2023 Benefits Guide
1015

Spokane Transit

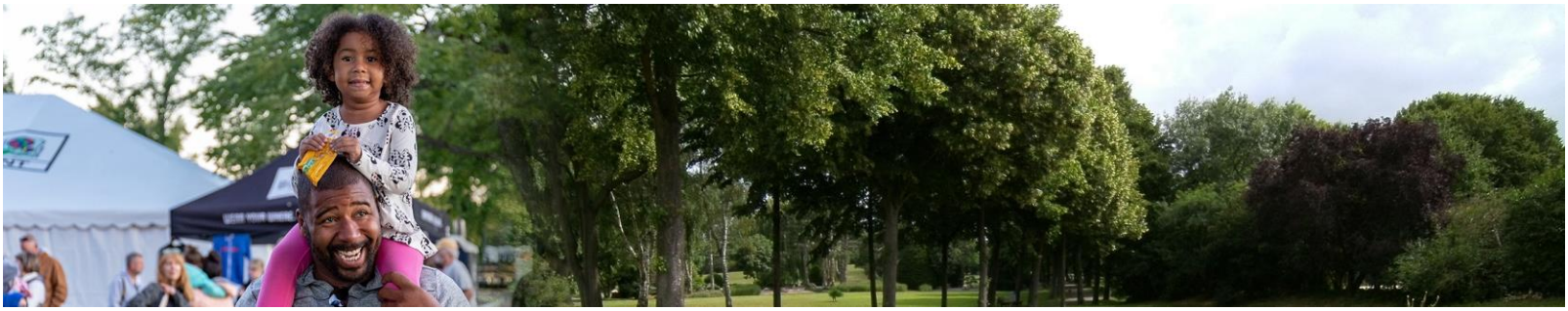
Here's some important information you should know.

Medicare Part D Notice: 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 the Annual Notices at the end of this guide for more details.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective 01/01/2023 through 12/31/2023



Welcome to your 2023 benefits. Our benefits program provides you with the best in coverage that is simple and easy to use. We offer programs that protect your health, your money, your family, and help you find balance between your concerns at work and at home. We also know the value of understanding your coverage so you know how to get care, when you need it, at the lowest cost. With the information and tools in this guide and related resources, we hope to help you be well today and work toward a healthy and secure future.

INSIDE THIS GUIDE

Are you eligible for benefits?

You're eligible for benefits if you are a full-time employee working 80+ hours per month.

Your eligible dependents

- Legally married spouse (including same-sex spouse)
- Natural, adopted, or step children up to age 26
- Tax dependents over age 26 who are disabled and dependent on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law

Family members such as parents, grandparents and siblings who are not your tax dependents as described above are not eligible for coverage. In addition, an employee of Spokane Transit Authority cannot be covered as both an employee and a dependent of another employee (for example, a spouse).

Dependent eligibility and verification process

Who are Eligible Dependents?

- Eligible dependents include your legal spouse, your legally recognized domestic partner and eligible children up to age 26
- Coverage may be available to eligible children regardless of student, residential or marital status; however, if your child is married, the spouse and/or children of that child is not eligible
- Eligible dependents may also include children whose coverage is required pursuant to a valid court, administrative order or Qualified Medical Child Support order
- Children placed for adoption - Placement for adoption is the assumption and retention of an obligation for total or partial support of a child in anticipation of adoption irrespective of whether the adoption has become final
- A child may be your biological, step, adopted, or children of your legally recognized domestic partner
- It also includes dependent unmarried children of any age who are physically or mentally challenged if they were enrolled in a Spokane Transit Health Plan and became disabled prior to turning 26 years of age

Who is not eligible for Spokane Transit coverage?

- Ex-spouses, even with a Qualified Domestic Relations Order requiring you provide health insurance coverage
- Former stepchild of an ex-spouse
- Extended family members, including mother, father, siblings, grandparents, grandchildren, in-laws, etc., under any circumstances
- A child who is your extended family member – grandchild, niece, nephew except when you are the "legal" guardian as established by a court of law
- Children Over age 26 years of age if they were not enrolled in a plan prior to becoming mentally or physically disabled
- Children placed for adoption when legal obligations are terminated

About dependent verification

Dependent verification helps make sure the Spokane Transit Authority medical and dental program covers only people who qualify. If you want to add family members to your coverage, you must provide verification documents to show they're eligible before they can be enrolled under your coverage.

You must submit all documents in English. Documents written in a foreign language must include a translated copy prepared by a professional translator and certified by a notary public.

Use the list(s) below to determine which verification document(s) you need to submit with your enrollment form(s). If you submit a tax return, you may submit just one copy if it includes all family members that require verification, such as your spouse and children. Submit the documents along with your enrollment form(s) within Spokane Transit Authority's enrollment timelines.

