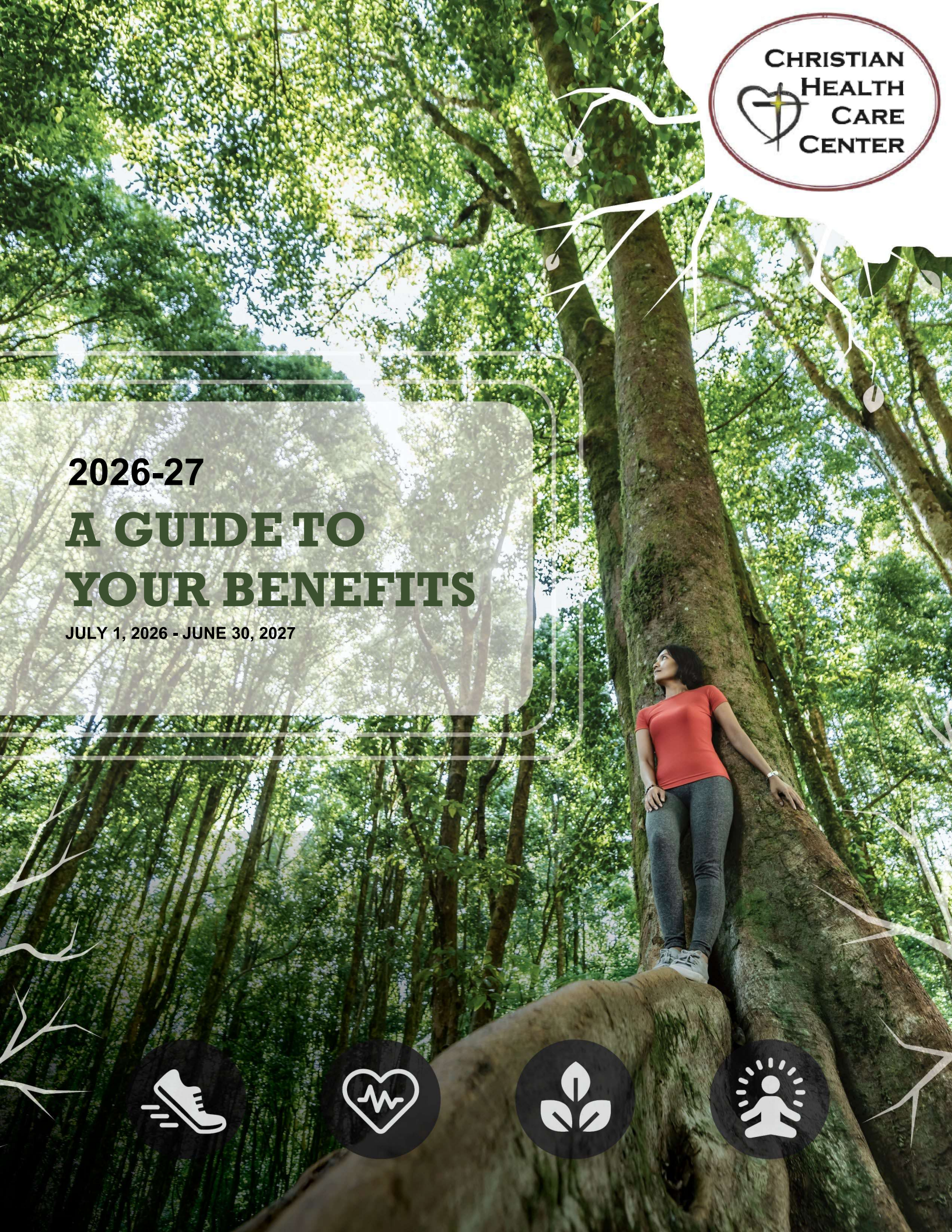

2026-27

A GUIDE TO YOUR BENEFITS

JULY 1, 2026 - JUNE 30, 2027

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WELCOME

We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your domestic partner (DP) and/or their children, where applicable by state law
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

Coverage Begins

- **New Hires:** Your coverage is effective on your date of hire. **Open Enrollment:** Changes made during Open Enrollment are effective July 1, 2026.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, RDP or child
- Lost coverage under your spouse's/RDP's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact Human Resources within 30 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

INSIDE

ENROLLMENT

Need enrollment instructions

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

HEALTH

MEDICAL COVERAGE

HDHP + HSA

The HDHP + HSA (High-Deductible Health Plan + Health Savings Account), provided through Premera, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open an HSA, which is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for any qualified health-related expenses (state taxation rules may apply). This includes most medical care and services, prescriptions, dental, vision and expenses related to meeting the plan's deductible. For a complete list of qualified health-related expenses, visit Publication 502.

For more information on the HSA, see page 16 in this benefit guide.

Individuals with HDHPs normally pay a lower amount each month but pay more on their yearly medical expenses before their insurance policy begins paying. You can visit any doctor, hospital or other health care provider you want, with greater cost savings in-network.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- You must meet the annual deductible before prescription co-insurance applies. The deductible is waived for medications on the preventive drug list.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year.

To find an in-network provider, go to www.premera.com and select Find Care. Search for providers in the Heritage Network

MEDICAL COVERAGE

PPO

The Preferred Provider Organization (PPO) plan, provided through Premera, gives you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the network.

A PPO plan relies on a network of health care clinics, hospitals and professionals who have agreed to provide their services at discounted rates. These preferred providers are considered "in-network." In general, you will pay less for in-network services than you would were you to seek care outside the network.

How You Pay for Services

- You pay a flat dollar amount–or copay–for covered health care treatments and services, such as doctor's office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage–or coinsurance–of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider visit: https://www.premera.com/visitor/find-a-doctor

- On the homepage, select **Find Care**, then Find a Doctor.
- Under Employer-based plans, select Browse all doctors and specialists.
- Select Just Browsing, then Continue and enter your City, State or Zip, then select Continue.
- Narrow your search by **Network** and select **BlueCard PPO**.
- You can then search for a doctor by name or specialty.

