Employee Benefit Guide

Washington Institute for Coagulation DBA: WACBD

December 1, 2023 – November 30, 2024

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This publication highlights recent plan design changes and is intended to fully comply with the requirement under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modification and should be kept with your most recent Summary Plan Descriptions.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 24 to 29 where Notice of Creditable Coverage and/or Notice of Noncreditable Coverage begin for more details.

About Your Benefits

At Washington Institute for Coagulation DBA: WACBD, we are committed to providing a comprehensive and valuable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your benefits. If you have any questions, feel free to reach out to Kim Snyder at **2066819071 ext 1031** or **Kim.Snyder@WACBD.org**.

Eligibility and Enrollment

You are eligible to participate in Washington Institute for Coagulation DBA: WACBD benefits if you are a full-time employee working at least 32 hours per week. If you enroll for benefits, you may also cover your:

- Legal spouse
- Domestic Partner
- Children up to age 26
- Unmarried children of any age who are mentally or physically disabled

Your benefits begin on the first of the month following your hire date. Please refer to the SPDs for each benefit to confirm whether you, your spouse and dependents are eligible.

Select Your Benefits Carefully

To get the most value from your benefits, carefully consider which options are right for you and your family.

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during Annual Enrollment. Any pre-tax benefit elections made during open enrollment must remain in effect until the following Annual Enrollment period, unless you experience a qualifying event which may allow for an election change. Examples of qualified life events include:

- Marriage, legal separation or divorce
- Birth or adoption of a child
- Change in a dependent's eligibility status
- Loss of eligibility for group health coverage, health insurance coverage, or Medicaid/CHIP
- Becoming eligible for a state premium assistance subsidy

If you believe you have a qualifying event please notify Human Resources immediately. You have 30 days from a qualified change in status to make changes. However, note that if you lose eligibility for Medicaid/CHIP, or become eligible for a state premium assistance subsidy, you have 60 days from that qualified change in status to make changes.

Keep in mind, the changes you make must be directly related to the event.

Medical Coverage

Terms to Know

- **Copay** - A set dollar amount you pay for a covered healthcare service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for healthcare services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered healthcare services after you reach the deductible. You pay a percentage of the cost, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide healthcare services. In-network providers typically provide services at a lower negotiated rate. If you receive services from a provider that is **In-Network** it will cost you significantly less than going to a provider that is **Out-of-Network.**
- **Formulary Drug List:** A drug formulary is a list of generic and brand-name drugs that have been evaluated for safety and effectiveness, and that your insurance company considers "best choices".
- **Generic Drugs**: FDA-approved, and shown to be just as safe and effective as their more expensive brand-name counterparts.
- **Brand Name Drugs:** Carriers regularly review the latest prescription drugs on the market and maintains a list of brand name drugs that are clinically effective and not cost-restrictive.
- **Specialty Drugs:** Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using the carrier's mail-order pharmacy. You can register for mail-order pharmacy by logging on to **www.premera.com**.

How the Plans Work

All plans use the Premera Blue Cross network and cover 100% of the cost for preventive care services like annual physicals and routine immunizations. The way you pay for care is different with each plan.

HDHP (High Deductible Health Plan): You pay the full negotiated cost for medical services and prescription drugs until you meet your annual deductible. If you meet the deductible, you and the plan share the costs (coinsurance) until you reach the annual out-of- pocket maximum.

PPO: This Plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your annual out-of-pocket maximum.

Telemedicine

Getting to the doctor when you're sick is never easy. That's why Premera Blue Cross offers telemedicine for non-emergency care. You can connect with a U.S. board-certified medical professional by phone or video chat. For further details, visit www.premera.com.

Medical and Prescription Coverage

Administered by Premera Blue Cross

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with a medical plan through Washington Institute for Coagulation DBA: WACBD.

