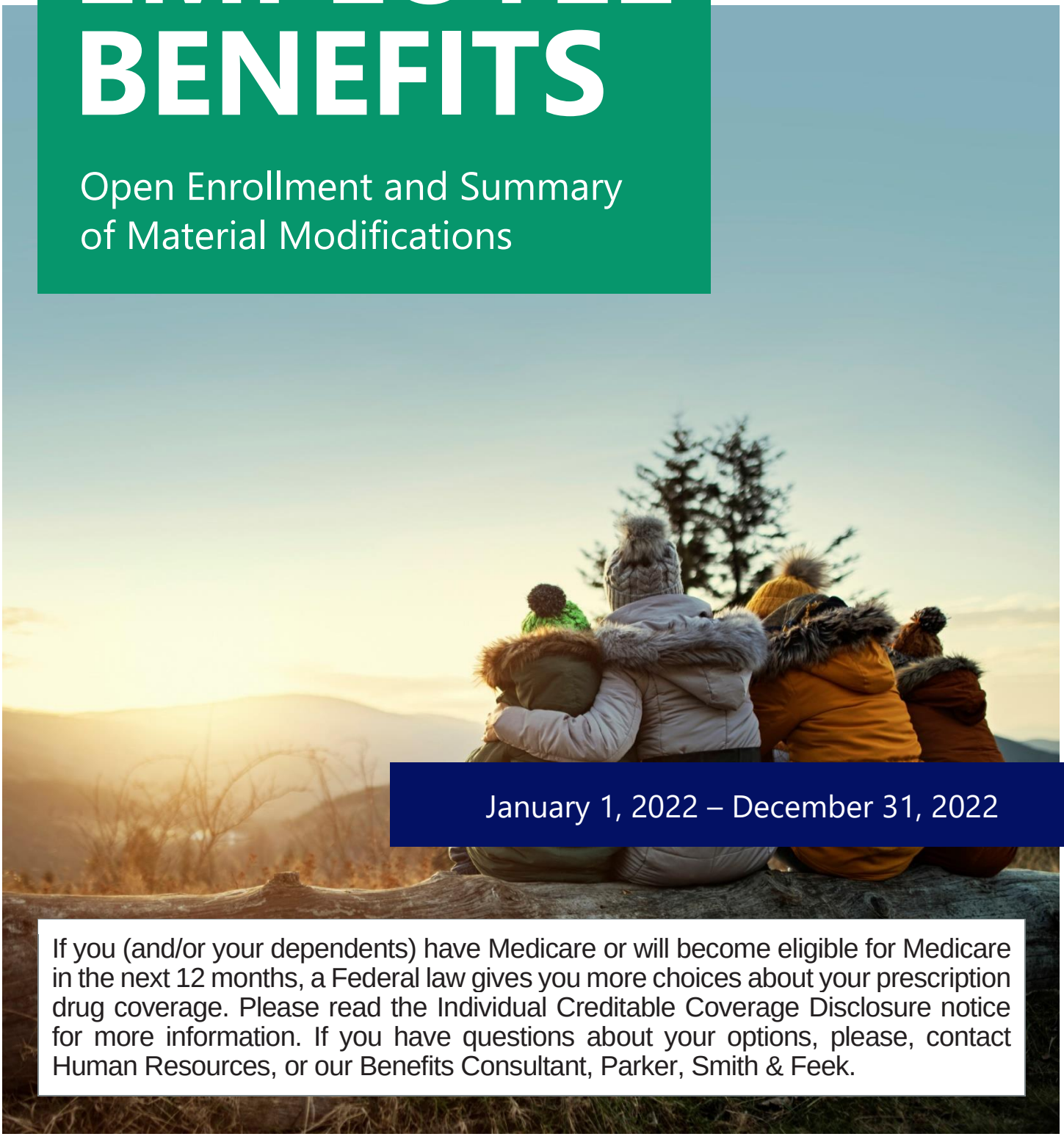
WHITMAN COLLEGE

EMPLOYEE BENEFITS

Open Enrollment and Summary of Material Modifications



January 1, 2022 – December 31, 2022

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

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. For specific tax or legal advice, please consult with your own tax or legal advisor for assistance. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

WELCOME TO WHITMAN COLLEGE

Our health care plan renews on January 1, 2022. This is the time when we review our benefit plan offerings, our projected costs based on our carrier's rate increases, and our future expected claims. We also look at the competitiveness of our program and what the College can afford. We are a self-insured plan, which means that the cost of non-catastrophic claims, (those under $125,000 during a calendar year), are borne by the College.

Our 2021 medical and pharmacy expenses have been right in line with what we expected. Because of that, we are happy to report that we will be able to maintain our current medical and dental premium rates for 2022.

In consultation with the Faculty and Staff Benefits Committees, we have made the following decisions related to our benefit offerings effective January 1, 2022:

- Premera Blue Cross will continue to administer our medical and dental benefits
- **NEW!** Orthodontia coverage now provided under our dental plan. See page 15 for details.
- Vision Service Plan (VSP) will continue to be our provider for routine vision exams and hardware benefits (lenses and frames)
- Life and disability benefits will continue to be offered through Lincoln Financial Group
- Our Employee Assistance Plan will continue with Cascade Centers
- You will continue to be able to set aside pre-tax dollars into a Flexible Spending Account (FSA) for healthcare or dependent care expenses administered by Navia Benefit Solutions

What you pay towards your medical, vision and prescription benefits will continue to be based on your salary, again, with no change from current, as illustrated on pages 5 and 6.

Whitman College will continue to pay the full employee-only premiums for dental coverage and you will continue to be responsible for the full cost to cover eligible family members.

This benefit guide provides the information you and your family need to make decisions about your benefits during this year's open enrollment, which will be from November 19 – December 3 with all changes effective January 1, 2022. You will learn about the plan changes, the open enrollment process, and plan costs. Please take a few minutes to review this important information so you can make the best coverage decisions for you and your family.