Your Premera ID card is the key to your plan. Once you receive your ID card, you can use your card to create an account at premera.com.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Premera HDHP+HSA $3,000		Premera PPO $2,000	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$3,000 / $6,000	$6,000 / $12,000	$2,000 / $6,000	$4,000 / $12,000
Out-of-Pocket Max (Individual/Family)	$3,425 / $6,850	Unlimited	$4,000 / $12,000	Unlimited
Office Visits (physician/specialist)	30%*	50%*	$25	30%*
Virtual Visits	30%*	50%*	$25	30%*
Routine Preventive Care	Covered in full	30%*	Covered in full	30%*
Diagnostics (lab/X-ray)	30%*	50%*	10%*	30%*
Complex Imaging	30%*	50%*	10%*	30%*
Chiropractic	30%*	50%*	$25	30%*
Ambulance	30%*		30%*	
Emergency Room	30%*		$150, then 10%*	
Urgent Care Facility	30%*	50%*	$25	30%*
Inpatient Hospital Stay	30%*	50%*	10%*	30%*
Outpatient Surgery	30%*	50%*	10%*	30%*
Prescription Drugs Retail (30 day supply)	30%*	30%*	$15 / $25 / $40	Cost share, then 40%
Prescription Drugs Mail order (90 day supply)	30%*	Not covered	3x retail	Not covered

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Premera PPO $1,000	
	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$1,000 / $3,000	$2,000 / $6,000
Out-of-Pocket Max (Individual/Family)	$3,000 / $9,000	Unlimited
Office Visits (physician/specialist)	$25	30%*
Virtual Visits	$25	30%*
Routine Preventive Care	Covered in full	30%*
Diagnostics (lab/X-ray)	10%*	30%*
Complex Imaging	10%*	30%*
Chiropractic	$25	30%*
Ambulance	30%*	
Emergency Room	$150, then 10%*	
Urgent Care Facility	$25	30%*
Inpatient Hospital Stay	10%*	30%*
Outpatient Surgery	10%*	30%*
Prescription Drugs Retail (30 day supply)	$15 / $25 / $40	Cost share, then 40%
Prescription Drugs Mail order (90 day supply)	3x retail	Not covered

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

VIRTUAL VISITS

98point6

Our telehealth program is a convenient and cost-effective way to get quick medical advice by phone, online or on your mobile device about many non-emergency conditions. It's just one more way our organization invests in you and your family.

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs. A call to our telehealth program will cost you 20%* on the HDHP plan and $10 on the PPO plan, regardless of your condition.

It's Convenient

Long wait times at the ER, urgent care center or doctor's office are an unfortunate reality for many. Whether you are at home or work or on the road, a medical professional is available 24/7/365 so you can get the care you need when and where it's convenient for you. Even better: There is no time limit to the consult, giving you plenty of time to ask questions and resolve your issue.

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away! Call 800-997-6196.

Get Care in Minutes

It takes just a few minutes to set up your medical history online. Once you submit a request, it often takes less than 10 minutes for a doctor to call you back.

Common Reasons to Call

- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Ear infections
- Diarrhea or constipation
- Headaches and migraines
- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections

Scan this code to watch a video about how telehealth works.

Services	98point6
24/7 Access	www.98point6.com/premera
Care Delivery	Text messaging
Provider Type	Primary Care Urgent Care Dermatology
Other	Prescribe medication Order medical tests

MENTAL HEALTH BENEFITS

Talkspace

In life, challenges are inevitable—luckily, finding support is now easier than ever. Through Talkspace, you gain access to live chat, video and audio sessions that seamlessly connect you with licensed therapists, psychiatrists and nurse practitioners across all 50 states. You can also message your therapist any time, and they'll usually reply within a day to offer support or guidance.

What's more, these sessions are affordable and covered by most major insurance providers, ensuring no conflict between your financial health and your mental well-being. With Talkspace, you have accessible, affordable support that's ready when and where you need it.

To learn more or start today, visit www.talkspace.com/premera

Scan this code to watch a video about mental health.

talkspace

ADDICTION HELP

Workit Health

Workit Health provides medication and virtual counseling to help you quit. The platform offers help for quitting smoking, gambling, sex addiction, alcohol, and opioid use.

Go to www.workithealth.com/premera or download the app. Have your Premera ID card at hand to sign up.