To enroll a spouse

Provide a copy of (choose one):

- Most recent year's 1040 Married Filing Jointly federal tax return that lists the spouse (black out financial information)
- Subscriber's and spouse's most recent 1040 Married Filing Separately federal tax return (black out financial information)
- Proof of common residence (example: a utility bill) and marriage certificate*
- Valid J-1 or J-2 visa issued by the U.S. Government

*If within two years of marriage, only the marriage certificate is required.

To enroll a state-registered domestic partner or legal union partner

Provide a copy of (choose one):

- Proof of common residence (example: a utility bill) and certificate/card of state-registered domestic partnership*
- Proof of financial interdependency (example: a shared bank statement - black out financial information) and certificate/card of state-registered domestic partnership*
- Valid J-1 or J-2 visa issued by the U.S. Government

*If within two years of state-registered domestic partnership, or establishment of a legal union from another jurisdiction as defined in statute, only the certificate/card of state-registered domestic partnership or legal union is required.

To enroll children

Provide a copy of (choose one):

- Most recent year's federal tax return that includes the child(ren) as a dependent and listed as a son or daughter (black out financial information)
  Note: You can submit one copy of your tax return if it includes all family members that require verification.
- Birth certificate (or hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner**
- Certificate or decree of adoption
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by U.S. Government

**If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner in order to enroll the child, even if not enrolling the spouse or state-registered domestic partner in STA's insurance coverage.

For Foreign Nationals

- Must provide current visa documentation showing marriage, (Social Security and financial information should be blacked out)
- Must provide current visa documentation showing date of birth of a child

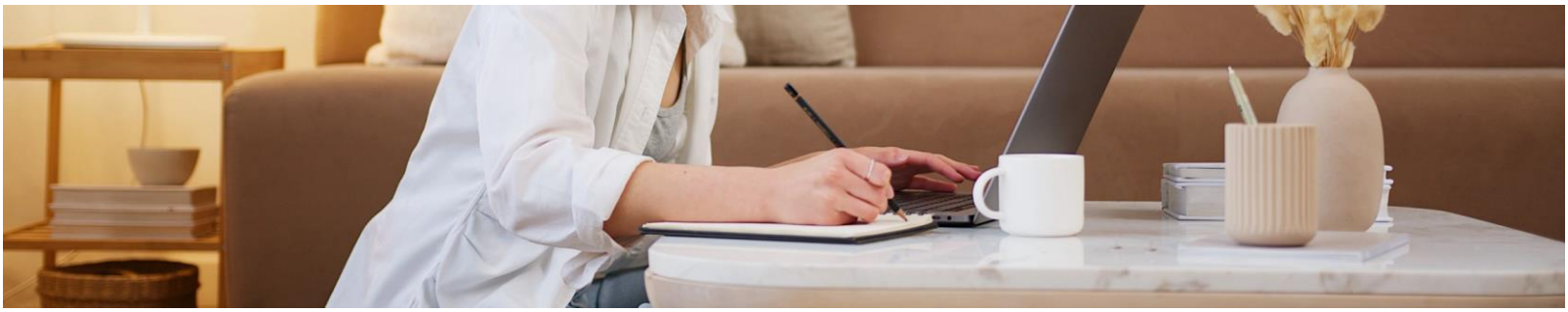
When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following 60 days of employment. If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

Changing your benefits

Outside of open enrollment, you may be able to add or remove dependents or change benefit options if you have a big change in your life and submit your change within 30 days. Eligible events include:

- change in legal marital status
- change in number of dependents or dependent eligibility status
- change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- change in residence that affects access to network providers
- change in your health coverage or your spouse's coverage due to your spouse's employment
- change in an individual's eligibility for Medicare or Medicaid
- court order requiring coverage for your child
- "special enrollment" event under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).



Compare our medical plans

Spokane Transit Authority offers different medical plans for different needs and budgets. Here's an overview of how each type of plan works.

PPO

Preferred Provider Option

- Premera Blue Cross Medical PPO Your Choice 250 Heritage Plus 1 Plan

A PPO gives you flexibility and choice, for a price. You can go to any doctor without a referral, but you will pay a larger share of the cost if they are not in the plan's network. You'll need to meet an annual deductible before the plan starts to pay.

HMO

Health Maintenance Organization

- Kaiser Permanente Medical HMO Core Buy-Up Plan
- Kaiser Permanente Medical HMO Core Plan

An HMO gives you more predictable costs but less flexibility. You pay a copay for most services, but all care must be received within the HMO network. Out-of-network care is not covered except in an emergency. You may need to meet a deductible before the plan starts to pay. You must choose a primary care physician (PCP) to manage routine care, referrals, and hospital stays. Kaiser plans are unique in that you do not have to select a PCP, and you must receive all care at Kaiser facilities.

Choosing a medical plan

Choosing a new medical plan? Check out these tips first.

