2026 Benefits Guide

BENTON COUNTY (Kaiser+$24k Life)

This benefit overview is a summary of your benefits as an eligible employee. It is intended to provide a brief description of 2026 coverage and is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which a program may be continued in force. This summary is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions, please refer to the applicable summary plan documents posted to www.wcif.net. 2026 documents will be posted as they are approved by respective carriers.

BENTON COUNTY (Kaiser+$24k Life)

Welcome to the 2026 Benefits Overview!

- Medical
- Life & Disability
- EAP
- Value Add Plans
- Resources

This is your opportunity as an employee to make thoughtful benefit elections for you and your family for the upcoming year. During this time current members may change plans, add or remove dependents to existing plans, enroll in a new line of coverage, terminate an existing line of coverage. All open enrollment plan changes will be effective January 1, 2026.

Take some time to review this Benefits Guide thoroughly to ensure you select the plan(s) that best meet you and your family's needs.

Remember, this is your opportunity to make changes or enroll in any plans offered, otherwise you will have to wait until the next open enrollment period unless you experience a qualifying event.

Look for this icon throughout the Guide for important information!

2026 Plan Changes

Kaiser Permanente Plan Changes

- **State Mandate — Clarification on Hearing Aids**
  - Hardware dollar limit removed. The benefit will now cover one device per ear with hearing loss, every 36 months; coinsurance applies — minimum deductible and coinsurance apply to HSA plans.
- **State Mandate — Clarification on Infertility Treatment**
  - Preliminary infertility evaluation and diagnosis is covered and may be required prior to receiving artificial insemination benefit coverage.
- **Federal Mandate — HSA Minimum Deductible Increase**
  - Adjustment made to HSA plan minimum deductible levels for 2026 — $1,700 employee / $3,400 family.

BENEFITS RESOURCE CENTER

Check out our NEW Benefits Resource Center!

We're thrilled to announce our new partnership with BeneBits™ to bring your employees engaging, bite-sized benefits videos that are sure to capture their attention!

In addition, we have a library of Carrier Resources from our medical, dental, vision, life & disability, and ancillary carriers.

WELLNESS RESOURCE CENTER

Welcome to your new go-to hub for all things Wellness!

- Centralized wellness resources on wcif.net
- Self-service for admins & employees
- Organized by category – Mind, Fitness, Nutrition, Preventive, Financial, Community
- Carrier + WCIF programs

MEDICAL / Kaiser Permanente

KAISER PERMANENTE®

*The highlight summary below shows **in-network benefits only**. For Out-of-network benefits, please refer to the Summary of Benefits and Coverage for this plan on the WCIF website.*

BENEFITS	Core HSA 1700
Deductible (Ded) **Individual** **Family**	$1,700 Aggregate Family: $3,400
Coinsurance (Coins)	20%
Out-of-pocket max *(Includes copay and deductible)* ***Individual*** ***Family***	$3,500 Aggregate Family: $7,000
Office Visit	Ded / Coins
Preventive Care	Covered in Full
Welcome Rider	Not Applicable
Manipulations (spinal) *20 Visits Per Calendar Year*	Ded / Coins
Diagnostic Laboratory and X-ray Services *Some services may require pre-authorization*	Inpatient: Covered under Hospital Services
	Outpatient: Ded / Coins
Inpatient Facility	Ded / Coins
Outpatient Surgery Facility	Ded / Coins
Emergency Care *(copay waived if admitted)*	Ded / Coins
Bariatric Surgery *($25,000 Lifetime Benefit)*	Covered at applicable cost share up to $25,000 Lifetime Maximum
Hearing Hardware ***(1 device / per ear / 36 months)***	After Minimum Deductible, Coinsurance Applies

Please note: Active employer group medical coverage can only be waived if you have other group coverage. *The Federal Summary of Benefits and Coverage (SBC) for this plan is located on the WCIF website using the following QR code.*

SCAN CODE to view the Summary of Benefits and Coverage!

MEDICAL / Kaiser Permanente

KAISER PERMANENTE®

Prescription Drug Coverage

Your medical insurance includes comprehensive prescription drug coverage. The level of coverage depends on whether the drug is generic or brand name, and whether it is on the Kaiser Permanente formulary, or preferred drug list. Your out-of-pocket cost is lowest when you buy generic drugs, and highest when you buy brand name drugs that are not on the formulary. To find out if your medication is on the formulary, please check the online list at kp.org.

PRESCRIPTION DRUGS	Core HMO $1,700 - IRS Qualified HSA Plan
Drug List	Large Group 3-Tier Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = non-preferred
Retail Cost Shares	Deductible then $10/$20/$40 per 30 day supply Certain preventive medications covered in full
Mail Cost Shares	3 x prescription cost share per 90 day supply
Day Supply	Retail: 30 Days / Mail: 90 Days / Specialty: 30 Days
Individual Deductible PCY	No Individual Deductible
Family Deductible PCY	No Family Deductible
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited

KAISER PERMANENTE®

HSA Plan Preventive Medications

Covered in full—deductible does not apply

The generic prescription drugs listed below are considered preventive medications on our health savings account (HSA)-qualified plans offered through large employer groups, if applicable.

Preventive medications are not subject to plan deductibles, copays, or coinsurance, when they are filled by the Kaiser Permanente Mail Order Pharmacy or select pharmacies in your network – which means these drugs are covered in full right from the start.

