sound family medicine

2019

EMPLOYEE BENEFITS SUMMARY

MEDICAL, DENTAL, VISION, DISABILITY, LIFE/AD&D, FLEXIBLE SPENDING ACCOUNTS, HEALTH SAVINGS ACCOUNT, EMPLOYEE ASSISTANCE PROGRAM

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 read the Individual Creditable Coverage Disclosure notice for more information. If you have questions about your options, please, contact Human Resources, or our Benefits Consultant, Parker, Smith & Feek.

TABLE OF CONTENTS

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This 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.

HEALTHCARE REFORM

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

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 As of January 1, 2019, the ACA tax penalty is repealed and you won't have to pay anything if you don't enroll.

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

Third, for most people the plans we offer are considered affordable and neither you nor any family members are eligible for the federal subsidies available in the Health Insurance Marketplace, even if you choose not to enroll in Sound Family Medicine's plan.

Please refer to your Notice of Health Insurance Marketplace Coverage for general information. For additional information Marketplace options in your area and subsidy calculators, go to www.healthcare.gov or call 1-800-318-2596.

ELIGIBILITY REQUIREMENTS

Employee	Regular employees working at least 30 hours per week
Dependents	Your legal spouse or domestic partner Dependent children may be covered until age 26**
Waiting Period	1st of the month following 60 days from your date of hire

*Domestic Partner must meet all requirements included in the "Affidavit of Qualifying Domestic Partnership". Eligible partner is extended the same rights and benefits as a spouse. Coverage also includes eligible children of partner.

**Disabled dependents beyond age 26 may still qualify for coverage. Please see Human Resources for more information.

NEWLY ELIGIBLE EMPLOYEES

If you are a new participant, you will need to go online to Paycom in order to select and enroll in your benefits. You are eligible for health benefits the first of the month following 60 calendar days from hire date. To enroll go to https://www.paycomonline.net/v4/ee/web.php/app/login. You have a maximum of 30 days from eligibility to enroll you and any eligible family members for coverage. If you don't enroll, or you waive coverage, you'll receive the default benefits shown below:

- Long Term Disability
- Basic Life Insurance and AD&D

If you'd like to participate in the Health FSA or Dependent Care FSA or make pre-tax deductions to your HSA account, you must indicate your election in Paycom.

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 April 1, 2019.

Other than during Open Enrollment, you may make limited changes to your benefits during the year only if you experience a qualifying status change, which may include:

- Loss of other employer sponsored coverage
- Change in family status, such as marriage, divorce, adoption and birth of a child
- A qualified court or administrative order that requires you to provide coverage for a dependent

For more information on what you may change, please contact human resources.

NEW IN 2019

REMINDER, IF YOU RECENTLY HAD A FAMILY STATUS CHANGE, THIS IS A GOOD TIME TO UPDATE YOUR BENEFICIARY INFORMATION.

MEDICAL

As of April 1, 2019 we will offer a third medical plan option: The QHDHP AWH 5000 Plan. There are a few provisions that differentiate this plan from our other offerings.

- The deductible is $5,000 for an individual and $10,000 for a family in-network. Out-of-network the deductible is $7,500 for an individual and $15,000 for a family.
- The out-of-pocket maximum is $6,000 for an individual and $12,000 for a family in-network. Out-of-network the out-of-pocket maximum is $12,000 for an individual and $24,000 for a family.
- After meeting the deductible, the copays for prescription drugs is $15 for generic, $45 for preferred brands, $70 for non-preferred brands and 30% for specialty.
- The plan has a more limited provider network called Aetna Whole Health – Puget Sound. The hospitals included in Pierce County are St. Anthony Hospital, St. Clare Hospital, and St. Joseph Medical Center. Please see page 3 for full instructions on how to search this network.
- Reduced payroll deductions for coverage. Please see pages 10-11 for rates.

We will continue to offer our QHDHP Base 2500 Plan and PPO Buy Up 1500 Plan with no material changes to benefits.

VOLUNTARY LIFE

If you have purchased voluntary life insurance, your monthly deductions may go up. Because the premium is based on age, when you or your spouse go from one age bracket to the next, monthly deductions will increase to reflect the new age bracket.

If you purchased voluntary life coverage when first eligible, you are allowed to increase your coverage by two increments without providing proof of good health, up to the guarantee issue amount during open enrollment. Employee coverage can be increased by two units of $10,000 and spouse coverage can be increased by two units of $5,000.

FLEXIBLE SPENDING ACCOUNTS

The IRS has increased the annual limit on the Health FSA. In 2019, you can set aside up to $2,700 per year pre-tax to pay for certain IRS-approved healthcare (medical, dental, vision) expenses not covered by the insurance plan.

