision	Covered in full	Reimbursed up to $76
Standard Bifocal	Covered in full	Reimbursed up to $112
Standard Trifocal	Covered in full	Reimbursed up to $142
Progressive	Covered in full	Reimbursed up to $140
Frames	Amount over $250 allowance	Reimbursed up to $60
Contacts		
Elective (in lieu of glasses)	Amount over $250 allowance	
Medically Necessary	Covered in full	Reimbursed up to $316

*** If you seek the service of an Out-of-Network provider balance billing may apply, members are responsible for the amounts in excess of the allowable charge.**

Dental Benefits: Non-Union

Dental Coverage

Dental plans pay a portion of the costs associated with dental care. You can seek care from any provider and will receive the highest level of coverage when you see an in-network provider.

Classification of Services

Preventive

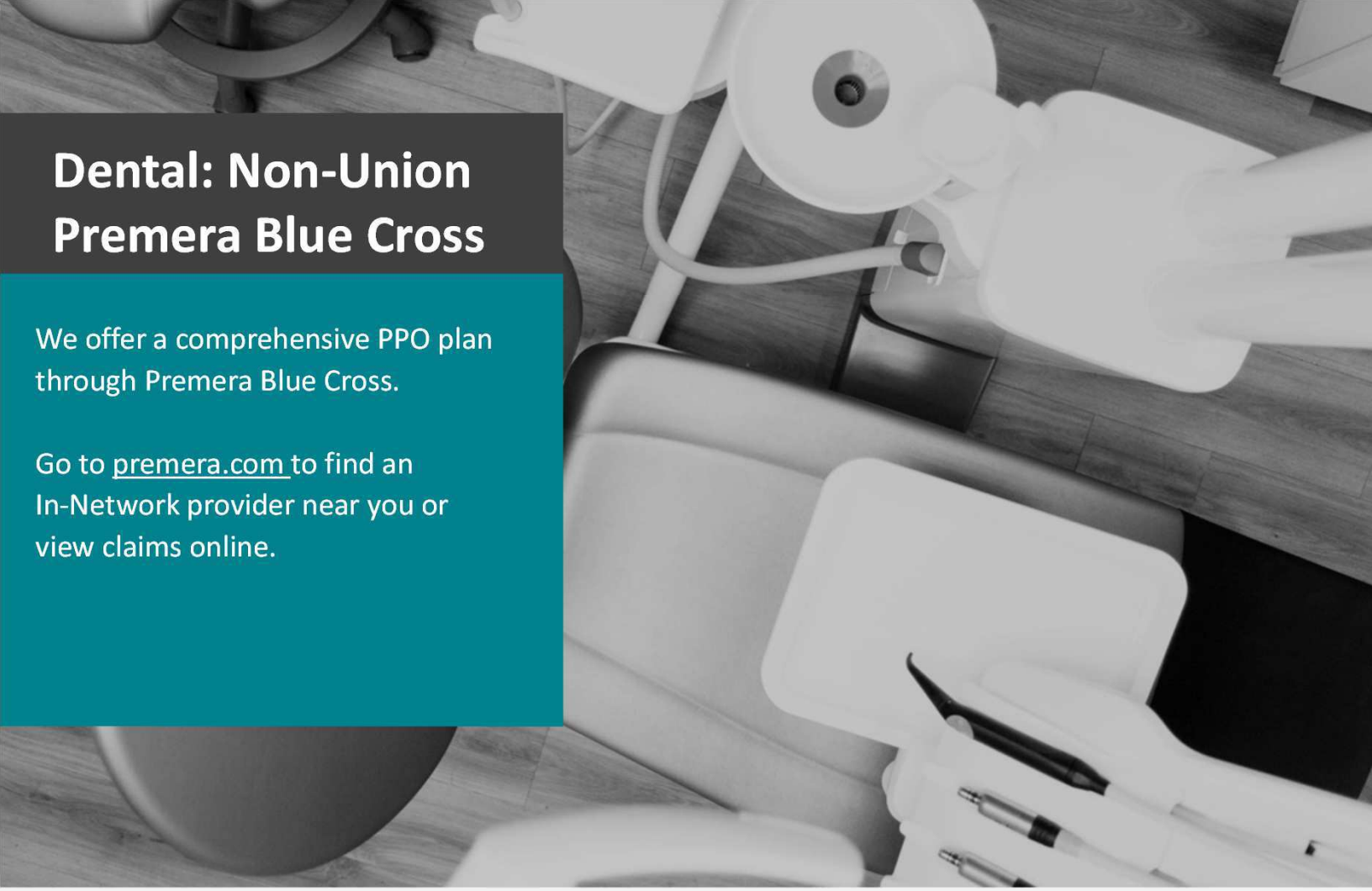
Typically includes routine cleanings, x-rays and fluoride treatments. Frequency limitations may apply.

