EMPLOYEE BENEFITS

July 1, 2018 - June 30, 2019

bassetti architects

WELCOME TO YOUR BENEFITS!

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

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Short-Term Disability
- Long-Term Disability
- Life and AD&D
- Employee Assistance Program

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

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

ELIGIBILITY

Employee

All eligible employees scheduled to work 20 or more hours per week are eligible for benefits. Coverage will begin on the first of the month following or coinciding with date of hire.

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, adoption, or placement of adoption
- 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.

COST SHARING - JULY 1, 2018 - JULY 31, 2018

Benefit Costs

Bassetti Architects contributes 100% to your Medical, Dental, and Vision coverage. Bassetti Architects contributes 0% to your dependents' Medical, Dental, and Vision coverage.

Medical and vision enrollment are bound to each other. For example, if you enroll yourself, spouse, and children in medical, the same must be true of vision.

Costs below reflect your premiums per month.

Medical Dental and Vision	Your cost	Bassetti Architects cost
Employee	$0.00	$516.77
Employee + SP/DP	$650.59	$516.77
Employee + SP/DP + Children	$1,236.76	$516.77
Employee + Children	$584.25	$516.77

Medical and Vision	Your cost	Bassetti Architects cost
Employee	$0.00	$476.17
Employee + SP/DP	$606.64	$476.17
Employee + SP/DP + Children	$1,142.61	$476.17
Employee + Children	$534.10	$476.17

Dental	Your cost	Bassetti Architects cost
Employee	$0.00	$40.60
Employee + SP/DP	$43.95	$40.60
Employee + SP/DP + Children	$94.15	$40.60
Employee + Children	$50.15	$40.60

Short-Term Disability

Covered at no cost to you

Long-Term Disability

Covered at no cost to you

Life and AD&D

Covered at no cost to you

Employee Assistance Program

Covered at no cost to you

- **SP:** Spouse
- **DP:** Domestic Partner

Cost Sharing - August 1, 2018 - June 30, 2019

Benefit Costs

Bassetti Architects contributes 100% to your Medical, Dental, and Vision coverage. Bassetti Architects contributes 0% to your dependents' Medical, Dental, and Vision coverage.

Dental and vision enrollment are bound to each other. For example, if you enroll yourself, spouse, and children in dental, the same must be true of vision.

Costs below reflect your premiums per month.

Medical Dental and Vision	Your cost	Bassetti Architects cost
Employee	$0.00	$516.77
Employee + SP/DP	$650.59	$516.77
Employee + SP/DP + Children	$1,236.76	$516.77
Employee + Children	$584.25	$516.77

Medical	Your cost	Bassetti Architects cost
Employee	$0.00	$471.52
Employee + SP/DP	$603.88	$471.52
Employee + SP/DP + Children	$1,135.04	$471.52
Employee + Children	$531.16	$471.52

Dental and Vision	Your cost	Bassetti Architects cost
Employee	$0.00	$45.25
Employee + SP/DP	$46.71	$45.25
Employee + SP/DP + Children	$101.72	$45.25
Employee + Children	$53.09	$45.25

Short-Term Disability

Covered at no cost to you

Long-Term Disability

Covered at no cost to you

Life and AD&D

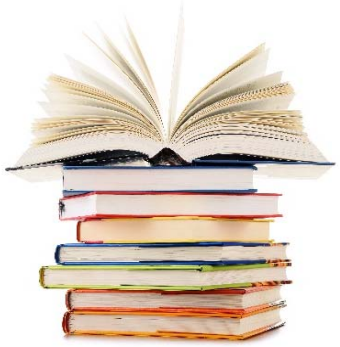
Covered at no cost to you

Employee Assistance Program

Covered at no cost to you

- **SP:** Spouse
- **DP:** Domestic Partner

BENEFIT DEFINITIONS



In-Network

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

Copayments and Coinsurance

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

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

Annual Deductible

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

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

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount of unreimbursed medical expenses 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.

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.

GRANDFATHER STATUS NOTICE

Grandfather Status Notice of Medical Plan

This group health plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your plan administrator/human resources department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

STAYING HEALTHY

Medical Benefits Overview

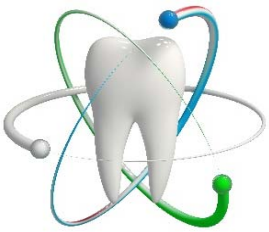
Comprehensive and preventive care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. The information below is a high-level overview of medical coverage only. Please see Human Resources for plan summaries detailing coverage information, limitations, and exclusions. Any deductibles, copays, and coinsurance amounts for percentages shown in the chart below are 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.**