	Premera Blue Cross Choice 1500 Gold	Premera Blue Cross Choice HSA Qualified 1500 Gold
	IN-NETWORK	IN-NETWORK
Deductible (Individual/Family)	$1,500/$3,000	$1,500/$3,000
Coinsurance	20%	20%
Out-of-Pocket Maximum (Individual/Family)	$7,000/$14,000	$3,900/$7,800
BASIC & PHYSICIAN CARE		
Preventive Care	$0	$0
Primary Care Office Visit	$25	DED + 20%
Specialist Office Visit	$55	DED + 20%
Independent Lab/X-Ray	DED + 20%	DED + 20%
Independent Diag MRI / CT	DED + 20%	DED + 20%
SICK AND QUICK CARE		
Urgent Care Facility	Hospital: $200 plus DED + 20%; Freestanding Center: $55 (Copay waived if admitted to hospital)	DED + 20%
Emergency Room	$200 plus DED + 20% (Copay waived if admitted to hospital)	DED + 20%
HOSPITALIZATION		
Inpatient Hospital	DED + 20%	DED + 20%
Outpatient Surgery	DED + 20%	DED + 20%
PHARMACY		
Retail (up to 30 days)	$20/$50/$80	DED then 20%
Mail Order (90 days)	$60/$150/$240	DED then 20%
Specialty Drugs	25%	DED then 20%
OUT-OF-NETWORK CARE		
Your medical plan offers out-of-network care. However, please be aware that you will be responsible for charges in addition to the out- of-network deductible and coinsurance. Out-of-network providers will typically charge you the difference between the amounts they bill and what the Premera Blue Cross pays (known as balance billing). These charges are in addition to, and do not count towards your out-of-network out-of-pocket maximum.		
Deductible (Individual/Family)	Individual: $3,000	$3,000/$6,000
Coinsurance	50%	50%
Out-of-Pocket Maximum (Individual/Family)	N/A	N/A

Finding In-Network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to www.premera.com or call the number on your Member ID Card to find providers in the Premera Blue Cross network.

Employee Medical Costs

Washington Institute for Coagulation DBA: WACBD contributes 100% for Employee and 50% for Dependents toward the cost of medical coverage.

Coverage Tier	Premera Blue Cross Choice 1500 Gold (Monthly Rates)	Premera Blue Cross Choice HSA Qualified 1500 Gold (Monthly Rates)
Adult Rate	$836.53	$801.86
Child Rate	$348.87	$334.41

Health Savings Accounts (HSA)

A Health Savings Account (HSA) provides you with a tax advantage that can help you pay for certain expenses on a pre-tax basis. As an eligible employee, you agree to set aside a portion of your pre-tax salary in a HSA, and that money is deducted from your paycheck over the course of the plan year.

	Health Savings Account (HSA)
What medical plan can I choose?	High Deductible health Plan (HDHP)
Who administers the HSA	Premera Blue Cross/Optum http://www.premera.com/
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses). https://www.irs.gov/publications/p969
When can I use the funds?	Funds are available as you contribute to the account
Can I roll over funds each year?	Yes, funds roll over from year to year and are yours to keep (even if you leave the company or retire)
How do I pay for eligible expenses?	With your Optum debit card
How much can I contribute each year?	$3,850 for individual coverage or $7,750 for family coverage in 2023. You may contribute additional funds to your HSA ($1,000 per tax year) if you will be 55 years or older by December 31 Learn more at :www.optum.com
Can I change my contributions throughout the year ?	Yes, you can log on to https://wacbd.ease.com to change your per- paycheck contributions at any time

Note: If you are enrolled in a non-HDHP, Medicare, Medicaid or Tricare, General Purpose Health Flexible Spending Account, Health Reimbursement Arrangement or claimed as someone else's tax dependent, by law you are not allowed to contribute to an HSA.

What Are the Tax Implications of an HSA?

Contributions to your HSA reduce your taxable income, and qualified medical expenses are never taxed. All money set aside in an HSA grows tax-deferred until age 65, when funds can be withdrawn for any non-medical purpose at ordinary tax rates, or tax-free when used for qualified medical expenses.

Dental Coverage

Administered by Delta Dental of Washington

Good oral care enhances overall physical health and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the dental benefit plan. Washington Institute for Coagulation DBA: WACBD contributes, 100% for Employee only for dental coverage.

