

EMPLOYEE BENEFITS

July 1, 2017 - June 30, 2018



NORTHWEST
INDIAN COLLEGE
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WELCOME TO YOUR BENEFITS!

This benefits guide is intended to assist you and your family in understanding and accessing your benefits. We know that occasionally you may need additional information or further explanation about the contents of this booklet. You are welcome to contact any member of Human Resources at your convenience. This booklet will cover information regarding the following:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Short-Term Disability
- Long-Term Disability
- Life and AD&D
- Supplemental Life and AD&D

Please note, this document is presented as a matter of information and is not intended to constitute a promise or contractual commitment by the company. The company reserves the right to unilaterally change or terminate any or all of the programs discussed herein, as well as all of its benefit plans and programs, at any time and without prior notice. Also, modifications may be necessary to comply with applicable legal requirements. In the event of any inconsistency between a statement contained in this document and the relevant plan document or summary plan description, the plan document or summary plan description will control this document.

If you have questions about your benefits or if you need assistance with claims resolution, we have a dedicated Employee Benefit Support service provided by AHT Insurance. Your Employee Benefit Support is available to provide confidential assistance for you and your covered family members. Please see the contact page at the end of this guide.



ELIGIBILITY

Employee

All eligible employees scheduled to work 21 or more hours per week are eligible for benefits. Coverage will begin on the first of the month following 60 days of employment after a 30 day orientation period.

Dependents

You may cover your eligible dependents, which include the following:



- Your legal spouse
- Your domestic partner*
- Your children up to the age of 26 (includes step children living at your address and/or for whom you have financial responsibility)
- Any dependent child who is incapable of self-support because of a physical or mental disability

*Benefits are extended to domestic partners; however, the value of these benefits must be included in your gross income and subject to federal income tax and FICA tax (unless the domestic partner is your tax dependent). This means a portion of your benefit contribution (the difference between the cost to cover you plus your domestic partner and the cost to cover just you) is deducted from your pay after taxes have been applied (referred to as "post tax"). It also means the premium your employer is paying on your behalf when you choose to cover your domestic partner is added to your taxable income. For more information, please contact Human Resources.

When can you enroll?

You can sign up for benefits at any of the following times:

- After completing initial eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

Qualified Life Event Changes

You may make changes to your healthcare and insurance benefits choices once a year during the Open Enrollment period. All benefits you select will be effective until our next renewal, unless you have a "qualified change in status" or leave employment. Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

- Marriage
- Divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you have a qualified life event, you must timely notify Human Resources and complete the necessary forms. For more information, refer to your benefits booklets.

STAYING HEALTHY

Medical Benefits Overview



The information below is a high-level overview of medical coverage only. Please see Human Resources for plan summaries detailing coverage information, limitations, and exclusions. Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which you are responsible. **Medical benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.**

Carrier

Regence

Carrier	Preferred/Participating/Non-Contractual and Out-of-Area (US Only) Providers	Out-of-Network Providers
Provider Network		
Calendar Year Deductible		\$200 Individual \$400 Family
Out-of-Pocket Limit (OOP limit) Includes Deductible, Coinsurance, and Copays		\$2,200 Individual \$4,400 Family
Coinsurance Carrier / Member	80%/20%	80%/20%
Office Visits		
Office Visit	\$20 copay, deductible waived	20% after deductible
Chiropractic 10 visits per calendar year	\$20 copay, deductible waived	20% after deductible
Acupuncture 8 visits per calendar year	\$20 copay, deductible waived	20% after deductible
Mental Health	\$20 copay, deductible waived	20% after deductible
Urgent Care	\$20 copay, deductible waived	20% after deductible
Preventive Care		
Office Visit, Screenings, Immunizations	Covered in full	20% after deductible
Hearing Exam Once per calendar year	Covered in full	20% after deductible
Lab & X-Ray		
Diagnostic Testing		20% after deductible
Imaging CT, PET Scans, MRIs		20% after deductible
Anesthesiologist		20% after deductible
Allergy Injections	Covered in full	20% after deductible
Rehabilitation		
Outpatient Physical / Occupational Therapy 60 visits per calendar year	\$20 copay, deductible waived	20% after deductible
Mental Health		
Inpatient (Mandatory pre-authorization)		20% after deductible
Outpatient Visit	\$20 copay, deductible waived	20% after deductible
Inpatient Facility and Inpatient Physician		
		20% after deductible

STAYING HEALTHY CONTINUED...