- CHECK THE NETWORK– Do you prefer specific doctors or hospitals? Visit the plan's website to find out if they are in-network. If not, you'll pay a bigger share of the cost.
- EVALUATE YOUR NEEDS– Do you... visit a chiropractor? ...have frequent doctor or urgent care visits? …get ongoing tests? ...take medications? …have surgery planned? Compare these costs under each plan.

WORDS TO KNOW

Understanding these terms will help you understand and compare plans

DEDUCTIBLE

The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.

COINSURANCE

After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 70%, your coinsurance share of the cost is 30%. You are billed for your coinsurance after your visit.

COPAY

A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.

OUT-OF-POCKET MAXIMUM

Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.

EMBEDDED

A term that describes some deductibles and most out-of-pocket maximums. "Embedded" means that no one person in a covered family will have to meet more than the individual deductible and/or out-of-pocket maximum.

AGGREGATE

A term that describes some deductibles. An "aggregate" deductible means that the entire family deductible must be met before the plan begins to share in costs for any covered family member.

IN & OUT-OF-NETWORK

In-network services will always be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

BALANCE BILLING

In-network providers can't bill you more than the plan allows, but out-of-network providers can. For example, if the provider fee is $100 but the plan allows only $70, an out-of-network provider may bill YOU the extra $30. This is called balance billing.

Kaiser Permanente Medical Option #1

KAISER PERMANENTE MEDICAL HMO CORE BUY-UP PLAN

BENEFITS	In-Network Only
Annual deductible	$250 per individual / $500 family limit
Annual out-of-pocket maximum	$2,000 per individual / $4,000 family limit
Primary provider office visit	$15 copay then Plan pays 100% after deductible
Specialist office visit	$30 copay then Plan pays 100% after deductible
Chiropractic care (up to 10 visits per year)	$15 copay then Plan pays 100% after deductible
Preventive care	Plan pays 100% (see contract for limitations)
Diagnostic lab and X-ray	Preventive: Plan pays 100%; Complex imaging: $30 copay then Plan pays 100% after deductible; All other: Plan pays 100% after deductible
Urgent care	$15 copay then Plan pays 100% after deductible
Emergency room (copay waived if admitted)	$250 copay then Plan pays 100% after deductible
Hospitalization	1st 5 days: $150 copay per day then Plan pays 100% after deductible
Outpatient surgery	Plan pays 100% after deductible
PRESCRIPTION DRUGS	
Annual out-of-pocket maximum	Prescriptions subject to medical out-of-pocket maximum
Preferred generic	**Pharmacy:** $20 copay then Plan pays 100%; **Mail order:** $40 copay then Plan pays 100%
Generic	**Pharmacy:** Value Based Drugs: $5 copay then Plan pays 100%; Non-preferred generic: Plan pays 50% up to $250; **Mail order:** Value Based Drugs: $10 copay then Plan pays 100%; Non-preferred generic: Plan pays 50% up to $750
Preferred brand	**Pharmacy:** $40 copay the Plan pays 100%; **Mail order:** $80 copay then Plan pays 100%
Non-preferred brand	**Pharmacy:** Plan pays 50% up to $250; **Mail order:** Plan pays 50% up to $750
Number of days' supply	**Pharmacy:** 30 days; **Mail order:** 90 days
ADULT VISION – Members 19 and Older	
Copay	**Exam:** $15 copay then Plan pays 100%; **Materials:** Plan pays 100% (reimbursed up to $150)
Frequency	**Exam:** 1 x every calendar year; **Materials**: 1 x every 2 consecutive calendar years
PEDIATRIC VISION – Under 19	
Copay	**Exam:** $15 copay then Plan pays 100% **Materials:** Covered in full (1 pair of frames & lenses)
Frequency	**Exam:** 1 x every calendar year **Materials:** 1 x every calendar year