	Delta Dental Core Plan		Delta Dental Buy Up Plan	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Annual Deductible (Individual/Family)	$50/$150	$50/$150	$50/$150	$50/$150
Annual Maximum (Per Person)	$750	$750	$1,500	$1,500
Preventive Care (Routine Cleaning and X-rays)	0%	0%	0%	0%
Basic Services (Fillings, Basic Root Canals)	50% after deductible	50% after deductible	20% after deductible	20% after deductible
Major Services (Extractions, Crowns)	Not Available	Not Available	50% after deductible	50% after deductible
Orthodontia (Children up to age 18)	Not Available	Not Available	50%	50%
Orthodontia Lifetime Maximum (Per Person)	Not Available	Not Available	$1,500	$1,500

**The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider. A non-network provider may balance bill you for the difference.*

Employee Dental Costs

Coverage Tier	Delta Dental Core Plan (Monthly Rates)	Delta Dental Buy Up Plan (Monthly Rates)
Employee Only	$31.10	$63.40
Employee + Spouse	$62.30	$126.80
Employee + Child(ren)	$78.10	$153.70
Employee + Family	$109.20	$217.00

Finding In-Network Dentists

You typically pay less for services when you use a dentist in the Delta Dental of Washington network. You can find an in-network dentist by visiting **www.deltadentalwa.com** or calling **(800) 554-1907.**

Vision Coverage

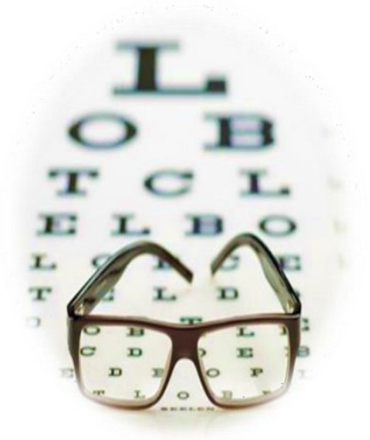
Administered by Vision Service Plan

Washington Institute for Coagulation DBA: WACBD vision plan covers routine eye exams and helps you pay for glasses or contact lenses. Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Washington Institute for Coagulation DBA: WACBD contributes, 100% for Employee only for vision coverage.

	Signature Plan C	
	In-Network	Out of Network
Eye Exam (Once every 12 months)	Covered in full after $10 copay	$50 allowance
LENSES (Once every 12 months)		
Single Vision	Covered in full after $25 copay	$50 allowance
Bifocal	Covered in full after $25 copay	$75 allowance
Trifocal	Covered in full after $25 copay	$100 allowance
Lenticular	Covered in full after $25 copay	$125 allowance
Progressive	Various copay	
Scratch Resistant		
Anti-Reflective Coating		
UV Protection		
FRAMES (Once every 12 months)		
Frames	Up to $150 allowance; 20% off remaining balance; Featured frame: $170 allowance; Costco: $80 allowance; Walmart/Sam's Club: $150 allowance	Up to $70 allowance
CONTACT LENSES (Once every 12 months)		
Fitting	Up to $60 copay	
Elective	Up to $150 allowance	Up to $105 allowance
Medically Necessary	Covered in full	$210 allowance
Lasik	Average 15% off the regular price or 5% off the promotional price	

Employee Vision Costs

Coverage Tier	Vision (Monthly Rates)
Employee Only	$8.63
Employee + Spouse	$13.81
Employee + Child(ren)	$14.10
Employee + Family	$22.73



Finding In-Network Eye Doctors

You can find an in-network eye doctor in the Vision Service Plan network by visiting **www.vsp.com** or calling **1 (800) 877-7195.**