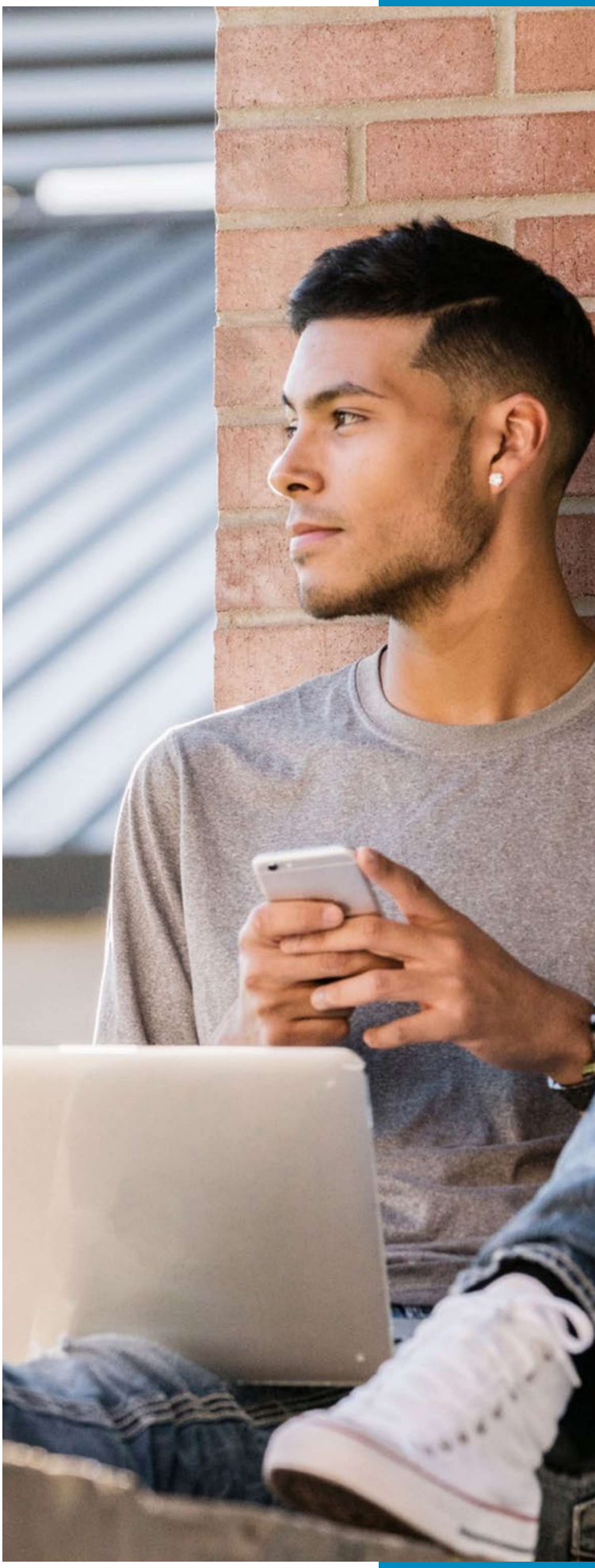
Workit Health

Boulder Care

Medication and virtual counseling to help you quit. They have an emphasis on opioid, alcohol and other substance abuse counseling.

Go to www.boulder.care/getstarted or download their app. Phone: 866-901-4860. Have your Premera ID card handy to sign up.

Boulder



DENTAL COVERAGE

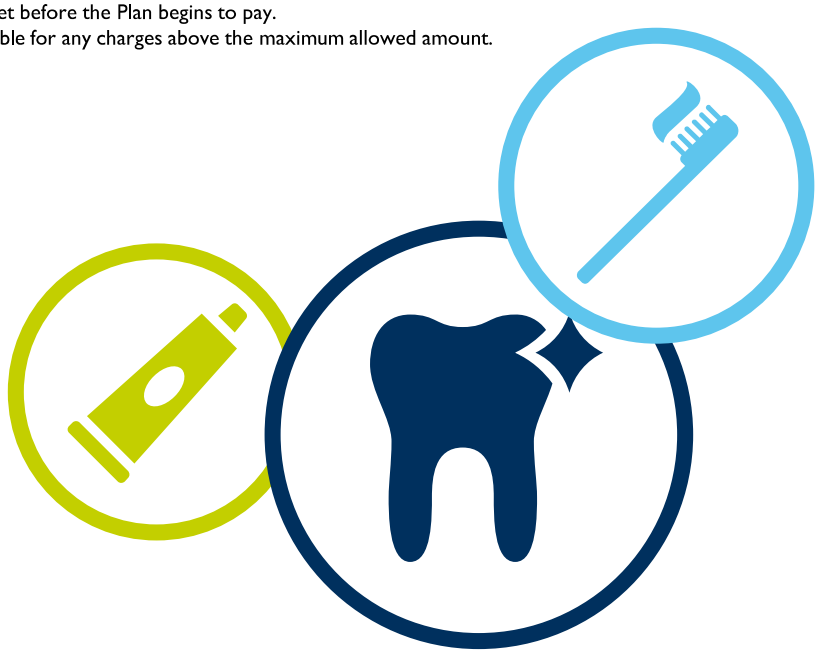
PPO

The two dental Preferred Provider Organization (PPO) plan, provided through Delta Dental, offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the Delta Dental network.

Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Delta Dental Base 2000		Delta Dental Buy-Up	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$50 / $150	$50 / $150	$0 / $0	$0 / $0
Annual Benefit Maximum (per person)	$2,000	$2,000	$2,000	$2,000
Preventive Services	0%	0%	0%	0%
Basic Services	20%*	30%*	10%*	20%*
Major Services	50%*	60%*	50%*	50%*
Orthodontic Services	Child Only 50%, $1,500 lifetime max	Child Only 50%, $1,500 lifetime max	Child & Adult 50%, $1,500 lifetime max	Child & Adult 50%, $1,500 lifetime max

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.



VISION COVERAGE

Vision Plan

Your eyesight is an integral part of your overall health and a key component of safety. This plan, provided through VSP, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the Signature vision network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan.

Receiving benefits from a network provider is as easy as making an appointment with the provider of your choice from the list of providers. The provider will coordinate all necessary authorizations you supply in your membership information.

Special discounts are offered on non-covered services, such as an additional pair of glasses, special lens options and LASIK.

To find an in-network provider, go to www.vsp.com and Find a doctor.

Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary of Benefits and Coverage (SBC) .

Key Benefits	VSP Signature	
	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10 copay	Up to $50
Materials Copay	$25 copay	
Frames (once every 12 months)	Up to $150 Allowance	Up to $70
Lenses (once every 12 months)		
Single Vision	Materials Copay	Up to $50
Bifocal	Materials Copay	Up to $75
Trifocal	Materials Copay	Up to $100
Contact Lenses (in lieu of glasses; once every 12 months)		
Contacts Fitting & Evaluation	$60 copay	
Medically Necessary	Covered in Full	Up to $210
Elective	Up to $150 Allowance	Up to $105

*If you are enrolled in the Medical Plan, Premera's Vision Benefits will act as secondary coverage. After your VSP plan benefits are exhausted, your provider may submit remaining eligible vision expenses to Premera for review and coverage.