Medical Benefits Overview



The information below is a high-level overview of medical coverage only. Please see Human Resources for plan summaries detailing coverage information, limitations, and exclusions. Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which you are responsible. **Medical benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.**

Carrier

Rehabilitation

Chemical Dependency and Detoxification

Dietary Education

Durable Medical Equipment, Prosthetics

Prescription Drugs

Emergency Room

Regence

Carrier	Preferred/Participating/Non-Contractual and Out-of-Area (US Only) Providers	Out-of-Network Providers
Provider Network		
Rehabilitation		
Inpatient Rehabilitation 60 days per calendar year		20% after deductible
Outpatient Physical / Occupational Therapy 60 visits per calendar year	\$20 copay, deductible waived	20% after deductible
Chemical Dependency and Detoxification		
Inpatient (Mandatory pre-authorization)		20% after deductible
Outpatient	\$20 copay, deductible waived	20% after deductible
Dietary Education	Covered in full	20% after deductible
Durable Medical Equipment, Prosthetics		20% after deductible
Prescription Drugs	Generic/Preferred Brand/Non-Preferred Brand	
Retail Pharmacy - 30 day supply		\$10/\$20/\$35
Mail Order - 90 day supply		\$25/\$50/\$87.50
	Many pharmacies offer generic prescriptions for \$4 (or other reduced prices) per prescription for up to a 30 day supply. Please check with your pharmacy to review a list of generics the pharmacy may offer at \$4 or other reduced prices.	
Emergency Room		\$75 copay then 20% after deductible Copoly waived if admitted Non-Emergency is not covered

- **PCY:** Per calendar year
- **Balance billing** may apply if a provider is not contracted. Members are responsible for amounts in excess of the allowable charge.
- **Pre-Authorization:** Services for Infusion Therapy, Kidney Dialysis and all Inpatient Treatment (including but not limited to facility, surgery, rehabilitation, residential treatment) must be pre-authorized by HMA's Health Services Department prior to services being rendered. Failure to pre-authorize services may result in denial of claim; the only exception is emergent treatment in the emergency room.

STAYING HEALTHY

Dental Benefits Overview



Great oral health is an essential part of a healthy lifestyle. Your teeth and gums are important for almost everything you do in a day - from speaking and eating to living without pain. It can help you manage diabetes, dramatically reduce hospitalizations and medical costs and stop dental conditions before they become major problems.

The information below is a summary of dental coverage only. Please see Human Resources for plan summaries detailing coverage information, limitations and exclusions. Coinsurance percentages shown in the chart below are amounts for which you are responsible.

Carrier

Delta Dental

Carrier	Delta Dental PPO Providers	Delta Dental Premier/Out-of-Network Providers
Provider Network		
Calendar Year Deductible	\$25 Individual \$75 Family Waived for Class 1 services	
Calendar Year Benefit Maximum <i>Max carrier will pay per calendar year</i>	\$2,000 Individual (Base Plan) \$3,000 Individual (Buy-Up Plan)	
Coinsurance		
Class I (Preventive)	0%	20%
	Oral exam, X-Ray, oral prophylaxis, fluoride, sealants, space maintainers, periodontal maintenance Deductible waived	
Class II (Basic)	10%	30%
	Amalgam fillings, extractions, periodontal, scaling, maintenance, surgery, maintenance, general anesthesia, root canal	
Class III (Major)	20%	50%
	Crowns, inlays, onlays, dentures, restoration, implantology	
Orthodontia - Buy Up Plan Only		
Lifetime Maximum (Children Only)	50% up to a lifetime maximum of \$1,000 (Buy-Up Plan)	
Out-of-Network Coinsurance <i>May Be Balance Billed</i>	20%/30%/50%	
Out-of-Network Reimbursement	Out-of-Network paid at maximum allowable	