Employee Monthly Benefit Cost

	Total Monthly Cost	Monthly ER Cost	Monthly EE Cost	Per Pay Period EE Cost	Payroll Deduction
Premera Choice 1500 Gold					
Employee Age 21+	$836.53	$836.53	$0.00	$0.00	$0.00
Employee Age Under 21	$348.87	$348.87	$0.00	$0.00	$0.00
Dependent Age 21+	$836.53	$418.27	$418.27	$193.05	$418.27
Dependent Age Under 21	$348.87	$174.44	$174.44	$80.51	$174.44
Premera Choice HSA Qualified 1500 Gold					
Employee Age 21+	$801.86	$801.86	$0.00	$0.00	$0.00
Employee Age Under 21	$334.41	$334.41	$0.00	$0.00	$0.00
Dependent Age 21+	$801.86	$400.93	$400.93	$185.04	$400.93
Dependent Age Under 21	$334.41	$167.21	$167.21	$77.17	$167.21
Delta Dental - Core Plan					
Employee	$31.10	$31.10	$0.00	$0.00	$0.00
Employee + Spouse	$62.30	$31.10	$31.20	$14.40	$31.20
Employee + Child(ren)	$78.10	$31.10	$47.00	$21.69	$47.00
Employee + Family	$109.20	$31.10	$78.10	$36.05	$78.10
Delta Dental - Buy Up					
Employee	$63.40	$63.40	$0.00	$0.00	$0.00
Employee + Spouse	$126.80	$63.40	$63.40	$29.26	$63.40
Employee + Child(ren)	$153.70	$63.40	$90.30	$41.68	$90.30
Employee + Family	$217.00	$63.40	$153.60	$70.89	$153.60
VSP Vision Plan					
Employee	$8.63	$8.63	$0.00	$0.00	$0.00
Employee + Spouse	$13.81	$8.63	$5.18	$2.39	$5.18
Employee + Child(ren)	$14.10	$8.63	$5.47	$2.52	$5.47
Employee + Family	$22.73	$8.63	$14.10	$6.51	$14.10

Basic Life and Accidental Death & Dismemberment Insurance

Administered by UNUM

Washington Institute for Coagulation DBA: WACBD provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance at no cost to eligible employees. All benefit eligible employees are automatically enrolled in this coverage.

	How it Works	Basic Life and AD&D (Company-paid benefit)
Basic Life	Your beneficiaries receive this benefit if you pass away	$50,000 Guarantee Issue Amount: $50,000
Basic AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	$50,000

The benefit will reduce to 65% upon reaching age 70, and to 50% at age 75.

Keep Your Beneficiaries Up to Date

- Make sure to keep this information updated so your benefit is paid according to your wishes.
- This may be done by completing a Beneficiary Designation form with your employer and the carrier.

Voluntary Life and Accidental Death & Dismemberment Insurance

Administered by UNUM

As an added benefit, you have the opportunity to purchase financial support through the Voluntary Life and Accidental Death and Dismemberment Plan. You **MUST** elect coverage on **YOURSELF** in order to elect coverage for a spouse and/or child(ren).

	How it Works	Voluntary Life and AD&D (Employee-paid benefit)
Life	Your beneficiaries receive this benefit if you pass away	**You:** Increments of $10,000 up to $500,000 or 5x annual earnings **Your spouse:** Increments of $5,000 up to $250,000 (not to exceed 100% of EE amount) **Your child(ren):** Increments of $2,000 up to $10,000; Birth to 6 months: $1,000
AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	**You:** Increments of $10,000 up to $500,000 or 5x annual earnings **Your spouse:** Increments of $5,000 up to $250,000 **Your child(ren):** Increments of $2,000 up to $10,000

The benefit will reduce to 65% upon reaching age 70, and to 50% at age 75.

Keep Your Beneficiaries Up to Date

- ❖ Make sure to keep this information updated so your benefit is paid according to your wishes.
- ❖ This may be done by completing a Beneficiary Designation form with your employer and the carrier.

IMPORTANT: An evidence of insurability (EOI) form must be submitted and approved by Carrier if:

- You are electing an amount over the Guarantee Issue (GI). The Guarantee Issue amounts are $100,000 for an employee and $15,000 for a spouse.
- Coverage is available up to the Guarantee Issue Limit without answering medical questions if you enrolled when you were initially eligible. If you didn't sign up when you were initially eligible you may have to answer medical questions to obtain this coverage.
- Please Note: If you are required to complete a medical questionnaire, you will be notified by HR.

Coverage will not be available until the UNUM provides approval.

Voluntary Life and AD&D Rates

Rates are subject to Age; please, see below for the expected rate.

Rates (Per $1,000 / Mo)			
Age:	**Employee**	**Spouse**	**Child**
15 - 24	$0.38	$0.57	$0.770
25 - 29	$0.51	$0.54	
30 - 34	$0.76	$0.67	
35 - 39	$1.19	$0.90	
40 - 44	$1.81	$1.34	
45 - 49	$2.71	$2.13	
50 - 54	$4.02	$3.17	
55 - 59	$5.60	$4.80	
60 - 64	$6.94	$6.81	
65 - 69	$10.03	$9.56	
70 - 74	$18.96	$18.09	
75+	$58.62	$55.90	
AD&D	$0.270	$0.150	$0.150

Long Term Disability Insurance

Administered by UNUM

Washington Institute for Coagulation DBA: WACBD offers group Long-term Disability coverage for those unexpected situations that may keep you from performing the daily responsibilities of your job. Your disability plan is designed to help supplement your income if you are unable to work for an extended period of time.