Antihypertensives

Ace inhibitors
benazepril
benazepril / amlodipine
benazepril / hctz
captopril
captopril / hctz
enalapril
enalapril / hctz
fosinopril
fosinopril / hctz
lisinopril
lisinopril / hctz
moexipril
moexipril / hctz
quinapril
quinapril / hctz
ramipril
trandolapril

Angiotensin receptor blockers (ARBs)
losartan
losartan / hctz

Beta-blockers
acebutolol
atenolol
atenolol / chlorthalidone
atenolol / hctz
betaxolol
bisoprolol
bisoprolol / hctz
carvedilol
labetalol
metoprolol / hctz
metoprolol succinate
metoprolol tartrate
nadolol
nadolol / bendroflumethiazide
pindolol
propranolol
propranolol / hctz

Calcium channel blockers
amlodipine
amlodipine / benazepril
diltiazem
diltiazem cr
diltiazem er
felodipine
isradipine
sotalol
timolol
verapamil
verapamil cr

Diuretics
amiloride
amiloride / hctz
bumetanide
chlorothiazide
chlorthalidone
eplerenone
furosemide
hydrochlorothiazide
indapamide
methyclothiazide
metolazone
spironolactone
spironolactone / hctz
torsemide
triamterene / hctz

Blood thinning agents

clopidogrel

Lipid lowering agents

atorvastatin
lovastatin
pravastatin
simvastatin

Diabetes medications

Oral hypoglycemics
glimepiride
glipizide
glipizide / metformin
glipizide er
glipizide xl
glyburide
glyburide / metformin
glyburide micronized
metformin
metformin er

Insulin
NPH insulin

Inhaled corticosteroids

ciclesonide

Osteoporosis drugs

alendronate
alendronate / vitamin D

Vitamins

generic prenatal vitamins with folate

This list only contains generic medications that are covered in full for HSA-qualified health plans and is subject to change at the discretion of Kaiser Permanente without prior notification. Not all dosage forms for drugs listed above are covered in full. Please consult your Benefits Booklet or call Member Services if you have questions about your drug coverage.

cr: controlled release
er: extended release
hctz: hydrochlorothiazide
xl: extended release

Basic Life & AD&D / The Standard

Basic Life & AD&D

Employer-paid life insurance is an important working benefit. It provides your loved ones with a little additional income if you pass away. It helps serve as a financial safety net during the most crucial income earning years. Your employer maintains a Basic Life/AD&D Plan for you that provides **a $24,000 benefit.**

Age Reduction Schedule	At Age: 70……..65% of original amount 75……..45% of original amount 80……..30% of original amount
AD&D Benefit	The AD&D benefit is equal to the amount of your Life Insurance Benefit. Certain Losses are payable at an amount less than 100% of the AD&D insurance benefit. See AD&D Table of Losses in Certificate.
Seat Belt Benefit	The amount of the Seat Belt Benefit is the lesser of (1) $25,000 or (2) the amount of AD&D Insurance Benefit payable for loss of your life.
Air Bag Benefit	The amount of the Air Bag Benefit is the lesser of (1) $5,000 or (2) the amount of AD&D Insurance Benefit payable for loss of your life.
Additional Features	Waiver of Premium Portability and Conversion Options Career Adjustment Benefit Higher Education Benefit Occupational Assault Benefit Public Transportation Benefit
Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75% of your basic life benefit to an overall maximum of $500,000 (voluntary life included).
Travel Assistance Benefit	The Travel Assistance Program helps employees cope with emergencies when the employee and/or their dependents travel more than 100 miles from home or internationally for trips up to 180 days. The program can also help with non-emergencies, such as trip planning.
Life Services Toolkit	The Life Services Toolkit includes online tools and services that can help employees create a will, make advance funeral plans and put their finances in order. After a loss, their beneficiary can consult experts by phone or in person and obtain other helpful information online.

Beneficiary Designation

Setting up beneficiaries isn't a one-time thing. Be sure to **review your beneficiary designations** regularly, especially after life events such as marriage, divorce, birth, and death. Circumstances might have changed for you or your beneficiaries, and you may need to alter your designations to reflect that. This is a great time of year to review and make any necessary changes.

SCAN THIS CODE FOR MORE INFO!

Voluntary Life / The Standard

Voluntary Life (VL)

The time you spend with your family is priceless, and you wouldn't trade those special moments together for anything in the world. But what would happen if you suddenly pass away?

Would your family have the funds to pay bills, your home mortgage, burial and funeral expenses? Would your family be able to live on one income and maintain their current lifestyle? What about medical expenses associated with a terminal illness? Would your family be financially prepared? Your employer offers you an excellent opportunity to help protect your loved ones by sponsoring group Voluntary Life (VL) coverage.

How much coverage may I get for myself and my dependents?

- You may elect VL coverage for yourself in units of $10,000 to a maximum of $500,000 or 6 times your annual salary (whichever is less) when combined with your employer-provided Basic Life/AD&D coverage.
- You may elect VL coverage for your spouse in units of $10,000 to a maximum of $250,000, but not to exceed 100% of your VL coverage.

You may elect VL coverage for your children in units of $2,000 to a maximum of $10,000, but not to exceed 100% of your VL coverage.

If you enroll within 31 days of benefit eligibility and actively working, you will automatically qualify for up to a set amount of insurance coverage called the "guarantee issue amount."

Guarantee issue coverage only applies during the

Guarantee Issue Amount*	Employee……..$200,000 Spouse……..$50,000 Children……..$10,000 **Note: At Open Enrollment, coverage can be increased up to $20k for employees and $10k for spouse/DP, up to the Guarantee Issue limit without providing Evidence of Insurability (EOI).**
Age Reduction Schedule	At Age: 70……..65% of original amount 75……..45% of original amount 80……..30% of original amount Spouse coverage amount terminates the date your spouse reaches age 70.
Waiver of Premium	If you become totally disabled while insured under the voluntary life plan, are under age 60 **and** complete a waiting period of 180 days, your voluntary life insurance may continue without premium payment until age 65 provided you give Standard satisfactory proof that you remain totally disabled.
Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75 percent of your voluntary life maximum benefit to an overall maximum of $500,000 (basic life included).
Portability and Conversion	You may continue your insurance if your employment with your employer terminates. Please see the Portability and Conversion page of this Guide for eligibility and timeline requirements.

Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Age as of December 31	Premium per $10,000 of coverage		Age as of December 31	Premium per $10,000 of coverage	
	Employee	Spouse		Employee	Spouse
Under 20	$0.56	$0.60	45 — 49	$2.35	$2.45
20 — 24	$0.66	$0.70	50 — 54	$3.91	$4.09
25 — 29	$0.71	$0.75	55 — 59	$5.81	$5.87
30 — 34	$0.82	$0.90	60 — 64	$8.74	$9.57
35 — 39	$0.98	$1.05	65 — 69	$12.53	$13.53
40 — 44	$1.45	$1.55	70 or Over	$12.53	N/A

SCAN THIS CODE FOR MORE INFO!

Voluntary AD&D / The Standard

Voluntary Accidental Death & Dismemberment (VAD&D)

It's a fact of life. Accidents happen, often when you least expect them. Car wreck on the freeway, fall from a ladder at home, mishap with machinery. According to the Centers for Disease Control and Prevention accidents were the 3rd leading cause of death in 2017. What if it happened to you?

Would your family have the funds to pay bills, the home mortgage, burial and funeral expenses? Would your family be financially prepared? Your employer offers you an excellent opportunity to help protect your loved ones by sponsoring group Voluntary Accidental Death and Dismemberment (VAD&D) coverage. Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Coverage Amount	Employee……..$25,000 increments to $500,000; Amounts over $250,000 limited to 10x your earnings Spouse……50% or 100% of your AD&D coverage amount Children……..10% of your AD&D coverage amount to a max of $30,000
Age Reduction Schedule	At Age: 70……..65% of original amount 75……..45% of original amount 80……..30% of original amount 85……..20% of original amount 90……..15% of original amount 95……..10% of original amount
Benefit Schedule	Table of Losses *Loss:* — *Percentage Payable* Loss of Life — 100% One hand or one foot — 50% Sight in one eye, speech, or hearing in both ears — 50% Two of more of the losses listed above — 100% Thumb and index finger of the same hand — 25% Quadriplegia — 100% Hemiplegia — 50% Paraplegia — 50%
Additional Features	Seat Belt Benefit Higher Education Benefit Career Adjustment Benefit Paralysis Benefit Common Disaster Benefit

Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Rate per unit (unit = $1,000)	
Employee	**$0.025**
Spouse/Domestic Partner	**$0.025**
Child(ren)	**$0.030**

SCAN THIS CODE FOR MORE INFO!

Base LTD / The Standard

Base Plan provided to employees enrolled in medical

Base Long Term Disability (LTD)

Have you ever thought about how you would protect yourself, your lifestyle, and those who count on you from an unexpected loss of income? Would you be able to meet your financial obligations if you became disabled and unable to work? If you depend on your regular paycheck to pay your bills, what would happen if you became sick or injured and couldn't work? Your employer provides eligible employees with Base LTD coverage to help protect a certain level of income.

Benefit Waiting Period	**180 Days**
Benefit Percentage	**40%**
Maximum Pre-disability Earnings	$10,000
Benefit Minimum	$100
Benefit Maximum	**$4,000**
Definition of Disability— Own Occupation Period	During benefit waiting period and first 24 months for which LTD benefits are paid, you will be considered disabled if you are unable to perform with reasonable continuity the material duties of your own occupation or suffering at least a 20% earnings loss of indexed pre-disability earnings.
Definition of Disability— Any Occupation Period	After the own occupation period, you will be considered disabled if you are unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of any occupation: That you are able to perform due to education, training or experience That is available at one or more locations in the local economy In which you can be expected to earn at least 60% of pre-disability earnings within 12 months of returning to work, regardless of whether you are working in that, or any other occupation.
Maximum Benefit Period	Social Security Normal Retirement Age (SSNRA)
Return to Work Incentive	12 Months
Survivor Benefit	Lump sum equal to 3 times gross monthly benefit

Guarantee issue coverage only applies during the initial eligibility period.

SCAN THIS CODE FOR MORE INFO!

Buy-Up LTD / The Standard

Buy-Up Plan available to employees in Base Plan

Voluntary Buy-up Long Term Disability (Buy-up LTD)

Base Plan provided to eligible employees, Buy-Up Plan available to employees in Base Plan

Since every employee's needs are different, your employer also provides eligible employees with the opportunity to apply for coverage under a voluntary Buy-up LTD plan from The Standard. The advantages of the Voluntary Buy-up LTD coverage include choice, flexibility, convenience, and peace of mind.

If you are enrolled in the Base LTD plan, your employer offers you an opportunity to purchase Voluntary Buy-up LTD benefits on a discounted basis based on your salary. This is an excellent opportunity to help protect yourself and your lifestyle. The coverage under the Voluntary Buy-up LTD plan increase the Base LTD plan benefits.

Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Benefit Amount: 60% of pre-disability earnings (up to $10,000 monthly salary)

Maximum Benefit: $6,000 per month **Waiting Period:** 90 days from the date of disability

Rates

If you elect the Buy-up LTD plan, your monthly premium rate for this plan is indicated in the tables below. Premiums for the Buy-up LTD plan will be deducted directly from your paycheck. If you do not enroll in the Buy-up LTD plan, subject to eligibility requirements, you will automatically be insured under the base LTD plan with no premium cost to you.