The annual maximum amount you may contribute into the Day Care FSA is $5,000 per calendar year (or $2,500 if married and filing separately).

MEDICAL COVERAGE

AETNA MEDICAL — QHDHP AWH 5000

The AWH 5000 is a Qualified High Deductible Health Plan (QHDHP). Enrollment on a QHDHP is a requirement of establishing a Health Savings Account (HSA). This is a lower premium and higher deductible and out-of-pocket maximum plan. The plan also utilizes the Aetna Whole Health network in the Puget Sound region. Please refer to the Aetna Whole Health Puget Sound Network Map for general locations of participating providers.

The plan encourages you to use in-network providers by charging you lower co-insurance amounts once you reach your deductible. You may have to pay amounts above that charge (also called balance billing). To find a list of in-network providers and facilities, please follow the below steps:

1. http://www.aetna.com/docfind/home.do
2. Search as guest and enter zip code
3. Under Aetna Whole Health Plans select (WA) Aetna Whole Health – Puget Sound – Managed Choice / Choice POS II
4. On the next screen identify the type of provider or facility to locate

Once you are enrolled on the QHDHP AWH 5000, you can register at www.aetna.com and perform provider searches.

QHDHP AWH 5000	AETNA WHOLE HEALTH	OUT-OF-NETWORK
Annual Calendar Deductible Individual Maximum per family	Applies unless noted $5,000 $10,000	Applies unless noted $7,500 $15,000
Out-of-Pocket Maximum Individual Maximum per family	(includes deductible, coinsurance, prescriptions) $6,000 $12,000	(includes deductible, coinsurance, prescriptions) $12,000 $24,000
Preventive Care Routine Exam Laboratory Services	100%, deductible waived	60%
Physician Services Office Visits Inpatient	80%	60%
X-Ray and Laboratory Services	80%	60%
Emergency Services	80%	Paid at the in-network level
Hospital Services Inpatient and Outpatient	80%	60%
Virtual Visits	80%	N/A
Outpatient Rehabilitation 25 visits per calendar year	80%	60%
Mental Health Outpatient	80%	60%
Spinal Manipulations 20 visits per calendar year	80%	60%
Acupuncture 20 visits per calendar year	80%	60%

DON'T FORGET YOUR ANNUAL EXAM PREVENTIVE CARE IS COVERED 100% (IN-NETWORK)

(CONTINUED) MEDICAL COVERAGE

AETNA MEDICAL — QHDHP BASE 2500

The Base 2500 is a Qualified High Deductible Health Plan (QHDHP). Enrollment on a QHDHP is a requirement of establishing a Health Savings Account (HSA).

The plan encourages you to use in-network providers by charging you lower co-insurance amounts once you meet your deductible. In-network providers agree to bill Aetna directly and to accept a negotiated fee as payment in full. Out-of-network providers have not and are reimbursed based on Medicare reimbursement rates. You may have to pay amounts above that charge (also called balance billing). To find a list of in-network providers, go to http://www.aetna.com/docfind/home.do. Please search under Aetna Standard Plans and select the Open Choice PPO network. Once you are enrolled you can register at www.aetna.com and perform provider searches.

QHDHP BASE 2500	OPEN CHOICE PPO	OUT-OF-NETWORK
Annual Calendar Deductible	Applies unless noted	Applies unless noted
Individual	$2,500	$5,000
Maximum per family	$5,000	$10,000
Out-of-Pocket Maximum	(includes deductible, coinsurance, prescriptions)	(includes deductible, coinsurance, prescriptions)
Individual	$5,000	$10,000
Maximum per family	$5,000	$10,000
Preventive Care Routine Exam Laboratory Services	100%, deductible waived	60%
Physician Services Office Visits Inpatient	80%	60%
X-Ray and Laboratory Services – Outpatient	80%	60%
Emergency Services	80%	Paid at the in-network level
Hospital Services Inpatient and Outpatient	80%	60%
Virtual Visits	80%	N/A
Outpatient Rehabilitation 25 visits per calendar year	80%	60%
Mental Health Outpatient	80%	60%
Spinal Manipulations 20 visits per calendar year	80%	60%
Acupuncture 20 visits per calendar year	80%	60%

HOW SOUND FAMILY MEDICINE HELPS YOU PAY YOUR MEDICAL DEDUCTIBLE

HEALTH SAVINGS ACCOUNTS (HSA)

You must be enrolled in a Qualified High Deductible Health Plan (QHDHP) to take advantage of the HSA

An HSA is a tax-advantaged savings account that belongs to you and is designed to help you save money pre-tax for when you have higher health care expenses. Similar to a Flexible Spending Account (FSA), you can set money aside in this account on a pre-tax basis to use for healthcare expenses. An HSA is different from a Flexible Spending Account in that it is a bank account that you own. If you leave the company, you take it with you. If you don't use the funds by the end of the year, it remains in your account for future use.