Eligibility Requirements

Full-Time Employees

Full-Time Employee	Dependents	Waiting Period
Employees who work 1,560 hours per year (full-time equivalency (FTE) of .75 or greater)	Your legal spouse or domestic partner* Dependent children may be covered until age 26	1st of the month coincident with or next following date of hire or status change

Full-time employees are eligible for the following benefits:

- Medical/prescription/vision plan
- Retirement savings plan
- Healthcare and dependent care flexible spending plan
- Employee Assistance Program
- Dental Plan
- Group life insurance
- Group AD&D insurance
- Optional life and AD&D insurance
- Optional group dependent life insurance
- Long term disability insurance

Part-Time Employees

Part-Time Employee	Dependents	Waiting Period
Employees who work less than 1,560 hours per year but at least 910 or more hours per year (.44 - .74 FTE)	Your legal spouse or domestic partner* Dependent children may be covered until age 26	1st of the month coincident with or next following date of hire or status change

Part-time employees are eligible for the following benefits:

- Medical/prescription/vision plan
- Retirement savings plan (1,000 hours and 1 year of service to enroll)
- Healthcare and dependent care flexible spending accounts
- Employee Assistance Program

** 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. Some tax status differences may apply.*

Enrollment Changes

For new employees, this is your chance to enroll in the Whitman College Employee Benefits Plan. You must enroll yourself and your dependents within 30 days of becoming eligible for benefits. You can enroll eligible dependents at the same time you enroll yourself.

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

Other than during Open Enrollment, you can make changes to your benefits during the year only if you experience a qualifying status change. Please refer to the Special Enrollment section later in this document (page 28).

Open Enrollment

This is the time of year to add or drop coverage for any eligible family members. If you do not enroll an eligible spouse or child now because they have coverage through another employer, you may only add that person on our plan during next year's Open Enrollment period, unless you experience a qualified family status change. Please refer to the Special Enrollment section later in this document (page 28).

Open enrollment also provides you an opportunity to change your voluntary life coverage with Lincoln. You may elect or increase voluntary life insurance coverage for yourself by either $10,000 or $20,000 with no questions ask (no Evidence of Insurability application is needed) during open enrollment if you haven't been previously declined for coverage. You may elect or increase voluntary life coverage for your spouse or domestic partner either $5,000 or $10,000 with no questions asked as long as he or she hasn't previously been declined for coverage.

If you wish to increase your voluntary life benefit amount by more than $20,000 for yourself and/or $10,000 for your spouse, you will be required to complete an Evidence of Insurability application to prove your good health and be approved by Lincoln Financial Group.

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

This is also the one time of year when you can choose to participate in our healthcare and dependent care flexible spending accounts for 2022.

What Do I Have To Do?

- If you are not making any changes, and do not want a healthcare or dependent care flexible spending account, you don't have to do anything.
- This is your opportunity to add coverage for your spouse or partner and children who were previously eligible but not enrolled.
- If you wish to participate in the Health FSA or Dependent Care FSA, you must make an election with Navia. Please follow the steps in the link provided to you via email. Visit **www.naviabenefits.com** and use Employer code: WMN.
- If you wish to drop coverage for yourself or any family members, now is the time to do so.
- If you wish to make changes to your voluntary life election, complete the Lincoln enrollment form and evidence of insurability form for increases of more than $20,000 for an employee and $10,000 for a spouse/domestic partner.
- **If you would like to make changes during open enrollment, email Krista Garcia in Human Resources at garciakl@whitman.edu to receive forms through BambooHR. Using BambooHR allows us to receive your forms securely and protect your information. All forms must be submitted to Human Resources by December 3rd. If you need assistance please contact Krista Garcia at garciakl@whitman.edu or (509) 527-5172.**

ALL FORMS MUST BE COMPLETED AND RETURNED TO HUMAN RESOURCES BY **DECEMBER 3RD**.

Where Do I Go If I Have Questions?

- See page 7 for customer service numbers and websites for the carriers.
- If you need assistance completing open enrollment forms, please contact Human Resources at (509) 527-5172 or via email at **HR@whitman.edu**.

Benefits Advocacy – Here To Help

Parker, Smith & Feek, Inc.

Whitman College has also 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 carriers. This includes claims issues, eligibility questions, network problems and general healthcare or insurance questions.

PARKER SMITH & FEEK

Your Account Manager	Email	Phone
Laura Fielding	lafielding@psfinc.com	(425) 709-3685

How Much Do I Have To Pay?

Employee Only Coverage

The amount you pay towards your employee only coverage depends upon your annual earnings and is as follows:

Category 1

- Full-time and part-time employees working 130 or more hours per month whose annual salaries are at or below the federal Health and Human Services Poverty Guideline (currently $26,500 for a family of four), will be exempt from making a monthly premium contribution for employee only coverage. Whitman College will pay 100% of the employee portion of monthly premium.

Category 2

- Full-time and part-time employees working 130 or more regularly scheduled hours per month whose annual salary is above $26,500 will pay a monthly premium contribution equal to 0.65% of their pay. If you receive an increase in pay during the year, your employee only monthly premium will be re-calculated, based on the new salary.

  Example – If you are currently making $30,000 or $60,000 per year, then you would use the following calculation to determine your employee-only monthly premium cost:

  Employee Salary $60,000 x .0065 = $390/12 months = $32.50 per month

  Employee Salary $30,000 x .0065 = $195/12 months = $16.25 per month

Category 3

- The monthly premiums for part-time employees working less than 130 hours per month but at least 910 hours per year will continue to be prorated, based on the full-time equivalent percentage. For example, a part-time employee working 20 hours per week will pay 50% of the monthly premium.

Family Coverage

Based on your salary, you will pay between 45% - 55% of the premium cost to cover your eligible family members for medical, vision, and prescription drug coverage. You will continue to pay 100% of the premium cost to cover your eligible family members for dental coverage. Please see the following chart which outlines the contributions you and Whitman will incur in covering your family members, for medical/vision and dental coverage.