If your employer IS OFFERING medical coverage through WCIF

Your Average Monthly Earnings (as of the prior December 31, or the date you become insured, whichever is later)	Monthly Premium Rate
$999 or under	$3.75
$1,000 through $1,499	$6.25
$1,500 through $1,999	$8.75
$2,000 through $2,499	$11.25
$2,500 through $2,999	$13.75
$3,000 through $3,499	$16.25
$3,500 through $3,999	$18.75
$4,000 through $4,499	$21.25
$4,500 through $4,999	$23.75
$5,000 through $5,499	$26.25
$5,500 through $5,999	$28.75
$6,000 through $6,499	$31.25
$6,500 through $6,999	$33.75
$7,000 through $7,499	$36.25
$7,500 through $7,999	$38.75
$8,000 through $8,499	$41.25
$8,500 through $8,999	$43.75
$9,000 through $9,499	$46.25
$9,500 or over	$48.75

SCAN THIS CODE FOR MORE INFO!

EAP / First Choice Health

First Choice Health®

EAP (Employee Assistance Program)

Welcome to the First Choice Health Employee Assistance Program (EAP). The plan offers up to 6 face-to-face sessions at no cost (no co-pay, deductible, or premium) with a qualified clinical expert who can assess your concerns and develop a plan of action.

We want to be the first place you turn when facing issues that interfere with your health, well-being, and productivity at work or home. Our professional staff and rich provider network ensure the right resources are available when you need them most.

The EAP program provides you, your household members, and children up to age 26, coaching and problem solving services that are free, convenient, and confidential with a licensed behavioral health provider.

EAP helps with a variety of family, relationship, emotional, behavioral, mental health, and substance abuse concerns, including:

• Anxiety/Depression/Other	• Alcohol/Drug/Other Addictions
• Mental Health Issues	• Grief and Loss
• Couples/Relationships/Parenting	• Work Conflict
• Crisis Support	• Domestic Violence

CONFIDENTIAL SERVICES

We know that making it possible to consult discreetly with a behavioral health provider is essential, and perhaps the most important role of the EAP. Be assured that information about you and your contact with the EAP is never released without your signed consent (except as required by law to ensure your or others' safety).

LEGAL CONSULTATIONS

You have access to a free 30-minute legal consultation, face-to-face, or by telephone. Typical issues include wills and estate planning, family and domestic concerns, motor vehicle matters, civil issues, elder law, divorce and parenting plans, juvenile issues, and a variety of other concerns. Should you decide to retain the attorney for ongoing services, you will receive a 25% reduction in the attorney's normal hourly fees. Legal forms and templates are also available free on the website.

Employment related concerns are not covered.

FINANCIAL SERVICES

Financial counselors are available for a free 30-minute telephone consultation. Topics include: budgeting, estate planning, credit card consolidation, savings, debt management, retirement planning, and more.

Look to **firstchoiceeap.com** for money-saving tips and resources on many other topics related to finances.

IDENTITY THEFT CONSULTATIONS

If you should become a victim, know that our Fraud Resolution Specialists are here to help. Our team of qualified legal professionals can provide you with step-by-step guidance and consultation about identity theft or fraud.

CHILDCARE REFERRALS

This convenient service offers families and parents resources for child-related needs. Qualified childcare professionals help identify services including: prenatal care, daycare, summer activities, special needs resources, adoption, child development, parenting skills, step-parenting, and college planning.

ELDERCARE SERVICES

If you're concerned about an aging or disabled loved one, our eldercare experts can provide you with resources, regardless of where your family member lives. This comprehensive service can save you time and increase your peace of mind with information on Medicare, Social Security, in-home care, transportation, chore services, assisted living, and many other resources.

HOME OWNERSHIP PROGRAM

The Home ownership program is a valuable tool to gain a competitive edge, and can save you thousands when buying, selling, or refinancing a home. Receive no-cost Home Ownership coaching with individualized strategies for success, plus access to a network of prescreened mortgage and real estate professionals.

24/7 Online Access to EAP Services

To access **webinars**, **trainings**, **tools**, and **forms**, visit the EAP website at:

fch.personaladvantage.com

Enter username:

WCIF

(800) 777-4114

24/7 TELEHEALTH

Convenient, private virtual therapy. Anytime, Anywhere. Talk with a licensed, professional therapist online to get advice, guidance and counseling.

It's professional.

Talkspace offers private and convenient mental health support on your schedule. Engage in counseling and therapy, from the convenience of your device. All care is delivered virtually by a behavioral health clinician or medical professional. Talkspace's network includes thousands of licensed, insured, and verified therapists who can treat a variety of needs.

It's convenient.

Help is available on your own time, at your own pace, and wherever it's most convenient. **Connect via text, phone or secure video.**

It's free to get started.

After your initial free sessions, you can continue to use Talkspace through your health insurance (some exceptions may apply), or with a membership/ subscription plan (monthly payments) which can be canceled at any time.

HERE'S HOW IT WORKS:

1. **You can self-refer through our direct Talkspace link:** www.talkspace.com/FirstChoiceHealthEAP.
2. **You may also call** First Choice Health EAP at (800) 777-4114 or request a referral online at www.firstchoiceEAP.com.
3. **Complete a brief matching questionnaire.**
4. **Match with a counselor and get started!** Communicate via whichever method best meets your needs.

VALUE ADD PLAN — PET INSURANCE / MetLife

Available to all employees

MetLife

Plan Highlights

2022 PET INNOVATION AWARD
PET INSURANCE OF THE YEAR

What is Pet Insurance?
Similar to health insurance for you and your family, Pet Insurance is coverage for dogs and cats that can help you be prepared for unexpected vet costs.

