Employee Benefits Enrollment Guide

Plan Year | 2020 - 2021

Quileute NATION

Open Enrollment is here! Quileute Tribal Council is pleased to announce that we will continue to offer our valued employees the following benefits:

- **Medical Plan with Regence Blue Shield**
- **Dental Plan with SunLife**
- **Vision Plan with VSP**
- **Life and Accidental Death and Dismemberment insurance**
- **Short Term Disability**

Quileute Tribal Council will be offering some new benefits on October 1st, including:

Voluntary ID Theft Protection coverage

Voluntary Pet Insurance

Voluntary Accident Insurance

Voluntary Critical Illness Insurance

<u>ALL</u> employees are required to complete a form this year. You have until 5pm September 24th to hand in your form to HR. If you do not complete a new form, we will assume you are making no changes and your benefits will carry over exactly as is today.

If you prefer to have someone go over Benefits with you and/or if you have questions, you may call our insurance broker, Brown & Brown any time between 8am and 5pm Monday to Friday on 206 272 3121.
Suzie Cosser will be happy to take your call and help you out!

MEDICAL & PRESCRIPTION DRUGS

Quileute Tribal Council offers you a medical and prescription drug plan administered through Regence, using the Regence *Preferred network of doctors and facilities in central and western Washington. You also have access to the Blue Card PPO network across the United States*. You do not need to select a Primary Care Provider or obtain referral for care.

How to Find A Provider:

- **Go to** www.regence.com and sign into your Regence Account
- **Click "Find a doctor" in the upper right corner**
- **Click the blue "Find a Doctor" link in the text**
- **Select the "Preferred" network**
- **Once on the site, you can search for providers by name, location and/or specialty.**

Your Medical Plan	When you use a Network Provider	When you don't use a Network Provider
List of Providers (Network)	**Any in network licensed Providers**	**Any licensed provider**
Do I need to pick a Primary Care Doctor?	**No**	**No**
Preventive Care	**No cost to you!**	Not covered
What I'd pay for visits with a provider	$20 Copay	Deductible then you pay 50%
Do I have to satisfy my deductible before I receive benefits?	**Yes** Except for Preventive Care Services, Copay Services, Lab and X-ray and Prescription Drugs	**Yes** For most services
What Is my deductible? (per calendar year)	For a single person: **$500** For families: **$1,500**	
What's the most I will pay in a calendar year? (Includes deductible and your medical coinsurance or your 20%)	For a single person: **$3,000** For families: **$9,000**	
What do I pay for prescription drugs?	**30-day supply** **Generic Drugs**: $10 **Preferred Brand Name**: $25 **Non-Preferred Brand Name**: $40 Mail order Rx cost is 2 times retail for a 90-day supply	

NOTE: If you seek the services of an Out-of-Network provider, you will pay more. Always seek In-Network care whenever possible.

Preventive care

In-network services covered at 100%

Most Regence members have 100% coverage for preventive services—care that detects an issue before it becomes a problem. You'll pay nothing for the care listed here when you see an in-network provider. We follow recommendations from three government agencies to determine which services we cover.[1]

You may have to pay for covered preventive care if:

- You see an out-of-network provider
- Your doctor provides preventive care outside the guidelines
- Your provider doesn't obtain any required pre-authorization (for example, physical therapy for fall prevention, genetic testing for BRCA 1 and 2 and lung cancer screening)

Also, diagnostic services are different from preventive. Diagnostic care looks at a problem you're already having. So ask your doctor if services are preventive or diagnostic. It's important to know because you may have to pay out of pocket for diagnostic care.

Check the list below to see which preventive services most of our plans cover. Some plans may have limitations or not cover all of these services. Check your plan benefits or call Customer Service at the number on the back of your member ID card if you have questions.

1. These scientifically supported guidelines are created by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA).

Regence

Members of all ages

The following services are provided as appropriate to need and age.*

Lab tests
- Cholesterol screening (if high risk)
- BRCA 1 and 2 testing and counseling (if high risk and meet criteria)
- Hepatitis B screening (if high risk)
- Hepatitis C screening (if high risk or born 1945–1965)
- HIV screening (15–65 or high risk)
- Sexually transmitted disease counseling during wellness exams
- Screening for gonorrhea, syphilis and chlamydia
- Tuberculosis screening
- Type 2 diabetes screening and counseling (40–70 if overweight or obese)

Procedures
- Abdominal aortic aneurysm screening (men only, 65+ and have ever smoked)
- Cervical cancer screening (Pap) (21+)
- Colon cancer screening (45+, see regence.com for details and limitations)
- Lung cancer screening (55–80 with history of smoking)
- Osteoporosis screening (women 65+ or at risk)
- Physical therapy to prevent falls (in community-dwelling adults 65+ and at high risk)
- Screening mammogram (40+ or at high risk)
- Sterilization (tubal ligation)

Examinations/counseling
- Annual wellness (physical) exam (18+)
- Blood pressure monitoring (18+)
- Breast cancer prevention counseling (if high risk)
- Depression screening during wellness exams
- Diabetes counseling (40–70 if overweight or obese)
- Diet behavior counseling (for those with hyperlipidemia)
- Heart disease prevention counseling (18+ and overweight or obese)
- HIV counseling (15–65 or at high risk)
- HPV screening every three years (30+)
- Interpersonal and domestic violence screening and counseling during wellness exams
- Obesity screening and counseling (6+)
- Sexually transmitted disease counseling during wellness exams
- Tobacco-use counseling (not programs or classes)
- Unhealthy alcohol use screening and behavioral counseling (18+)

Immunizations
- Chicken pox (varicella)
- Diphtheria, pertussis (whooping cough), tetanus (DPT)
- Hemophilus influenzae type b (Hib)
- Hepatitis A and B
- Herpes zoster (shingles) (50+)
- HPV (up to 45)
- Influenza (flu)
- Measles, mumps, rubella (MMR)
- Meningitis
- Pneumonia

* When an age range is listed, such as 15-18, your coverage includes the first age through the second.

Pregnant members

During pregnancy, members may receive preventive services described under "Members of all ages," plus the following:

Lab tests
- Anemia screening
- Gestational diabetes screening
- Hepatitis B screening
- HIV screening and counseling
- Rh(D) incompatibility screening
- UTI screening

Breastfeeding / chestfeeding supplies and support
- Breast pump / lactation pump (non–hospital-grade)
- Lactation support and counseling

Children

Children may receive age-appropriate* preventive services described under "Members of all ages," plus the following:

Newborns (up to 62 days of age)
- Congenital hypothyroidism screening
- Gonorrhea medication for the eyes
- Jaundice (bilirubin) screening
- Metabolic screening
- PKU screening
- Sickle cell anemia screening

Youths (up to 21)
- Anemia screening
- Dyslipidemia (high cholesterol and fat in blood)
- Lead poisoning screening

Examinations/counseling
- Dental caries (up to age 6, starting when first tooth appears)
- Eye exam (3–5)
- Fluoride varnish (up to age 6 when applied by primary care clinician)
- Newborn hearing screening (up to 62 days)
- Skin cancer counseling (6 months–24 years for those with fair skin type)
- Well-child exams (up to age 18)

Immunizations

Children may receive age-appropriate immunizations described under "Members of all ages," plus the following:
- Polio
- Rotavirus

* When an age range is listed, such as 15-18, your coverage includes the first age through the second.