The HSA account is set up in your name through Optum Bank. They will hold the funds, but you are responsible for managing them. The HSA account is a tax-qualified account (similar to an IRA). You may make deposits on a pre-tax basis, subject to certain limitations, and the money grows tax-free. You can use the funds in your HSA account for qualified health expenses incurred by you, your spouse and any dependents you claim on your tax return (with a few exceptions). Your dependents do not need to be enrolled on Sound Family Medicine's QHDHP AWH 5000 or Base 2500 in order for you to use the HSA funds to pay for their qualified health expenses. Use of the funds for anything other than a qualified health expense is a taxable event.

Note: Although the Affordable Care Act allows parents to keep adult children on their policies until the child reaches age 26, you cannot use funds from your HSA to pay for the child's care after they reach age 24. That is because "dependent" is defined differently for HSA purposes than it is under the ACA provisions that extend dependent coverage to adult children.

2019 HSA Contributions

Contributions to the HSA account may be made by you and by your employer. Sound Family Medicine will contribute $50 per month to your HSA account while you are enrolled in the HSA plan. Contributions will be made over 24 pay periods therefore there will be two pay periods without HSA contributions. If you have an annual preventive exam, you will receive an additional $100 in your HSA account from Sound Family Medicine (to receive this one time contribution, submit a copy of your Explanation of Benefits (EOB) for your preventive exam to HR).

The maximum amount you can contribute to your HSA in 2019 (from all sources) is determined annually by the IRS.

- Individual only coverage: $3,500
- Individual, plus one or more covered family members: $7,000
- Additional catch-up contribution for those 55+: $1,000

It is your responsibility to confirm you are eligible to receive contributions to your Health Savings Account.

To receive contributions you must NOT have other health coverage for yourself including:

- Coverage through an individual plan
- Coverage through a spouse or parent
- Access to a Spouse's Flexible Spending Arrangement
- Be a dependent on someone else's tax return
- Coverage though a state or federal program
  - Tricare/Champus/Veterans Administration
  - Native/ Tribal plan
  - Medicare
  - Medicaid

For questions about your eligibility for the HSA, contact HR.

Note: Health Savings Accounts and employer HSA contributions are not subject to ERISA or COBRA. HSA information is included in this Summary to provide you with a complete overview. It is not our intent to include your account in our ERISA benefits program.

SAVE MONEY PRE-TAX FOR HEALTH CARE EXPENSES

(CONTINUED) HOW SOUND FAMILY MEDICINE HELPS YOU PAY YOUR MEDICAL DEDUCTIBLE

Establishing & Managing Your HSA Account — Optum Bank

For current participants: HSA accounts will rollover and remain active in 2019, as long as you chose to remain on the QHDHP AWH 5000 or Base 2500 during open enrollment. For new participants: HSA accounts will be set up with Optum Bank effective your eligible entry date upon selection of the QHDHP AWH 5000 or Base 2500 in Paycom. Contributions cannot be posted to your account until your account is set up. To transfer or rollover funds from an HSA account with another bank, please call 1-866-988-2006 to start the process. You will receive a welcome kit, debit card and PIN from Optum. Your HSA debit card may be used to pay for services subject to your deductible and other cost shares (Keep in mind that since this is an actual bank account, you may only use funds that have already been deposited into the account.)

Fees

Because this is an actual bank account, Sound Family Medicine will only have the ability to contribute to the account. Anything else that needs to be managed (change of address, accessing balance, etc.) must be performed by the account holder (you). In addition, it's subject to bank fees just as any other account would be. Sound Family Medicine will pay the monthly account service fee, but additional fees may apply for things like NSFs, paper statements, etc. For a complete list of fees and other Optum Bank information, visit our Sound Family Medicine intranet page under Benefits.

ONCE YOUR ACCOUNT EXCEEDS $2,000 YOU CAN INVEST THE EXCESS FUNDS.

Interest And Investments

Your HSA account will accrue a small amount of interest; rates increase with account size. Once your account exceeds a $2,000 balance, you'll be allowed to invest the excess funds in mutual funds offered through Optum Bank. To activate your investment account you must register for online access to your HSA account at optumbank.com. Details of the funds available for investment can be found at the Optum website.