WEALTH

HEALTH SAVINGS ACCOUNT (HSA)

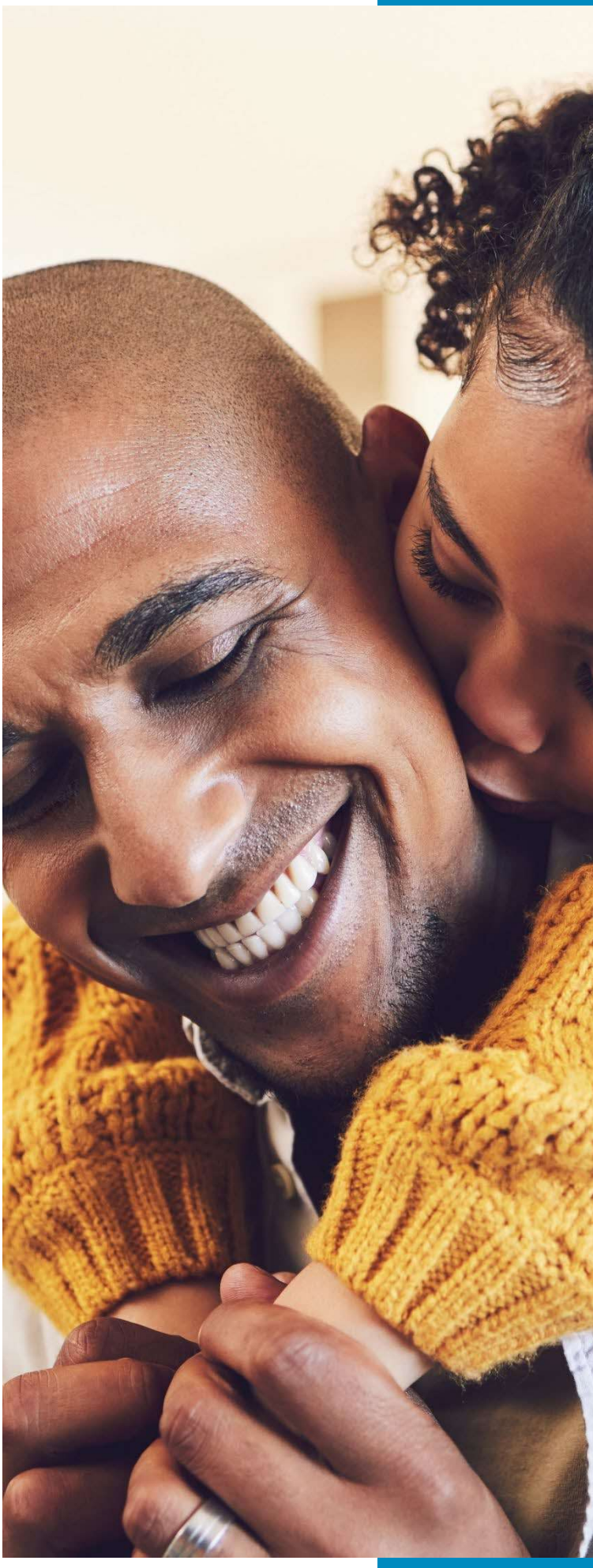
The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions or make after-tax contributions that are deductible when you file your taxes.
- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Contribution Limits

Coverage Tier	2026
Individual	$4,400
Family	$8,750
Catch-up Contributions	$1,000



HEALTH SAVINGS ACCOUNT (HSA)

Key Features of the HSA

Triple-Tax Advantage

- You contribute funds pre-tax through convenient payroll deductions. This means the money comes out of your paycheck before income tax is calculated. So, you get to keep a bigger portion of your paycheck.
- HSA funds grow tax free, and unused funds roll over year to year. So, the more you save, the more your account will grow—just like a bank savings account.
- If you need to use your HSA funds, you can withdraw them tax free to pay for qualified health care expenses now and in the future—even in retirement.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it. You can use it to pay for doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free.

Savings Potential

Your HSA is like a "health care 401(k)." There is no "use it or lose it" rule. Your account grows over time as you continue to roll over unused dollars from year to year.

Portability

Your HSA is yours for life. The money is yours to spend or save, even if you change health plans,[1] retire or leave the organization.

Qualified Health Care Expenses

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in Publication 502 (https://www.irs.gov/forms-pubs/about-publication-502).
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)
- Medigap insurance premiums

Important Notes

- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969 (https://www.irs.gov/forms-pubs/about-publication-969).
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

Scan this code to watch a video about how an HSA works.

1. You must be enrolled in an IRS-qualified high-deductible health plan to contribute to an HSA.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

The flexible spending accounts (FSAs), provided through **iSolved Benefit services**, are tax-advantaged accounts that can help you cover certain qualified out-of-pocket expenses. Each account works in much the same way but has different eligibility requirements, list of qualified expenses and contribution limits. You may choose to enroll in the following accounts.

	Health Care FSA (HCFSA)	Limited-Purpose FSA (LPFSA)	Dependent Care FSA (DCFSA)
Eligibility Requirements	You must be benefits eligible; enrollment in an HCFSA disqualifies you from making or receiving HSA contributions	You must be benefits eligible; most employers also require enrollment in a qualified high-deductible health plan	Available to all eligible employees
Examples of Qualified Expenses	• Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions	• Dental and vision coinsurance only • Dental and vision deductibles only • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia	• Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers • Care of household members who are physically or mentally incapable of caring for themselves and who qualify as your federal tax dependent
Annual Contribution Limit	$3,400	$3,400	$7,500 per family (or $3,750 each if you are married and file separate tax returns)

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **You must enroll each year to participate.**
- **HCFSA:** Unused funds of up to $680 from one year can carry over to the following year. Carryover funds will not count against or offset the amount that you can contribute annually. Unused funds over $680 will **not** be returned to you or carried over to the following year.
- **DCFSA:** Unused funds will NOT be returned to you or carried over to the following year.

