EMPLOYEE BENEFITS

July 1, 2018 - June 30, 2019

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

Employees eligible for benefits are those who work at least 21 hours per week. The benefit start dates are as follows:

- Non-Contract (Classified) Employees - Eligible on the first day of the month following completion of the 90 day probationary period.
- Contract (Administrative, Exempt and Faculty) Employees - Eligible on the first of the month following the hire date.

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	
Provider Network	Preferred/Participating/Non-Contractual and Out-of-Area (US Only) Providers	Out-of-Network Providers
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
Urgent Care	$20 copay, deductible waived	
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
Mental Health		
Inpatient (Mandatory pre-authorization)	20% after deductible	
Outpatient Visit	$20 copay, deductible waived	20% after deductible
Inpatient Facility and Inpatient Physician (Mandatory pre-authorization)	20% after deductible	

STAYING HEALTHY CONTINUED...

Medical Benefits Overview

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Carrier	Regence	
Provider Network	Preferred/Participating/Non-Contractual and Out-of-Area (US Only) Providers	Out-of-Network Providers
Rehabilitation		
Inpatient Rehabilitation 60 days per calendar year (Mandatory pre-authorization)	20% after deductible	
Outpatient Physical Therapy / Occupational Therapy / Massage 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 Copay 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	
Provider Network	Delta Dental PPO Providers	Delta Dental Premier/Out-of-Network Providers
Calendar Year Deductible	$25 Individual $75 Family Waived for Class 1 services	
Calendar Year Benefit Maximum *Max carrier will pay per calendar year*	$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 May Be Balance Billed	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	Vision Service Plan	
Provider Network	Choice Network Providers	Out-of-Network Providers
Plan Copays		
Eye Exam	$10 copay	
Hardware (lenses and frames)	$25 copay	
Contacts (standard fitting and evaluation)	$25 copay	
Benefit Frequency		
Eye Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Contacts (in lieu of glasses)	Every 12 months	
Benefit Allowances	Based on when services are first rendered	
Exam	Covered in full	Up to $45
Frames	Up to $120	Up to $70
Lenses		
Single	Covered in full	Up to $30
Lined Bifocals	Covered in full	Up to $50
Lined Trifocals	Covered in full	Up to $65
Elective Contacts (in lieu of lenses)	Up to $120 including exam and fitting	Up to $105 including exam and fitting
Lens Treatments		
Anti-reflective Coating	Discounted	Not covered
Standard Progressive Lenses	Up to In-Network Lined Bifocal allowance	Up to Out-of-Network Lined Bifocal allowance
Scratch Resistant Coating	Discounted	Not covered
Buy-Up Plan	Same as Base Coverage except: 1) Frames limited to once every 12 months 2) Frame up to $150 for In-Network and $75 for Out-of-Network 3) Lens treatments covered in full for VSP Choice Providers (anti-reflective coating, progressive and photochromatic)	

- 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 21 hours per week.
Benefit Reduction Schedule	To 65% at age 70; to 50% at age 75

Supplemental Life and AD&D

Carrier	Unum	
	Maximum Amount	**Guarantee Issue**
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
0-24	$0.500	$0.250
25-29	$0.500	$0.250
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

Child Rate per $2,000	
Life Rate	$0.060
AD&D Rate	$0.040

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.

If there is a loss of coverage based on loss of Medicaid or CHIP eligibility, you have 60 days from the date of the loss to request enrollment.

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.

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.

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, 2018. 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)

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
State Relay 711

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid

Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003 / TTY: Maine relay 711

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

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: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid

Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

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

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
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/masshealth/

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://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

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

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059
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
Phone: 855-697-4347

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://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

OMB Control Number 1210-0137 (expires 12/31/2019)

To see if any other states have added a premium assistance program since January 31, 2018, 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.

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

LIBC Group Health Plan (the "Plan") provides health benefits to eligible employees of Lummi Indian Business Council, Northwest Indian College, Silver Reef Hotel, Casino Spa and Lummi Commercial Company ("we"), and their eligible dependents. The Plan creates, receives, uses, maintains, and discloses health information about Plan participants ("you"). The Plan has adopted policies to safeguard the privacy of your health information and comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Notice is effective July 1, 2018 and remains in effect until we change or replace it.

This Notice describes how your protected health information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law. It also describes the Plan's responsibilities and your rights with respect to your PHI.

Generally, PHI is health information, including demographic information, collected from you or created or received by a healthcare provider, a healthcare clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health or condition;
- The provision of healthcare to you; or
- The past, present, or future payment for the provision of healthcare to you.

The Plan's Responsibilities

The Plan is required by law to:

- Ensure that health information that identifies you is kept private, except as such information is required or permitted to be disclosed by law;
- Describe the Plan's responsibilities and privacy practices with respect to your PHI;
- Abide by the terms of this Notice as currently in effect; and
- Inform you in the event of a breach of your unsecured PHI.

How the Plan May Use and Disclose Your Information

The Plan and its business associates, which are service providers that assist us in administering the Plan or providing Plan services to you, use and disclose PHI in the ways described below. For purposes of this Notice, "the Plan" includes its business associates. We will not use or share your information other than as described in this Notice.

In order to administer your Plan coverage effectively, the Plan is permitted by law to use and disclose your PHI in certain ways without your authorization. The following list describes the ways that the Plan is legally allowed or required to use and disclose your PHI without your prior written authorization:

For treatment

To ensure that you receive appropriate treatment and care, the Plan may use and disclose your PHI to coordinate care between the Plan and your provider. For example, we may disclose your PHI to healthcare providers for their treatment activities.