Filing Your Taxes

Each year you'll receive a Year-end Status Report, IRS Form 1099-SA and IRS Form 5498-SA.IRS Form 1099-SA provides you with the distributions made from your Health Savings Account in that tax year. IRS Form 5498-SA provides you with all the contributions made to your Health Savings Account in that tax year. This information is used to complete IRS Form 8889.

MEDICAL COVERAGE

AETNA MEDICAL – PPO BUY UP 1500

The plan encourages you to use in-network providers by charging you lower co-pays and co-insurance amounts. In-network providers agree to bill Aetna directly and to accept a negotiated fee as payment in full. Out-of-network providers have not and are reimbursed based on Medicare reimbursement rates. You may have to pay amounts above that charge (also called balance billing). To find a list of in-network providers, go to http://www.aetna.com/docfind/home.do. Please search under Aetna Standard Plans and select the Open Choice PPO network. Once you are enrolled you can register at www.aetna.com and perform provider searches.

PPO BUY UP 1500	OPEN CHOICE PPO	OUT-OF-NETWORK
Annual Calendar Deductible Individual Maximum per family	Applies unless noted $1,500 $3,000	Applies unless noted $3,000 $6,000
Out-of-Pocket Maximum Individual Maximum per family	(includes deductible and office visit copays) $4,000 $8,000	(includes deductible and office visit copays) $8,000 $16,000
Preventive Care Routine Exam Laboratory Services	100%, deductible waived	50%
Physician Services Office Visits Inpatient	PCP: $30 copay Specialist: $40 copay, deductible waived	50%
X-Ray and Laboratory Services – Outpatient	80%	50%
Emergency Services	80% after $150 copay, deductible waived	Paid at the in-network level
Hospital Services Inpatient and Outpatient	80%	50%
Virtual Visits	$30 copay	N/A
Outpatient Rehabilitation 25 visits per calendar year	$40 copay, deductible waived	50%
Mental Health Outpatient	$30 copay, deductible waived	50%
Spinal Manipulations 20 visits per calendar year	$40 copay, deductible waived	50%
Acupuncture 20 visits per calendar year	$40 copay, deductible waived	50%

DON'T FORGET YOUR ANNUAL EXAM PREVENTIVE CARE IS COVERED 100% (IN-NETWORK)

PHARMACY COVERAGE

AETNA

This plan requires the use of appropriate generic drugs. When available, a generic drug will be dispensed in place of a brand name drug. If a generic equivalent isn't manufactured, the applicable brand name copay or coinsurance will apply.

	QHDHP AWH 5000	QHDHP Base 2500	PPO Buy Up 1500
	RETAIL (30 DAY SUPPLY)	RETAIL (30 DAY SUPPLY)	RETAIL (30 DAY SUPPLY)
Deductible	Medical deductible applies		None
Generic	$15	$15	$10
Preferred Brand	$45	$25	$35
Non-Preferred	$70	$40	$60
Specialty	30% (to $150)	Above copays apply	Above copays apply
Mail Order (90 day supply)	2X retail copay	2X retail copay	2X retail copay

Retail prescriptions from an out-of-network pharmacy are covered at 60% of the recognized charge after the applicable copay. You will be responsible for paying for the out-of-network prescription in full and submitting it to Aetna for reimbursement.

VIRTUAL AND TELEPHONIC CARE

24/7 ACCESS TO A BOARD CERTIFIED PHYSICIAN VIA PHONE OR VIDEO!

TELADOC

Teladoc provides you with 24/7 access to a board certified physician via phone or video without a trip to the doctor's office. The providers can diagnose and prescribe medications for non-emergent medical conditions such as:

- Cold and flu
- Rashes
- Headaches
- UTI
- Asthma
- Sore throat
- Allergies
- Bronchitis
- Fever
- And much more!

How does it work?

Go online to www.teladoc.com/aetna, have your medical ID card ready, and click on Set Up Account. You can also call 855-835-2362 for assistance. Once your account is set up and you need to use the service, you can view doctor profiles and set a time with the doctor of your choice and pay for your appointment. He/she will call you either by phone or video, whichever you prefer to conduct your appointment.

What does it cost?

A virtual visit is covered under the medical plan and treated as an office visit.

If you are enrolled in the QHDHP AWH 5000 or Base 2500, this visit is subject to the deductible; however a virtual visit is between $38 and $45 compared to an average office visit charge from your doctor at $100 or more.

If you are enrolled in the PPO Buy Up 1500, this visit is subject to a copay of $30.