- **Balance billing** may apply if a provider is not contracted. Members are responsible for amounts in excess of the allowable charge.
- **Pre-Treatment Estimate:** If your dental work will be extensive, you should have your dentist submit the proposed treatment plan to the insurance company before you begin treatment. The insurance company will provide you with a summary of the plan's coverage and your estimated out-of-pocket costs.

STAYING HEALTHY

Vision Benefits Overview



Good visual health plays an extremely important role in contributing to overall health. Periodic eye examinations are an important part of routine preventive healthcare. Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss. Vision care is essential to maintaining a healthy lifestyle. Eye exams can detect symptoms of diseases such as diabetes, hypertension, multiple sclerosis, brain tumors, osteoporosis and rheumatoid arthritis.

The information below is a summary of vision coverage only. Please see Human Resources for plan summaries detailing coverage information, limitations and exclusions.

Carrier

Provider Network

Plan Copays

Eye Exam

Hardware
(lenses and frames)

Contacts
(standard fitting and evaluation)

Benefit Frequency

Eye Exam

Lenses

Frames

Contacts (in lieu of glasses)

Benefit Allowances

Exam

Frames

Lenses

Single

Lined Bifocals

Lined Trifocals

Elective Contacts (in lieu of lenses)

Lens Treatments

Anti-reflective Coating

Standard Progressive Lenses

Scratch Resistant Coating

Buy-Up Plan

Vision Service Plan

Choice Network Providers

Out-of-Network Providers

\$10 copay

\$25 copay

\$25 copay

Every 12 months

Every 12 months

Every 24 months

Every 12 months

Based on when services are first rendered

Covered in full

Up to \$45

Up to \$120

Up to \$75

Covered in full

Up to \$30

Covered in full

Up to \$50

Covered in full

Up to \$65

Up to \$120 including exam and fitting

Up to \$105 including exam and fitting

Discounted

Not covered

Up to Bifocal allowance

Up to \$75

Discounted

Not covered

Same as Base Coverage except frames limited to once every 12 months (frame up to \$150).

Lens treatments covered in full (anti-reflective coating, progressive and photochromatic) by VSP Choice Network provider. Non-VSP Choice Network provider reimbursements are the same as the Core coverage.

- If you choose to go to an out-of-network provider, you will have to submit a reimbursement claim form which can be found on www.vsp.com.

PLANNING FOR THE UNEXPECTED

Short-Term Disability

Short-Term Disability (STD) insurance pays a percentage of your salary if you become temporarily disabled, meaning that you are not able to work for a short period of time due to sickness or injury (excluding on-the-job injuries, which are covered by workers compensation insurance). Please see Human Resources for plan summaries detailing coverage information, limitations and exclusions.

Carrier	Unum
Weekly Benefit Amount	60%
Maximum Weekly Benefit	\$500
Benefits Begin on	
Illness	8th day
Accident	8th day
Duration of Benefits	11 weeks



Long-Term Disability

In the event that your illness or injury continues beyond your Short-Term Disability benefits, you may be eligible for Long-Term Disability benefits. The duration of benefits depends on your age when the disability occurs due to coordination of disability with Social Security retirement and/or disability benefits.

Carrier	Unum
Monthly Benefit Amount	60%
Maximum Monthly Benefit	\$2,500
Benefits Begin on	91st day
Duration of Benefits	If you are prevented from performing the material and substantial duties of your regular occupation, LTD will continue up to Normal Retirement age or until you are no longer disabled. To qualify, at least 20% income loss is required.