Kaiser Permanente Medical Option #2

KAISER PERMANENTE MEDICAL HMO CORE PLAN

BENEFITS	In-Network Only
Annual deductible	$350 per individual / $700 family limit
Annual out-of-pocket maximum	$2,000 per individual / $4,000 family limits
Primary provider office visit	$20 copay then Plan pays 100% after deductible
Specialist office visit	$40 copay then Plan pays 100% after deductible
Chiropractic care (up to 10 visits per year)	$20 copay then Plan pays 100% after deductible
Preventive care	Plan pays 100% (see contract for limitations)
Diagnostic lab and X-ray	Preventive: Plan pays 100%; Complex imaging: $40 copay then Plan pays 100% after deductible; All other: Plan pays 100% after deductible
Urgent care	$20 copay then Plan pays 100% after deductible
Emergency room (copay waived if admitted)	$300 copay then Plan pays 100% after deductible
Hospitalization	1st 5 days: $200 copay per day then Plan pays 100% after deductible
Outpatient surgery	Plan pays 100% after deductible
PRESCRIPTION DRUGS	
Annual out-of-pocket maximum	Prescriptions subject to medical out-of-pocket maximum
Preferred generic	**Pharmacy:** $20 copay then Plan pays 100%; **Mail order:** $40 copay then Plan pays 100%
Generic	**Pharmacy:** Value Based Drugs: $5 copay then Plan pays 100%; Non-preferred generic: Plan pays 50% up to $250; **Mail order:** Value Based Drugs: $10 copay then Plan pays 100%; Non-preferred generic: Plan pays 50% up to $750
Preferred brand	**Pharmacy:** $40 copay then Plan pays 100%; **Mail order:** $80 copay then Plan pays 100%
Non-preferred brand	**Pharmacy:** Plan pays 50% up to $250; **Mail order:** Plan pays 50% up to $750
Number of days' supply	**Pharmacy:** 30 days; **Mail order:** 90 days
ADULT VISION - Members 19 and Older	
Copay	**Exam:** $20 copay then Plan pays 100%; **Materials:** Plan pays 100% (reimbursed up to $150)
Frequency	**Exam:** 1 x every calendar year; **Materials:** 1 x every 2 consecutive calendar years
PEDIATRIC VISION – Under 19	
Copay	**Exam:** $20 copay then Plan pays 100% **Materials:** Covered in full (1 pair of frames & lenses)
Frequency	**Exam:** 1 x every calendar year **Materials:** 1 x every calendar year

Premera Blue Cross Medical Option

PREMERA BLUE CROSS MEDICAL PPO YOUR CHOICE 250 HERITAGE PLUS 1 PLAN

BENEFITS	In-Network	Out-of-Network
Annual deductible	$250 per individual / $750 family limit	
Annual out-of-pocket maximum	$2,000 per individual / $4,000 family limit	Not applicable
Primary provider office visit	Plan pays 85% after deductible	Plan pays 60% after deductible
Specialist office visit	Plan pays 85% after deductible	Plan pays 60% after deductible
Chiropractic care (up to 10 visits per year)	Plan pays 85% after deductible	Plan pays 60% after deductible (in-network limitations apply)
Preventive care	Plan pays 100% (see contract for limitations)	Not covered
Diagnostic lab and X-ray	Preventive: Plan pays 100%; All other: Plan pays 85% after deductible	Plan pays 60% after deductible (see contract for limitations)
Urgent care	Plan pays 85% after deductible	Plan pays 60% after deductible
Emergency room (copay waived if admitted)	$75 copay then Plan pays 85% after deductible	
Hospitalization	1st 3 days: $200 copay per day then Plan pays 85% after deductible	Plan pays 60% after deductible
Outpatient surgery	Plan pays 85% after deductible	Plan pays 60% after deductible
PRESCRIPTION DRUGS		
Annual deductible	$100 (up to $300 per family)	Combined with in-network
Generic	**Pharmacy:** Plan pays 90% (multi-source); **Mail order:** $10 copay then Plan pays 100%	**Pharmacy:** Cost Share then Plan pays 60% (of allowable); **Mail order:** Not covered
Preferred brand	**Pharmacy:** Plan pays 70% after Rx deductible (multi-source); **Mail order:** $50 copay then Plan pays 100%	**Pharmacy:** Cost Share then Plan pays 60% (of allowable) after Rx deductible; **Mail order:** Not covered
Non-preferred brand	**Pharmacy:** Plan pays 50% after Rx deductible (multi-source); **Mail order:** $100 copay then Plan pays 100%	**Pharmacy:** Cost Share then Plan pays 60% (of allowable) after Rx deductible; **Mail order:** Not covered
Number of days' supply	**Pharmacy:** 30 days; **Mail order:** 90 days	**Pharmacy:** 30 days; **Mail order:** Not applicable
ADULT VISION – Members 19 and Older		
Copay	**Exam:** Plan pays 100%; **Materials:** Plan pays 100% (reimbursed up to $150)	**Exam:** Plan pays 60% after deductible; **Materials:** Plan pays 100% (in-network limitation apply)
Frequency	**Exam:** Once every calendar year; **Materials:** Once every 2 consecutive calendar years	**Exam/Materials:** In-network limitations apply;
PEDIATRIC VISION – Under 19		
Copay	**Exam:** Plan pays 85% after deductible **Materials:** Covered in full (1 pair of frames & lenses)	
Frequency	**Exam:** 1 x every calendar year **Materials:** 1 x every calendar year	