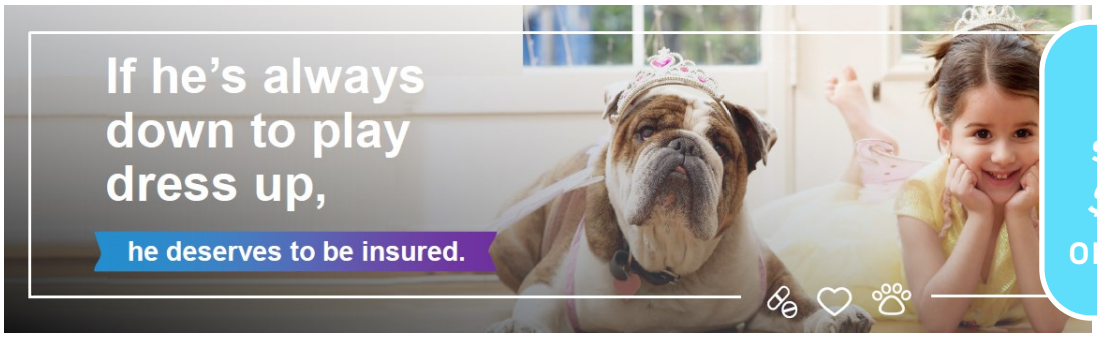
Why MetLife Pet Insurance?
With MetLife, pet parents have the power of choice to customize their Pet Insurance to meet their needs.

Coverage includes:
- accidental injuries
- illnesses
- exam fees
- surgeries
- medications
- ultrasounds
- hospital stays
- X-rays and diagnostic
- hip dysplasia
- hereditary conditions
- congenital conditions
- holistic care
- chronic conditions
- alternative therapies
- and much more!

How much will it cost?
Each pet's premium will be unique based on the age, breed, location, as well as what coverage amount you select. Plus, if you go claim-free in a policy year, we'll automatically decrease your deductible by $25 or $50. There are also a variety of discounts available. You can set up automatic payment through the online portal.

Can I still use my vet?
Yes! You can visit any U.S. licensed vet, emergency clinic, or specialist. Your coverage is also portable—you can take your coverage with you if you leave your employer.

SCAN THIS CODE FOR MORE INFO!



Pet parents spend *nearly $4,500 a year* on annual care.

Get a quote by visiting:
metlifepetinsurance.com/WCIF
OR **Call** 1-800-GET-MET8

VALUE ADD PLAN — DISCOUNT CENTER / BenefitHub

BenefitHub™

Available to all employees

Check out BenefitHub for everyday savings!

Tally Up Your Annual Savings to Over $5,000!

With Wurth Discount Marketplace, employees can save over $5,000 a year! Receive access to exclusive discounts in almost every shopping category.

Ride in style with auto savings.

Travel to new destinations.

Spruce up your home and treat the fam.

Look stylish with new apparel.

Experience more with event tickets.

See you how much you can save!

Scan the QR code to enroll today!
Use code: **IBWY7X**

RESOURCES

Dependent Eligibility

The following dependents are eligible for coverage after the employee has satisfied their initial waiting period required by the employer. Please note, dependents must be enrolled in the same plan(s) as the employee.

- A lawful spouse or domestic partner (legally separated spouses may not be eligible)
- Child(ren) of employee, spouse or domestic partner to the age of 26 including:
  - biological,
  - step,
  - foster,
  - adopted children from the date of assumption of legal obligation for total or partial support,
  - children required by court order or qualified medical child support order (QMCSO) to be covered by a participant
  - Disabled dependent child(ren) over age 26. See employer for details.

All other dependent children are not eligible without evidence of legal guardianship.

Enrollment Changes for Qualified Life Events

Many benefits are regulated by Section 125 regulations (if applicable) and other plan rules require that elections not be changed except during new hire or annual open enrollment periods. However, certain qualified events allow you to change your elections during the plan year. Below is a chart of the Life Events that allow for a mid-year change. Please reach out to your Human Resources Department with any questions and specific timeframe requirements.

Dependent	Enrollment Deadline
Newborn Child	Within 60 days of birth
Adopted Child	Within 60 days of placement in an employee's home
Foster child	Within 60 days of placement in an employee's home
Child Under Legal Guardianship	Within 60 days of legal guardianship being granted to employee
Spouse	Within 31 days of the date of marriage
Domestic Partner	Within 31 days of Washington State registration *or* within 31 days of the date of completed Affidavit of Domestic Partnership
Dependent of Spouse / Domestic Partner	*If existing dependent*, same rules as spouse/domestic partner (31 days – as shown above)
	If acquired *after* spouse's/domestic partner's effective date (60 days – as shown above)
Event	**Enrollment Deadline**
Involuntary Loss of Other Coverage	Within 31 days of the date the other coverage ended
State Medical Assistance and Children's Health Insurance Program (CHIP)	Within 60 days from the date of event

RESOURCES

Waiver of Medical Coverage

Active employer group medical coverage can only be waived if you have other group coverage.

Group coverage can be:

- Another employer plan
- Coverage through a spouse's/domestic partner's employer plan
- Government health plan
- Tricare
- VA (with ACA letter)
- Medicaid (Washington Apple Health)
- HealthPlanFinder (State marketplace plan)
- Medicare*

*If an employee waives active group coverage through the employer in favor of Medicare, Medicare Secondary Payer rules prohibit the employer from providing any incentive to waive active coverage. This includes HRA contributions and premium reimbursement for Medicare Supplement plans.

Beneficiary Designation

Setting up beneficiaries is not a one-time thing. Be sure to **review your beneficiary designations** regularly, especially after life events such as marriage, divorce, birth, and death. Circumstances might have changed for you or your beneficiaries, and you may need to alter your designations to reflect that.

This is a great time of year to review and make any necessary changes.