Basic

Typically includes fillings, extractions, root canals, root planing and sealants. You may be responsible for the additional cost for composite fillings.

Major

Typically includes crowns, dentures, implants and oral surgery. We recommend getting a pre-treatment estimate before seeking care.



Dental: Non-Union
Premera Blue Cross

We offer a comprehensive PPO plan through Premera Blue Cross.

Go to premera.com to find an In-Network provider near you or view claims online.

	Premera Blue Cross Plan A with Ortho Plan A		Premera Blue Cross Optima Plan C	
	In-Network	**Out-of-Network ***	**In-Network**	**Out-of-Network ***
Network	**Dental Choice**		**Dental Choice**	
Plan Year Deductible **Plan Year: 2022**	$0/Individual		$0/Individual	
	$0/Family		$0/Family	
Plan Year Maximum	$2,000	$1,750	$2,000	$1,750
Diagnostic & Preventive Services **Exams, Cleanings, X-Rays & Sealants**	Yr 1: 30% Yr 2: 20% Yr 3: 10% Yr 4+: Covered in full		Covered in full	
Basic Services **Fillings, Endodontics, Periodontics & Oral Surgery**	Yr 1: 30% Yr 2: 20% Yr 3: 10% Yr 4+: Covered in full		20%	
Major Services	50%		50%	
Orthodontia (Child and Adult)	50% up to a $1,000 Lifetime Maximum		Not covered	

*** If you seek the service of an Out-of-Network provider balance billing may apply, members are responsible for the amounts in excess of the allowable charge.**

Basic Life and AD&D: Non-Union Sun Life

We are pleased to provide you with an employer paid Basic Life and Accidental Death and Dismemberment (AD&D) benefit through Sun Life.

Please contact HR to ensure your beneficiary is up to date.

	Basic Life and AD&D
Benefit Amount	1x Basic Annual Earnings
Maximum Benefit	$250,000
Age Reduction Schedule	65% at age 70 45% at age 75

Voluntary Life and AD&D
Non-Union Sun Life

You have the option to purchase additional Life and AD&D (Accidental Death & Dismemberment) protection. Life insurance pays your beneficiary a benefit should you die, and AD&D insurance pays a benefit should your death result from an accident or if you are severely injured in an accident. Age may affect coverage levels. See language below. Coverage is provided through SunLife.

Employee	Spouse	Dependents
Increments of $10,000 up to $300,000 Guaranteed Issue amount up to $100,000 $110,000 - $300,000 will require Evidence of Insurability.	Increments of $5,000 up to $300,000 Guaranteed Issue amount up to $20,000 $25,000 - $300,000 will require Evidence of Insurability.	Options of $5,000 or $10,000

Voluntary Long-Term Disability: Non-Union Sun Life

A Long-Term Disability is an illness or injury that prevents you from working for an extended period of time.