Prescription drug savings

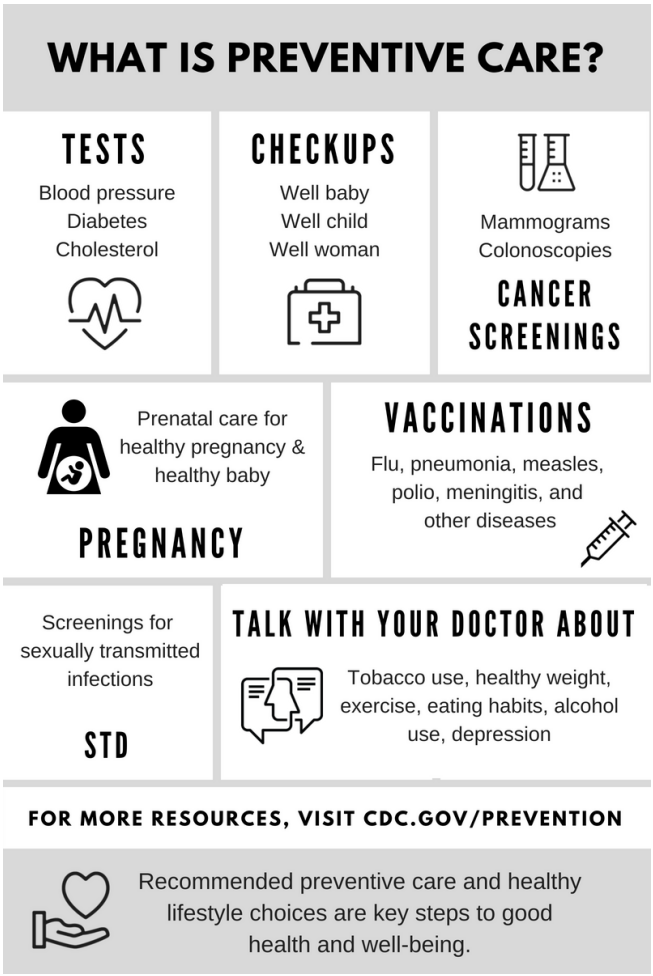
Are prescription drug costs breaking your budget?

A little research before you go to the pharmacy could result in huge savings.

	Insider tip	Rx expert!
	Your medical plan includes prescription drug coverage. You pay a different amount depending on the "tier" or class of drug.	GENERIC drugs are always the least expensive. Get in the habit of asking your doctor or pharmacist if there's a generic alternative.
	A FORMULARY is a list of drugs that are preferred by the plan. Plans use formularies to encourage the most cost-effective drugs.	If a generic drug is not available, ask your doctor whether there is an effective brand name medication that is on the plan's preferred drug list.
	A PARTICIPATING PHARMACY (one that contracts with your medical plan) will usually offer the best price. You can find a participating (in-network) pharmacy on your plan's website or app.	SHOP AROUND! Even within the same drugstore chain, you may find a better price at a different location. Your medical plan may have an online tool or app to compare prices. Or try websites like goodrx.com or lowestmed.com
	SPECIAL HANDLING REQUIRED? Your plan may require preauthorization (plan approval) or step therapy (trying certain drugs before others). Specialty drugs such as injectables may need to be purchased from a certain provider.	Talk with your doctor about your course of treatment and confirm whether your plan requires any special procedures.
	You can get maintenance medicines by MAIL ORDER, usually in a 90-day supply. You can submit refills through a website or app, or by phone. It may take one to two weeks to receive your package.	Compare your plan's mail-order copay and shipping costs against your local pharmacy price. If costs are comparable, and mail order is a hassle for you, find out if your plan will cover a 90-day prescription from a local pharmacy.

Preventive care & you

Your body doesn't come with an owner's manual, but you must take care of it to make sure it will keep running for a long time. An important part of self-care is getting preventive medical exams to check that you're staying healthy or to identify and treat diseases before they become serious.



Prevention is a habit

- Make healthy lifestyle choices—food, exercise, sleep, safety.
- Schedule an annual physical with your primary care doctor and follow your doctor's recommendations.
- Set health and wellness goals and work towards them daily.

Know your numbers

Keep a record of your health screening dates and results so you can talk to your doctor about any changes.

- Date of last checkup
- Height and weight
- Blood pressure
- Cholesterol
- Immunizations and vaccines
- Other test results

What preventive care do you need?

Visit **healthfinder.gov** and enter your age and sex in the app to get a list of recommended preventive screenings for your stage in life. Talk to your doctor about which are appropriate for you.

Is it preventive or diagnostic?

You benefit both financially and health-wise when you get annual medical checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it's fully covered in-network.

But did you know that, depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (you share the cost)?

Preventive care services

- Help you stay healthy by checking for disease before you have symptoms or feel sick
- Can include flu shots and other vaccinations, physical exams, lab tests and prescriptions
- 100% covered when delivered by an in-network provider

Diagnostic services

- Check for disease after you have symptoms or because of a known health issue
- Can also include physical exams, lab tests and prescriptions
- You pay your share of the cost

PREVENTIVE: At Don's annual checkup, his doctor orders a blood sugar test to screen for diabetes, even though Don does not have symptoms.