REGENCE ADVICE24

Get 24/7 health advice you can trust

If you have a question, don't know how to treat a health condition or are unsure about what kind of care you need, just call Regence Advice24 at 1 (800) 267-6729. Registered nurses are there 24/7/365 to get you on the right track. **Regence Advice24 is not insurance but is offered in addition to your medical plan to help you get information and support when you need it.**

A Regence Advice24 nurse will:

- Ask about your symptoms
- Direct you to an emergency room when necessary
- Help you decide if you should see a doctor
- Provide helpful self-care suggestions for minor injuries and illnesses
- Help you prepare for a doctor visit
- Help you understand your prescription
- Connect you with one of these program specialists if you need extra support on the call: certified diabetes educators, pharmacists, registered dietitians, respiratory therapists and social workers

Call anytime day or night when:

- You or a covered family member is sick, hurt or needs health care advice
- You're not sure whether to go to the emergency room, make a doctor's appointment or treat your problem at home

Regence Advice24 nurses:

- Have an average of 20+ plus years of nursing experience
- Are supported by doctors and the most advanced information systems
- Are able to assess your symptoms and help you decide on the best level of care

Some examples of health problems you can get help with:

- Vomiting, nausea or upset stomach
- Cuts, minor burns, scrapes
- Colds, viruses, coughing
- Dizziness and headaches
- Sore throats or flu
- Back pain
- Crying or hot baby
- Just feeling bad but you don't know why

Help by phone

Info on 5,500 health topics, plus translation services for 170+ languages and support for the hearing impaired

Regence

PHARMACY QUICK GUIDE

Get the most from your pharmacy benefit

Have a prescription to fill? Wondering if you should switch to a generic or use our home delivery service? Here are some quick tips and programs you need to know about.

How to fill your prescription

Whether you have a new prescription or need to refill an existing one, our network of more than 65,000 participating pharmacies has you covered—across the country and around your corner.

Show your member ID card to your pharmacist so they can file your claim with us online and tell you how much you owe.

Programs to stretch your pharmacy dollar

Our programs are designed to put valuable medication and health support into your hands, while also saving you money.

Covered-drug list

When it comes to choosing medications, it's important to know how the list of covered drugs—or formulary—works.

The covered-drug list divides medications into multiple tiers, each with its own cost share. Before we add a medication to the list, our team of doctors and pharmacists carefully evaluate how safe and effective it is while assessing whether it will improve health.

What does this mean for you? By knowing whether your benefit covers your medication as well as which tier it falls under, you'll know how much you owe.

Generics

Generic and brand-name medications have the same strength, quality and purity. But, generics can cost up to 80% less. So, ask your doctor if there is a generic drug that will work for you.

Home delivery

You can get some medications—like the ones you take for a chronic condition—mailed to you at the location of your choice. That means fewer trips to the pharmacy, and it can even save you a copay or lower your out-of-pocket costs if you have coinsurance.

90-day fills

You can pick up 90-day supplies of most long-term medications at one of our Extended Supply Network (ESN) retail pharmacies or have our Home Delivery Program ship it to the location of your choice. Visit **regence.com/pharmacy**, select your type of coverage or simply sign in, and click on **Find a Pharmacy** to locate an ESN retail pharmacy or register for home delivery.

Clinical programs

Our pharmacists work behind the scenes to help you get the medications you need when you need them. We also look out for safety concerns, such as potential drug interactions or duplicate prescriptions, that could affect you.

Regence

Specialty Pharmacy

We know that living with a complex health condition can be stressful and sometimes confusing. Our specialty pharmacy services are here to support you with the care and medications you need, every step of the way. In some cases, your plan may require that you use our Specialty Pharmacy.

To assist you with the complexities of your condition and its treatment, our Specialty Pharmacy services will help you coordinate refills, monitor side effects, and give you 24-hour access to clinical specialists. You'll even get injectable supplies for free—and everything can be delivered to your home or location of your choice.

Blood Glucose Meter Program

If you have diabetes, you're eligible to receive a new LifeScan OneTouch® glucose meter at no cost. Order your meter directly from LifeScan by calling 1 (855) 306-2278.

Understanding pre-authorization

To ensure you're getting an effective drug at an affordable price, we review prescriptions for some medications before we cover them. Drugs on the pre-authorization list include many for which equal or more effective and lower-cost options exist.

If your drug needs pre-authorization, you'll want to do one of two things:

1. Talk with your doctor to see if there's an alternative treatment that does not require pre-authorization.

OR

2. Have your doctor or pharmacist request pre-authorization for your medication. You may need to get that authorization before you can get your prescription filled.

Stay connected

Visit **regence.com** to find drug coverage, pricing, network pharmacies and more.

Questions? Call the Customer Service number on your member ID card.

Regence

Care on Demand: Telehealth

How to access virtual doctor visits

You don't have to leave the house to see a doctor. Your Regence health plan includes care-on-demand telehealth, which gives you access to virtual doctor visits from the comfort of home—24 hours a day, 7 days a week, 365 days a year.

Why telehealth

With today's unprecedented demand on doctors, hospitals and urgent care facilities, telehealth virtual visits are a convenient, affordable alternative for routine care. Telehealth doctors can treat common health conditions—from pink eye, rashes and ear infections to anxiety and depression. They can even send a prescription to your local pharmacy. Plus, getting care from home helps minimize the spread of infection. Telehealth doctors can't treat COVID-19 but can help assess symptoms.

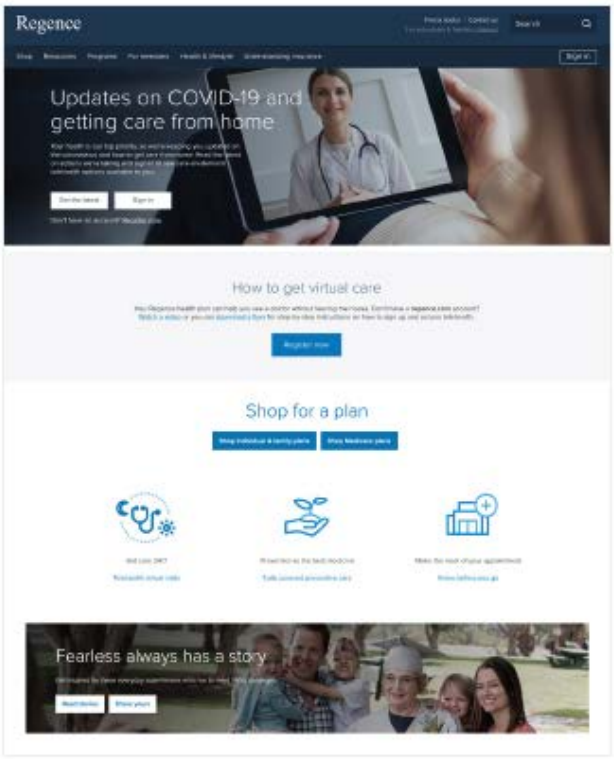
We're also partnering with providers to expand your access to virtual visits with doctors you'd normally see in-person. Reach out to your doctors to find out what virtual options they offer.

Regence

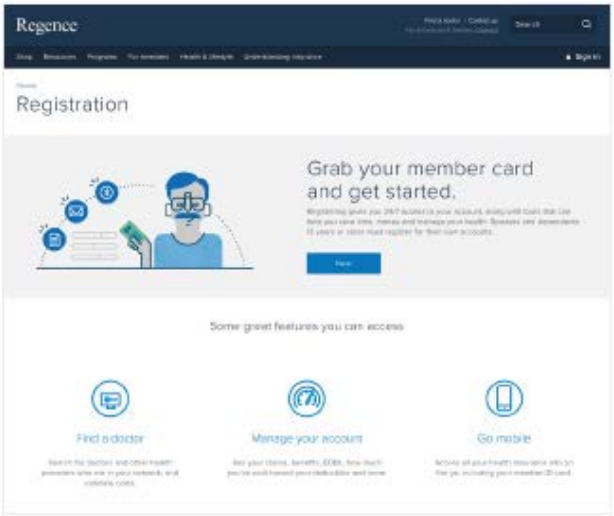
Get started

If you haven't already registered on regence.com, follow these simple steps. If you're already registered, please sign in and skip ahead to step 8.