Members are only eligible for guarantee issue coverage in disability plans ***within their first 31 days of benefit eligibility***. Members who do not enroll within the guarantee issue period and decide to enroll at a later date will be subject to medical underwriting. Applications received after the first 31 days of eligibility or applicants requesting more than the guarantee issue limits must submit a Medical History Statement and be approved by the carrier before coverage becomes effective. Please review each benefit for specifics under your plan.

RESOURCES

MEDICAL / Kaiser Permanente

wa.kaiserpermanente.org
1.888.901.4636 (customer service)
1.800.297.6877 (24-hour nurseline)

KAISER PERMANENTE®

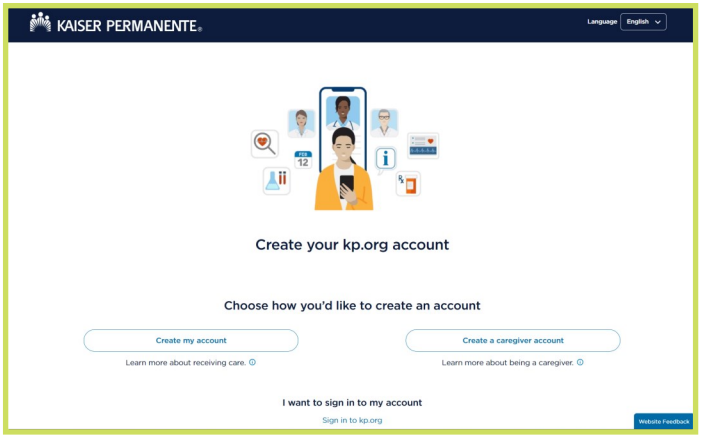
CLAIMS ADDRESS
Claims Processing, Kaiser Permanente
PO Box 30766
Salt Lake City UT, 84130

PRESCRIPTION DRUG CLAIMS
OptimumRx
PO Box 650334
Dallas TX, 75265

Create an Account

As soon as you receive your ID number register for online services. Register by visiting healthy.kaiserpermanente.org/register

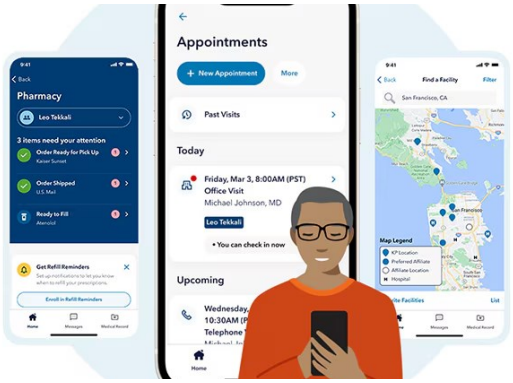
- Access your digital ID card
- Start or schedule virtual care
- Make in-person appointments
- Contact your care team
- Refill prescriptions
- View your lab results and medical record
- Pay bills



KP Mobile App

You'll have convenient, anywhere access to your health plan information – and more:

- **Find Care:** Know where to go for care. Find in-network doctors, hospitals, urgent care, and more.
- **Access your ID card** digitally.
- **Check claims** information and status.
- **Track your spending:** Know exactly how close you are to meeting your deductible and out-of-pocket maximum.
- **Sign in easily** and securely using Touch or Face ID.



In-Person Visit (Inside Kaiser Facilities):

1. Go to https://www.kaiserpermanente.org
2. Click "DOCTORS & LOCATIONS" at the top of the screen, then "WASHINGTON"
3. Under "WHAT CAN WE HELP YOU FIND", choose search type "DOCTORS" OR "LOCATIONS"
4. Fill in as much information as possible to narrow the search
5. Click "SEARCH"

In-Person Visit (Outside Kaiser Facilities):

1. Go to https://www.kaiserpermanente.org
2. Click "DOCTORS & LOCATIONS" at the top of the screen, then "WASHINGTON"
3. Look at the third paragraph and click "DOCTORS AND IN-NETWORK LOCATIONS"
4. Click on "QUICK SEARCH" in the bottom left corner
5. Use the dropdown menu under network to find "ACCESS PPO"
6. Fill in the rest of the information requested
7. A list of providers will appear along with contact information

RESOURCES

MEDICAL / Kaiser Permanente

wa.kaiserpermanente.org
1.888.901.4636 (customer service)
1.800.297.6877 (24-hour nurseline)

KAISER PERMANENTE®

CLAIMS ADDRESS
Claims Processing, Kaiser Permanente
PO Box 30766
Salt Lake City UT, 84130

PRESCRIPTION DRUG CLAIMS
Optum Rx
PO Box 650334
Dallas TX, 75265

Online Features & Virtual Care

See how easy it is to stay on top of your care and get care at home. When you register at **kp.org/wa/register** and download the Kaiser Permanente app, you get the most out of your membership.

E-VISITS
For common health conditions, members can fill out a short online questionnaire anytime. Get a personalized care plan or prescription, every day of the week, 9 a.m. to 9 p.m., including holidays.

PHONE VISITS
Members can talk to a clinician who can see their health history. Phone visits and 24/7 advice (no appointment needed) are available. Care options include routine or follow-up care as well as most prescription and lab orders.

VIDEO VISITS
Members can meet face to face with a clinician via video, by appointment, for the same high-quality care as an in-person visit. Video visits are also available 24/7 with no appointment needed for minor health conditions. Care options include routine or follow-up care as well as most prescription and lab orders.

24/7 ONLINE CHAT
Members can chat online with a Kaiser Permanente clinician to get real-time care, treatment, and prescriptions.

24/7 ADVICE
Licensed medical professionals are available to speak to members, anytime, day or night. Members can call 1-800-297-6877 (TTY 711) for advice about urgent and minor conditions as well as help in choosing the right care and advice about self-care.