How it Works	Who Pays for the Benefit
You will receive **60%** of your income up to **$6,000** per month in the event that you become disabled for over **90** days. You must meet the definition of disability as stated in the contract. This benefit may be offset by other income sources, such as Workers' Compensation and Social Security. Should you become permanently disabled, this benefit will continue until your Social Security Normal Retirement Age or until you are no longer disabled.	Washington Institute for Coagulation DBA: WACBD

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local Human Resources department.

Benefit	Vendor	Policy Number	Phone	Website or Email
Medical	Premera Blue Cross	4020847; 4010847	1-800-722-1471	www.premera.com
Dental	Delta Dental of Washington	14626	(800) 554-1907	www.deltadentalwa.com
Vision	Vision Service Plan	30101122	1 (800) 877-7195	www.vsp.com
Health Savings Account	Premera Blue Cross/Optum	4020847; 4010847	(800) 722-4714	www.premera.com
Life and AD&D	UNUM	704035 012	1 (866) 679-3054	www.unum.com
Voluntary Life and AD&D	UNUM	704036	1 (866) 679-3054	www.unum.com
Long-Term Disability	UNUM	070435	1 (866) 679-3054	www.unum.com

Name	Title	Phone	Email
Kim Snyder	Chief Financial Officer/COO	2066819071 ext 1031	Kim.Snyder@WACBD.org

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WOMEN'S HEALTH & 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 the plan. Therefore, the following deductibles and coinsurance apply:

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Choice 1500 Gold, Choice HAS Qualified 1500 Gold.

If you would like more information on WHCRA benefits, please call your Plan Administrator at 1 (800) 722-1471.

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website:https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone:(678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website:https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website:https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance PremiumPayment Program(KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website:https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website:www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone:1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance PremiumWebpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website:https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website:http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website:https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website:http://www.insureoklahoma.org Phone: 1-888-365-3742	Website:http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website:Children's HealthInsurance Program(CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website:http://www.eohhs.ri.gov/ Phone:1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website:https://www.scdhhs.gov Phone: 1-888-549-0820	Website:http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance PremiumPayment (HIPP)Program| Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website:https://medicaid.utah.gov/ CHIP Website:http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website:HealthInsurance PremiumPayment (HIPP) Program | Department of Vermont HealthAccess Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website:https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website:https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
Washington Institute for Coagulation is committed to the privacy of your health information. The administrators of the Premera Blue Cross Choice 1500 Gold and Premera Blue Cross Choice HSA Qualified 1500 Gold (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Kim Snyder at 2066819071 ext 1031 or Kim.Snyder@WACBD.org.

HIPAA SPECIAL ENROLLMENT RIGHTS

Premera Blue Cross Choice 1500 Gold and Premera Blue Cross Choice HSA Qualified 1500 Gold Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Premera Blue Cross Choice 1500 Gold and Premera Blue Cross Choice HSA Qualified 1500 Gold (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Kim Snyder at 2066819071 ext 1031 or Kim.Snyder@WACBD.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Washington Institute for Coagulation

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 Washington Institute for Coagulation 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. **Washington Institute for Coagulation has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Washington Institute for Coagulation coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Washington Institute for Coagulation coverage, be aware that you and your dependents will not be able to get this coverage back.

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 Washington Institute for Coagulation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Washington Institute for Coagulation 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).

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).

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Date:	**12/01/2023**
Name of Entity/Sender:	**Washington Institute for Coagulation**
Contact—Position/Office:	**Kim Snyder**
Office Address:	**921 Terry Ave Ste A** **Suite 1900, Seattle, WA 98104-1239**
Phone Number:	**2066819071 ext 1031**

MARKETPLACE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Gallagher

Insurance | Risk Management | Consulting

Washington Institute for Coagulation
DBA: WACBD,
December 1, 2023 – November 30, 2024

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting