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 Accidental Death and Dismemberment
- Supplemental Life and Accidental Death and Dismemberment

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.
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.**

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Preferred / Participating / Non-Contractual and Out-of-Area (US Only) Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network</td>
<td>$1,500 Individual&lt;br&gt;$4,500 Family</td>
<td>$3,500 Individual&lt;br&gt;$10,500 Family</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>80%/20%</td>
<td>50%/50%</td>
</tr>
<tr>
<td>Out-of-Pocket Limit (OOP limit) Includes Deductible, Coinsurance, and Copays</td>
<td>Covered in full&lt;br&gt;(Flu shots covered in full)</td>
<td>Covered in full&lt;br&gt;50% after deductible</td>
</tr>
<tr>
<td>Coinsurance Carrier / Member</td>
<td>$35 copay, deductible waived</td>
<td>$35 copay, deductible waived</td>
</tr>
</tbody>
</table>

**Office Visits**

- **NEW** Telehealth through MDLive
- Acupuncture, Chiropractic, Massage Therapy
- No visit limit

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Outlay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$35 copay, deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$35 copay, deductible waived</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Preventive Care**

- Office Visit, Screenings, Immunizations
- Hearing Exam Once per calendar year
- Covered in full<br>(Flu shots covered in full) |

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Outlay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab &amp; X-Ray</td>
<td>Covered in full&lt;br&gt;20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>Covered in full&lt;br&gt;20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Imaging</td>
<td>Covered in full&lt;br&gt;20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>CT, PET Scans, MRIs</td>
<td>Covered in full&lt;br&gt;20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>Covered in full&lt;br&gt;20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>Covered in full&lt;br&gt;20% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

**Mental Health**

- Inpatient (Mandatory pre-authorization)
- Outpatient Visit $35 copay, deductible waived |

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Outlay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility and Inpatient Physician</td>
<td>Covered in full&lt;br&gt;20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Mandatory pre-authorization)</td>
<td>$35 copay, deductible waived</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

**NEW** Telehealth through MDLive
## 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.**

<table>
<thead>
<tr>
<th>Carrier Service</th>
<th>Out-of-Network Providers</th>
<th>Preferred / Participating / Non-Contractual and Out-of-Area (US Only) Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network</td>
<td>Out-of-Network Providers</td>
<td>Preferred / Participating / Non-Contractual and Out-of-Area (US Only) Providers</td>
</tr>
</tbody>
</table>

### Provider Network

#### Rehabilitation
- **Inpatient Rehabilitation**
  - 60 days per calendar year
  - (Mandatory pre-authorization)
  - 20% after deductible
  - 50% after deductible
- **Outpatient Physical Therapy / Occupational Therapy**
  - 60 visits per calendar year
  - $35 copay, deductible waived
  - 50% after deductible
- **Chemical Dependency and Detoxification**
  - Inpatient
    - (Mandatory pre-authorization)
    - 20% after deductible
    - 50% after deductible
  - Outpatient
    - $35 copay, deductible waived
    - 50% after deductible
    - Covered in full
    - 50% after deductible
- **Dietary Education**
- **Durable Medical Equipment, Prosthetics**
- **Prescription Drugs**
  - Retail Pharmacy - 30 day supply
  - Mail Order - 90 day supply
  - Generic / Preferred Brand / Non-Preferred Brand / Specialty
    - $10 / $25 / $50 / $75
    - $25 / $62.50 / $125

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**
  - **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.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>60 days per calendar year</td>
</tr>
<tr>
<td>Outpatient</td>
<td>60 visits per calendar year</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$35 copay, deductible waived</td>
</tr>
<tr>
<td>Occupational</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chemical</td>
<td>Inpatient</td>
</tr>
<tr>
<td>Detoxification</td>
<td>Outpatient</td>
</tr>
<tr>
<td>Dietary Education</td>
<td></td>
</tr>
<tr>
<td>Durable Equipment</td>
<td></td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
</tr>
<tr>
<td>Prescription</td>
<td>$10 / $25 / $50 / $75</td>
</tr>
<tr>
<td>Drugs</td>
<td>$25 / $62.50 / $125</td>
</tr>
<tr>
<td>Emergency Room</td>
<td></td>
</tr>
<tr>
<td>PCY</td>
<td></td>
</tr>
<tr>
<td>Balance billing</td>
<td></td>
</tr>
<tr>
<td>Pre-Authorization</td>
<td></td>
</tr>
</tbody>
</table>
With MDLIVE, you can visit with a doctor 24/7 from your home, office or on the go. Our network of Board Certified doctors is available by phone or secure video to assist with non-emergency medical conditions.