IN-PERSON VISIT
If a member wants to see a clinician in person, they can make an appointment with the Kaiser Permanente Washington app, go to kp.org, or call their doctor's office.

Take advantage of Kaiser Permanente's Perks and Wellness tools at kp.org—

Drug & health encyclopedias and guides	Interactive tools and calculators, symptom checker and more	Recipes and natural medicine information
Get a wellness coach!	Join health classes and support groups	Access to the Calm, Headspace, and myStrength apps at no cost
Quit smoking with the Quit for Life Program	Enjoy reduced rates on a variety of health programs and services	Reduced rates for specialty health services (massage, chiropractic, etc.)

RESOURCES

MEDICAL / Kaiser Permanente

wa.kaiserpermanente.org
1.888.901.4636 (customer service)
1.800.297.6877 (24-hour nurseline)

CLAIMS ADDRESS Claims Processing, Kaiser Permanente
PO Box 30766
Salt Lake City UT, 84130

KAISER PERMANENTE®

Core HMO Members:
In-network Care Through Regional & National Networks

Travel in other Kaiser Permanente Regions

Kaiser Permanente (KP) has medical facilities in CA, CO, GA, HI, MD, OR, VA and Washington D.C. Before receiving care at a KP facility outside of the KP WA area, call Member services to get a visiting member ID number.

Pay your standard in-network copay, coinsurance, or deductible at the nearest Kaiser Permanente medical facility.

Travel Across the U.S. (all states outside of WA, ID Kootenai and Latah counties)

Pay your standard in-network copay, coinsurance, or deductible:

- Nearest Aetna PPO network provider using the Aetna Signature Administrators Network: **aetna.com/asa**.

International Travel

- Nearest urgent care facility or hospital.
- Health Advice from our Travel Advisory Service: **kp.org/wa/travel-service**.

SCAN THIS CODE FOR MORE INFO!

RESOURCES

Life, Disability / The Standard

standard.com | **(800) 848-5132 (customer service)**

POLICY NUMBERS

Basic Life: 645273-G
VAD&D: 645273-E
VL: 645273-H
LTD: 645273-F

Travel Assistance

assistamerica.com | **1.800.872.1414** (customer service)
medservices@assistamerica.com (email)
01-AA-STD-5201
(Travel assist reference number)

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.

Contact Travel Assistance

800.872.1414
United States, Canada, Puerto Rico, US Virgin Islands and Bermuda

Everywhere else:
+1.609.986.1234

Text:
1.609.334.0807

Email:
medservices@assistamerica.com

REFERENCE NUMBER:
01-AA-STD-5201

Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories

Credit card and passport replacement and missing baggage and emergency cash coordination

Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission

Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond

Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded

Don't forget to download the Assist America mobile app - access your Mobile ID Card, receive travel alerts, access to Assist America's Emergency Operations Center, and more!

RESOURCES

Portability / The Standard

Portability & Conversion

WCIF offers various products that are underwritten by The Standard. Some plans are eligible for Portability/ Conversion. Below is a table that outlines the availability by product.

	PORTABLE	CONVERTIBLE
Basic Life	Yes	Yes
Basic AD&D (this is built into Basic Life)	Yes	No
Voluntary Term Life	Yes	Yes
Long Term Disability (base)	No	Yes
Long Term Disability (buy-up)	No	Yes
Voluntary AD&D	No	No

Portability

Portability takes the group plan and rolls it over to a group portability policy. Those leaving employment due to disability or retirement are not eligible for portability, and coverage must have been in place for 12 continuous months Employees must apply for portability within 31 days of the date of termination. Portability forms are available on WCIF's website: WCIF.net.

Conversion – Life

Conversion takes a group plan and converts it into an individual whole life plan. Those leaving employment due to disability or retirement are only eligible for conversion options. Employees must apply for conversion within 31 days of the date the coverage ends. Conversion forms are available on WCIF's website: WCIF.net.

Conversion – Disability

Conversion takes a group plan and converts into another policy through The Standard. Employees must apply for conversion within 31 days of the date coverage ends. Conversion forms are available on WCIF's website: WCIF.net. Premiums for this coverage are payable quarterly and are due, in advance, on the first day of each quarter. Long Term Disability benefit amounts over $4,000.00 are subject to medical underwriting.

Please note, Life/AD&D and Disability products are not subject to COBRA.
If you are interested in continuing coverage through portability or conversion, please do the following:

- **Confirm the coverage you are enrolled in with your HR department**
- **Call (800) 378-4668, elect option 7, and enter extension 6785**
- **Your policy number is: 645273**
- **Portability rates are listed in your Certificate. You can access a copy of your certificate at WCIF.net**
- **When ready to apply for Portability or Conversion, please work with your employer to complete the employer statement on the forms, which are also available at WCIF.net**

RESOURCES

Life Services Toolkit / The Standard

Resources and Tools to Support you and your Beneficiary

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of death. The Standard does more than help protect your family from financial hardship after a loss. Standard has partnered with Health Advocate[SM] to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain other helpful information online.

Services to Help You Now

Visit the Life Services Toolkit website at standard.com/ mytoolkit and entire user name "assurance" for information and tools to help you make important life decisions.

Estate Planning Assistance: Online tools walk you through the steps to prepare a will and create other documents.

Financial Planning: Consult online services to help you manage debt, and take care of other financial matters with confidence.

Health and Wellness: Timely articles about nutrition, stress management and wellness help employees.

Identity Theft Prevention: Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.

Funeral Arrangements: Use the website for guidance on how to begin, find funeral related services and make decisions in advance.

If you are a recipient of an Accelerated Benefit[1], you may access the services for beneficiaries.