Per Month, effective January 1, 2022	Medical/Vision Your Contribution	Medical/Vision Whitman College Pays	Medical/Vision Total Premium
Employee			
	Category 1, 2 or 3	Varies	$682
Spouse/Domestic Partner*			
<$35,000	$260	$318	$578
$35,000-$55,000	$275	$303	$578
$55,001-$70,000	$289	$289	$578
$70,001-$90,000	$303	$275	$578
>$90,000	$318	$260	$578
Child or Children			
<$35,000	$236	$287	$523
$35,000-$55,000	$248	$275	$523
$55,001-$70,000	$262	$261	$523
$70,001-$90,000	$275	$248	$523
>$90,000	$287	$236	$523
Spouse/Domestic Partner* & Children			
<$35,000	$495	$605	$1,100
$35,000-$55,000	$522	$578	$1,100
$55,001-$70,000	$550	$550	$1,100
$70,001-$90,000	$578	$522	$1,100
>$90,000	$605	$495	$1,100

Per Month, effective January 1, 2022	Dental Your Contibution	Dental Whitman College Pays	Dental Total Premium
Employee	$0	$39	$39
Spouse/Domestic Partner*	$39	$0	$39
Child or Children	$29	$0	$29
Spouse/Domestic Partner* & Children	$68	$0	$68

** Includes benefits coverage for domestic partners and their children. Due to IRS regulations, contributions for domestic partners are made on a post-tax basis. In addition, any premiums paid by Whitman College on behalf of a domestic partner will be considered taxable income to the employee.*

Please note that when your contributions are 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.

What's Changing?

New ID Cards!

Everyone will receive new Premera ID cards, even if you are not making any plan changes at renewal. These new ID cards contain additional details about the health plan. Your ID number and group number are not changing so you can continue to use your current ID card until the new ones arrive.

For details on benefit updates, please refer to the corresponding sections of this guide.

- **Medical**: See page 8.
- **Dental**: See page 15.
- **Flexible Spending Account**: See page 18.
- **Long Term Care**: See page 24.
- **Employee Assistance Plan**: See page 25.

Contact Information

Refer to this list when you need to contact a benefits vendor.
For general information, contact Human Resources.

Enrollment & Eligibility	Human Resources	509-527-5172	**HR@whitman.edu**
Medical, Vision and Prescription Drugs	Premera Blue Cross Nurseline	800-722-1471 800-841-8343	**www.premera.com**
Rx Mail Order	Express Scripts	800-391-9701	
Virtual Care	98point6 DoctorOnDemand		**www.98point6.com/premera** **www.doctorondemand.com/premera**
Behavioral Health	TalkSpace		**www.talkspace.com/premera**
Dental	Premera Blue Cross	800-722-1471	**www.premera.com**
Vision	Vision Service Plan	800-877-7195	**www.vsp.com**
Flexible Spending Arrangement (FSA)	Navia Benefits	800-669-3539	**www.naviabenefits.com** **flexplan@naviabenefits.com**
Employee Assistance Program (EAP)	Cascade Centers/ Canopy	800-433-2320	**www.cascadecenters.com**
Travel Assistance	On Call International	*U.S.:* 866-525-1955 *Outside U.S.:* 603-328-1955	**www.mysearchlightportal.com** Group ID: LFGTravel123
Life Insurance and Long Term Disability	Lincoln Financial Group	800-423-2765	**www.lfg.com**
Benefits Advocacy	Laura Fielding Parker, Smith & Feek	(425) 709-3685 lafielding@psfinc.com	**www.psfinc.com**

MEDICAL COVERAGE

Premera Blue Cross

What's Changing

No Surprises Act

Consolidated Appropriations Act, 2021, added consumer protections from certain out-of-network balance bills, effective January 1, 2022. Out-of-network providers are not allowed to balance bill you for:

- Non-emergency health care when you get surgical or ancillary services at an in-network hospital or other facility, e.g., anesthesia
- Emergency room services
- Air ambulance services

Colonoscopy

The United States Preventive Service Task Force has updated the recommended screening for Colorectal Cancer to age 45. The plan continues to pay for all colonoscopies at 100% with in-network providers no matter if they are preventive or diagnostic in nature.