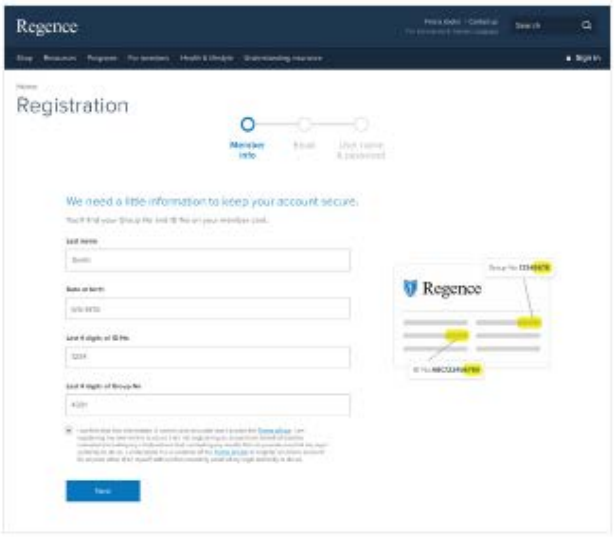
1. Register from the regence.com homepage by selecting Sign in or Register now.



2. Grab your member ID card.

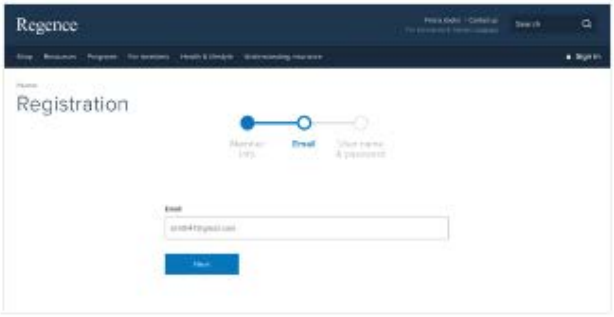


3. Enter your member info, including:
   - Last name
   - Date of birth
   - Last 4 digits of member ID number
   - Last 4 digits of group number

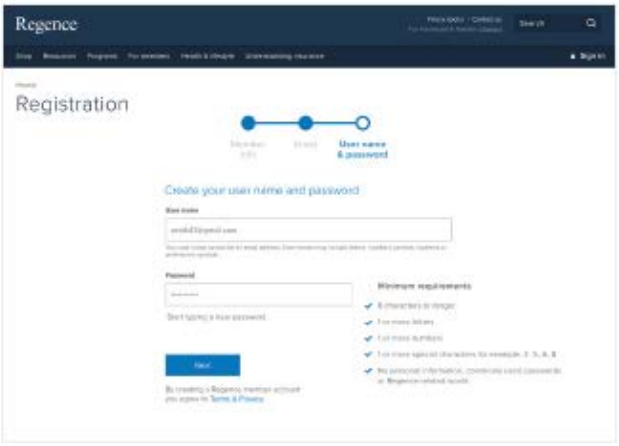


4. Enter your email address.

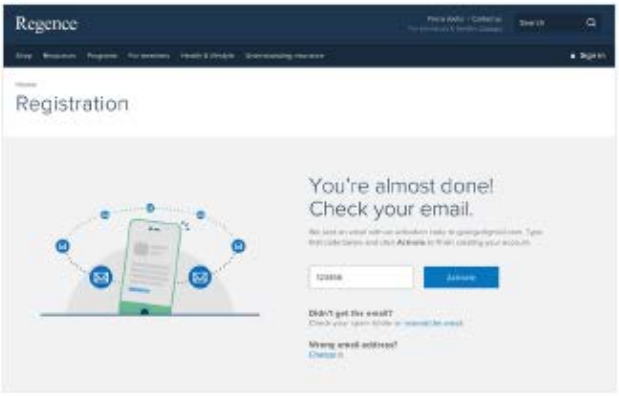
   Note: *If the email is already on file and associated with an online account, you'll have the option to continue with this address or enter a different one.*



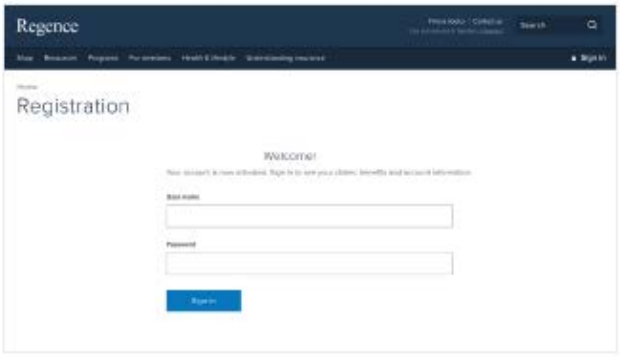
5. Create your username and password.



6. For security purposes, you'll receive an email with an activation code. Enter it to complete your registration.



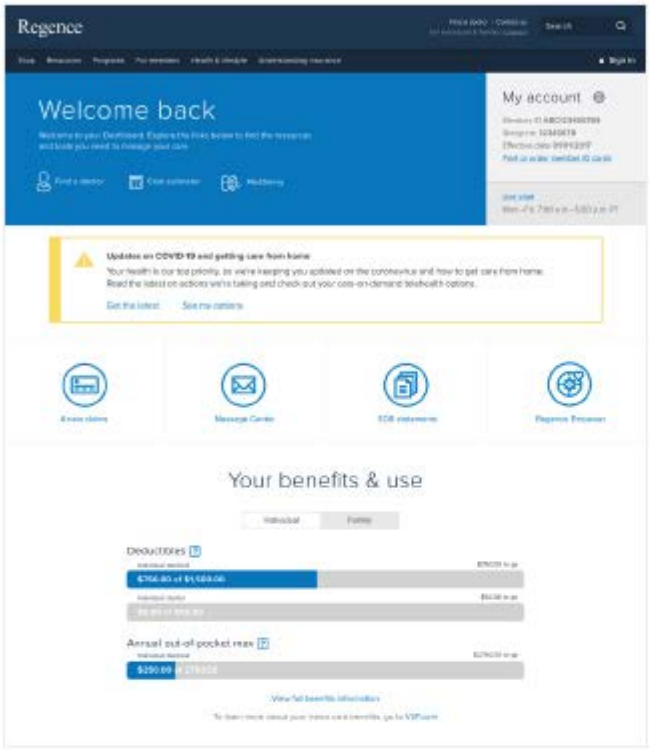
7. Now that your account is active, you can sign in.



8. You'll be directed to your personalized Member Dashboard with this alert.

9. Click through to your telehealth provider's website where you can activate your account. You're encouraged to do it now, so you're all set when you need to access care.

10. Get started. Anytime you need a virtual visit, just sign in to regence.com. From your Member Dashboard, you can go straight to your telehealth provider and request a visit.

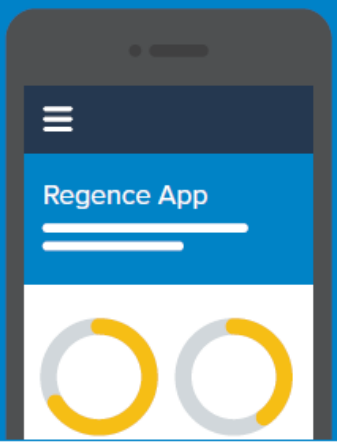


With a telehealth virtual visit, you can skip the waiting room, avoid germs and see a doctor when it's convenient for you. Grab your member ID card and sign up now.

Get on-the-go access with the Regence app

The Regence mobile app gives you easy and secure access to all your health information. It's iPhone and Android ready, and waiting for you to download.

Just sign in with your existing Regence account or create a new one from the app—then use fingerprint security to sign in. That means you won't need a password after setup!

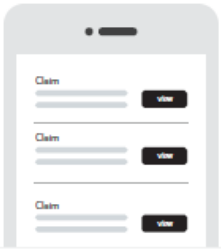


Personalized dashboard

- See your deductibles and out-of-pocket max.
- Find in-network doctors, hospitals and urgent care.
- Contact us—send secure messages to Member Services, tap to call or share feedback on your app experience.