DIAGNOSTIC: Grace's doctor orders a blood sugar test because she complains of increased thirst, frequent urination, weight loss, and fatigue—all symptoms of diabetes.

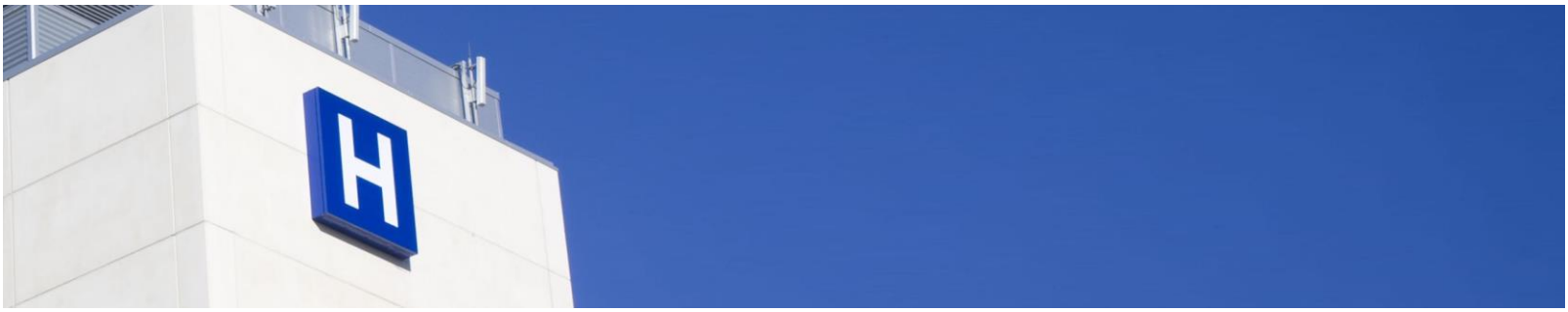
PREVENTIVE: As part of her well woman exam, Vanessa receives a mammogram to make sure there have been no changes since last time.

DIAGNOSTIC: Darla visits her doctor because she found a lump. Her doctor schedules a mammogram and a biopsy to check for cancer.

PREVENTIVE: Aki's doctor orders lab work during his annual physical, including a cholesterol check.

DIAGNOSTIC: Hector was diagnosed with high cholesterol two years ago. He has blood tests twice a year to check his cholesterol levels and make sure his medication is the right dose.

If you're unsure why a test was ordered, ask your doctor. And don't forget to schedule your preventive care visits. Many people use a key date like their birthday or anniversary as a reminder to make their appointments each year.



Know where to go

ER or urgent care?

The emergency room shouldn't be your first choice unless there's a true emergency.

Consider urgent care for...	Go to the emergency room for...
Symptoms, pain or conditions that require quick medical attention but do not require hospital care, such as:	Serious or life threatening conditions that require immediate treatment that you can get only at a hospital, such as:
- Earache - Sore throat - Rashes - Sprains - Broken fingers or toes - Flu - Fever up to 104 degrees	- Chest pain or severe abdominal pain - Trouble breathing - Loss of consciousness - Severe bleeding that can't be stopped - Large broken bones - Major injuries from a car crash, fall or other accident - Fever above 104 degrees

Dental

Dental coverage provides periodic preventive care, and if there's a problem, helps with the cost of dental work.

	DELTA DENTAL OF WASHINGTON DENTAL PPO PLAN		
BENEFITS	**PPO**	**Premier**	**Out-of-Network**
Annual deductible	$50 per individual / $150 per family		
Annual plan maximum	$1,750 per individual		
Diagnostic and preventive	Plan pays 100%	Plan pays 90%	Plan pays 80%
Basic services			
Fillings	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 70% after deductible
Root canals	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 70% after deductible
Periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 70% after deductible
Major services	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible
Orthodontia services			
Orthodontia	Plan pays 50%	Plan pays 50%	Plan pays 50%
Dependent children	Covered	Covered	Covered
Adults and eligible full-time students	Covered	Covered	Covered
Lifetime maximum	$1,750 per individual		

Other benefits

As a member of ATU 1015, you also have the following benefits provided by Spokane Transit Authority:

Life Insurance – Symetra

Basic Life	$25,000
Basic AD&D	$5,000

Disability - Symetra

Long Term Disability Policy	Salary replacement insurance if you are off work with a qualifying disability; pays up to 60% of your monthly earnings (maximum benefit of $4,000 per month). Premiums are paid 100% by STA.

VEBA – HRA VEBA

$25 per month contribution to your account.

You can use your VEBA to reimburse yourself for medical, dental, vision and prescription expenses now or later.

Retirement - DRS

Public Employees Retirement System through Washington Department of Retirement Systems; contributions are made by you and Spokane Transit Authority.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Travel Assistance Program

24-hour-a-day emergency help

Your Travel Assistance Program

Call anytime from anywhere. We're available 24/7 to assist you.