Virtual visits are not meant to replace your primary care provider, but to eliminate unnecessary trips to the emergency room and urgent care.

DENTAL COVERAGE

GUARDIAN

Contracted providers agree to bill Guardian directly and to accept a negotiated fee as payment in full. Allowable charges for out-of-network providers are paid based on allowed amounts, as determined by Guardian. It is recommended that for services costing over $500 your dentist submit a treatment plan to Guardian.

DENTAL BASE PLAN	DENTALGUARD PREFERRED	ALL OTHER DENTISTS
Annual Calendar Individual Maximum per family	Applies to Basic and Major Treatment $50 $150	
Preventive Care (Exams, X-rays, etc.)	100%	100%
Basic Services (Fillings Extractions, etc.)	80%	80%
Major Services (Crowns, Bridges, Dentures, etc.)	50%	50%
Annual Maximum per calendar year	$1,000	
Orthodontia	Not Covered	
Rollover Amounts	$350 in-network if $500 of annual max is used Maximum account limit is $1,000	

DENTAL BUY UP PLAN	DENTALGUARD PREFERRED	ALL OTHER DENTISTS
Annual Calendar Individual Maximum per family	Applies to Basic and Major Treatment $25 $75	
Preventive Care (Exams, X-rays, etc.)	100%	100%
Basic Services (Fillings Extractions, etc.)	90%	80%
Major Services (Crowns, Bridges, Dentures, etc.)	60%	50%
Annual Maximum per calendar year	$2,000	
Orthodontia (adults & children)	50% $1,500 Lifetime Maximum	
Rollover Amounts	$600 in-network if $800 of annual max is used Maximum account limit is $1,500	

VISION

VSP	VISION SERVICE PLAN	OUT-OF-NETWORK
Vision Exam 1 exam every 12 months	$10 copay	Up to $45 allowance
Eyeglass Lenses 1 exam every 12 months	$25 copay (combined with frames)	Single Vision - Up to $30 Lined Bifocal – Up to $50 Lined Trifocal – Up to $65
Contact Lenses 1 pair every 12 months	$130 allowance	Up to $105 allowance
Frames 1 every 12 months	$25 Hardware copay (combined with lenses) $130 allowance	Up to $70 allowance

HOW MUCH DO I HAVE TO PAY?

The following contributions are effective April 1, 2019.

	Total Monthly Premium	SFM Pays (Monthly)	You Pay (Monthly)	You pay (+per pay period)
MEDICAL	**QHDHP AWH 5000**			
Self	$426.19	$416.19	$10.00	$5.00
Self & spouse*	$894.99	$819.99	$75.00	$37.50
Self & child(ren)	$809.77	$759.77	$50.00	$25.00
Family*	$1,278.57	$1,128.57	$150.00	$75.00
MEDICAL	**QHDHP BASE 2500**			
Self	$611.90	$506.90	$105.00	$52.50
Self & spouse*	$1,284.96	$812.46	$472.50	$236.25
Self & child(ren)	$1,162.61	$847.61	$315.00	$157.50
Family*	$1,835.69	$1,226.69	$609.00	$304.50
MEDICAL	**PPO BUY UP 1500**			
Self	$680.71	$456.35	$224.36	$112.18
Self & spouse*	$1,429.48	$764.09	$665.39	$332.70
Self & child(ren)	$1,293.38	$798.85	$494.53	$247.27
Family*	$2,042.15	$1,180.07	$862.08	$431.04

*Includes coverage for domestic partners. Due to IRS regulations, contributions for domestic partners are made on a post-tax basis. In addition, any premiums paid will be considered taxable income.

Please note that your contributions will be taken out of your paycheck on a pre-tax basis, 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 change in family status, such as marriage, divorce, birth of a child, or change in employment status. This means you may not drop coverage for a dependent during the year unless there is a qualified change in family status.

WELLNESS NON-PARTICIPATION – 15-30% SURCHARGE

The rates below are based on either being a tobacco user and/or non-participation in the wellness program initiative.

	Tobacco User Rates (Per Pay Period+) 15%	Wellness Non-Participation (Per Pay Period+) 15%	Tobacco & Wellness Non-Participation (Per Pay Period+) 30%
MEDICAL	**QHDHP AWH 5000**		
Self	$5.75	$5.75	$6.50
Self & spouse*	$43.13	$43.13	$48.75
Self & child(ren)	$28.75	$28.75	$32.50
Family*	$86.25	$86.25	$97.50
MEDICAL	**QHDHP BASE 2500**		
Self	$60.38	$60.38	$68.25
Self & spouse*	$271.69	$271.69	$307.13
Self & child(ren)	$181.13	$181.13	$204.75
Family*	$350.18	$350.18	$395.85
MEDICAL	**PPO BUY UP 1500**		
Self	$129.01	$129.01	$145.83
Self & spouse*	$382.61	$382.61	$432.51
Self & child(ren)	$284.36	$284.36	$321.45
Family*	$495.70	$495.70	$560.35

(+Per Pay Period equaling 24 pay periods; there will be two (2) pay periods without a charge towards health benefit deductions).