Member ID card

- View your card on the app and it's stored for anytime access—even without an internet connection.
- Show your digital member ID card at the doctor's office for easy check-in.



Claims and benefits

- View your claims and detailed EOB statements.
- See your copay, deductible and coinsurance amounts.
- Download your benefits booklet.

Learn more at regence.com/mobile

Find providers and get cost estimates at regence.com and on our mobile app.

How to search for an in-network provider

Knowing your network can save you money, and we want you to get the most value out of your coverage. That's why we've made it easy to search for in-network doctors, specialists, clinics or pharmacies with our **Find a Doctor** tool. Here's how to use it:

The first step is to register at regence.com using the information on your member ID card. That way, whenever you sign in the search results and benefits information will be customized to you.

After you've registered, sign in to regence.com and select **Find a Doctor.** Note that your home address is used as the starting location for your search. However, you can change the location to suit you, whether searching for a provider near your home, workplace or travel spot.

Choose a search category to find doctors or health facilities by name, specialty or type. Then filter results to match your needs (distance, gender, who is accepting new patients, languages spoken and more).

Review comments from other patients, or check a provider's quality information to feel confident in your choices.

DENTAL

Your Dental Plan is offered through Sun Life Financial. You can use any licensed dentist; however, when you use a Sun Life Dental Network Preferred Dentist, you are guaranteed to only be billed for negotiated contract rates (i.e., no balance billing).

Your Dental Plan	DENTAL
List of Providers (Network)	Sun Life Dental Network
Do I need to pick a Primary Care Dentist?	**No**
Preventive Care (exams, cleanings, x-rays, fluoride treatment, sealants, space maintainers)	**No cost to you!**
Deductible	$25 for individual, $75 for Family
Basic Restorative Care (fillings, simple extractions, oral surgery, root canals, periodontics)	You pay 20%
Major Restorative Care (inlay/onlays, crowns, dentures, implants, bridges)	You pay 50%
TOTAL DENTAL PAID BY PLAN	**Sun Life will pay maximum of $2,000** per person per calendar year
Orthodontia	You pay 50% - Sun Life will pay up to $1,000 *lifetime maximum* for dependent children under 19 years of age

Note: Class One services (preventive care) do not count towards the Dental Annual Maximum

VISION

Your Vision Plan is offered through VSP. You can use any licensed eye doctor; however, when you use an In-Network VSP doctor, you get the most benefit for your money.

Your Vision Plan	VSP Signature Plan
Your Eye Exam Allowance (routine eye exam, contact lens fitting covered)	**$10 Copay** One exam per calendar year
Hardware Allowance (lenses, frames or contacts)	Covered up to $130 Every other calendar year

YOUR COSTS

Please note that your Medical election will automatically enroll you in Dental and Vision also and will match enrollment exactly. I.e. If you elect Employee + Spouse coverage for Medical, then you will also have Employee + Spouse coverage for Dental and Vision.
Quileute Tribal Council pays most of the premium cost for employees on these plans; you pay just **$25 per paycheck** if enrolling as an Employee Only. If you wish to enroll dependents on your plan, your cost will be **$75 per paycheck**.

MEDICAL, DENTAL AND VISION MONTHLY COSTS

YOUR ENROLLMENT	YOU PAY PER PAYCHECK
Employee Only	$25
Employee & Spouse	$75
Employee & Child	$75
Employee & Children	$75
Employee, Spouse & Child	$75
Employee, Spouse & Children	$75

*Note that payroll deduction only applies for employees who are actively at work and working enough hours to qualify for benefits, or those on approved Family Medical Leave (which can be obtain through **Quileute Tribal Council** Human Resources). Otherwise you will be offered **Quileute Tribal Council** Continuation of Coverage and pay the Total Monthly Cost.

LIFE AND AD&D

QUILEUTE TRIBAL COUNCIL provides Life and Accidental Death & Dismemberment coverage for yourself and your dependents, offered through The Hartford. You will pay 50% of the premium for this coverage.

The premium is 13 cents per $1,000 of benefit, so if your salary is $40,000 per year, for example, you will pay $5.20 per month.

- Full-time employees working 30 or more hours per week have a benefit of one time your annual salary in Life/AD&D coverage. Note- there is a reduction in benefits starting at age 65.

You must have a beneficiary on file with Human Resources Office so they know who should get your life insurance benefit. If you have had any changes, please stop by Human Resources Office to complete a new beneficiary form and update your records. A couple of notes about selecting your Beneficiary:

- If you are married, your spouse must be named your beneficiary or complete a form acknowledging a different person. (*See Human Resources Office for form.)*
- If your beneficiary is a minor child, life insurance benefit will be released to their guardian.
- Your beneficiary may live anywhere in the world, even outside the U.S.
- **PLEASE NOTE:** If you are married to another Quileute employee, you are only eligible to enroll on the **employee** life insurance. You may **not** elect spouse insurance if your spouse also is an employee enrolled on the life insurance. If you have dependent children, **only one of you** may elect the child life insurance, not both.

SHORT-TERM DISABILITY

Short-term Disability Insurance ensures that you will have income in the event you are hurt or sick and cannot work; it's paycheck insurance! Disability insurance is provided ***at no cost to you.*** The benefit will cover you up to 60% of your base salary to a maximum of $1,200 per week once you have been disabled for more than 14 days. You will continue to receive benefits for as long as you are disabled up to a maximum of 11 weeks.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program is there for you should you require assistance for any challenges life presents. It includes services for resources to seek assistance with anxiety and depression, relationship issues, crisis support and alcohol and drug problems, to name a few. ***This benefit is provided at no cost to you.***

The EAP provides you up to 5 face to face or in person sessions with a clinical expert who can assess your concerns and develop a plan of action.

A confidential telephonic service is also available 24/7.

Welcome to your Employee Assistance Program (EAP)

We're here to coach and guide you through the challenges in your life. Call your EAP–we can help!

OUR SERVICES INCLUDE SUPPORT FOR:

- Anxiety and Depression
- Couples/Relationship/ Parenting
- Crisis Support
- Alcohol/Drug Problems
- Grief and Loss
- Work Conflict
- Compulsive Behaviors
- Domestic Violence
- Legal and Financial
- Childcare and Eldercare
- Home Ownership
- ID Theft
- Healthy Living Tips

CONTACT US

Your free and confidential EAP is always available to assist you!

(800) 777-4114
FirstChoiceEAP.com

Your company's complimentary EAP program is available 24/7 and covers employees, spouses, domestic partners, and children up to age 26. The EAP is here to help when you're facing issues that interfere with your health, well-being, and productivity at home or at work.

The EAP offers up to **5 sessions face-to-face or telehealth** (no co-pay, deductible, or premium) with a qualified clinical expert who can assess your concerns and develop a plan of action. If you need a legal* or financial consultation, or ID theft resolution, you can speak with an expert for up to 30 minutes at no charge. EAP consultants can also provide you with childcare and eldercare information and resources for anywhere in the country. Additionally, the Home Ownership program is a valuable tool to gain a competitive edge as a buyer, and can save you thousands when buying or selling a home.

Simply call us at (800) 777-4114 or visit our website to request an appointment.

FREE / CONFIDENTIAL / AVAILABLE 24/7

Online Tools & Resources

Login www.FirstChoiceEAP.com

Username: quileutenation

Mobile-friendly searchable database of resources, healthy tips and recipes, parenting advice, legal forms, and more.

First Choice Health.

*Workplace issues are excluded.

Employee Assistance Program

WELLNESS & SUPPORT

How to Use BetterHelp Online Platform

Note – BetterHelp is not appropriate for clients in crisis. If you need immediate support, call 1-800-777-4114.

HOW DOES IT WORK?