Scan this code to watch a video about how an FSA works.

BASIC LIFE INSURANCE

Life insurance, provided through **Prudential**, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D (employer-paid)

	Benefit Amount
Employee	50,000

Scan this code to watch a video about how life insurance works.

IMPUTED INCOME

Imputed income is the value of non-monetary compensation or benefits provided to you by the school, such as health insurance premiums and life insurance coverage. Even though these benefits are not received in cash form, they are considered part of your overall compensation package and are subject to taxation.

Under federal tax law, if the total coverage of your company-paid basic life insurance is more than $50,000, the premium paid for the coverage above $50,000 is considered imputed income and will be added to your W-2 earnings. You must pay federal, state and Social Security taxes on this amount.

VOLUNTARY LIFE INSURANCE

Life insurance, provided through **Prudential** provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Supplemental Life and AD&D (employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

Coverage Tier	Benefit Amount	Guaranteed Issue Amount
Employee	Increments of $5,000, Up to $500,000 Not to exceed 5x annual salary	$200,000
Spouse	Increments of $2,500 up to $200,000 Not to exceed 50% of employee benefit amount	$55,000
Child(ren) **Birth – 6 months** **6 months – Age 26**	Flat $10,000	$10,000

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.

Scan this code to watch a video about how life insurance works.

INSURANCE CALCULATOR

Employee & Spouse Rates Per $1,000 of coverage	
Age	**Rate**
Under 35	$.06
35-39	$.10
40-44	$.15
45-49	$.24
50-54	$.42
55-59	$.71
60-64	$0.97
65-69	$1.61
70-74	$2.85
75+	$4.80
Child Rate	
Monthly is $1.20 regardless of the number of children in the family	

Here's how to calculate your monthly premium:

Step 1
Select your volume (amout of coverage) = $ _____

Step 2
Multiply your volume by your Age Rate = $ _____

Step 3
Divide the amount in Step 2 by $1,000 = $ _____
Monthly Premium

Evidence of Insurability (EOI)

- **First Eligible**: up to guarantee issue, no EOI
- **Qualifying event**: Enrolling or increasing to guarantee issue, no EOI
- **Open enrollment:** enrolling or increasing requires EOI
- **No qualifying event**: enrolling or increasing requires EOI

Annual Life Increases

For those already enrolled, you can increase your coverage up to the guaranteed issue of $200,000 in $10,000 increments, up to $50,000 per year, with no EOI.

HOW MUCH LIFE INSURANCE DO YOU NEED?

Estimating your life insurance needs

There is no one-size-fits-all answer to how much life insurance you need. The ideal coverage should:

- Replace your income
- Cover funeral or memorial costs
- Pay for long-term care in case of a terminal illness
- Meet other financial obligations, such as mortgage payments and deb

Income x 10: A simple estimation

A simple way to estimate your life insurance needs is to multiply your annual income by 10. This will give you a rough idea of a policy's face value.

- **Number of dependents**: A lump sum for each child to cover educational and other expenses.
- **Additional debts**: Include any existing debts that need to be settled.
- **Inheritance goals**: For those who wish to leave a lasting financial legacy, consider increasing your coverage.

Life Insurance calculator example

Your Age: **35**
Your gender: **Female**
Do you have a Spouse/Domestic partner: **Yes**
Children: **2**
Age of youngest child: **9 years**
Annual salary: **$60,000**

Estimated life insurance needs are $891,000

Some of the key assumptions made include:
Monthly housing costs: $1,355
Years to cover housing: 29 years
Number of children: 2
Child college costs: $373,720
Expensed covered by spouse/partner: 35%
Savings and investments: $251,800

Prudential provides a life insurance calculator on their website:

https://www.prudential.com/financial-education/calculate-life-insurance

DISABILITY INSURANCE

Disability insurance, provided through **Prudential** provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