U.S. and Canada:
1-877-823-5807

Anywhere else (collect or direct):
(240) 330-1422

Emergencies happen. When they happen far from home, it's comforting to know there's a team of multilingual professionals standing by to help.

Your Travel Assistance Program offers a variety of 24-hour-a-day services in more than 200 countries and territories worldwide—and each one is just a phone call away.

Medical Services

- Assistance finding physicians, dentists and medical facilities.
- Monitoring during a medical emergency to determine if care is appropriate or if evacuation is required.
- When medically necessary, free transportation[1,2] under medical supervision to a hospital/treatment facility or to your place of residence for treatment.
- Arrangement for your traveling companion's return home if previously made arrangements must change due to your medical emergency.
- When medically necessary, free transportation[1,2] home for dependent children under the age of 26 who were traveling with you and are left unattended because of your hospitalization. A qualified escort will be arranged if necessary.
- Free round-trip transportation[2]—we arrange and pay for the most direct round-trip economy flight—for one immediate family member or friend to visit you if you're traveling alone and are likely to be hospitalized for seven consecutive days.
- Replacement of medication and eyeglasses.[3]
- In the event of death while traveling, all necessary government authorizations and a container appropriate for transportation will be arranged and paid for, as well as return home of the remains for burial.

Other Key Services

- Pre-trip information, including visa, passport, inoculation and immunization requirements; cultural information; embassy and consulate referrals; foreign exchange rates; and travel advisories.
- Emergency message relay to and from friends, relatives and business associates.
- If requested, new travel arrangements or change of airline, hotel and car rental reservations.
- An advance of up to $500 in emergency cash after satisfactory guarantee of reimbursement from you. You are responsible for any fees associated with the transfer or delivery of funds.
- Help locating and replacing lost or stolen luggage, documents and personal possessions.
- Help locating an attorney and advancement of bail bond, where permitted by law, after satisfactory guarantee of reimbursement from you. You are responsible for attorneys fees.
- Assistance with telephone interpretation in all major languages, or referral to an interpretation or translation service for written documents.

Pet insurance from Nationwide®

With two budget-friendly options, there's never been a better time to protect your pet.

Our popular My Pet Protection® pet insurance plans now feature more choices and more flexibility

- **Get cash back on eligible vet bills:** Choose your reimbursement level of 50% or 70%[1]
- **Available exclusively for employees:** Plans with preferred pricing only offered through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Choose your level of coverage with My Pet Protection®

50% reimbursement

$20-$35/month[2]

70% reimbursement

$27-$47/month[2]

How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed.

Get a fast, no-obligation quote today at **PetsNationwide.com**

[1]Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states. [2]Starting prices indicated. Final cost varies according to plan, species and ZIP code.

Nationwide®

Cost of coverage

Spokane Transit

Health Insurance Rates Effective 01/01/2023

(Full-Time Employees)

Carrier Premium		Allocated Cost			Bi-Weekly
Coverage Level		Coverage Level	Employer	Employee	Employee Amt
Premera "Your Choice"					
Employee	$1,110.75	Employee	$999.67	$111.08	$55.54
Employee + Spouse	$2,221.58	Employee + Spouse	$1,888.34	$333.24	$166.62
Employee + Children	$1,962.65	Employee + Children	$1,681.19	$281.46	$140.73
Employee + Family	$3,073.46	Employee + Family	$2,569.86	$503.60	$251.80
Kaiser - "Buy Up Plan"					
Employee	$668.77	Employee	$635.33	$33.44	$16.72
Employee + Spouse	$1,337.53	Employee + Spouse	$1,203.79	$133.74	$66.87
Employee + Children	$1,183.72	Employee + Children	$1,073.06	$110.66	$55.33
Employee + Family	$1,852.49	Employee + Family	$1,641.49	$211.00	$105.50
Kaiser - "Core Plan"					
Employee	$570.39	Employee	$541.87	$28.52	$14.26
Employee + Spouse	$1,140.77	Employee + Spouse	$1,026.69	$114.08	$57.04
Employee + Children	$1,009.58	Employee + Children	$915.18	$94.40	$47.20
Employee + Family	$1,579.97	Employee + Family	$1,400.01	$179.96	$89.98
1598, 3939 & Non-Reps Only					
Kaiser - "CDHP"					
Employee	$589.43	Employee	$559.97	$29.46	$14.73
Employee + Spouse	$1,178.86	Employee + Spouse	$1,060.98	$117.88	$58.94
Employee + Children	$1,043.29	Employee + Children	$945.75	$97.54	$48.77
Employee + Family	$1,632.72	Employee + Family	$1,446.77	$185.96	$92.98
Dental	$102.91		$97.77	$5.14	$2.57
Date Issued: October 25, 2022.					