Who are the doctors?
MDLIVE has the nation’s largest network of telehealth doctors. On average, their doctors have 15 years of experience practicing medicine and are licensed in the state where patients are located. Their specialties include primary care, pediatrics, emergency medicine and family medicine. Their doctors are committed to providing convenient, quality care and are always ready to take your call.

When should I use MDLive?
- Instead of going to the ER or an urgent care center for a non-emergency issue
- During or after normal business hours, nights, weekends and even holidays
- If your primary care doctor is not available
- To request prescription refills (when appropriate)
- If traveling and in need of medical care

How much does it cost?
Free. It costs nothing to sign up and Lummi Nation covers the complete cost of your visit.

IMPORTANT: MDLive covers Medical visits only. Behavioral / Mental Health visits such as counseling are not currently a covered benefit for Lummi Nation. You are responsible for the full cost should you call regarding a Behavioral / Mental health condition.

Are your children eligible?
Yes. MDLIVE has pediatricians on call 24/7/365. Please note, a parent or guardian must be present during any interactions involving minors. They ask parents to establish a child record under their account. Parents must be present on each call for children 18 or younger.

Common conditions treated
- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Diarrhea
- Ear Infections
- Fever
- Headache
- Infections
- Insect Bites
- Joint Aches
- Rashes
- Respiratory Infections
- Sinus Infections
- Skin Infections
- Sore Throat
- Urinary Tract Infections
- And More!

MDLive Website: MDLIVE.com/hma
MDLive Phone: 877.596.0967
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.

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Delta Dental PPO Providers</th>
<th>Delta Dental Premier/Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network</td>
<td>$25 Individual ($75 Family Waived for Class 1 services)</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$2,000 Individual (Base Plan)</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Benefit Maximum</td>
<td>$3,000 Individual (Buy-Up Plan)</td>
<td></td>
</tr>
<tr>
<td>Max carrier will pay per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Coinsurance**

- **Class I (Preventive)**
  - 0%
  - Oral exam, X-Ray, oral prophylaxis, fluoride, sealants, space maintainers, periodontal maintenance
  - Deductible waived

- **Class II (Basic)**
  - 10%
  - Amalgam fillings, extractions, periodontal, scaling, maintenance, surgery, maintenance, general anesthesia, root canal

- **Class III (Major)**
  - 20%
  - Crowns, inlays, onlays, dentures, restoration, implantology

**Orthodontia - Buy Up Plan Only**

- Lifetime Maximum
  - (Children Only)

**Out-of-Network Coinsurance**

- May Be Balance Billed

**Out-of-Network Reimbursement**

- 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.
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.

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Vision Service Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network</td>
<td>Choice Network Providers</td>
</tr>
<tr>
<td><strong>Plan Copays</strong></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Hardware (lenses and frames)</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Contacts (standard fitting and evaluation)</td>
<td>$25 copay</td>
</tr>
<tr>
<td><strong>Benefit Frequency</strong></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Every 12 months</td>
</tr>
<tr>
<td>Lenses</td>
<td>Every 12 months</td>
</tr>
<tr>
<td>Frames</td>
<td>Every 24 months</td>
</tr>
<tr>
<td>Contacts (in lieu of glasses)</td>
<td>Every 12 months</td>
</tr>
<tr>
<td><strong>Benefit Allowances</strong></td>
<td>Based on when services are first rendered</td>
</tr>
<tr>
<td>Exam</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Frames</td>
<td>Up to $120</td>
</tr>
<tr>
<td>Lenses</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Single</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Lined Bifocals</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Lined Trifocals</td>
<td>Up to $120 including exam and fitting</td>
</tr>
<tr>
<td>Elective Contacts (in lieu of lenses)</td>
<td></td>
</tr>
<tr>
<td><strong>Lens Treatments</strong></td>
<td></td>
</tr>
<tr>
<td>Anti-reflective Coating</td>
<td>Discounted</td>
</tr>
<tr>
<td>Standard Progressive Lenses</td>
<td>Up to In-Network</td>
</tr>
<tr>
<td>Lined Bifocal allowance</td>
<td>Lined Bifocal allowance</td>
</tr>
<tr>
<td>Discounted</td>
<td>Same as Base Coverage except:</td>
</tr>
<tr>
<td></td>
<td>1) Frames limited to once every 12 months</td>
</tr>
<tr>
<td></td>
<td>2) Frame up to $150 for In-Network and $75 for Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>3) Lens treatments covered in full for VSP Choice Providers (anti-reflective coating, progressive and photochromatic)</td>
</tr>
<tr>
<td><strong>Buy-Up Plan</strong></td>
<td></td>
</tr>
</tbody>
</table>

- 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](http://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.