Benefits Summary

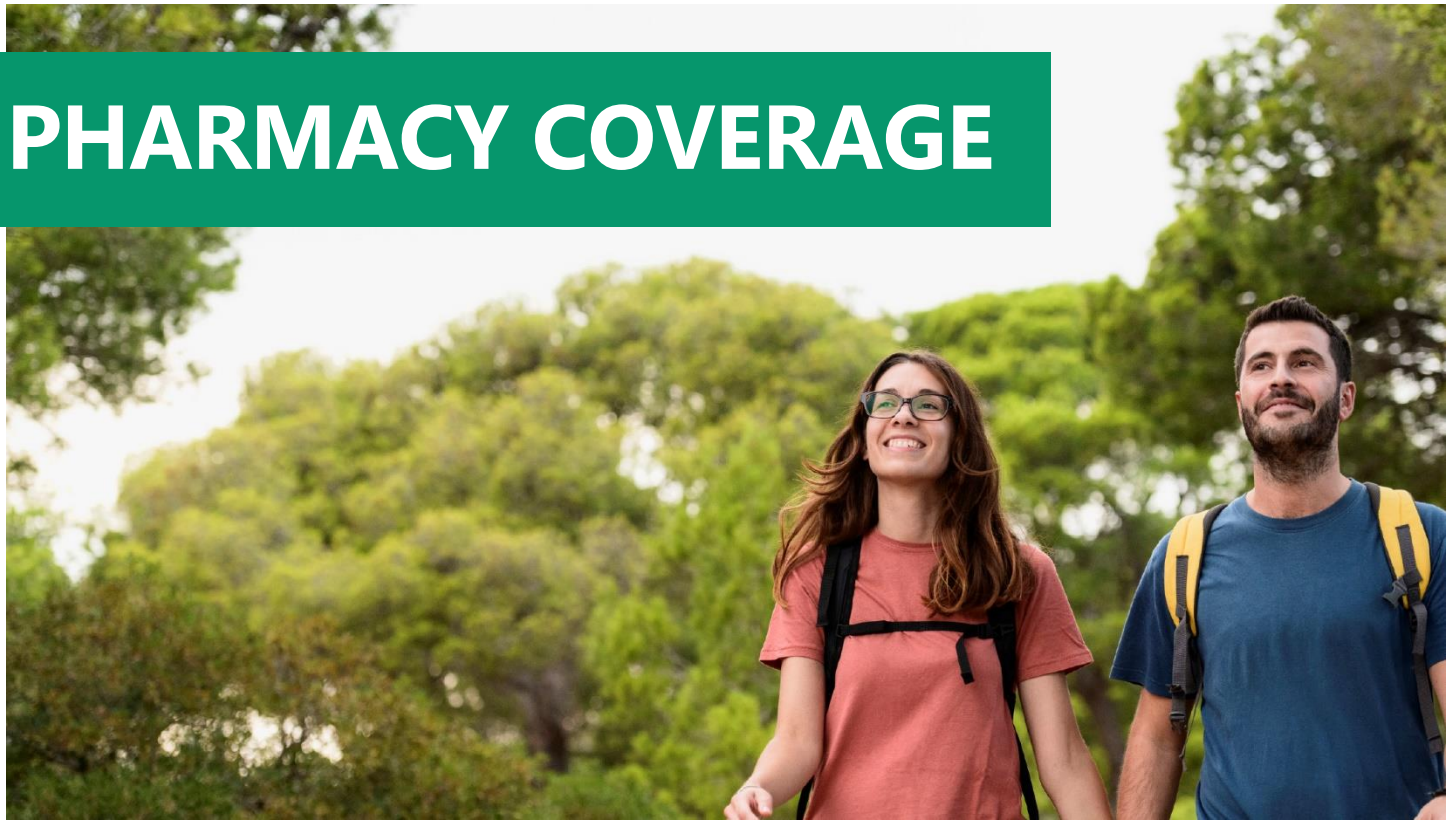
The plan encourages you to use in-network providers by charging you lower co-pays and co-insurance amounts. In-network providers agree to bill Premera directly and to accept a negotiated fee as payment in full. Out-of-Network providers have not and you may have to pay amounts above Premera's allowable charge (also called balance billing). To find a list of in-network providers, go to **www.premera.com** and search for providers in the **Heritage Plus** Network. The deductible and out-of-pocket maximum are on a calendar-year basis and reset every January 1st.

DON'T FORGET YOUR ANNUAL EXAM.

PREVENTIVE CARE IS COVERED 100%.

	In-Network: Heritage Plus
Annual Deductible	
Individual	$500
Maximum per family	$1,000
Out-of-Pocket Maximum	
Individual	$2,500
Maximum per family	$5,000
Preventive Care	
Routine Exam	Paid at 100%, deductible waived
Laboratory Services	Paid at 100%, deductible waived
Physician Services	
Office Visits	Paid at 100% after $25 copay, deductible waived
Inpatient	Paid at 80% after deductible
Outpatient X-Ray and Laboratory Services	Paid at 80%, deductible waived
Emergency Services	Paid at 80% after deductible
Hospital Services	
Inpatient and Outpatient	Paid at 80% after deductible
Outpatient Rehabilitation	
45 visits per calendar year	Paid at 100% after $25 copay, deductible waived
Mental Health Outpatient	Paid at 100% after $25 copay, deductible waived
Spinal Manipulations	
12 visits per calendar year	Paid at 100% after $25 copay, deductible waived
Acupuncture	
12 visits per calendar year	Paid at 100% after $25 copay, deductible waived
Vision Exam	Paid at 100%, deductible waived
Out-of-Network	
OON Deductible	$500
Maximum per family	$1,000
OON Out-of-Pocket Maximum	
Individual	$4,500
Maximum per family	$9,000
Out-of-Network Coinsurance	Paid at 60% after deductible

PHARMACY COVERAGE



Premera Blue Cross

A formulary is a list of covered medications that have been categorized into medication types based on cost, efficacy and availability of options within therapeutic groups. Our pharmacy benefit uses the Essentials Formulary which is based on the use of preferred medications that are both effective and lower cost, and require a prescription to purchase. If you choose to purchase preferred medications, your copayment will be lower. If you take a medication regularly, we encourage you to purchase them through our mail order program. You experience the convenience of home delivery and at a lower cost to you. Mail order allows you to purchase up to a 90-day supply of medication for just two retail copays!

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. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you'll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name drug copay or coinsurance. If there is a medical reason why you cannot take the generic, you may appeal the generic requirement to Premera to have the penalty waived.

	Retail (30-day supply)	**Mail Order** (90-day supply)
Preferred Generics	$10 copay per script	$20 copay per script
Preferred Brand	$20 copay per script	$40 copay per script
Preferred Specialty Drugs ***Thru Accredo Mail Order Specialty Pharmacy Only***	Not Available	$40 copay per script, limited to 30-day supply
Non-Preferred Generic/Brand	$80 copay per script	$160 copay per script
Non-Preferred Specialty	Not Available	$80 copay per script, limited to 30-day supply
Notice regarding Medicare Part D	Our medical plans offer what is called "creditable coverage," which means a Medicare-eligible person will not have to buy a Medicare Part D supplement for prescription drugs, and will not be subject to the 1% per month late enrollment charge assessed by Medicare for purchasing Part D at a later date. If you have questions about your options, please contact Human Resources.	

Retail prescriptions from an out-of-network pharmacy are covered at 60% after the applicable copay. There is no coverage for specialty drugs or mail order from a pharmacy not in the network.

Is my medication covered? Are they preferred?