Pre-Existing Condition Exclusions Disabilities related to an injury or illness for which you have consulted a physician, received medical attention, taken prescription drugs or medicines, or incurred expenses during the 90 days prior to the coverage effective date are excluded if you become disabled during the first 12 months of coverage.

PLANNING FOR THE UNEXPECTED

Basic Life and AD&D

Life insurance can be used to help replace the lost income so the survivor can maintain the same standard of living. Basic Life insurance and Accidental Death and Dismemberment (AD&D) coverage is provided at no cost to you. Please see Human Resources for plan summaries detailing coverage information, limitations and exclusions.

Carrier	Unum
Life and AD&D	\$10,000 - All active employees working a minimum of 25 hours per week.
Benefit Reduction Schedule	To 65% at age 70; to 50% at age 75

Supplemental Life and AD&D

Carrier	Unum	Guarantee Issue
	Maximum Amount	
Employee	Increments of \$10,000 not to exceed the lesser of 5x annual earnings or \$500,000	\$200,000
Spouse	Increments of \$5,000 up to \$250,000	\$25,000
Child	Increments of \$2,000 up to \$10,000 (Live birth to 6 months is \$1,000)	\$10,000

Guarantee Issue, the maximum you can receive without completing an Evidence of Insurability form.

Evidence of Insurability

New employees are able to elect up to Guarantee Issue without medical underwriting within 31 days of their eligibility date. Existing employees participating in the Supplemental Life program can elect up to Guarantee Issue without medical underwriting between 6/01 - 6/30 of each year for a 7/01 effective date.

Age Band	Employee Rate per \$10,000	Spouse Rate per \$5,000	Child Rate per \$2,000
0-24	\$0.500	\$0.250	Life Rate \$0.060
25-29	\$0.500	\$0.250	AD&D Rate \$0.040
30-34	\$0.610	\$0.305	
35-39	\$0.910	\$0.455	
40-44	\$1.400	\$0.700	
45-49	\$2.270	\$1.135	
50-54	\$3.750	\$1.875	
55-59	\$5.950	\$2.975	
60-64	\$7.920	\$3.960	
65-69	\$12.610	\$6.305	
70-74	\$22.110	\$11.055	
75+	\$39.320	\$19.660	
AD&D Rates	\$0.020	\$0.010	



Benefit Reduction Schedule is based on employee's age for both employee and spouse reductions.

LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please contact HR.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Enrollment Notice

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

UNDERSTANDING COBRA

Common Questions

What is COBRA?

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA is a federal statute that requires employers to provide employees and their dependents who lose coverage under a group health plan maintained by the employer, as a result of a qualifying event, with an opportunity to continue group health insurance coverage.

What employers are subject to COBRA?

Employers who employed 20 or more employees on more than 50 percent of the business days in the prior calendar year are subject to COBRA. Small-employer plans, church plans, and governmental plans are not subject to COBRA. However, state and local governments are required to comply with parallel continuation coverage requirements under the Public Health Service Act. Individuals covered under the Federal Employees Health Benefit Program are provided with similar, but not identical, rights to continue coverage.

Pursuant to COBRA, who is a qualified beneficiary?

A qualified beneficiary is any individual who, on the day before the qualifying event, is covered under a health plan by virtue of being on that day either:

- An employee;
- A spouse of a covered employee;
- A dependent child of the covered employee*; or
- Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.

*A child covered under the plan pursuant to a qualified medical child support order (QMCSO) will also be a qualified beneficiary if he or she experiences a qualifying event.

Each qualified beneficiary has an independent right to elect COBRA. For example, if an employee and his spouse were covered under the health plan on the day before the qualifying event, the spouse may elect COBRA even if the employee declines coverage.

What is a COBRA qualifying event?

A qualifying event is any of a set of specified events that occur while a health plan is subject to COBRA and that results in a loss of coverage to a covered employee, covered spouse of a covered employee or a covered dependent child of a covered employee.