	Premera Blue Cross	
Provider Network	Heritage Plus	Out-of-Network
Annual Deductible Applies first unless copay only or otherwise noted	$500 individual $1,500 family	$1,000 individual $3,000 family
Out-of-Pocket Limit (OOP limit) Includes Deductible, Coinsurance, and Copays (including Rx)	$4,000 individual $12,000 family	$8,000 individual $24,000 family
Coinsurance Carrier / Member	80% / 20%	50% / 50%
Preventive Care		
Office Visit, Screenings, Immunizations	No charge	Not covered
Office Visits		
Office Visit	$25 copay	50%
Mental Health	$25 copay	50%
Alternative Care Visits combined across all networks		
Chiropractic	$25 copay 12 visits PCY	50% 12 visits PCY
Outpatients Rehabilitation Visits combined across all networks		
Physical / Occupational / Massage	$25 copay 30 visits PCY	50% 30 visits PCY
Lab & X-ray		
Diagnostic Testing	20%	50%
Imaging, CT, PET Scans, MRIs	20%	50%
Prescription Drugs		
Generic / Preferred Brand / Non-Preferred Brand	$10 / $40 / $80	Heritage network copay + 50%
Mail Order	2x copay	Heritage network copay + 50%
Urgent Care	$200 hospital-based copay + 20% $25 freestanding center copay	$200 hospital-based copay + 20% 50% freestanding center
Emergency Room	$200 copay + 20% Copay waived if admitted	

- **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.

STAYING HEALTHY

Dental Benefits Overview



Great oral health is an essential part of a healthy lifestyle. Your teeth and gums are important for almost everything you do in a day - from speaking and eating to living without pain. It can help you manage diabetes, dramatically reduce hospitalizations and medical costs, and stop dental conditions before they become major problems. The information below is a summary of dental coverage only. Please see Human Resources for plan summaries detailing coverage information, limitations, and exclusions. Coinsurance percentages shown in the chart below are amounts for which you are responsible.

	July 1, 2018 - July 31,2018		August 1, 2018 - June 30, 2019	
	Delta Dental of WA		Direct Dental Administrators	
Provider Network	PPO	Premier & Non-Participating	DHA PPO	Out-of-Network
Annual deductible	$50 individual $150 family		$50 Individual $150 Family	
Is Deductible waived for Class I Services?	Yes		Yes	
Annual benefit maximum Max provider will pay PCY	$1,000		$1,000	
Do Class I Services accumulate towards the benefit maximum?	Included		Included	
Coinsurance				
Class I (Preventive) Exams, X-Rays, Cleanings	0%	20%	0%	0%
Class II (Basic) Fillings, oral surgery, endodontics	20%	30%	10%	20%
Class III (Major) Inlays, onlays, crowns, bridges	50%	60%	40%	50%
Additional benefits				
Composite rider	Included		None	
TMJ	50% up to $1,000 PCY $5,000 lifetime		50% up to $1,000 PCY $5,000 lifetime	
Waiting periods				
Class III (Major) Services	None		None	
Out-of-network coinsurance	Can be balance billed by a non-participating provider		Can be balance billed by a non-participating provider	
Out-of-network reimbursement	Maximum allowable fees		Maximum allowable fees	

To find a DHA In-Network Provider visit: www.directdentalplans.com/findprovider

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

STAYING HEALTHY

Vision Benefits Overview

Good visual health plays an extremely important role in contributing to overall health. 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.

	July 1, 2018 - July 31,2018		August 1, 2018 - June 30, 2019
	Vision Service Plan		Direct Dental Administrators
Network	Signature	Out-of-network	Any Licensed Vision Provider
Plan copays			
Eye Exam	$10 copay		
Hardware (lenses and frames)	$20 copay		Please see Benefit Allowances
Contacts (standard fitting and evaluation)	$0 copay		
Benefit Frequency			
Eye Exam	Once every 12 months		
Lenses and Frames	Once every 24 months		No benefit frequency limits
Contacts (in lieu of lenses and frames)	Once every 24 months		
Benefit Allowances			
Exam	100%	Up to $50	
Frames	Up to $130	Up to $70	
Lenses			
Single	100%	Up to $50	75% coinsurance, up to $300 benefit maximum
Lined Bifocals	100%	Up to $75	
Lined Trifocals	100%	Up to $100	
Elective Contacts (in lieu of lenses and frames)	Up to $130	Up to $105	
Lens Enhancements			
Anti-reflective Coating			
Standard progressive Lenses	Discounted	Not covered	Please see Benefit Allowances
Scratch Resistant Coating			

Any Licensed Vision Provider: means you may see any vision provider you wish. You will pay out-of-pocket for vision services upfront and obtain an itemized receipt for your expenses. Submit a Vision Claim Reimbursement Form along with a copy of the itemized receipt. Reimbursement will then be sent to you.

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.

Mutual of Omaha

Definition of Disability	Disability means that because of an injury or illness you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job.
Weekly Benefit Amount	60%
Maximum Weekly Benefit	$1,500
Benefits Begin on	
Illness	31st day
Accident	31st day
Benefit Duration	9 weeks

Long-Term Disability

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

Mutual of Omaha

Definition of Disability	You are prevented from performing at least one of the main duties of his or her own occupation during the first 3 years.
Monthly Benefit amount	60%
Maximum Monthly Benefit	$7,500
Benefits Begin on	91st day
Duration of Benefits	To Social Security Normal Retirement Age

PLANNING FOR THE UNEXPECTED

Basic Life and AD&D

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

Mutual of Omaha

Life and AD&D	$30,000
Benefit Reductions	65% at age 65 50% at age 70
Accelerated Death Benefit	75% of life benefit
Conversion	You have the option of converting your group life coverage to your own individual policy.