(CONTINUED) HOW MUCH DO I HAVE TO PAY?

For 2019, Sound Family Medicine will continue to pay 85% of the premium cost for dental benefits for employees, and will continue to pay 100% of the employee premium cost for vision benefits for employees.

	Total Monthly Premium	SFM Pays (Monthly)	You Pay (Monthly)	You pay (+per pay period)
DENTAL		**DENTAL BASE PLAN**		
Self	$39.89	$33.91	$5.98	$2.99
Self & spouse*	$79.62	$33.91	$45.71	$22.86
Self & child(ren)	$94.68	$33.91	$60.77	$30.39
Family*	$134.42	$33.91	$100.51	$50.26
DENTAL		**DENTAL BUY UP PLAN**		
Self	$47.35	$33.91	$13.44	$6.72
Self & spouse*	$93.85	$33.91	$59.93	$29.97
Self & child(ren)	$123.07	$33.91	$89.16	$44.58
Family*	$169.55	$33.91	$135.64	$67.82

	Total Monthly Premium	SFM Pays (Monthly)	You Pay (Monthly)	You pay (+per pay period)
VISION		**VSP VISION RATES**		
Self	$5.20	$5.20	$0.00	$0.00
Self & spouse*	$8.32	$5.20	$3.12	$1.56
Self & child(ren)	$8.49	$5.20	$3.29	$1.65
Family*	$13.69	$5.20	$8.49	$4.25

(+Per Pay Period equaling 24 pay periods; there will be two (2) pay periods without a charge towards health benefit deductions).

FLEXIBLE SPENDING ACCOUNTS (FSA)

NAVIA BENEFITS

The federal government takes about 30% of each dollar that you earn in FICA and Federal Income tax. The remaining 70% is your net income. With an FSA you can set aside money from your paycheck, before the federal government takes their 30%, to pay for medical, dental, vision and day care expenses. You pay less in taxes, and your money buys more medical (including dental and vision) services than before. Upon your eligibility date or at open enrollment of each year you may elect to set aside a certain amount of money to cover medical premiums, medical expenses, and dependent care.

Note: Health Care FSA participation is only available to employees and 2% or less shareholders. Participation in the Health Care FSA makes you ineligible for the Health HSA. Due to IRS regulations, domestic partners and their children are not eligible for health care reimbursement.

REMEMBER THE USE IT OR LOSE IT RULE!

HEALTH CARE FSA

This program allows you to set aside up to $2,700 per year so that you can pay for certain IRS approved medical care expenses not covered by the insurance plan with pre-tax dollars. Some examples include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Chiropractic services
- Acupuncture
- Prescription copays
- Dental services and orthodontia

Remember the Use it or Lose It Rules which dictate that plan balances cannot be carried into the next year and any remaining amounts will be forfeited.

If you are currently participating in the health care account and cannot use up the balance of your account by March 31, 2019, you will be allowed an additional 2 1/2 months to incur expenses. You must incur expenses by June 15, 2019 and file for reimbursement by June 30, 2019.

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

If you also have an HSA Account

If you are contributing to a Health Savings Account, you cannot also establish a regular Health Care FSA. For that matter, neither can your spouse. Instead, you have the option of setting up a limited purpose (LP) FSA which allows you to set aside monies for dental and vision expenses only.

DAY CARE FSA

Similar to the Health Care FSA, you may also use pre-tax dollars to pay for qualified dependent care. The annual maximum amount you may contribute into the Day 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)

The entity you use for day care must report their income as taxable earnings to be a qualified day care provider.

DISABILITY INCOME

CIGNA

Sound Family Medicine disability coverage is essentially "paycheck insurance" and offers you financial stability and peace of mind. Eligiblity may include if you are unable to perform the material duties of your job due to sickness, injury or pregnancy. Upon approval, you may receive the following benefits:

	LONG TERM DISABILITY
Benefits Begin	On the 91st day, contingent upon satisfying the definition of disability as stated in your policy
Percentage of Income Replaced	60% of basic monthly earnings
Maximum Benefit available	Non-Exempt: Up to $5,000 per month Physicians & Exempt: Up to $10,000 per month
Benefit Duration	Up to age Social Security Normal Retirement Age if considered totally disabled.