The specified events are:

- Termination of employment or reduction of hours of the covered employee (other than by reason of gross misconduct);
- Death of a covered employee;
- Divorce or legal separation of a covered employee from the covered employee's spouse;
- A covered employee becoming entitled to Medicare benefits; and
- A dependent child ceasing to be a dependent child under the terms of the health plan

A qualifying event must: a) result in a loss of coverage; and b) be a result of one of the above specified events. Note that, although the employee's Medicare entitlement is a permissible qualifying event under COBRA, it will rarely cause a loss of coverage due to the Medicare secondary payer rules. Therefore, the employee's Medicare entitlement is usually not a true qualifying event.

What is an election period under COBRA?

Individuals that experience a qualifying event must be provided with an opportunity to elect COBRA continuation coverage at any time during the election period. An election period must be at least 60 days long.

The election period ends on the later of sixty days following: a) the date coverage under the plan terminates; or b) the date on which the qualified beneficiary receives notice from the Plan Administrator.

A qualified beneficiary's election is deemed to be made on the date it is sent to the employer or Plan Administrator.

This is a brief explanation of COBRA. Please see Human Resources for more details or visit

<http://www.dol.gov/dol/topic/health-plans/cobra.htm>. 10

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	FLORIDA – Medicaid Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
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	GEORGIA – Medicaid Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
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+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	IOWA – Medicaid Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	NEW HAMPSHIRE – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	NEW JERSEY – Medicaid and CHIP 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
LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	NEW YORK – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	NORTH CAROLINA – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

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

MASSACHUSETTS – Medicaid and CHIP

Website: <http://www.mass.gov/eohhs/gov/departments/mashealth/>

Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: <http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.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://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx

Phone: 1-855-632-7633

NEVADA – Medicaid

Medicaid Website: <http://dwss.nv.gov/>

Medicaid Phone: 1-800-992-0900

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

Medicaid Website:

http://www.coverva.org/programs_premium_assistance.cfm

Medicaid Phone: 1-800-432-5924

CHIP Website:

http://www.coverva.org/programs_premium_assistance.cfm

CHIP Phone: 1-855-242-8282

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>

<http://www.oregonhealthcare.gov/indexes.html>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:

<http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>

Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>

Phone: 1-888-549-0820

WASHINGTON – Medicaid

Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>

Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website:

<http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx>

Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website:

<https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>

Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/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

BENEFIT DEFINITIONS

In-Network

Consider your health care options highlighted in this guide. Some plans give you the freedom to use any health care provider of your choice. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying the difference between the Reasonable and Customary (R&C) charges and what the provider charges. R&C charges are set by the insurance carrier and are the amounts that are generally considered reasonable based on what most providers charge for a particular service in a geographic area.

Copayments and Coinsurance

A copayment (copay) is the fixed dollar amount you pay for certain in-network services. In some cases, you may be responsible for coinsurance after copay is made.

Coinsurance is the percentage of covered expenses shared by the employee and the plan. In some cases, coinsurance is paid after the insured meets a deductible. For example, if you pay 20% of an in-network covered charge, the plan pays 80%.

Annual Deductible

Your annual deductible is the amount of money you must first pay out-of-pocket before your plan begins paying for services covered by coinsurance. Some services, such as office visits, require copays and do not apply to the deductible.

After you meet your deductible, the plan pays for a percentage of eligible expenses (coinsurance) until you meet your out-of-pocket maximum. If you receive services from an out-of-network provider, the plan pays a lower percentage of coinsurance. Refer to your health care plan summaries for more information.

Out-of-Pocket Maximum

Some plans feature an out-of-pocket maximum, which limits the amount of coinsurance you will pay for eligible health care expenses. Once you reach that maximum, the plan begins to pay 100% of eligible expenses. There may be separate in- and out-of-network annual out-of-pocket maximums. Generally, copays, R&C charges, and deductibles do not apply to your out-of-pocket maximum.