To find out which drugs are part of the Essentials Formulary:

1. Visit **www.premera.com**
2. Scroll to the bottom and under Pharmacy select "Covered Drugs"
3. Select the E1/E4 formulary for a full listing of medication classifications

Once you are enrolled with Premera, you can search the formulary from your member portal:

1. Log on to your member portal at **www.premera.com**
2. Under "Prescriptions" at the top of the page, select "Manage Prescriptions"
3. Select "Search drug prices" to access the Express Scripts interactive cost and coverage tool

VIRTUAL AND TELEPHONIC CARE

98point6 or Doctor on Demand

Virtual care provides 24/7 access to a board certified, licensed family practice doctor or pediatrician via text or video and can be used for many of your medical issues. It replaces expensive visits and long wait times at the ER or urgent care clinic to diagnose and treat those acute, non-emergent medical issues that may arise such as:

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

Doctors can also write short term prescriptions and will send the script electronically to the pharmacy of your choice. After the visit, at your request, the doctor will send electronic chart notes to your primary care doctor. Virtual care is not a substitute for a primary care doctor.

How does it work?

Download the app and set up your account. Make sure you have your Premera ID card ready. The average wait time is 3–7 minutes. You can have your visit via smart phone, tablet or computer.

Services	98point6	Doctor on Demand
24/7 Access	www.98point6.com/premera	www.doctorondemand.com/premera
Care Delivery	Text messaging	Phone Video chat
Provider Type	Primary care Urgent Care Dermatology	Primary care Urgent Care Dermatology Mental Health
Other	Prescribe medication Order medical tests	Prescribe medication Order medical tests

Talkspace Behavioral Health Care

You can receive behavioral health counseling through Talkspace. Once you have established a relationship with your provider, you have access to unlimited text messaging. Go to the Talkspace site at **https://redemption.talkspace.com/redemption/premera** or mobile app and select the provider that best fits your care criteria prior to making your appointment.

Physical Therapy

Physera connects you to an expert physical therapist through your phone or smart device. You'll receive a live video visit, an assessment, and a personalized treatment plan so you can get back to feeling better fast. They can even send portable exercise equipment to your home. Visit **www.physera.com/premera** to get started.

Chronic Condition Support with Livongo

Premera offers a no cost comprehensive chronic condition support program through Livongo to help anyone with diabetes management, diabetes prevention and hypertension management. If you qualify, you will get:

- Personal health support from expert coaches
- Management and strategy support
- Connected technology that delivers real-time results and remote monitoring
- Continuing education content support

Participation is completely voluntary and you can opt out at any time. Livongo will reach out to anyone who meets the criteria to participate in the program or you can call 1-800-945-4355.

Centers of Excellence (COE)

The COE offers favorable pricing and quality services from designated providers for approved surgeries. This benefit is available for knee and hip replacements and CAR-T & Gene Therapy. When you take advantage of the Centers of Excellence program, you also get lower out-of-pocket costs since your deductible and coinsurance will be waived, meaning your surgery will be covered in full. Providers are selected for their quality care and favorable pricing.

To access this program, and get the preferred pricing, call Premera customer service at 1-800-722-1471 and they will connect you with the program manager. Participation in this program is voluntary.

Medical Transportation

Do you live more than 50 miles away from the Designated Center of Excellence? If so, Premera will make pre-paid travel plans for you (up to the IRS maximum). You must contact Premera's customer service for prior authorization.

DENTAL COVERAGE

Premera Blue Cross

What's Changing

Effective January 1, 2022, orthodontia is covered for adults and children. The plan will pay 50% up to a $2,000 lifetime maximum.

Bitewing x-rays are limited to one set (up to 4 images) per calendar year.

Sealants are covered for those under age 19 and are limited to permanent molars only. Replacements are limited to once every 24 consecutive months.

Prefabricated stainless steel, porcelain, ceramic, resin or other esthetic coated stainless-steel crowns are limited to once per tooth every 24 consecutive months.

Repair or recement of inlays, crowns, onlays, bridgework and dentures are covered when services are done 6 or more months after initial placement.

Nightguards are limited to once every 36 months. Nightguard repair, reline and adjustments are limited to once every 12 consecutive months when services are performed 6 or more months after initial placement of nightguard.

Periodontal surgery is covered in the same quadrant once every 36 months.

Periodontal soft tissue grafts are covered in the same quadrant once every 36 months.

Services and supplies for treatment of temporomandibular joint (TMJ) disorders are covered on the same basis as any other condition.

Benefit Summary

Our plan uses preferred providers through the Premera Dental Choice network. These providers agree to bill Premera Blue Cross directly and to accept a negotiated fee as payment in full. Charges for out-of-network providers are paid based on allowed amounts, as determined by Premera. You may be responsible for any additional amounts (also called balance billing) if you use a non-network provider. The deductible and annual maximum are on a calendar-year basis and reset every January 1st.

	Premera Dental Choice Network	All Other Dentists
Eligibility for Coverage	Full-time employees working 1,560 hours per year	
Annual Deductible *Individual* *Maximum per family*	(Waived for Preventive Care) $50 $100	
Preventive Care (exams, x-rays, etc.)	Paid at 100%	
Basic Services (fillings, extractions, etc.)	Paid at 80%	
Major Services (crowns, bridges, dentures, etc.)	Paid at 50%	
Annual Maximum	$1,500 per covered person (Preventive Care does not apply)	
Orthodontia	Paid at 50% up to $2,000 lifetime maximum Adults & Children	

VISION COVERAGE

Vision Service Plan

Our vision benefits through Vision Service Plan (VSP) provide coverage for comprehensive routine vision care. If you choose to use a VSP provider, your out-of-pocket costs will be much lower. To access our VSP plan, simply visit **www.vsp.com**, select a VSP provider and make an appointment. The provider will take care of the rest.

If you choose to use a non-VSP provider, you will need to submit a claim to VSP and you will be reimbursed up to the scheduled amounts for out-of-network providers.

	VSP Signature	All Other Providers
Vision Exam *Every 12 months*	Paid at 100%	Reimbursed up to $50
Eyeglass Lenses *Every 12 months*	Paid at 100%	Reimbursed up to $50-$125
Frames *Every 12 months*	$130 allowance; $150 allowance for featured frames and then 20% discount on amounts over the allowance. $70 allowance at Costco	Reimbursed up to $70
Contact Lenses *Every 12 months* *In lieu of Glasses*	$130 allowance Contact lens covered at 100% after $60 copay	Reimbursed up to $105, including the exam

FLEXIBLE SPENDING ARRANGEMENTS

Navia Benefit Solutions

Our Flexible Spending Arrangements (FSA) allow you to use pre-tax dollars to reimburse yourself for out-of-pocket health care expenses (such as copays and deductibles), and/or dependent care expenses. Navia sets up an account which you deposit pre-tax dollars from every paycheck. Like your premium contributions, these FSA accounts are permitted by Section 125 of the Internal Revenue Code and, as such, there are rules associated with them. To learn more about FSA plans, please review materials located on the Whitman College HR benefit site: **https://www.whitman.edu/open-enrollment**.