FINANCIAL PEACE OF MIND IF YOU ARE UNABLE TO PERFORM YOUR JOB.

LIFE AND AD&D INSURANCE

CIGNA

Sound Family Medicine purchases life and accidental death and dismemberment (AD&D) insurance for all full-time employees.

	LIFE AND AD&D INSURANCE
Benefits	Non-Exempt employees have a basic benefit of $10,000. Physicians and Exempt employees have a basic benefit of $20,000. If death is the result of an accident (as defined by the contract), then the beneficiary(ies) will receive an additional benefit. A scheduled benefit is paid for amputation or paralysis of limbs.

Voluntary Life & Accidental Death and Dismemberment

If you want additional group life and/or AD&D insurance, you may purchase additional amounts through payroll deductions. Here is what our plan offers:

	EMPLOYEE	SPOUSE	CHILD
Increments	$10,000	$5,000	$2,000
Maximum	The lesser of: 5 x your annual salary, or $500,000	$250,000 not to exceed 50% of the employee amount	$10,000
New Hire Guarantee Issue	$100,000	$50,000	$10,000

If you enroll more than 30 days after your original eligibility date or if you elect to increase your existing amounts outside of open enrollment, you will be subject to evidence of insurability. Coverage will not be in effect until Cigna reviews and approves your application. Evidence of insurability does not apply to AD&D insurance.

(CONTINUED) LIFE AND AD&D INSURANCE

Premiums for the voluntary life and AD&D are based on a combination of your age and your elected benefit amount. These premiums will be deducted on a post-tax basis. Monthly voluntary life and AD&D costs are reflected below.

Employee/Spouse Life

EMPLOYEE AGE	COST PER $1,000
Under 25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.11
45-49	$0.17
50-54	$0.27
55-59	$0.43
60-64	$0.67
65-69	$1.27
70-74	$2.06
75-79	$3.46
80+	$6.77

Child Life

COST PER $1,000
$0.17

AD&D

COST PER $1,000
$0.03

To get your monthly cost:

Take your amount elected, divide by 1,000, then multiply by your age rate. For example, a 40-year old electing $130,000 life coverage would calculate:

130 x $0.11 = $14.30 per month

Remember: Your voluntary life premiums will increase on the plan anniversary in which you or your spouse age into a higher age bracket.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CIGNA

The EAP is a completely free and confidential program that helps you and/or your family members address life issues, big or small. Benefits include up to 3 face-to-face visits and are offered to all employees and immediate family members. They can help with:

- Marital and family concerns
- Difficult relationships
- Depression
- Substance abuse
- Grief and loss
- Financial entanglements
- Other personal stressors
- Many other issues

You may visit the website to:

- Find information about parenting, retirement, finances, and more
- Locate schools, camps, eldercare/childcare providers
- Use financial calculators and retirement planners
- Read books, articles, and guides
- Watch videos or listen to audio file

The EAP is available to help, just call 800-538-3543. You can access on line at www.cignabehavorial.com/cgi

USING YOUR EAP DOES NOT COST YOU ANYTHING!

OTHER VALUABLE TOOLS

Discount Programs

Aetna's Discount Programs provide value to members for services such as vision care, gym memberships, natural therapy services and weight loss programs. Sign in to www.aetna.com for more information.

Will Preparation Program

Cigna's Will Preparation Program helps you and your family to plan and protect your financial future by using a simple online tool. This allows you to building customized wills or other legal documents such as living wills and power of attorneys. Visit www.CignaWillCenter.com to learn more.

Identity Theft Program

Identify theft can be a problem for consumers. Cigna's Identity Theft Program provides customers with access to personal case managers who give assistance and guidance in case of credit card fraud or emergency travel arrangements. For more information call 1.888.226.4567.

College Tuition Benefit Rewards

Employees enrolled in the Guardian dental plan have the opportunity to earn Tuition Rewards that can be used to pay for up to one year's tuition at a SAGE Scholar college. For more information on the program visit www.guardian.collegetuitionbenefit.com. In order check your benefit and enroll if you are not already participating, please call (215) 839-0119 or email admin@collegetuitionbenefit.com.

WELLNESS

The goal of our wellness program is to motivate and support all our employees in taking their health seriously, and helping them to improve their health and productivity. We are now entering our 6th year of promoting wellness at Sound Family Medicine.

We continue to provide on-site biometric screenings and the ability to take health risk assessments on line for anyone enrolled in our medical plans through Aetna.