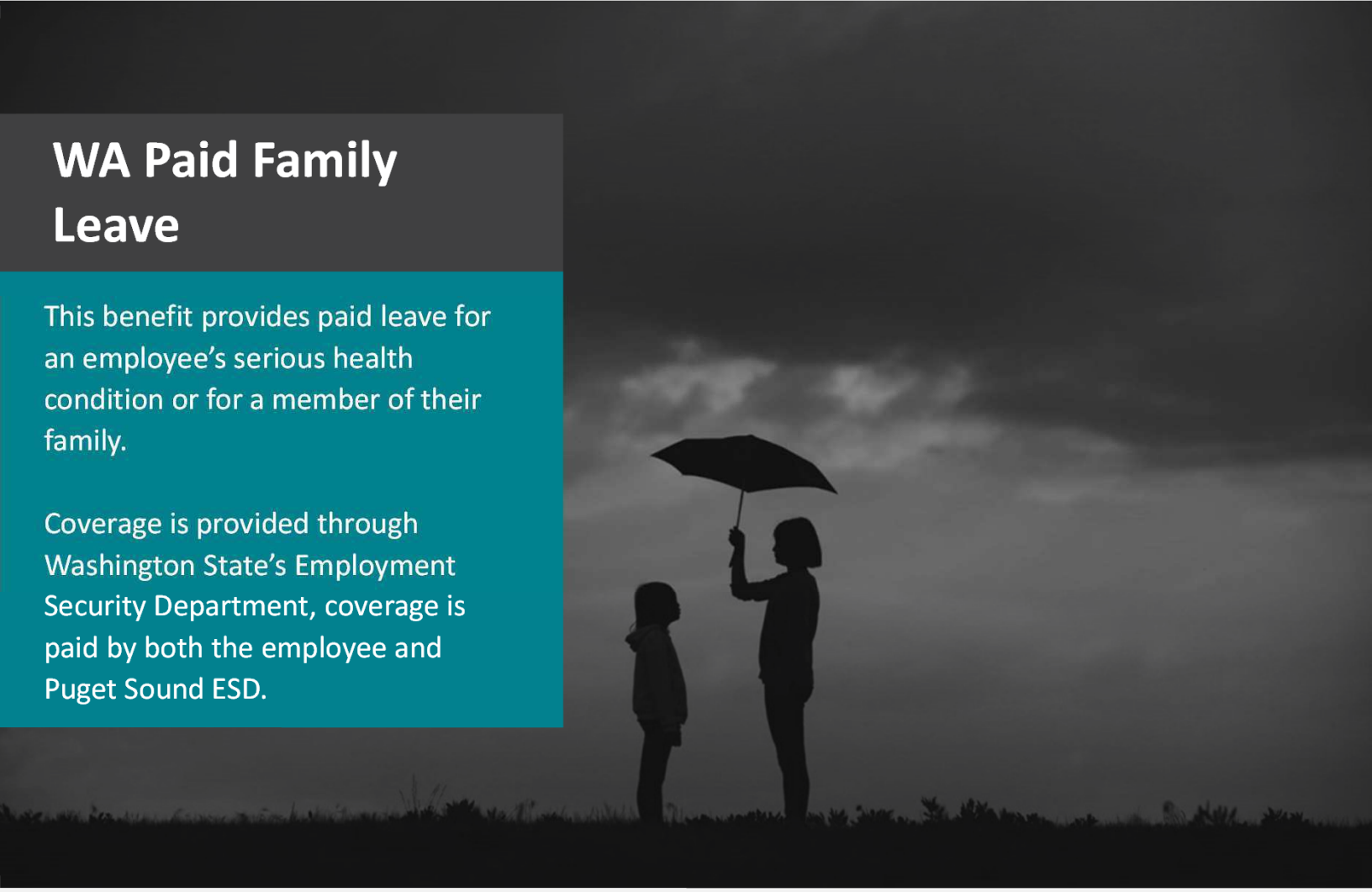
Coverage is provided at **full cost to you** through Sun Life.

	Voluntary Long-Term Disability
Benefits Begin	After 90 days
Percentage of Income Replaced	60%
Maximum Monthly Benefit	$5,000
Maximum Duration	Social Security Normal Retirement Age

WA Paid Family Leave

This benefit provides paid leave for an employee's serious health condition or for a member of their family.

Coverage is provided through Washington State's Employment Security Department, coverage is paid by both the employee and Puget Sound ESD.



	Washington Paid Family Leave
Benefits Begin	7 day waiting period
Percentage of Income Replaced	Varies based upon income
Maximum Benefit	Up to $1,000 per week
Maximum Duration	Up to 12 weeks (Up to 16 weeks for childbirth)

Employee Assistance Program
First Choice

No matter where you are on your journey, there are times when a little help can go a long way. From checking off daily tasks to working on more complex issues, your program offers a variety of resources, tools and services available to you and your household members.