Be careful when making your election because money left in your account at the end of the year will be forfeited – in other words, use it or lose it! There is one exception and that is for your health care account; we do allow you to roll over up to $570 unused contributions from one year to the next. Once you select the amount(s) you want to deposit for the year, you cannot change or discontinue those deposits unless you experience a change in family status (marriage, divorce, birth or adoption of a child, change in employment). So be sure to elect to set aside money that you KNOW you will need – don't use these accounts as a "rainy day fund."

You or your family members do not have to be enrolled in the Whitman College medical plan to participate in our FSA plans.

What's Changing

The maximum amount you can elect for the health care account is increasing to $2,850 for the plan year beginning January 1, 2022.

The maximum amount you can elect effective January 1, 2022 for the dependent care account is $5,000 ($2,500 if married and filing separately).

Reminder! If you currently participate in the Flexible Spending Arrangement, any unused health care or dependent care balance will roll over to the 2022 plan year. Please take that into consideration as you plan for your FSA election for 2022. This is the last year that the roll over will be unlimited; at the end of 2022 only $570 of health care FSA dollars will be allowed to roll over and dependent care roll over will be discontinued.

Health Care FSA

This program allows you to set aside up to $2,850 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
- Over-the-counter medication
- Menstrual products

Those who enroll in the health care account will receive an FSA debit card at no additional cost. The debit card is pre-loaded for the entire amount you have elected into your health care account this year, and you have the option of using the debit card to pay for health care expenses (copayments, deductibles, etc.). Please carefully read the materials from Navia to learn about the advantages and responsibilities associated with using the debit card.

Your health care FSA election is available to you on the first day of coverage (January 1 or your enrollment date for new hires). That means you can use your entire election at any time during the plan year and Whitman College will continue to take deductions from your paycheck in equal amounts over the course of the year.

In many instances, due to IRS compliance requirements, you will still need to send in your debit card receipts to Navia after using the debit card. This is to ensure the expense you paid for with the debit card is an IRS approved expense. Navia has several options to submit these receipts such as through their app, online portal, via email, mail or fax.

While you should only set aside enough money for those expenses you know you will incur during the plan year, the roll-over provision allows you to carry forward up to $570 into the next plan year. Please see the information from Navia Benefit Solutions for more information.

Note: Due to IRS regulations, domestic partners and their children are not eligible for health care reimbursement.

Dependent Care FSA

Similar to the health care FSA, you may also use pre-tax dollars to pay for qualified dependent care. Expenses can be for your dependent children 12 and under, and in some cases elder care, and must be so you can work, actively look for work or be a full-time student. 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 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). This limit is set by the IRS and is a calendar year limit. Different than the health care account, you can only get out of your account the amount that has been deducted from your paycheck.

Note: Election changes are also allowed when there is a change in cost or coverage of your childcare provider.

DISABILITY, LIFE AND LONG-TERM CARE INSURANCE

Disability Income

Lincoln Financial Group

Did you know that one in eight workers will be disabled for five or more years during their working careers? If this happens to you, can you afford to be out of work and without pay for an extended period – on top of the medical bills that come with a serious illness or injury?

Whitman College's long term disability coverage is essentially "paycheck insurance" and offers you financial stability and peace of mind. If you are unable to perform the material duties of your job due to sickness, injury or pregnancy, you will receive the following benefits:

	Long-Term Disability
Coverage Begins	1st of the month coinciding with or next following date of employment or qualification date
Eligibility	FT Employees: 1,560 hours per year Job-Share Employees: 1,040 hours per year
Benefits Begin	Benefits will begin once you have been disabled (as defined below) for 180 days
Percentage of Income Replaced	60% of basic monthly earnings
Maximum Benefit available	Up to $10,000 per month
Benefit Duration	Up to Social Security Normal Retirement Age with benefits limited if your disability begins after age 60
Definition of Disability	You are considered disabled and eligible for benefits because of sickness or injury if you are limited from performing the material and substantial duties of your regular occupation. You will continue to receive benefits if, after benefits have been paid for 24 months, you are limited from working in any occupation for which you are qualified based on your education and experience.
Rehabilitation Benefits	You will be encouraged to participate in a rehabilitation program while you are disabled; your participation is voluntary.
Exclusions	Any acts of war, whether declared or undeclared; intentionally self-inflicted injury of any kind, while sane or insane; participation in the commission of any assault or felony.
Limitations	Benefits for disabilities due to substance abuse and mental or nervous disorders are limited to a maximum of 24-months of benefits per occurrence of disability
Pre-existing Condition Limitation	Your disability will not be covered by this plan if it is due a pre-existing condition. You have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescription drugs or medicines in the 3 months prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.
Cost of Benefit	This employee benefit is paid for by Whitman College

Any disability benefits you may receive are taxable income and need to be reported to the IRS.

Life and AD&D Insurance

Lincoln Financial Group

Whitman College purchases life and accidental death and dismemberment (AD&D) insurance for all full-time employees.

Benefits	1.5 times annual earnings up to a maximum of $500,000
Eligibility	FT Employees: $1,560 hours per year Job-Share Employees: 1,040 hours per year
Age Reduction	Benefit reduces to 65% at age 70 and 50% at age 75, rounded to the nearest $1,000
Dependent Life	Spouse: $5,000 Children: age 14 to age 26, $5,000
Cost of Benefit	The employee portion of this benefit is paid for by Whitman College; dependent life is an optional benefit that is paid by the employee. The cost to cover all dependents is $1.17 per month.