1. Call FCH EAP at (800) 777-4114 or go online to www.firstchoiceEAP.com to request services.
2. FCH EAP provides your unique registration access to the BetterHelp platform.
3. Complete a brief matching questionnaire.
4. Match with a counselor and get started right from your smart phone, tablet, or computer (it may take up to 24 hours to receive a match).

WHAT IS A SESSION?

Each of your free EAP sessions becomes one week of free access to BetterHelp. For example, three EAP sessions will be three weeks of services through BetterHelp. Weeks of service do not need to be back-to-back. However, any exchange with your provider through the BetterHelp platform during that time will count as service usage.

Missed appointments or late cancellations will count as service usage.

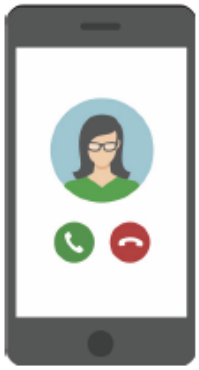
HOW WILL WE COMMUNICATE?

You can talk to your counselor however you feel comfortable. There are four communication methods available:

Messaging (Unscheduled)

Live Chat (Scheduled)

Live Phone (Scheduled)



Live Video (Scheduled)

To schedule a live session at a time that's convenient for you, just view your counselor's calendar and choose an available time. The drop down menu allows you to specify live chat, phone, or video communication.

Ready to start? Call (800) 777-4114 or request a referral online at www.firstchoiceEAP.com.

First Choice Health®

(800) 777-4114 www.FirstChoiceEAP.com

Your EAP service is free, confidential and available 24/7 to help you balance your work, family, and personal life.

COVID RESOURCES - RELIEF CENTER

During these unprecedented times, we are seeing the greater community pull together to help one another in many ways. Our insurance broker, Brown & Brown, has created a site specifically for us that contains Brown & Brown Relief Center content to help us with our changing world.

Visit **www.quileutenation.benefithub.com** to gain access TODAY and explore savings on products and services related to accommodating remote working and daily staples, including:

- Financial Wellness Center by Prudential, including financial tools and strategies to help navigate these challenging times.
- Health & Behavioral Health Services
- Family Care & Child Learning
- Pet Care
- Home & Home Office Discounts
- Food & Food Delivery Services
- General Household & Office Supplies

The Benefit Hub tool includes cash back rewards for frequent users, so an account must be created if you access any discount programs through the site.

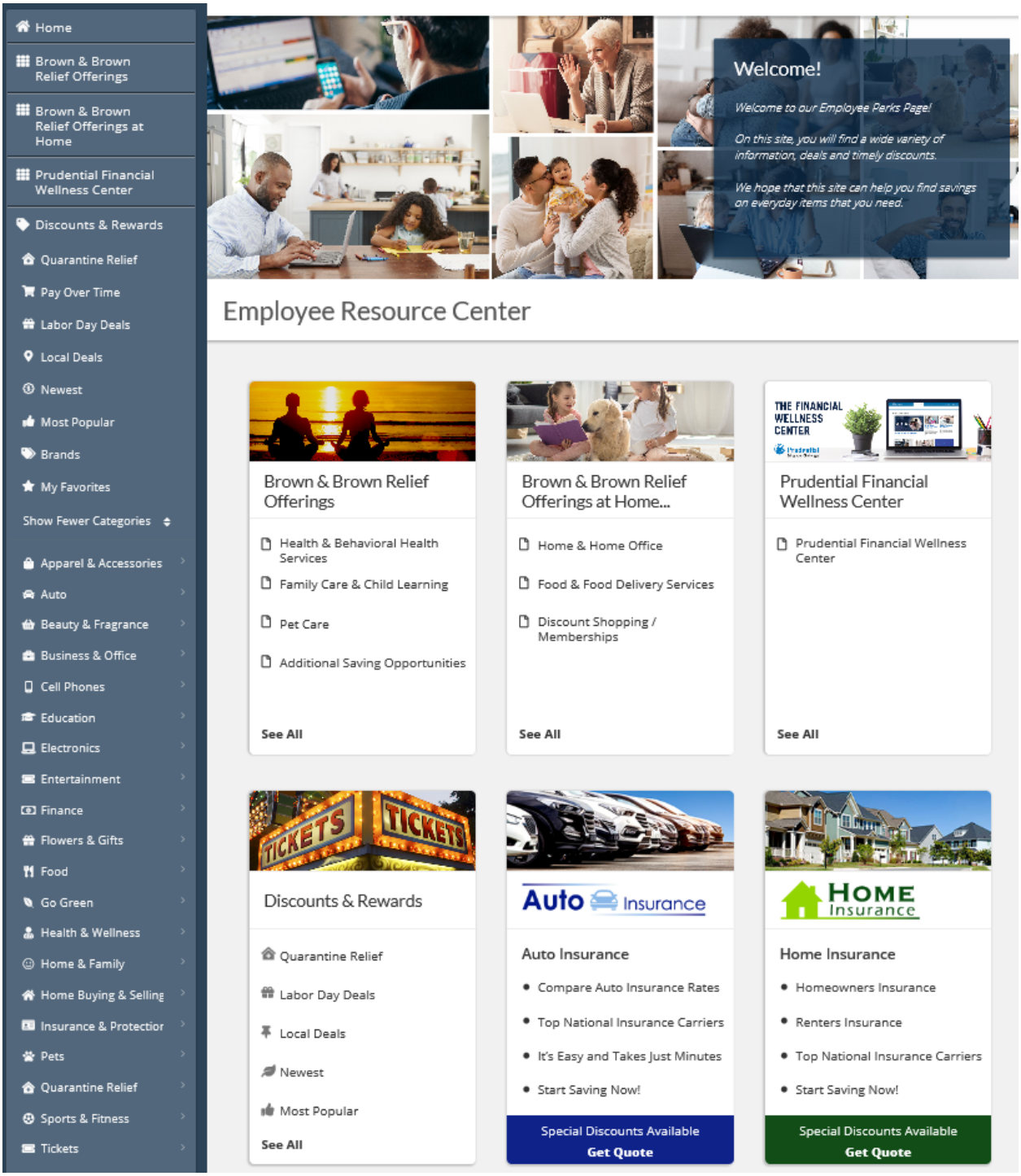
You may feel free to share this site with others who can take advantage of it.

Next steps:

1. **Jump into the site and explore the content**. There are many discount programs available that may be helpful to you.

2. **Click over to the Prudential Financial Wellness site** and see all of the helpful material that is available there.

Some examples of resources available……



…… Plus more on the site!

New for 2020-2021!

PET INSURANCE

When a pet owner enrolls with Trupanion, they're covered by one simple plan.

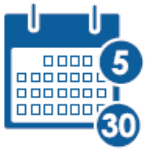
WHAT'S COVERED		WHAT'S NOT COVERED
✓ Diagnostic tests	✓ Prosthetic devices	✗ Pre-existing conditions — conditions that show symptoms in the 18 months before enrollment or during waiting periods
✓ Medications	✓ Orthotic devices	✗ Preventive care — vaccinations, flea and tick control, etc.
✓ Surgeries	✓ Carts	✗ Spay or neuter
✓ Hospital stays	✓ Supplements	✗ Exam fees and sales tax, where applicable
✓ Prescription foods	✓ Herbal therapy	

WHO
8 Weeks +

All dogs and cats over 8 weeks of age can enroll for lifelong coverage.

WHAT
90% Coverage

Covers 90% of eligible costs for all new illnesses and injuries.



WHEN
5 – 30 Days

Experience Rate Program policies begin on the first of the month, with full coverage starting after applicable policy waiting periods: 5 days for injuries and 30 days for illnesses.

WHERE
US, Canada, Puerto Rico

Visit any veterinary, emergency care, or specialty hospital in the US, Canada, and Puerto Rico. Including US and Canadian military installations (CONUS and OCONUS).