USAble Life

Coverage is bound to enrollment in medical plan

Life and AD&D	$20,000
Benefit Reductions	65% at age 65 50% at age 70 30% at age 75
Accelerated Death Benefit	75% of life benefit
Conversion	You have the option of converting your group life coverage to your own individual policy.

Life Consultation and Referral Resources

Employee Assistance Program

Each person's life includes its own unique set of challenges. To help you cope with these challenges, we offer an Employee Assistance Program (EAP). This program is available to you and your household members. Enrollment is automatic and we pay the full cost for your coverage. All employees are eligible for confidential access to trained counselors 24/7 via telephone for assistance with issues.

Mutual of Omaha

Consultation Service

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions
- 3 face to face session with a counselor (per household per calendar year)

Online Tools and Resources

- Online will preparation
- Legal library and online forms
- Telephonic financial consultation
- Dependent and elder care assistance and referral services
- Financial tools and resources
- Identity theft victim resources

Call: 800.316.2796; or
Visit: mutualofomaha.com/eap

Worldwide Travel Assistance Program

Experincing an emergency while traveling can be especially difficult. Knowing who to call for medical problems, curency exhange issues or lost luggage is critical. Take comfort in knowing that Travel Assistance travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

- Pre-trip assistance
- Travel assistance services 24/7
- Telephonic translation and interpreter sercices 24/7
- Locating legal services
- Baggage assistance with lost, stolen, or delayed baggage
- Emergency payment and cash assistance for medical expenses
- Document replacement
- Vehicle return
- Locating medical providers and referrals
- Comprehensive ID theft assistance guide
- And more…

For inquiries within the U.S. call toll free: 800.856.9947
Outside the U.S. call collect: 312.935.3658

LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

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

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

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

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

Newborns' and Mothers' Health Protection Act

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

Special Enrollment Notice

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

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

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

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

UNDERSTANDING COBRA

Common Questions

What is COBRA?

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

Who is a qualified beneficiary?

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

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

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

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

What is a COBRA qualifying event?

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

The specified events are:

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

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

What is an election period under COBRA?

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

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

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

This is a brief explanation of COBRA. Please see Human Resources for more details or visit http://www.dol.gov/dol/topic/health-plans/cobra.htm.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

FLORIDA – Medicaid

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

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid

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

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

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

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

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Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: (855) 632-7633

Lincoln: (402) 473-7000

Omaha: (402) 595-1178

NEVADA – Medicaid

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

SOUTH DAKOTA - Medicaid

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

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm

CHIP Phone: 1-855-242-8282

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

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/indexes.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

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

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

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

Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

WASHINGTON – Medicaid

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

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

WEST VIRGINIA – Medicaid

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

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

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

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

STILL HAVE QUESTIONS?

We encourage all of our employees and their families to become familiar with your benefits. If you do not find what you need, please use the following contact information to speak directly with a benefits professional that can better serve you. Employee Benefit Support is available Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Standard Time. All calls are confidential and monitored until resolution. Due to HIPAA Privacy, EBS may need to obtain your written authorization in order to assist with certain issues. If needed, an authorization form will be provided to you. You can always contact the providers directly as well.

Benefit	Carrier	Customer Service Information	
General Employee Benefit Support	AHT Insurance	Benefit Support: Phone: Email:	Karen Platner, Account Executive 206.336.2975 kplatner@ahtins.com
		Benefit Support: Phone: Email:	Genae Gillespie, Account Manager 206.336.0410 ggillespie@ahtins.com
Medical	Premera Blue Cross	Group Number: Customer Service: Network: Website:	4761-9505721 800.722.1471 Premera Heritage Plus www.premera.com
Dental	Delta Dental 07/01/18 - 07/31/18	Group Number: Customer Service: Network: Website:	10822 800.554.1907 Delta Dental PPO www.deltadentalplans.com
Dental	Direct Dental Administrators 08/01/18 - 06/30/2019	Group Number: Customer Service: Network: Website:	501BA0818 415.526.1401 Dental Health Alliance (DHA) PPO www.directdentalplans.com
Vision	Vision Service Plan 07/01/18 - 07/31/18	Group Number: Customer Service: Network: Website:	Last 4 digits of employees SSN 800.877.7195 Signature www.vsp.com
Vision	Direct Dental Administrators 08/01/18 - 06/30/2019	Group Number: Customer Service: Network: Website:	501BA0818 415.526.1401 Any licensed vision provider www.directdentalplans.com
Disability	Mutual of Omaha	Group Number: Customer Service: Website:	Pending 800.877.5176 www.mutualofomaha.com
Life and AD&D	Mutual of Omaha	Group Number: Customer Service: Website:	Pending 800.775.8805 www.mutualofomaha.com
Life and AD&D	USAble Life	Group Number: Customer Service: Website:	50020259 800.370.5856 www.usablelife.com
Employee Assistance Program	Mutual of Omaha	Customer Service: Website:	800.316.2796 mutualofomaha.com/eap