Voluntary Life

If you want additional group life insurance, you may purchase additional amounts through payroll deductions. You must be enrolled in voluntary life to purchase life insurance for your spouse or child.

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

When you are first eligible you can purchase up to the guaranteed issue amount regardless of your health status. If you don't purchase when first eligible or you want coverage that is more than the guaranteed issue amount, you will be required to prove your good health by completing an Evidence of Insurability form and being approved by Lincoln. Once per year during open enrollment you are given the opportunity to enroll or increase your life benefit by $10,000 or $20,000 for yourself and $5,000 or $10,000 for spouse/domestic partner without providing proof of good health. This open enrollment benefit is not available to employees or spouses who have previously been declined by Lincoln or who have dropped coverage.

You may elect an amount for voluntary AD&D that is different than your voluntary life election. You do not need to be enrolled in voluntary life to enroll in voluntary AD&D.

	Employee	Spouse	Child
Term Life Insurance			
Benefit Available	Lesser of 5x annual earnings or $500,000	Lesser of 50% of employee election or $250,000	$2,500; $5,000; $7,500; $10,000 (children age 14 days – 6 months are only eligible for a $250 benefit)
Available in increments of:	$10,000	$5,000	$2,500
Guaranteed Issue	$150,000	$30,000	$10,000
AD&D			
Benefit Available	Same as Life	Same as Life	Same as Life
Guaranteed Issue	Full Benefit	Full Benefit	Full Benefit
Age Reduction Schedule			
Reduction schedule applies to Life, AD&D and Supplemental benefits	At age 70, benefit reduces to 65% of original amount At age 75, benefit reduces to 50% of original amount		
Increasing your Election			
When can I increase my Election?	At open enrollment by $10,000 or $20,000	At open enrollment by $5,000 or $10,000	At open enrollment
Is there medical underwriting?	No	No	No
	Medical underwriting applies if the new election is over the guaranteed issue amount or if the open enrollment increase is greater than two benefit increments.		

Because the premium is based on your age, when you go from one age bracket to the next, monthly deductions will increase to reflect the new age bracket. Age brackets are in 5-year increments (30–34, 35–39, etc.). If applicable, your new deductions will be deducted from your paycheck with the first payroll after January 1st.

Please contact HR for more information about this offering including rates and an application.

Long-Term Care

What's Changing

Starting January 1, 2022, a new payroll tax will be deducted from your paycheck to fund the Washington State Long-Term Care Trust established by the legislature and signed into law back in 2019. The tax is $0.58/$100 of payroll or $5.80 of every $1,000 of earnings. Long-term care is expensive. Seven in ten Washington residents who are 65 will need long-term services and support in their lifetime. As our life expectancy grows, there is a greater concern for a gap between our health expectancy and our life expectancy. Long-term care coverage is intended to help pay for the care many need later in life.

To learn more about the Washington Cares Fund, go to **http://www.wacaresfund.wa.gov/**. If you were enrolled in a LTC plan before November 1, 2021, you can permanently opt-out of the Washington Cares Fund and avoid paying the tax. You must opt-out before December 31, 2022.

EMPLOYEE WELLBEING

Employee Assistance Program

Cascade Centers – Soon to be Canopy

The Employee Assistance Program (EAP) is a completely free and confidential counseling program that helps you and/or your family members address life issues, big or small. Benefits are offered to all employees and immediate family members, and can help with:

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

Your calls to Cascade Centers are answered by master's level counselors who will help you determine what type of help you need. This contact is done by phone or text message 24/7/365. They also have a robust website for more self-service and educational opportunities. Contact them by:

- Calling: 800-433-2320
- Texting: 503-850-7721
- Email: **info@cascadecenters.com**
- Website: **www.cascadecenters.com**

Cascade Centers is changing its name to Canopy in 2022, but the above phone numbers and websites will continue to connect you to services. Additional details regarding the rebrand will be shared once they are available.

Here is a high-level overview of all of the services you have access to with Cascade Centers:

- Up to three, no cost, in person or by phone (your choice) counseling sessions per person, per issue. Cascade will locate a counselor, who will reach out to you to set up an appointment.
- Help in finding eldercare or childcare services – locate resources, set up site visits.
- Legal consultation and mediation – a free 30-minute office or telephone consultation with an attorney or mediator, plus a 25% discount for any needed legal services.
- Financial coaching – 30 days of financial coaching to help develop better spending habits, reduce debt, improve credit, increase savings and plan for retirement.
- Pet parenting – support for new pet parents, discounts on pet insurance and bereavement support when you lose a pet.
- Home ownership and rental assistance – discounts on closing and refinancing, plus help finding places to rent, temporary housing.

Staying Healthy

Are you looking for ways to stay healthy? Your health plan provides you with many tools to do so. Staying healthy is not only good for you and your family, but it also helps our health plan performance by keeping costs low. Log on to **www.premera.com** and create an account for access to:

- Wellness tools
- Review claims
- Personal Health Statement
- Healthcare cost and quality tools (in the "Find the Provider" area)

Personal Health Support

Healthcare navigators are available to you and your family when you have any type of complex medical event. Licensed professionals work with you and your providers as a single point of contact to advocate on your behalf – with both Premera and your doctor. Premera can help you navigate the health system, understand you health situation, and help you make informed decisions. To connect with a healthcare navigator, call 888-742-1479 or email **healthhelp@premera.com**.

Going Paperless

Did you know that you can choose to reduce your clutter and help protect your privacy by notifying Premera to communicate with you electronically? In a few short steps you can update your profile to receive your explanation of benefits (EOB) via email.

1. Log in at **www.premera.com**
2. Click "Manage my Account" under Member Services
3. Select "Go Paperless" from the menu on the left

TRAVEL ASSISTANCE

On Call International

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

Prescription and medical services will be paid by your medical insurance; the services provided by On Call International simply help with the arrangements for access to health care. Ask Human Resources for a brochure if you would like more information about this service.

Please note that this service will be discontinued in March 2022.

IMPORTANT LEGAL INFORMATION

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 and still apply for income-based subsidies.