You pay 100% of the premium for pet insurance:

(You may select different deductibles for different pets in the same household if you wish)

Age Band	$75 Deductible Recovery & Comp Care Rider: No		$250 Deductible Recovery & Comp Care Rider: No		$500 Deductible Recovery & Comp Care Rider: No	
	Dog	Cat	Dog	Cat	Dog	Cat
8 weeks - 2 years old	$47.24	$19.03	$37.92	$15.28	$29.15	$11.74
3 - 5 years old	$57.99	$19.58	$46.56	$15.72	$35.79	$12.08
6 - 7 years old	$75.00	$27.94	$60.21	$22.43	$46.28	$17.24
8 - 10 years old	$105.26	$34.55	$84.51	$27.74	$64.96	$21.32
11+ years old	$118.66	$71.85	$95.26	$57.68	$73.22	$44.34

ID THEFT PROTECTION COVERAGE

Identity Monitoring

NEW Allstate Digital Footprint	✓
NEW IP address monitoring	✓
Auto-on monitoring	✓
Rapid alerts	✓
High-risk transaction monitoring	✓
Social media reputation monitoring	✓
Sex offender registry	✓
Credit and debit card monitoring	✓
Bank account transaction monitoring	✓
401(k) and HSA account monitoring	✓
Student loan activity alerts	✓
Financial transaction monitoring	✓
Lost wallet protection	✓
Digital exposure reports	✓
Dark web monitoring	✓
Human-sourced intelligence	✓
Compromised credentials	✓
Data breach notifications	✓
Deceased family member coverage	✓
Social media account takeover	✓
Mobile app with full functionality	✓

Credit

Tri-bureau credit monitoring	✓
Credit score tracking	✓
Unlimited TransUnion credit reports and scores	✓
Credit freeze assistance	✓
Credit lock (adult and child)	✓
Annual tri-bureau report and score	✓
Credit report disputes	✓

Remediation

Full-service, 24/7 remediation support	✓
$1 million insurance policy[†]	✓
Stolen fund reimbursement[†]	✓
Tax fraud refund advance[†]	✓
401(k) and HSA reimbursement[†]	✓
Tap-to-call from mobile app	✓

You pay 100% of the premium for ID theft coverage:

PrivacyArmor Plus

Employee	**$9.95** /employee/month
Employee plus family	**$17.95** /family/month

CRITICAL ILLNESS COVERAGE

We are pleased to offer Voluntary Critical Illness coverage to you and your dependents, through The Hartford. In the event of a claim approval, you receive a benefit payout of either $10,000 or $20,000 (you decide upon sign up). The following conditions are covered:

Coverage Amounts	Description
EMPLOYEE COVERAGE AMOUNT(S)	$10,000 or $20,000
SPOUSE COVERAGE AMOUNT	50% of Employee's Coverage Amount
CHILD(REN) COVERAGE AMOUNT	$5,000
GUARANTEED ISSUE AMOUNT(S)[1]	Employee: $20,000 Spouse and/or Child(ren): All amounts
REDUCTION DUE TO AGE	Not Included

Critical Illness Benefits

The Hartford's Critical Illness plan will pay a lump sum benefit for a covered person diagnosed with any of the following covered illnesses while insurance is in effect, subject to any Pre-existing Condition Limitation. State specific variations may apply to the benefits shown below.

COVERED ILLNESS	BENEFIT
Cancer	
Invasive Cancer	100% of coverage amount
Non-Invasive Cancer	25% of coverage amount
Benign Brain Tumor	100% of coverage amount
Vascular	
Heart Attack	100% of coverage amount
Heart Failure/Transplant	100% of coverage amount
Coronary Artery Disease/Bypass Graft	25% of coverage amount
Angioplasty/Stent	25% of coverage amount
Stroke	100% of coverage amount
Aneurysm	25% of coverage amount
Other Specified	
Major Organ Failure/Transplant	100% of coverage amount
End Stage Renal Failure	100% of coverage amount
Coma	100% of coverage amount
Paralysis	100% of coverage amount
Loss of Vision	100% of coverage amount
Loss of Hearing	100% of coverage amount
Loss of Speech	100% of coverage amount
Bone Marrow Disease/Transplant	25% of coverage amount

You may also purchase coverage for spouse and/or child in addition to yourself. Spouse may elect up to 50% of your coverage amount and you may elect up to $5,000 benefit for your child or children.
Please note this coverage does have a pre-existing condition limitation. This means if you were diagnosed with or treated for any condition within 12 months prior to being insured and within 12 months after becoming insured, you will not be eligible to receive a benefit. Other limitations may apply; please see policy for complete information.

You pay 100% of the premium for Critical Illness

The costs are as follows for $10,000 of coverage:

Attained Age Uni-Tobacco Monthly Premium Rates for $10,000 Coverage Amount				
Age	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
18-24	$3.29	$4.96	$4.51	$6.37
25-29	$4.07	$6.10	$5.28	$7.51
30-34	$4.62	$6.92	$5.84	$8.33
35-39	$6.20	$9.27	$7.41	$10.68
40-44	$9.17	$13.78	$10.38	$15.19
45-49	$14.79	$22.44	$16.00	$23.85
50-54	$21.05	$32.14	$22.26	$33.55
55-59	$29.13	$44.70	$30.34	$46.12
60-64	$41.37	$63.69	$42.59	$65.10
65-69	$57.27	$87.91	$58.48	$89.32
70-74	$76.43	$117.30	$77.64	$118.72
75-79	$100.40	$153.71	$101.61	$155.12

And for $20,000 coverage:

Attained Age Uni-Tobacco Monthly Premium Rates for $20,000 Coverage Amount				
Age	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
18-24	$6.59	$9.91	$7.80	$11.33
25-29	$8.14	$12.20	$9.36	$13.61
30-34	$9.25	$13.84	$10.46	$15.25
35-39	$12.39	$18.54	$13.60	$19.95
40-44	$18.34	$27.56	$19.55	$28.97
45-49	$29.58	$44.88	$30.79	$46.29
50-54	$42.10	$64.28	$43.32	$65.70
55-59	$58.25	$89.41	$59.46	$90.82
60-64	$82.75	$127.37	$83.96	$128.78
65-69	$114.54	$175.82	$115.75	$177.23
70-74	$152.87	$234.61	$154.08	$236.02
75-79	$200.81	$307.42	$202.02	$308.83

ACCIDENT COVERAGE

We are pleased to offer Voluntary Accident coverage to you and your dependents, through The Hartford. In the event of a claim approval, you receive a benefit payout relevant to the nature of the injury. Coverage is as follows:

Accident Benefits			
The Hartford's Accident plan(s) will pay each scheduled benefit for treatment, injury or services incurred by a covered person who is injured in an accident while insurance is in effect, subject to any plan limitations and exclusions. State specific variations may apply to the benefits shown below.			
Emergency, Hospital & Treatment Care Package[3]:			
Treatment/Service	**Detail** (Per covered person)		**Plan 2**
ACCIDENT FOLLOW-UP	Up to 3 Treatments/accident within 365 Days		$75
ACUPUNCTURE	Up to 10 visits/accident within 365 Days		$25
AMBULANCE – AIR	Once/accident within 365 Days		$900
AMBULANCE – GROUND	Once/accident within 365 Days		$300
BLOOD/PLASMA/PLATELETS	Once/accident within 365 Days		$200
CHILD CARE	Up to 30 Days/accident while insured is confined		$25
CHIROPRACTIC CARE	Up to 10 visits/accident within 365 Days		$25
DAILY HOSPITAL CONFINEMENT	Up to 365 Days/lifetime (Total daily and ICU)		$200
DAILY ICU CONFINEMENT	Up to 30 Days/accident (Subject to 365 Days/lifetime)		$400
DIAGNOSTIC EXAM	Once/accident within 365 Days		$200
EMERGENCY DENTAL – CROWN	Highest benefit once/accident within 365 Days		$300
EMERGENCY DENTAL – EXTRACTION	Highest benefit once/accident within 365 Days		$100
EMERGENCY ROOM	Once /accident within 365 Days		$150
HOSPITAL ADMISSION	Once/accident within 365 Days		$1,000
INITIAL PHYSICIAN OFFICE VISIT	Once/accident within 365 Days		$75
LODGING	Up to 30 Nights/lifetime		$125
MEDICAL APPLIANCE	Once/accident within 365 Days		$100
PHYSICAL THERAPY	Up to 10 Visits/accident within 365 Days		$25
REHABILITATION FACILITY	Up to 15 Days/lifetime within 365 Days		$100
TRANSPORTATION	Up to 3 Trips/accident		$300
URGENT CARE	Once /accident within 365 Days		$75
X-RAY	Once/accident within 365 Days		$50
Specified Injury & Surgery Benefit Package:			
Injury/Treatment/Service	**Detail** (Per covered person)		**Plan 2**
ABDOMINAL/THORACIC SURGERY	Once/accident within 365 Days		$1,500
ARTHROSCOPIC SURGERY	Once/accident within 365 Days		$300
BURN – 2ND DEGREE (≥ 34% OF BODY SURFACE)	Highest benefit once/accident within 365 Days		$1,000
BURN – 3RD DEGREE (≥ 18IN2 OF BODY SURFACE)	Highest benefit once/accident within 365 Days		$10,000