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Unum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Benefit Amount</td>
<td>60%</td>
</tr>
<tr>
<td>Maximum Weekly Benefit</td>
<td>$500</td>
</tr>
<tr>
<td>Benefits Begin on</td>
<td>8th day</td>
</tr>
<tr>
<td>Illness</td>
<td>8th day</td>
</tr>
<tr>
<td>Accident</td>
<td>8th day</td>
</tr>
<tr>
<td>Duration of Benefits</td>
<td>11 weeks</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Unum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Benefit Amount</td>
<td>60%</td>
</tr>
<tr>
<td>Maximum Monthly Benefit</td>
<td>$2,500</td>
</tr>
<tr>
<td>Benefits Begin on</td>
<td>91st day</td>
</tr>
<tr>
<td>Duration of Benefits</td>
<td>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.</td>
</tr>
</tbody>
</table>

**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.
**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.

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Unum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life and AD&amp;D</td>
<td>$10,000 - All active employees working a minimum of 21 hours per week.</td>
</tr>
<tr>
<td>Benefit Reduction Schedule</td>
<td>To 65% at age 70; to 50% at age 75</td>
</tr>
</tbody>
</table>

**Supplemental Life and AD&D**

<table>
<thead>
<tr>
<th>Carrier</th>
<th><strong>Maximum Amount</strong></th>
<th>Guarantee Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Increments of $10,000 not to exceed the lesser of 5x annual earnings or $500,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>Increments of $5,000 up to $250,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>Child</td>
<td>Increments of $2,000 up to $10,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Employee Rate per $10,000</th>
<th>Spouse Rate per $5,000</th>
<th>Child Rate per $2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-24</td>
<td>$0.50</td>
<td>$0.25</td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>$0.50</td>
<td>$0.25</td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>$0.610</td>
<td>$0.305</td>
<td></td>
</tr>
<tr>
<td>35-39</td>
<td>$0.910</td>
<td>$0.455</td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td>$1.400</td>
<td>$0.700</td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>$2.270</td>
<td>$1.135</td>
<td></td>
</tr>
<tr>
<td>50-54</td>
<td>$3.750</td>
<td>$1.875</td>
<td>Life Rate $0.060</td>
</tr>
<tr>
<td>55-59</td>
<td>$5.950</td>
<td>$2.975</td>
<td>AD&amp;D Rate $0.040</td>
</tr>
<tr>
<td>60-64</td>
<td>$7.920</td>
<td>$3.960</td>
<td></td>
</tr>
<tr>
<td>65-69</td>
<td>$12.610</td>
<td>$6.305</td>
<td></td>
</tr>
<tr>
<td>70-74</td>
<td>$22.110</td>
<td>$11.055</td>
<td></td>
</tr>
<tr>
<td>75+</td>
<td>$39.320</td>
<td>$19.660</td>
<td></td>
</tr>
<tr>
<td>AD&amp;D Rates</td>
<td>$0.020</td>
<td>$0.010</td>
<td></td>
</tr>
</tbody>
</table>

Benefit Reduction Schedule is based on employee's age for both employee and spouse reductions.
**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.
Pursuant to COBRA, who is a qualified beneficiary?

- 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, 2020. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Eligibility Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://myalhipp.com">http://myalhipp.com</a> Phone: 1-855-692-5447</td>
</tr>
<tr>
<td>ALASKA – Medicaid</td>
<td>Website: <a href="http://myakhipp.com">http://myakhipp.com</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
</tr>
<tr>
<td>ARKANSAS – Medicaid</td>
<td>Website: <a href="http://myarhipp.com">http://myarhipp.com</a> Phone: 1-855-MyARHIPP (855-692-7447)</td>
</tr>
<tr>
<td>CALIFORNIA – Medicaid</td>
<td>Website: <a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a> Phone: 1-800-541-5555</td>
</tr>
<tr>
<td>IOWA – Medicaid and CHIP (Hawki)</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/default.htm">http://www.kdheks.gov/hcf/default.htm</a> Phone: 1-800-792-4884</td>
</tr>
<tr>
<td>KANSAS – Medicaid</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/default.htm">http://www.kdheks.gov/hcf/default.htm</a> Phone: 1-800-792-4884</td>
</tr>
<tr>
<td>KENTUCKY – Medicaid</td>
<td>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: KIHIPP <a href="mailto:PROGRAM@ky.gov">PROGRAM@ky.gov</a> KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718 Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></td>
</tr>
<tr>
<td>MONTANA – Medicaid</td>
<td>Website: <a href="http://dhhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dhhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084</td>
</tr>
<tr>
<td>NEVADA – Medicaid</td>
<td>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900</td>
</tr>
</tbody>
</table>