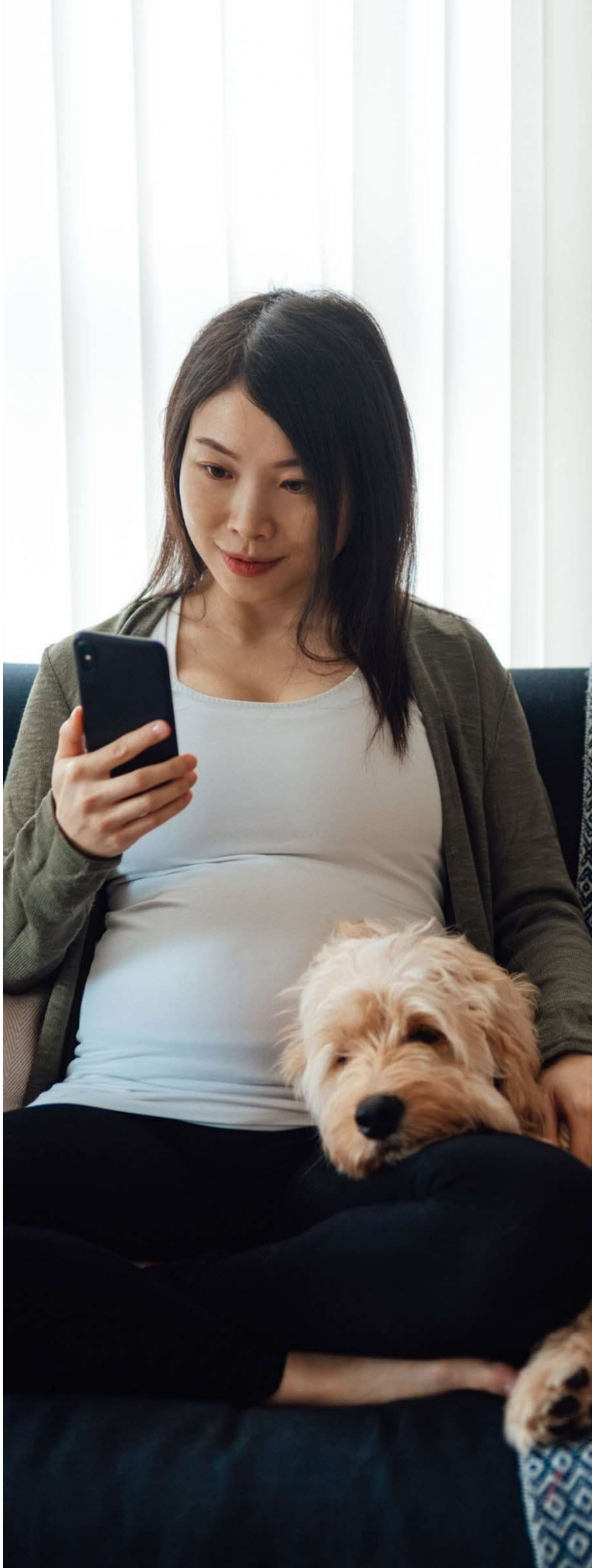
Short-Term Disability

Provided at NO COST to you	
Benefit	60% of base salary
Maximum monthly benefit	$1,000
When benefit begins	After 14th day of diability
When benefit ends	Normal Social Security Retirement Age

Long-Term Disability

Provided at NO COST to you	
Benefit	60% of base salary
Maximum monthly benefit	$5,000
When benefit begins	After 90th day of disability
When benefit ends	Normal Social Security Retirement Age

Scan this code to watch a video about how disability insurance works.



VOLUNTARY ACCIDENT INSURANCE

Accident Insurance

Accident insurance, provided through **Prudential** can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: you visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But treating a broken leg can cost thousands of dollars. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

Accident insurance pays a fixed cash benefit directly to you when you have a covered accident-related injury, like a sprain or bone fracture. Examples of covered expenses include:

- Doctor's office visits
- Diagnostic exams
- Broken leg rehab treatment
- Physical therapy sessions

Accident Insurance in Practice	
Situation	Abed broke his leg in a bike accident.
Covered Benefits	• Doctor's office visits • Diagnostic exams • Broken leg rehab treatment • Physical therapy sessions
Total Benefit Paid Directly to Employee	Up to $25,000

Scan this code to watch a video about how an accident plan works.

VOLUNTARY CRITICAL ILLNESS

Critical Illness Insurance

About half of U.S. adults report being unable to pay an unexpected medical bill of $500 without going into debt.[1] With critical illness insurance provided through **Prudential** you won't have to. This benefit provides a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition such as a heart attack or stroke. You can use this benefit however you like, including to help pay for:

- Increased living expenses
- Prescriptions
- Travel expenses
- Treatments

Critical Illness Insurance in Practice	
Situation	Britta had a heart attack while raking leaves.
Covered Benefits	Heart attack diagnosis
Total Benefit Paid Directly to Employee	$20,000

Scan this code to watch a video about how a critical illness plan works.

1. Kaiser Family Foundation. "Americans' Challenges with Health Care Costs." Kaiser Family Foundation, kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs.

VOLUNTARY HOSPITAL INDEMNITY

Hospital Indemnity Insurance

When you or a dependent need to be hospitalized, your family deserves to focus on their well-being, not the stress of a stint at the hospital, which can cost an average of $3,025 per inpatient day.[1] Hospital indemnity, provided through **Prudential** pays a fixed cash benefit directly to you when you experience:

- Hospital admissions
- Hospital stays
- Intensive care unit stays

Hospital Indemnity Insurance in Practice	
Situation	Craig was hospitalized following a car accident.
Covered Benefits	• Hospital admission • Hospital stay • Intensive care unit stay

Scan this code to watch a video about how a hospital indemnity plan works.

1. Kaiser Family Foundation. "Expenses per Inpatient Day." Kaiser Family Foundation, kff.org/health-costs/state-indicator/expenses-per-inpatient-day.

WELLBEING

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is full of challenges and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The Employee Assistance Program (EAP) is provided at NO COST to you through First Choice Health.

The EAP can help with the following issues, among many others:

- Mental health
- Relationships
- Substance use
- Child and eldercare
- Grief and loss
- Legal or financial issues

EAP Benefits

- Assistance for you and your household members
- Up to FOUR (4) in-person or virtual sessions with a counselor per event, per year, per individual
- Unlimited toll-free phone access and online resources

QUESTIONS?

To learn more, visit www.firstchoiceeap.com

For questions, contact (800) 777-4114
Login at firsthchoiceap.com

Username: lsnw

Scan this code to watch a video about how an EAP works.