- Face-to-face visits with counselors
- Referrals for childcare and eldercare services
- Phone sessions with financial experts
- Expert consultation to help with your legal needs
- Online self-assessment and self-help programs
- Identity theft resolution assistance

Call First Choice 24/7 days a week at 800.777.4114 or firstchoiceeap.com

EAP code: PSESD

Employees Enrolled in the Premera Blue Cross plans receive an additional Employee Assistance Program through Lifestyle Guidance Resources

Phone: 1-844-862-0898

TTY: 1-800-687-0353

Online: guidanceresources.com/Web ID: premerawellness

PSA Union Only
SEBB - (School Employee Benefits Board)

Union members become eligible for SEBB medical, dental, and vision coverage the first day of the month following their hire date.

Go to myaccount.hca.wa.gov to create and view your MySEBB account.

Medical, dental, and vision plan options will depend on your county of residence.

Additional benefits offerings:

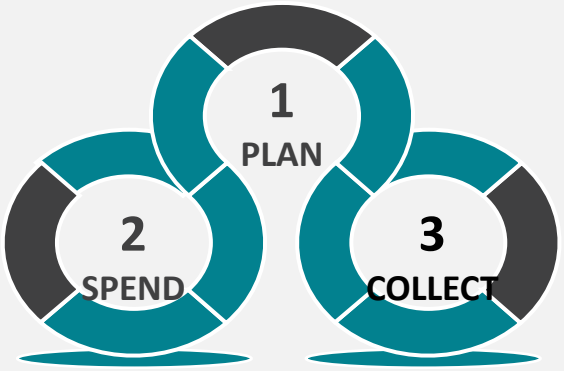
- The **Dependent Care Assistance Program (DCAP),** which allows you to set aside pretax money from your paycheck to help pay for qualifying childcare or elder care expenses.
- Basic **Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance** at no cost for employees, as well as supplemental life insurance for purchase.
- Basic **Long-Term Disability (LTD) Insurance** at no cost for employees, as well as supplemental LTD insurance for purchase.
- A **Medical Flexible Spending Arrangement (FSA)**, which allows you to set aside pretax money from your paycheck to pay for out-of-pocket health care costs.

Visit https://www.hca.wa.gov/employee-retiree-benefits for more information.

Flexible Spending Account (FSA)
Navia Benefit Solutions

Flexible Spending Accounts (FSAs) help employees save up to 40% on health and dependent care expenses. For employees enrolled in traditional health plans, health care FSAs are used to pay for prescription drugs, copays, deductibles, and other out-of-pocket costs. Dependent care FSAs are great options to save and pay for childcare. Employees enrolled in qualified HDHPs can use limited-purpose FSAs for vision and dental expenses, thereby maximizing their HSA savings. Coverage is provided by Navia Benefit Solutions. Please visit naviabenefits.com. Navia code: PSE.

Use your funds on eligible expenses by swiping your debit card or paying up front and submitting for reimbursement.



Submit IRS-required documentation to substantiate your claims and collect your reimbursement.

Health/Limited Health FSA

Dependent Care Account Program (DCAP)

Health FSA

Out-of-pocket medical, Rx, dental & vision expenses such as copays, deductibles and coinsurance. You can set aside up to $2,750 per year.

DCAP

Covers children up to age 13, disabled children of any age, or a disabled spouse. You can set aside up to $5,000 per year ($2,500 if married, filing jointly).

Limited-Purpose FSA

Out-of-pocket dental & vision expenses such as copays, and coinsurance. You can set aside up to $2,750 per year. *H.S.A. Premera Blue Cross QHDHP Plan enrollment required.*

DCAP Eligibility

Both you and your spouse (if applicable) must be working, be looking for work, or be full-time students.

Resources On the Go
Kaiser Permanente

Care Chat

Care Chat is an online messaging feature that lets you get real-time medical care from a Kaiser Permanente care provider. It's available 7 days a week, 24/7.