Because we value your health and wellness and want to encourage you to take these assessments and complete these screenings, non-participation in these programs will result in a 15% surcharge to your medical premiums. You can also qualify for a $50 gift card by completing the Health Risk Assessment. If you find taking these assessments or completing these screenings is a hardship for you please discuss available options with the HR Dept.

We will also continue to have a premium differential in 2019 for tobacco users of 15%. You will be asked to complete an affidavit stating whether or not you use tobacco. If you are looking for ways to quit smoking please see the HR Dept. for more details. If you are able to complete a cessation program you will be able to have the premium surcharge removed.

Remember – all health information that you provide as part of the wellness plan is completely confidential. No one at SFM or anyone at Aetna will see your information.

TRAVEL ASSISTANCE

WORLDWIDE MEDICAL EMERGENCY ASSISTANCE WHENEVER YOU TRAVEL 100+ MILES FROM HOME.

CIGNA SECURE TRAVEL

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

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

Policy # SOK606078, Group #57

Inside USA and Canada: 1-888-226-4567

Outside USA: 1-202-331-7635

VETERINARY PET INSURANCE

This voluntary plan is a financial safety net for unexpected veterinary expenses. With coverage from Nationwide Pet Insurance, you can focus on giving your pet the best care possible, instead of focusing on the cost of treatment.

Enroll today to receive your discount:

877-738-7874
http://www.petinsurance.com/soundfamilymedicine

CONTACT INFORMATION

REFER TO THIS LIST WHEN YOU NEED TO CONTACT A BENEFITS VENDOR. FOR GENERAL INFORMATION, CONTACT HUMAN RESOURCES.

Medical and Prescription Drugs	Aetna www.aetna.com	877.204.9186
Dental	Guardian www.guardiananytime.com Group # 00454184	800.541.7846
Vision	Vision Service Plan (VSP) www.vsp.com Group #30073013	800.877.7195
Flexible Spending Arrangement (FSA)	Navia Benefits www.naviabenefits.com Group ID: SDM	800.669.3539
Health Savings Account (HSA)	Optum Bank www.optumbank.com	866.234.8913
Virtual Visits	Teladoc www.teladoc.com/aetna	855.835.2362
Life and AD&D Insurance	Cigna www.cigna.com #SGM608315 (Life) #SOK606078 (AD&D)	800.238.2125
Travel Assistance	Cigna Secure Travel Policy#SOK606078 Group #57	Within the U.S. & Canada: 888.226.4567 All Other Locations: 202.331.7635
Long Term Disability	Cigna www.cigna.com #SGD606778	800.362.4462
Pet Insurance	Nationwide Insurance http://www.petinsurance.com /soundfamilymedicine	877.738.7874

YOUR HR TEAM
IS HERE TO HELP!

WHERE DO I GO IF I HAVE QUESTIONS?

YOUR HR TEAM:

Kevin Hamlet
Director of Human Resources
253.286.4102 office
206.919.5346 mobile

Jessica Bradshaw
Human Resources Generalist
253.286.4107 office
801.637.5082 mobile

Dona Vann
Payroll/Benefits Specialist
253.286.4103 office

Tina Kist
Human Resources Assistant
253.286.4109 office

HR Email: humanresources@soundfamilymedicine.com

BENEFITS ADVOCACY

Sound Family Medical has partnered with Parker, Smith & Feek to provide you and your family with individualized assistance with insurance problems you are unable to resolve directly with the carrier. This includes claims issues, eligibility questions, network problems and general healthcare or insurance questions. Your personal benefits champion is:

Laura Fielding lafielding@psfinc.com 425.709.3685

PARKER | SMITH | FEEK

ANNUAL REMINDERS

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. You received a copy of the Sound Family Medicine Group Health Plan Privacy Notice when you were hired. This notice describes how medical information about you may be used and disclosed, and how you can access that information.

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

COBRA

COBRA continuation coverage is a temporary continuation of coverage under our employee benefit plan. Please contact our HR Department 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.

IMPORTANT NOTICE FROM SOUND FAMILY MEDICINE 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 Sound Family Medicine 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. Sound Family Medicine has determined that the prescription drug coverage offered by the Sound Family Medicine 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 Sound Family Medicine 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, you 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 Sound Family Medicine 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 Sound Family Medicine and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Sound Family Medicine 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:	April 1, 2019
Name of Entity/Sender:	Sound Family Medicine
Contact--Position/Office:	Kevin Hamlet
Address:	3908 10th St SE Puyallup, WA 98374
Phone Number:	(253) 286-4102

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 January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, 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


sound
family medicine