For payment

To ensure that claims are paid accurately and you receive the correct benefits, the Plan may use and disclose your PHI to determine plan eligibility and responsibility for coverage and benefits. For example, the Plan may use and disclose your PHI when it confers with other health plans to resolve a coordination of benefits issue. The Plan may also use your PHI for utilization review activities.

For healthcare operations

To ensure quality and efficient plan operations, the Plan may use and disclose your PHI in several ways, including plan administration, quality assessment and improvement, vendor review and for health care fraud and abuse detection and compliance. For example, the Plan may use and disclose your PHI to assist in the evaluation of a vendor who supports the Plan for underwriting and related purposes. The Plan is not allowed to use genetic information to decide whether to give you coverage or the price of that coverage.

Disclosures to the plan sponsor

For the purpose of administration, the Plan may disclose PHI to certain employees of the Plan Sponsor Lummi Nation. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Other Permitted Uses and Disclosures

Federal regulations allow us to use and disclose your PHI, without your authorization, for several additional purposes, in accordance with federal and state law:

- To a coroner or medical examiner;
- To cadaveric organ, eye or tissue donation programs;
- For research purposes, as long as certain privacy-related standards are satisfied;
- Public health;
- Reporting and notification of abuse, neglect or domestic violence;
- Oversight activities of a health oversight agency;
- Judicial and administrative proceedings;
- Law enforcement;
- To avert a serious threat to health or safety;
- Specialized government functions (for example, military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations);
- Workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness; and
- Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law.

Also, for health and safety, and when consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Uses and Disclosures that you May Authorize

The following uses and disclosures will only be made with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute a sale of PHI;
- Most uses and disclosures of psychotherapy notes; and
- Other uses and disclosures not otherwise described in this Notice.

You may revoke your authorization in writing at any time by contacting us. (See "How to Contact Us" below.) Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon your written authorization and prior to receiving your revocation. We also may continue to use and disclose your PHI after revocation if the authorization was obtained as a condition of securing insurance and other law provides us with the right to contest a claim under

the policy or the policy itself. Finally, if applicable state law provides you greater rights or protections concerning your PHI, we will follow such laws.

Your Rights

You have certain rights regarding access to, and the use and disclosure of your PHI as described below. To exercise any of these rights, contact us. (See "How to Contact Us" below.) Specifically, you have the right to:

Inspect and copy

You have the right to inspect your PHI. Any request for access to your health information should be sent to us in writing. (See "How to Contact Us" below.) If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. We may deny your request in writing in certain, very limited circumstances. We may charge a reasonable, cost-based fee. If you are denied access, you may request that the denial be reviewed by submitting a written request to us.

Amend

You have the right to request to amend your PHI if you think it is incorrect or incomplete. You must provide the request and your reason(s) for the request in writing to us. (See "How to Contact Us" below.) You will be notified in writing if your request is denied. If your request is denied, you have the right to submit a written statement disagreeing with the denial, which will be appended or linked to the health information in question.

Receive an accounting of disclosures

You have the right to request a list of certain disclosures of your PHI that the Plan or our business associates have made. We will include all of the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you have asked us to make). Your request must be made in writing and state the time period of the request, which may not be longer than six years prior to your request. The first request within a 12-month period will be provided to you free of charge, and any additional requests within this time period may be subject to a reasonable, cost-based fee. The Plan will notify you prior to charging a fee, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Be notified of a breach

You have the right to be notified in the event that the Plan discovers a breach of unsecured PHI.

Personal representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Obtain a copy of this Notice

You have a right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time, even if you have previously agreed to receive the Notice electronically.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, see "How to Contact Us" below. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plan.

How to Contact Us

The Plan has designated Lummi HR Department as its contact person for all issues regarding the Plan's privacy practices and your privacy rights at Lummi Nation, 2665 Kwina Road, Bellingham WA 98226, 360-312-2023.

STILL HAVE QUESTIONS?

We encourage all of our employees and their families to become famili 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 Standar 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: Phone: Email:	Stephanie Stone 206.336.2993 sstone@ahtins.com
Medical	Healthcare Management Administrators, Inc.	Group Number: Customer Service: Network: Website:	020267B 800.869.7093 Preferred Provider Network www.accesshma.com
Medical PPO Network	Regence Blue Shield	Group Number: Customer Service: Network: Website:	020267B 888.367.2112 Regence PPO www.regence.com
Pharmacy	CVS Caremark	Group Number: Customer Service: Website:	24079002 866.885.4944 www.caremark.com
Dental	Delta Dental	Group Number: Customer Service: Network: Website:	00707 800.554.1907 Delta Dental PPO www.deltadentalwa.com
Vision	Vision Service Plan administered by Ameritas	Group Number: Customer Service: Network: Website:	10-301733 800.877.7195 Choice Network www.vsp.com
Short-Term Disability Long-Term Disability Life and AD&D	Unum	Group Number: Customer Service: Website:	614168 866.679.3054 www.unum.com
Supplemental Life and AD&D	Unum	Group Number: Customer Service: Website:	614169 866.679.3054 www.unum.com
Employee Assistance Program	Life Balance	User ID and Password: Phone: Website:	lifebalance 800.854.1446 www.unum.com/lifebalance
Human Resources	Northwest Indian College	Phone: Website:	360.392.4230 www.nwic.edu


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