No appt. needed | Care on the go | Extended hours

24/7 Consulting Nurse

Want care advice or know if you should get immediate medical attention? Our Consulting Nurse Service can help 24/7. A nurse will listen to your concerns, and if necessary, direct you to the best location to get care. *You'll need to give your member ID number.*

No appt. needed | Care on the go | Extended hours

Smart-Phone App

Download on the App Store

GET IT ON Google Play

Get it done on the go with Kaiser Permanente's mobile app*:

- Find doctors, medical offices, urgent care, pharmacies and more
- Exchange messages with your care team
- Schedule an appointment with your Kaiser Permanente care team
- Refill or transfer prescriptions
- Access your digital ID card
- View your deductible and out-of-pocket maximum

Online Visit

For common medical issues that don't need a physical exam, such as a sore throat or allergies, go online and get a diagnosis and a treatment plan, usually within 2 hours.

No appt. needed | Care on the go

**If you are a Washington resident outside the Vancouver/Longview area, please download the Washington-specific app.*

Resources On the Go
Premera Blue Cross

Doctor On Demand

Doctor On Demand is a convenient and affordable option for a variety of medical services, including General Medical and Dermatology. Access quality healthcare from the comfort of home, during your lunch break, or while traveling. You can even get a prescription sent to your local pharmacy. Web, phone, or mobile app.

Create an account or log in at **https://patient.doctorondemand.com**

98point6

98point6 is a **text-based** primary care app that you can download to your Smart Phone/iPhone. Connect with a primary care physician right from your phone. Get treatment for a cough while commuting to work or get care for a child's stomach pain while at a weekend event. Available Nationwide 24/7/365 days. Visit **98point6.com/Premera**.

24-Hour Nurseline

You and your family have access to a 24/7 nurse line. This service is **free** and **confidential**. You are connected with a registered nurse who will ask the right questions, listen to your concerns and help you determine where and when to see treatment.

Call **800-841-8343** to discuss symptoms and get advice on where to go for care.

TalkSpace

Premera's behavioral health network includes Talkspace. With Talkspace, you can easily connect to therapists and psychiatrists by video and text for about the same cast as an in-person visit.

- Sign-up for Talkspace at **blue.premera.com/Bhsupport**
- Get matched with the best therapist for you
- Start messaging your therapist right away

Smart Phone App

Get it done on the go with Premera mobile app:

- Find doctors and other providers
- Monitor claims
- Show proof of coverage—no card required
- View your deductible and what you've spent toward your out-of-pocket maximum

Download on the App Store

GET IT ON Google Play

Medical Coverage While Traveling

Kaiser Permanente:

If you are in one of Kaiser Permanente's National Service Areas (California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington (Clark & Cowlitz Counties and Washington DC) you can contact member services at **1-800-446-4296** and obtain a Visiting Membership to that location and receive treatment with the exception of preventive Services.

Premera Blue Cross (BlueCard):

When you seek care in Southwest Washington, in another state, or outside of the United States, you have access to the BlueCard network (BlueCard Worldwide Program for outside the U.S.).

- To access network provider information in **SW Washington or in other states**, visit **www.bcbs.com**. You can also download the National Doctor & Hospital Finder app to search, or call BlueCard Access at **1.800.810.BLUE (2583).**

Emergency Care:
You can self refer to the closest Emergency Room and receive services at the network benefit. Prior Authorization is required if admitted.

Travel Emergency Assistance
With your SunLife coverage, you receive an emergency travel assistance program and ID theft protection services provided by Assist America.

This program immediately connects you to doctors, hospitals, pharmacies and other services if you experience a medical or non-medical emergency while traveling 100 miles away from your permanent residence, or in another country.

Visit **assistamerica.com** or call Toll **Free 800-872-1414**
Email: medservices@assistamerica.com Ref# 01AA-SUL-100101

Voluntary Benefits
NW Benefit Solutions

In addition to benefits plans outlined in this guide, you have the opportunity to purchase voluntary benefits from NW Benefit Advisors. NW Benefit Advisors offers benefits that pay you directly for situations such as Short-Term Disability, Critical Illnesses, and Accidents. These products are voluntary and some are paid for by you through payroll deductions, others are paid through direct debit. For more information about these products, please visit NWBenefitAdvisors.com/employees.

Disability

Helps replace a portion of your income to help make ends meet if you become disabled from a covered accident or covered sickness.