BURN – SKIN GRAFT (FOR 3RD DEGREE BURN)	Once/accident		25% of burn benefit	
CONCUSSION	Up to 3 Concussions/year within 365 Days		$150	
EYE INJURY – OBJECT REMOVAL	Highest benefit once/accident within 365 Days		$200	
EYE INJURY – SURGERY	Highest benefit once/accident within 365 Days		$400	
HERNIA REPAIR	Once/accident within 365 Days		$150	
JOINT REPLACEMENT	Once/accident within 365 Days		$2,000	
KNEE CARTILAGE – WITH REPAIR	Highest benefit once/accident within 365 Days		$750	
KNEE CARTILAGE – WITHOUT REPAIR			$150	
LACERATION – 2" TO 6"	Highest benefit once/accident within 365 Days		$300	
LACERATION – 6" OR GREATER	Highest benefit once/accident within 365 Days		$600	
RUPTURED DISC	Once/accident within 365 Days		$750	
TENDON/LIGAMENT/CUFF – SINGLE	Highest benefit once/accident within 365 Days		$800	
TENDON/LIGAMENT/CUFF – 2 OR MORE			$1,000	
Specified Injury & Surgery Benefit Package: Dislocations (dollar amounts shown are for Open Surgical injuries)				
Injury	**Detail** (Per covered person)		**Plan 2**	
SPOUSE BENEFIT AMOUNTS	--	100% of Employee's Coverage Amount		
CHILD(REN) BENEFIT AMOUNTS	--	100% of Employee's Coverage Amount		
ANKLE, FOOT BONES (EXCEPT TOES)	Once/joint/lifetime (Open or closed)		$1,000	
COLLARBONE – ACROMIO/SEPARATION			$500	
COLLARBONE – STERNOCLAVICULAR			$1,000	
ELBOW			$1,000	
FINGER, TOE			$200	
HIP			$4,000	
KNEE			$1,800	
LOWER JAW			$1,000	
SHOULDER (GLENOHUMERAL)			$1,000	
WRIST			$1,000	
HAND BONES (EXCEPT FINGERS)			$1,000	
CLOSED (NON-SURGICAL)		50% of open benefit		
INCOMPLETE/WITHOUT ANESTHESIA		25% of closed benefit		
MULTIPLE DISLOCATIONS/FRACTURES	--	≤ 200% of highest benefit		
Specified Injury & Surgery Benefit Package: Fractures (dollar amounts shown are for Open Surgical injuries)				
Injury	**Detail** (Per covered person)		**Plan 2**	
SPOUSE BENEFIT AMOUNTS	--	100% of Employee's Coverage Amount		
CHILD(REN) BENEFIT AMOUNTS	--	100% of Employee's Coverage Amount		
ANKLE	Once/bone/accident within 365 Days		$1,000	
FOOT BONES (EXCEPT TOES)			$1,000	
COCCYX			$400	

COLLARBONE/CLAVICLE OR STERNUM			$1,000	
FINGER, TOE			$200	
FOREARM – RADIUS OR ULNA			$1,000	
HIP, THIGH/FEMUR			$4,000	
KNEECAP/PATELLA			$1,000	
LOWER JAW/MANDIBLE (EXC. ALV. PROCESS)			$1,000	
LOWER LEG – FIBULA OR TIBIA			$1,200	
NOSE, FACIAL BONES (EXCEPT JAW BONES)			$600	
PELVIS (EXCEPT COCCYX)			$1,500	
VERTEBRAE – PROCESSES			$400	
RIB			$400	
SHOULDER BLADE/SCAPULA			$1,000	
SKULL – DEPRESSED			$6,000	
SKULL – NON-DEPRESSED/SIMPLE			$1,500	
UPPER ARM/HUMERUS			$1,000	
UPPER JAW/MAXILLA (EXC. ALVEOLAR PROCESS)			$1,000	
VERTEBRAE – BODY			$1,200	
WRIST, HAND BONES (EXCEPT FINGERS)			$1,000	
CLOSED (NON-SURGICAL)		50% of open benefit		
CHIP FRACTURE		25% of closed benefit		
MULTIPLE FRACTURES/DISLOCATIONS	--	≤ 200% of highest benefit		
Catastrophic Benefits Package:				
Injury/Treatment/Service	**Detail** (Per covered person)		**Plan 2**	
ACCIDENTAL DEATH – EMPLOYEE	Within 365 Days		$30,000	
ACCIDENTAL DEATH – SPOUSE		50% of employee benefit		
ACCIDENTAL DEATH – CHILD(REN)		25% of employee benefit		
COMMON CARRIER DEATH	Within 365 Days	3 times death benefit		
COMA (≥ 168] CONTINUOUS HOURS)	Once/accident within 365 Days		$10,000	
HOME HEALTH CARE	Up to 30 Days/accident		$50	
PARALYSIS – QUADRIPLEGIA	Highest benefit once/accident within 365 Days		$10,000	
PARALYSIS – PARAPLEGIA			$5,000	
PROSTHESIS – SINGLE	Highest benefit once/accident within 365 Days		$750	
PROSTHESIS – 2 OR MORE			$1,500	
Catastrophic Benefits Package: Dismemberments				
Injury	**Detail** (Per covered person)		**Plan 2**	
SPOUSE BENEFIT AMOUNTS	--	100% of Employee's Coverage Amount		
CHILD(REN) BENEFIT AMOUNTS	--	100% of Employee's Coverage Amount		
BOTH HANDS OR BOTH FEET	Within 365 Days		$30,000	
SIGHT – BOTH EYES			$30,000	
SPEECH & HEARING (BOTH EARS)			$30,000	

1 HAND & 1 FOOT	Once/accident within 365 Days		$30,000	
1 HAND/FOOT & SIGHT OF 1 EYE			$30,000	
1 HAND OR 1 FOOT			$15,000	
SIGHT – 1 EYE			$15,000	
SPEECH OR HEARING (BOTH EARS)			$15,000	
THUMB & INDEX FINGER (SAME HAND)			$5,000	
Additional Plan Features & Services:				
POLICY AGE LIMIT	Coverage terminates when the employee reaches age 80			
PORTABILITY	Included			
CONTINUATION OF COVERAGE	Included			
CONTINUITY OF COVERAGE	Included			
ABILITY ASSIST® 1	Included			
HEALTH CHAMPIONSM 1	Included			
Enrollment & Contribution:				
ENROLLMENT TYPE	Annual Open Enrollment[4]			
EMPLOYEE CONTRIBUTION	100% employee paid (Voluntary)			
NUMBER OF ELIGIBLE EMPLOYEES	141			

You pay 100% of the premium for Accident:

Rate Information:				
PLAN TYPE	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
MONTHLY RATES – PLAN 2[2]	**$14.99**	**$23.65**	**$25.53**	**$40.01**
INITIAL RATE GUARANTEE PERIOD	2 Years			

Please note: Pet Insurance, Critical Illness and Accident all have participation requirements which need to be met before we can put the plan in place. We will advise you immediately if you elect the coverage and we are unable to implement the coverage at this time. You will not be charged any premium if you elect and we do not place the coverage.