ADDITIONAL RESOURCES

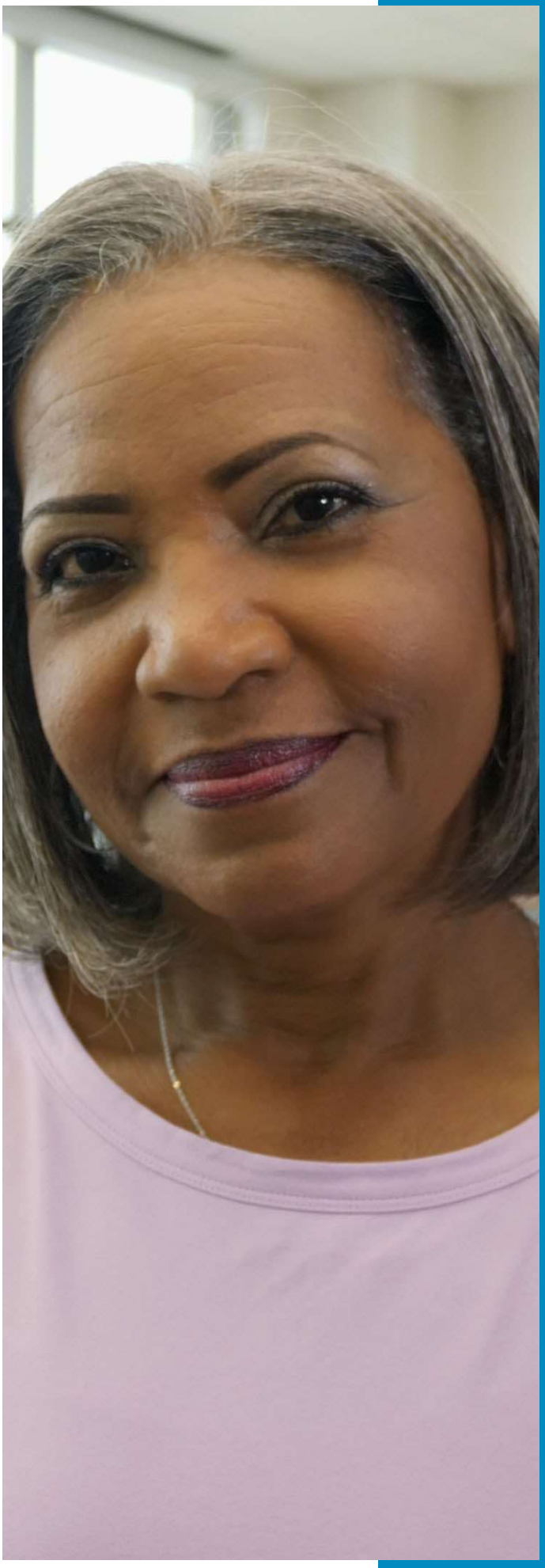
MEDICARE GUIDANCE

HUB Medicare Advocacy

The HUB Senior and Individual Team Medicare advocacy service is available at no cost to you and your family members who are approaching Medicare eligibility and/or who are already Medicare eligible. HUB can:

- Answer basic questions about Medicare coverage and enrollment
- Provide guidance on how to avoid late enrollment penalties and coverage gap pitfalls, including COBRA
- Compare current coverage to Medicare and explain the differences between the two
- Provide retiree benefits counseling
- Help individuals shopping for Medicare Supplement Plans, Advantage Plans and Part D

For more information or to get started, email medicarehub@hubinternational.com.



PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members. Contribution amounts are based on 26 pay periods.

Medical

Coverage	Premera HSA 3000			
	Monthly Premium	CHCC Monthly	Employee Monthly	Employee Per Paycheck
Employee Only	$845.93	$805.98	$39.95	$18.44
Employee + Spouse	$1,903.35	$805.98	$1,097.37	$506.48
Employee + Child(ren)	$1,480.38	$805.98	$674.40	$311.26
Employee + Family	$2,537.80	$805.98	$1,903.35	$878.47

Coverage	Premera PPO $2,000			
	Monthly Premium	CHCC Monthly	Employee Monthly	Employee Per Paycheck
Employee Only	$948.21	$805.98	$142.23	$65.64
Employee + Spouse	$2,133.48	$805.98	$1,327.50	$612.69
Employee + Child(ren)	$1,659.37	$805.98	$853.39	$393.87
Employee + Family	$2,844.63	$805.98	$2,210.18	$1,020.08

Coverage	Premera PPO $1,000			
	Monthly Premium	CHCC Monthly	Employee Monthly	Employee Per Paycheck
Employee Only	$1,005.47	$805.98	$199.49	$92.07
Employee + Spouse	$2,262.31	$805.98	$1,456.33	$672.15
Employee + Child(ren)	$1,759.58	$805.98	$953.60	$440.12
Employee + Family	$3,016.41	$805.98	$2,210.43	$1,020.20

Voluntary Hospital Indemnity

Coverage	Monthly Premium	Employee Per Paycheck
Employee Only	$24.73	$11.41
Employee + Spouse	$47.69	$22.01
Employee + Child(ren)	$60.40	$27.88
Employee + Family	$37.44	$17.28

PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members. Contribution amounts are based on 26 pay periods.

Dental

Coverage	Delta Dental Base			
	Monthly Premium	CHCC Monthly	Employee Monthly	Employee Per Paycheck
Employee Only	$45.00	$38.25	$6.75	$3.12
Employee + Spouse	$87.57	$38.25	$49.32	$22.76
Employee + Child(ren)	$107.99	$38.25	$69.74	$32.19
Employee + Family	$150.54	$38.25	$112.29	$51.83

Coverage	Delta Dental – Buy Up			
	Monthly Premium	CHCC Monthly	Employee Monthly	Employee Per Paycheck
Employee Only	$53.20	$38.25	$22.60	$6.90
Employee + Spouse	$103.42	$38.25	$72.82	$30.08
Employee + Child(ren)	$125.68	$38.25	$95.08	$40.35
Employee + Family	$175.89	$38.25	$145.29	$63.53