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

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

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 60 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 Whitman College 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 Human Resources for a copy of the General Notice of COBRA Continuation Rights. This notice explains your rights and obligations to receive COBRA benefits.

We are not always aware when a COBRA event takes place, unless notified by you. The most common examples are divorce, or when a child exceeds the maximum age. When such an event occurs, the Notice of Qualifying Event must be postmarked within 60 days of the qualifying event for the affected person to be eligible for COBRA continuation. If you have questions about COBRA please contact Human Resources.

Important Notice from Whitman College 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 Whitman College 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. Whitman College has determined that the prescription drug coverage offered by the Whitman College 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?

Plan Participants who also are eligible for Medicare have the following three options concerning prescription drug coverage:

- You may stay in the Plan and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare prescription drug open enrollment period (October 15–December 7 of each year); or (2) if you lose Plan coverage. This is the best option for most Plan participants who are eligible for Medicare.
- You may stay in the Plan and also enroll in Medicare prescription drug coverage at this time. The Plan will pay prescription drug benefits as the primary payer in most instances. Medicare will pay benefits as a secondary payer,

and thus the value of your Medicare prescription drug coverage will be greatly reduced. Your current coverage under the Plan pays for other health benefits as well as prescription drugs and will not change if you choose to enroll in Medicare prescription drug coverage.

- You may reject all coverage under the Plan and choose coverage under Medicare as your primary and only payer for all medical and prescription drug expenses. If you do so, you will not be able to receive coverage under the Plan, including prescription drug coverage, unless and until you are eligible to reenroll at the next enrollment period for which you are eligible, if any. Your current coverage pays for other types of health expenses, in addition to prescription drugs, and you will not be eligible to receive any of your current health and prescription drug benefits if you reject coverage under the Plan and choose to enroll in Medicare, including a Medicare prescription drug plan, as your primary and only payer.

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 Whitman College 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 Whitman College 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:	January 1, 2022
Name of Entity/Sender:	Whitman College
Contact—Position/Office:	Cara Setchell
Address:	345 Boyer Avenue Walla Walla, WA 99362
Phone Number:	(509) 527-5970

Premium Assistance under Medicaid and the Children's Health Insurance Program

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (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 1, 2021. 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
Health Insurance Premium Payment (HIPP) Program:
Website: **http://dhcs.ca.gov/hipp**
Phone: 916-445-8322
Email: **mailto: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

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: **http://www.in.gov/fssa/hip/**
Phone: 1-877-438-4479
All other Medicaid
Website: **https://www.in.gov/medicaid/**
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: 1-800-338-8366
Hawki Website: **http://dhs.iowa.gov/Hawki**
Hawki Phone: 1-800-257-8563
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

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

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: 1-855-459-6328
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**
Phone: 1-877-524-4718
Kentucky Medicaid Website: **https://chfs.ky.gov**

LOUISIANA – Medicaid

Website: **www.medicaid.la.gov**
or **www.ldh.la.gov/lahipp**
Phone: 1-888-342-6207 (Medicaid hotline)
or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: **https://www.dhhs.nh.gov/oii/hipp.htm**
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

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 and CHIP

Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx

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/hipp/**
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: **https://www.hca.wa.gov/**
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: **http://mywvhipp.com/**
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 1, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Service
www.cms.hhs.gov
1-877-267-2323, menu option 4, ext. 61565

Whitman College : Your Choice (Copay) NGF

Coverage for: Individual or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-722-1471 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-722-1471 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 Individual / $1,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care, copayments, prescription drugs and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $2,500 Individual / $5,000 Family, Out-of-network: $4,500 Individual / $9,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-722-1471 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	40% coinsurance	None
	Specialist visit	$25 copay/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance (deductible does not apply)	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance (deductible does not apply)	40% coinsurance	Prior authorization recommended for some outpatient imaging tests. Penalty for out-of-network: no penalty.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.premera.com/documents/052149_2022.pdf	Preferred generic drugs	$10 copay/prescription (retail), $20 copay/prescription (mail)	$10 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 90 day supply retail and mail. Member pays 1 copay per 30 days retail. No charge for specific preventive drugs. Prior authorization recommended for some drugs.
	Preferred brand drugs	$20 copay/prescription (retail), $40 copay/prescription (mail)	$20 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 90 day supply retail and mail. Member pays 1 copay per 30 days retail. Prior authorization recommended for some drugs.
	Preferred specialty drugs	$40 copay/prescription	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization recommended for some drugs.
	Non-preferred generic drugs Non-preferred brand drugs Non-preferred specialty drugs	Non-pref. generic: $80 copay/prescription (retail), $160 copay/prescription (mail) Non-pref. brand: $80 copay/prescription (retail), $160 copay/prescription (mail) Non-pref. specialty: $80 copay/prescription	Non-pref. generic: $80 copay/prescription + 40% coinsurance (retail), not covered (mail) Non-pref. brand: $80 copay/prescription + 40% coinsurance (retail), not covered (mail) Non-pref. specialty: Not covered	Non-pref. generic and non-pref. brand: Covers up to a 90 day supply retail and mail. Member pays 1 copay per 30 days retail. Non-pref. specialty drugs: Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization recommended for some drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization recommended for some services. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	Hospital-based: 20% coinsurance Freestanding center: $25 copay/visit	Hospital-based: 20% coinsurance Freestanding center: 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $25 copay/visit Facility: 20% coinsurance (deductible does not apply)	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $25 copay/visit Inpatient: 20% coinsurance	40% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Habilitation services	Outpatient: $25 copay/visit Inpatient: 20% coinsurance	40% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 90 days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior authorization recommended to buy some medical equipment. Penalty for out-of-network: no penalty.
	Hospice services	20% coinsurance	40% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one exam per calendar year (under age 19).
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Infertility treatment	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations	• Hearing aids	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 1-800-842-5357. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-722-1471 or TTY 1-800-842-5357, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-722-1471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-722-1471.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$500**
Specialist copay	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$500**
Specialist copay	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$30
Copayments	$1,000
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,070**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$500**
Specialist copay	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.