What do I need to do?

ALL employees must complete the included enrollment form, even if you are not making any changes. The form must be submitted to HR no later than end of day on September 24th. If you do not return your form, it will be assumed you wish to make no changes, and your elections will carry over exactly as is today.

QUESTIONS & ANSWERS

Changes that can be made effective October 1, 2020:

- Enroll for the first time or waive coverage.
- Add or remove dependent coverage in the medical/vision/dental plans.
- Enroll in the new coverages for the first time.

If I don't make changes now, when can I make changes?

Open Enrollment is your one time during the year to make changes **(enroll in coverage yourself or make changes to family member elections)**, drop coverage or make changes to elections to benefits.

- Otherwise the only reason you can change mid-year would be due to a Qualifying Life Event, i.e. Birth of a child, Marriage, Divorce, Death, Spouse getting new coverage, Spouse losing their coverage.
- Mid-year changes must be reported to Human Resources Office within 30 days of the event

Beneficiary Change Form if you would like to update your Life Insurance beneficiary.

Where do I find these forms?

- Contact the Human Resources Office for all forms.

When are the forms due and where do I return them?

- **All forms are due back to Human Resources Office no later than September 24th by 5:00pm.**

When do changes go into effect?

- Any changes made during Open Enrollment will be effective **October 1, 2020**.

Who is eligible for coverage?

- Eligible employees include full-time employees regularly scheduled to work 30 or more hours per week
- Eligible dependents include married spouse and legal dependent children up to age 26.

What will I pay for coverage?

- Refer to costs beginning on page 15 of this Guide and throughout.
- Note that employee pricing is for employees who are actively at work or on approved Family Medical Leave, otherwise, you will be offered Quileute Tribal Council Continuation of Coverage and must pay full cost of coverage.

WHO ARE YOU GOING TO CALL?

QUILEUTE TRIBE

Human Resources Department
(360) 374-4366/4367/2175
hr@quileutenation.org

OTHER HELPFUL PEOPLE:

Medical, Prescriptions	Regence Blue Shield	1-888-231-8424	www.regence.com
Dental	SunLife	1-800-786-54330344	www.sunlife.com
Vision	Vision Service Plan	1-800-877-7195	www.vsp.com
Life, Disability, Critical Illness and Accident	The Hartford	1-800-523-2233	www.thehartford.com
EAP	First Choice Health	1-800-777-4114	www.firstchoiceeap.com
Pet Insurance	Trupanion	1-855-210-8749	www.trupanion.com
ID Theft Protection	InfoArmor	1-800-789-2720	www.infoarmor.com

If your issue is not resolved, you can contact our insurance brokers at Brown & Brown for assistance:

Suzie Cosser **206-272-3121** **scosser@bbseattle.com**

ANNUAL NOTICES

Each year Federal Law requires you are notified regarding laws and regulations that apply to you through your employer sponsored benefit plans. Below are a number of notices that satisfy the requirement.

PATIENT PROTECTIONS AND SELECTION OF PROVIDERS

Quileute Tribal Council group health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Regence Blue Shield.

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from Quileute Tribal Council group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Regence Blue Shield.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, provides participants with the following rights:

Special Enrollment Rights

If an individual experiences a loss of coverage or if an employee has a new dependent, an eligible employee and/or a dependent may have special enrollment rights to participate in medical coverage under the group health plan immediately without being required to wait until the next annual open enrollment period. For this purpose, a loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative health coverage. A loss of other coverage for this purpose does not include, however, termination due to the nonpayment of required contributions, for cause due to the filing of a fraudulent application or claim, or where the individual voluntarily terminates other coverage. The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption. Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable.

Effective as of April 1, 2009, if an individual's Medicaid or State Children's Health Insurance Program ("CHIP") coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual may immediately enroll in the Plan by submitting a request within 60 days after the loss or gain of eligibility.

MICHELLE'S LAW

Effective as of January 1, 2010, pursuant to a new federal law known as Michelle's law, if a serious illness or injury requires a dependent child to change from full-time to part-time student status or take a leave of absence from a college, university or other accredited educational institution, medical coverage may be temporarily extended if all of the following requirements are satisfied:

The dependent child was enrolled in the Plan on or before the reduction in status or leave of absence began;
The reduction in status or leave of absence would have otherwise caused the dependent child's medical coverage under the Plan to terminate; and
The dependent child's attending physician provides a written certification which states that the reduction in status or leave of absence is medically necessary and due to a serious illness or injury.

If all of the above requirements are satisfied, medical coverage will be extended until the earliest of the following dates:

One year after the date on which student status was reduced from full-time to part-time;
One year after the date on which the leave of absence began;
The date on which the reduction in status or leave of absence is no longer medically necessary; or
The date on which the child's medical coverage would otherwise terminate under the Plan (for example, due to the attainment of the limiting age).

After this temporary extension period ends COBRA continuation coverage may be available.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. 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 the 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).

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

A Health Benefit Program that provides both medical and surgical benefits and mental health and/or substance abuse benefits shall not impose any limits on mental health or substance abuse benefits that violate the requirements of ERISA.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding any contrary provision in any group health insurance policy under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a qualified medical child support order ("QMCSO"). Participants may obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE

If you cease to be eligible for health coverage under the Plan due to service in the U.S. military, you and your eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). You and your dependents may also be entitled to elect to continue your health coverage under COBRA if you cease to be eligible for health coverage due to your military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage

Length of USERRA Continuation Coverage

You may elect to continue health coverage under the Plan for yourself and your eligible dependents for the period that is the lesser of:

24 months, beginning with the first day you are absent from work to perform military service; or

The period beginning on the first day you are absent from work to perform military service (including any extension described in the last section of this document) and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If you give Employer advance notice of a period of military service that will be 30 days or less, the Plan Administrator will treat your notice as an election to continue your health coverage during your military service unless you specifically inform Employer, in writing, that you want to cancel your health coverage during your military leave. You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms or paperwork to continue your health coverage during your military service.

If you give Employer advance notice of a period of military service that will be 31 days or longer, the Plan Administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. Unlike COBRA, your dependents do not have a separate right to elect USERRA coverage. If you want USERRA continuation coverage for any member of your family, you must elect it for yourself and all eligible dependents who are covered under the Plan when your military service begins.

If you choose USERRA continuation coverage, you must return the USERRA election form to the Plan Administrator within 60 days of the date it was provided to you. If you do not timely return the election form, USERRA continuation coverage will not be available to you and your eligible dependents.

A special rule applies if you do not give Employer advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your health coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity);

You affirmatively elect to reinstate the coverage; and

You pay all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If your period of military service is more than 30 days, beginning on the 31st day of your military service your required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if you do not timely pay any required premiums for that coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated. The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elect USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
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	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Important Notice from Quileute Tribal Council About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Quileute Tribal Council and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

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

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Quileute Tribal Council coverage will be affected. For those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents. *See* pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Quileute Tribal Council coverage, be aware that you and your dependents will not be able to get this coverage back until our next annual Open Enrollment for an October, 2021 effective date.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Quileute Tribal Council and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Quileute Tribal Council changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 8, 2020
Name of Entity/Sender:	Quileute Tribal Council
Contact--Position/Office:	Human Resources
Address:	21 Quileute Nation Street, La Push WA 98350
Phone Number:	(360) 374 4305