If you or your dependents are eligible for premium assistance under Medicaid and the Children’s Health Insurance Program (CHIP) in Alabama, you may be eligible for assistance paying your employer health plan premiums. Contact your State Medicaid or CHIP office to find out if premium assistance is available.
<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOUISIANA</td>
<td>Medicaid</td>
<td><a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a></td>
<td>1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</td>
</tr>
<tr>
<td>MISSOURI</td>
<td>Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742 Phone: 573-751-2005</td>
</tr>
<tr>
<td>OREGON</td>
<td>Medicaid</td>
<td><a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a></td>
<td>1-800-699-9075</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td><a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a></td>
<td>1-888-549-0820</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.eohhs.ri.gov">http://www.eohhs.ri.gov</a></td>
<td>1-855-432-5924 Phone: 1-855-242-8262</td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>Medicaid and CHIP</td>
<td><a href="https://wysocialservices.gov/publications/p1/p10095.pdf">https://wysocialservices.gov/publications/p1/p10095.pdf</a></td>
<td>1-800-362-3002</td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**
Employee Benefits Security Administration
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)
1-777-267-2323, Menu Option 4, Ext. 61565
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, 2019 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

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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.
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.

Copayment
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.
BENEFITS CONTACT APP - STRIVE BENEFITS

All your benefit insurance contact information in one place

Need to look up a medical provider? Need to contact a benefit advocate to assist with benefit questions or claims issues? Want to know your high level overview of benefits?

First check on STRIVE, your online resource for Benefit Support!

**Benefit Contacts** – Call our broker, HR, or insurance company with questions. They're just a click away!

**Accessibility** – If you are at the dentist and have no idea what the name of your insurance plan is, check STRIVE first.

**Store Your ID cards** – Take a picture of your ID cards and email them to your doctor.

**Employee Benefit Guide** – Quickly glance through your benefits.

How to download Strive—Easy as A, B, C!

A. Download STRIVE BENEFITS from either the App Store or Google Play

B. Enter your service key (not case sensitive) and then press Login:

   **The Service Key is NWIC**

C. On the next screen enter your email address and create a six-digit code. Going forward you will just need your email address and six-digit code to access all your benefit contacts.

Q: What if I want my family members to use STRIVE?

A. Great! Ask them to download the app and use your email address and 6 digit code to login.
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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Carrier</th>
<th>Customer Service Information</th>
</tr>
</thead>
</table>
| General Employee Benefit Support | AHTInsurance                        | Benefit Support: Matt Sackman  
Phone: 206.336.2989  
Email: msackman@ahtins.com |
| Claims and Billing Support     | AHTInsurance                        | Benefit Support: Stephanie Stone  
Phone: 206.336.2993  
Email: sstone@ahtins.com |
| Human Resources               | Northwest Indian College             | Phone: 360.392.4230  
Website: www.nwic.edu |
| Medical                      | Healthcare Management Administrators, Inc. | Group Number: 020267B  
Customer Service: 800.869.7093  
Network: WA, OR, ID, UT: HMA Preferred  
Other States: PHCS Wrap  
Website: www.accesshma.com |
| Pharmacy                     | Costco Health Solutions              | Group Name: LUM  
Customer Service: 877.908.6024  
Website: costcohealthsolutions.com |
| Telehealth                    | MDLive                              | Group Number: 020267B  
Phone: 877.596.0967  
Website: MDLIVE.com/hma  
Cost: Free |
| 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: 10-301733  
Customer Service: 800.877.7195  
Network: Choice Network  
Website: www.vsp.com |
| Short-Term Disability        | Unum                                | Group Number: 614168  
Customer Service: 866.679.3054  
Website: www.unum.com |
| Long-Term Disability         | Unum                                | Group Number: 614169  
Customer Service: 866.679.3054  
Website: www.unum.com |
| 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.unum.com/lifebalance |