Critical Illness

Critical Illness supplements your medical and your disability income insurance. The lump-sum benefit is paid when you need it most, upon diagnosis, so you can rest assured that you will have funds to offset upcoming out-of-pocket costs.

Accident

Accident benefit payments can help you with your medical deductibles and copays, and cover household expenses like groceries, mortgage payments and childcare, which can begin to pile up if you have to take some time off from work.

Hospital Confinement

Provides a lump-sum benefit for a covered hospital confinement or outpatient surgery to help with co-payments and deductibles that are not covered by most major medical plans.

Contact Us
Non-Union

	Vendor	Group Number	Phone Number	Website/Email
Medical/Rx	Kaiser Permanente	HMO $100: 0034400 HMO $1000: 2028000	888.901.4636	kp.org/wa
Medical/Rx/Dental/Vision	Premera Blue Cross	4018730	800.722.1471	premera.com
Life & AD&D/LTD	Sun Life	219780	800.669.3539	sunlife.com
FSA/DCAP/HSA	Navia Benefit Solutions	Navia Code: PSE	800.862.6266	naviabenefits.com
Voluntary	NW Benefit Advisors	N/A	425.827.8397	Barbara@nwbenefitadvisors.com
EAP	First Choice	EAP Code: PSESD	800.777.4114	firstchoiceeap.com
Local Advisor	Propel Insurance	N/A	253.310.4137	Hannah.Balera@propelinsurance.com
Plan Administrator	Benefits Administrator	N/A	425.917.7624	Benefits@psesd.org

Annual Compliance Notices

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30-days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60-days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60-days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60-days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Benefits Administrator at 800 Oakesdale Avenue SW, Renton, WA 98037, or call (425) 917-7624, or benefits@psesd.org.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (425) 917-7624.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (425) 917-7624 for more information.

Annual Compliance Notices

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under Puget Sound Educational Service District Health Benefits Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (425) 917-762.

Newborns' and Mothers' Health Protection Act Notice

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To continue benefits beyond the 3-week period, please see the dependent eligibility and enrollment guidelines outlined in your plans Benefit Guide. If the mother isn't eligible to receive obstetrical care benefits under this plan, the newborn isn't automatically covered for the first 3 weeks. For newborn enrollment information, please see the dependent eligibility and enrollment guidelines outlined in your plans Benefit Guide.

Benefits are provided on the same basis as any other care, subject to the child's own cost-shares, if any, and other provisions as specified in this plan. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Genetic Information Nondiscrimination Act (GINA) Disclosures

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Annual Compliance Notices

Medicare Part D Creditable Coverage Notice

Important Notice from Puget Sound Educational Service District 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 Puget Sound Educational Service District 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. Puget Sound Educational Service District has determined that the prescription drug coverage offered by Kaiser and Premera Health Benefits 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 Puget Sound Educational Service District coverage will not be affected. Plan participants can retain their existing coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage. If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may (or may not) enroll back into Puget Sound Educational Service District benefit plan during the open enrollment period.

Annual Compliance Notices

Medicare Part D Creditable Coverage Notice – Continued

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 Puget Sound Educational Service District 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 October 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 Puget Sound Educational Service District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	01/01/2022
Name of Entity/Sender:	Puget Sound Educational Service District
Address:	800 Oakesdale Avenue SW, Renton, WA 98037
Phone Number:	(425) 917-7624
Email:	benefits@psesd.org

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	CALIFORNIA
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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
ARKANSAS Medicaid	**FLORIDA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA Medicaid

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)

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

KANSAS Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY 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

LOUISIANA Medicaid

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

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

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA 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

MISSOURI Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE Medicaid

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

NEW JERSEY Medicaid and CHIP	UTAH Medicaid and CHIP
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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OKLAHOMA Medicaid and CHIP	**VERMONT Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON Medicaid	**VIRGINIA Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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
PENNSYLVANIA Medicaid	**WASHINGTON Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
RHODE ISLAND Medicaid and CHIP	**WEST VIRGINIA Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
NEW YORK Medicaid	**WISCONSIN Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
NORTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
NORTH DAKOTA Medicaid	
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Contact Us

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(425) 917-7624
benefits@psesd.org