Preventive Care Services

Preventive care is covered in-network at 100% for those services that are generally linked to designated routine wellness exams and screenings. Examples of preventive care include:

- Annual routine physicals, immunizations
- Bone-density tests, cholesterol screening
- Mammograms, pap smears, pelvic exams, PSA exams
- Sigmoidoscopies, colonoscopies

There may be limits on how often you can receive preventive care treatments and services. You should ask your health care provider whether your visit is considered preventive or non-preventive care.

STILL HAVE QUESTIONS?

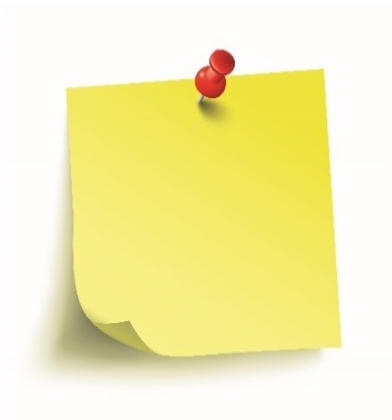
We encourage all of our employees and their families to become familiar with your benefits. If you do not find what you need, please use the following contact information to speak directly with a benefits professional that can better serve you. Employee Benefit Support is available Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Standard Time.



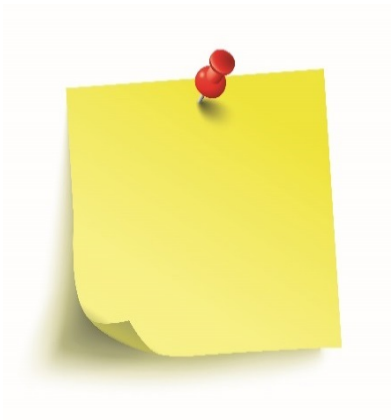
All calls are confidential and monitored until resolution. Due to HIPAA Privacy, EBS may need to obtain your written authorization in order to assist with certain issues. If needed, an authorization form will be provided to you. You can always contact the providers directly as well.

Benefit	Carrier	Customer Service Information	
Employee Benefit Support	AHT Insurance	Benefit Support:	Stephanie Stone
		Phone:	206.336.2993
		Email:	sstone@ahtins.com
Medical	Healthcare Management Administrators, Inc.	Group Number:	020267B
		Customer Service:	800.869.7093
		Network:	Preferred Provider Network
		Website:	www.accesshma.com
Medical PPO Network	Regence Blue Shield	Group Number:	020267B
		Customer Service:	888.367.2112
		Network:	Regence PPO
		Website:	www.regence.com
Pharmacy	CVS Caremark	Group Number:	24079002
		Customer Service:	866.885.4944
		Website:	www.caremark.com
Dental	Delta Dental	Group Number:	00707
		Customer Service:	800.554.1907
		Network:	Delta Dental PPO
		Website:	www.deltadentalwa.com
Vision	Vision Service Plan administered by Ameritas	Group Number:	010-350732
		Customer Service:	800.877.7195
		Network:	Choice Network
		Website:	www.vsp.com
Short-Term Disability Long-Term Disability Life and AD&D	Unum	Group Number:	614168
		Customer Service:	866.679.3054
		Website:	www.unum.com
Supplemental Life and AD&D	Unum	Group Number:	614169
		Customer Service:	866.679.3054
		Website:	www.unum.com
Employee Assistance Program	Life Balance	User ID and Password:	lifebalance
		Phone:	800.854.1446
		Website:	www.lifebalance.net
Human Resources	Northwest Indian College	Phone:	360.392.4268
		Website:	www.nwic.edu

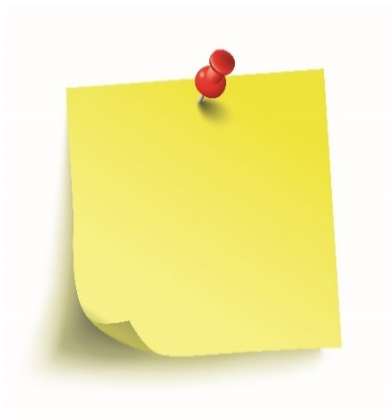
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