Need help?

Get help with your benefits however you feel most comfortable. You have many different ways to get answers to your questions and assistance with coverage and claims issues. Use the resources on the following pages freely!

Reach out to your benefit advocate for personal and confidential assistance with general benefit questions; eligibility and coverage, health care claim or billing issues (when warranted).

Jessica Russo

Jessica.Russo@alliant.com
(509) 343-9516

Plan contacts

Plan type	Provider	Phone	Web	Policy #
Medical HMO – Buy-Up	KAISER PERMANENTE	(888) 901-4636	wa.kaiserpermanente.org	4992500
Medical HMO - Core		(888) 901-4636	wa.kaiserpermanente.org	4926600
Medical PPO	PREMERA BLUE CROSS	(800) 722-1471	www.premera.com	1016820
Dental PPO	DELTA DENTAL	(800) 554-1907	www.deltadentalwa.com	00693
Life and AD&D	SYMETRA / VTS	(800) 796-3872	www.symetra.com	01-007750-22
HRA VEBA	HRAveba	(888) 659-8828	www.hraveba.org	YA218
Human Resources	Spokane Transit	(509) 344-1880 HRHelpDesk@spokanetransit.com		

Important plan notices & documents

Health plan notices

These notices must be provided to plan participants on an annual basis and are available at the end of this guide:

Medicare Part D Notice	Describes options to access prescription drug coverage for Medicare eligible individuals
Women's Health and Cancer Rights Act	Describes benefits available to those that will or have undergone a mastectomy
Newborns' and Mothers' Health Protection Act	Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
HIPAA Notice of Special Enrollment Rights	Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
HIPAA Notice of Privacy Practices	Describes how health information about you may be used and disclosed
Notice of Choice of Providers	Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)	Describes availability of premium assistance for Medicaid eligible dependents

COBRA continuation coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Plan documents

Important documents for our health plan and retirement plan are available at the end of this guide. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Human Resources at (509) 344-1880.

This enrollment guide constitutes a Summary of Material Modifications (SMM) to Spokane Transit Authority. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY PLAN DESCRIPTIONS

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

SUMMARY OF BENEFITS AND COVERAGE

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

- Kaiser Permanente Medical HMO Core Buy-Up Plan
- Kaiser Permanente Medical HMO Core Plan
- Kaiser Permanente Medical Access PPO Consumer Health Driven Plan (CDHP)
- Premera Blue Cross Medical PPO Your Choice 250 Heritage Plus 1 Plan

Medicare Part D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Spokane Transit Authority 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. Spokane Transit Authority has determined that the prescription drug coverage offered by the following 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:

- **Kaiser Permanente Medical HMO Core Buy-Up Plan**
- **Kaiser Permanente Medical HMO Core Plan**
- **Kaiser Permanente Medical Access PPO Consumer Health Driven Plan (CDHP)**
- **Premera Blue Cross Medical PPO Your Choice 250 Heritage Plus 1 Plan**

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.

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.

If you decide to join a Medicare drug plan, your coverage will not be affected. See below for more information about what happens to your current coverage if 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.

If you decide to join a Medicare drug plan, your Spokane Transit Authority coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the plans listed below is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan and Part D will coordinate with your existing prescription drug coverage.

- **Kaiser Permanente Medical HMO Core Buy-Up Plan**
- **Kaiser Permanente Medical HMO Core Plan**
- **Kaiser Permanente Medical Access PPO Consumer Health Driven Plan (CDHP)**
- **Premera Blue Cross Medical PPO Your Choice 250 Heritage Plus 1 Plan**

If you do decide to join a Medicare drug plan and drop your coverage through Consumer Auto Liquidators, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

You should also know that if you drop or lose your current coverage with Spokane Transit Authority 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.

Contact your plan at the number listed below. 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 Spokane Transit Authority changes. You also may request a copy of this notice at any time.

- **Kaiser Permanente Insurance Company** (888) 901-4636
- **Premera Blue Cross** (800) 722-1471

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 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 800-MEDICARE (800-633-4227). TTY users should call (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 socialsecurity.gov, or call them at (800) 772-1213 (TTY (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: **10/01/2022**

Plan Administrator:
Human Resources
1230 W. Boone Avenue
Spokane, WA 99201
(509) 344-1880

Women's Health and Cancer Rights Act

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 (509) 344-1880.

Newborns' and Mothers' Health Protection Act

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). If you would like more information on maternity benefits, call your plan administrator at (509) 344-1880.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Spokane Transit Authority's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Spokane Transit Authority's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.

- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Spokane Transit Authority's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 of your modified adjusted household income

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the plan administrator at (509) 344-1880.

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – 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
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

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/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102

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 | email: HHSHIPPProgram@mt.gov

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/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
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
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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 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)

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.83% (9.61% in 2022) of your modified adjusted household income.

Notes

Spokane Transit