Vision

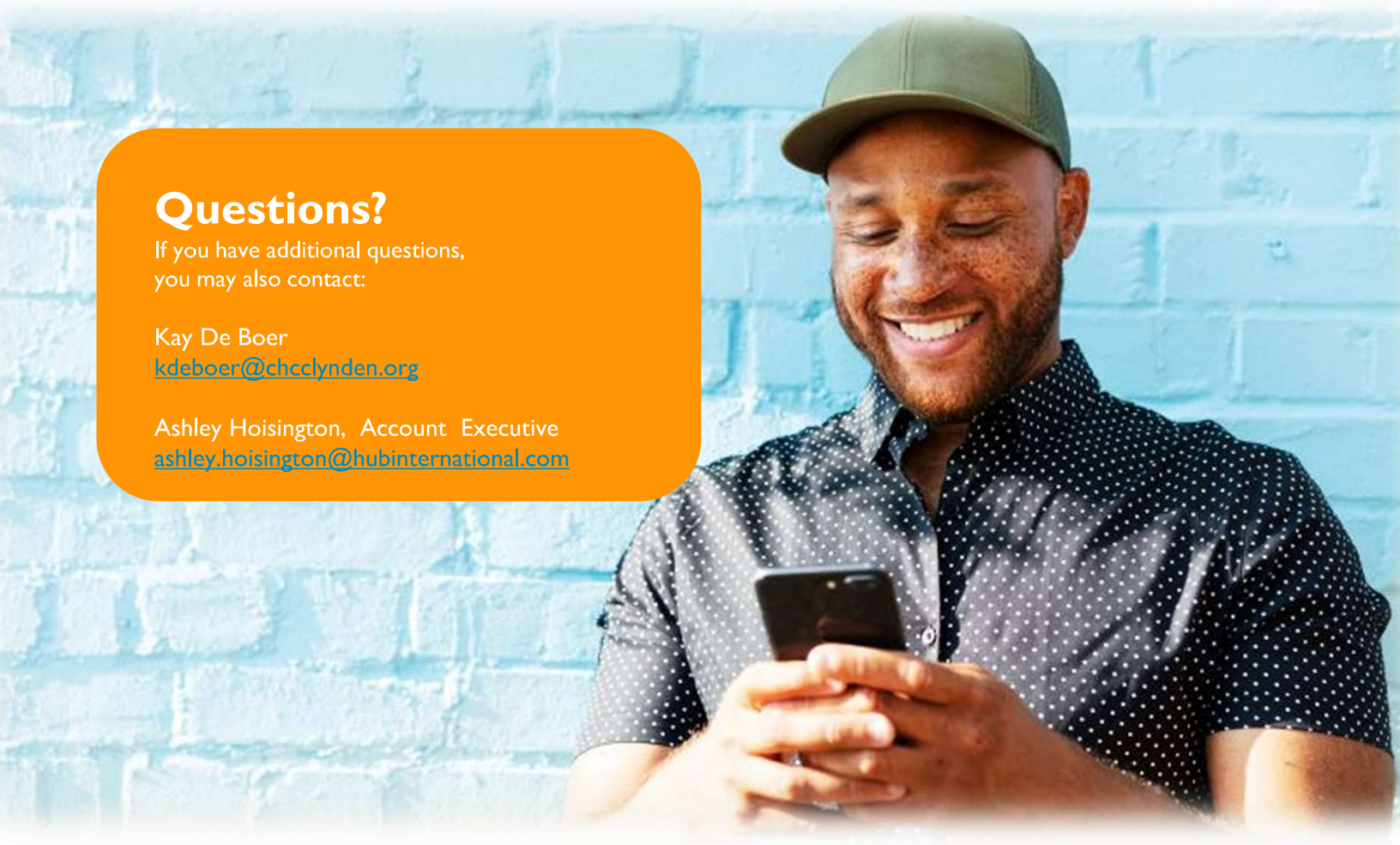
Coverage	Voluntary Vision			
	Monthly Premium	CHCC Monthly	Employee Monthly	Employee Per Paycheck
Employee Only	$6.88	$5.85	$1.03	$0.48
Employee + Spouse	$11.02	$5.85	$5.17	$2.39
Employee + Child(ren)	$11.26	$5.85	$5.41	$2.50
Employee + Family	$18.15	$5.85	$12.30	$5.68

Voluntary Accident

Coverage	Monthly Premium	Employee Per Paycheck
Employee Only	$7.32	$3.38
Employee + Spouse	$12.71	$5.87
Employee + Child(ren)	$23.40	$10.80
Employee + Family	$16.55	$7.64

CONTACTS

Coverage	Carrier	Phone Number	Plan #	Website
Medical	Premera	800-722-1471	#4028357	www.premera.com
Dental	Delta Dental	800-554-1907	Buy-Up: #00793 Base: #00794	www.deltadentalwa.com
Vision	VSP	800-877-7195	#30104018	www.vsp.com
Life AD&D	Prudential	800-778-4357	#51977	www.prudential.com
Disability	Prudential	800-778-4357	#51977	www.prudential.com
Employee Assistance Program (EAP)	First Choice Health	800-777-4114	Username: lsnw	www.FirstChoiceEAP.com
FSA	ISolved	866-370-3040	n/a	Isolvedbenefitservices.com



Questions?

If you have additional questions, you may also contact:

Kay De Boer
kdeboer@chcclynden.org

Ashley Hoisington, Account Executive
ashley.hoisington@hubinternational.com

BENEFIT TERMINOLOGY

Allowed amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95—the allowed amount for that service.

Balance billing

When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is $100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is $30.

Copayment

Oftentimes referred to as a "copay," this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $1,500, your plan will not pay anything for certain medical services until you have paid $1,500. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance policy. Hamlin Robinson School also allows domestic/civil union partners to be listed as dependents.

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

BENEFIT TERMINOLOGY

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, The PPO features an in-network family deductible of $1,500. If one member of the family satisfies the individual $750 deductible, the medical carrier will pay 80% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining $750, the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, The PPO features a family out-of-pocket maximum of $9,000. If one member of the family satisfies the individual out-of-pocket maximum of $4,500, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

BENEFIT TERMINOLOGY

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts.

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to traditional PPO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and employee, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren't forfeited; they roll over and accumulate over time.

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Member health statement

Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

BENEFIT TERMINOLOGY

Negotiated rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic.

Non-preferred provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

BENEFIT TERMINOLOGY

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs.

Preferred provider

A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Hamlin Robinson School, though there are insurance benefits the school pays for entirely, while there are others that you pay for yourself.

Premium (Medical)

The amount that is paid for your medical coverage. You and Hamlin Robinson School share this cost, which is paid monthly to the insurance carrier.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

Scan this code to watch a video about benefit terms.

BENEFIT TERMINOLOGY

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

Urgent care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.