[1]An Accelerated Benefit allows a covered individual who becomes terminally ill to receive a portion of their Life insurance proceeds while living, if all other eligibility requirements are met.

Services for Your Beneficiary

Life Insurance beneficiaries[2] can access services for 12 months after the beneficiary receives the Life claim letter. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

Grief Support: Care Managers with advanced training are on call to provide grief sessions by phone in in-person. Beneficiaries are eligible up to six in-person confidential grief sessions.

Legal Services: Your beneficiaries can obtain legal assistance from experienced attorneys with a telephone consultation or in-person meeting for up to 30 minutes with a network attorney.

Financial Assistance: Your beneficiaries can schedule up to 30-minute telephone sessions with to financial counselors who can help with issues.

Support Services: During an emotional time, your beneficiaries can receive help planning a funeral or memorial service. Work-life advisors can guide them to resources to manage other issues.

Online Resources: Your beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries.

The Life Services Toolkit is not available to Life insurance beneficiaries who are minors or to non-individual entities such as trusts, estates, charities.

The Life Services Toolkit is provided through an arrangement with Health Advocate[SM] and is not affiliated with The Standard. Health Advocate is solely responsible for providing and administering the included service. This service is not an insurance product.

RESOURCES

Employee Assistance Program (EAP / First Choice Health

firstchoiceeap.com
1.800.777.4114 (customer service) | eap@fchn.com

First Choice Health

Employee Assistance Program

ONLINE EAP SERVICES

To access **webinars**, **trainings**, **tools**, and **forms**, visit the EAP website at:

fch.personaladvantage.com

Enter username:

WCIF

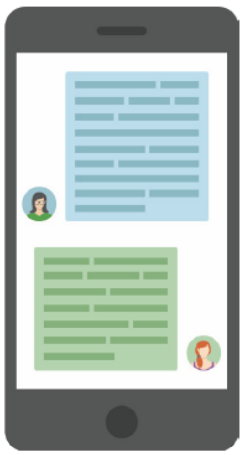
(800) 777-4114

24/7 Telehealth with Talkspace

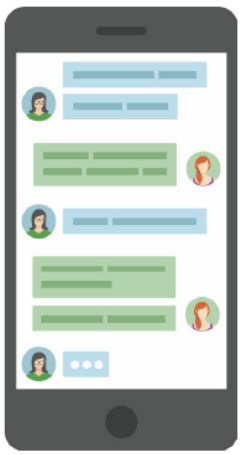
Convenient, private virtual therapy. Anytime, Anywhere. Talk with a licensed, professional therapist online to get guidance and counseling.

There are four communication methods available:

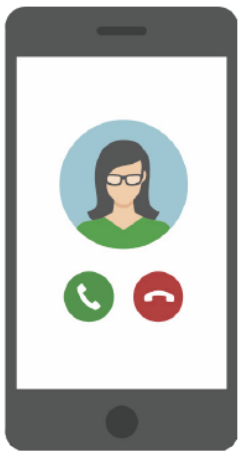
Messaging (Unscheduled)



Live Chat (Scheduled)



Live Phone (Scheduled)



Live Video (Scheduled)

Ready to start? Call (800) 777-4114 or request a referral online

RESOURCES

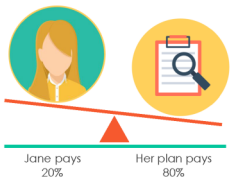
GLOSSARY OF HEALTH COVERAGE & MEDICAL TERMS

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. In either case, the policy or plan governs. The full six-page glossary can be found on the WCIF website under Plan Information. **Bold** text indicates a term defined in the full Glossary.

Allowed Amount
Maximum amount on which payment is passed for covered health care services. This may be called 'eligible expense," "payment allowance," or "negotiated rate". If your provider charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**)

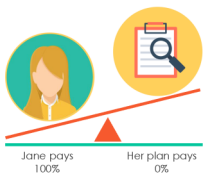
Balance Billing
When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may **not** balance bill you for covered services.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the **allowed amount** for the service. You generally pay coinsurance plus any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100, and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



Copayment
A fixed amount (for example, $20) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

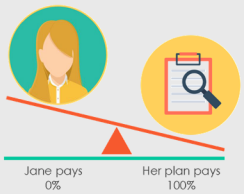
Deductible
The amount you ***could*** owe during a coverage period (usually one year) for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Formulary
A list of drugs your **health insurance** or **plan** covers. A formulary may include how much you pay for each drug. If the plan uses "tiers," the formulary may list which drugs are in which tiers. For example, a formulary may include generic drug and brand name drug tiers.

Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Out-of-pocket Limit
The most you could pay during a coverage period (usually one year) for your share of the costs of covered services.



After you meet this limit, the **plan** will usually pay 100% of the **allowed amount**. This limit helps you plan for health care costs. This limit never includes your **premium**, your **balance-billed charges**, or health care your **health insurance** or plan doesn't cover. Some health insurance or plans don't count all of your **copayments**, **deductibles**, **coinsurance payments**, **out-of-network payments** or other expenses toward this limit.

Preferred Provider
A **provider** who has a contract with your health insurance or **plan** to provide services to you at a discount. Check your health insurance policy or plan documents to see if you can see all preferred providers without paying extra or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may be smaller, so you may have to pay more. Your policy may use the term 'in-network' instead of "preferred".

REQUIRED ANNUAL NOTIFICATIONS

Important Notice from Washington Counties Insurance Fund About Your Prescription Drug Coverage and Medicare Part D

If you or a covered family member are, or will soon become Medicare Part D eligible, please read this notice carefully and keep it with your records. This notice has information about your current prescription drug coverage with Washington Counties Insurance Fund (WCIF) 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 through Medicare Prescription Drug Plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. The carriers have determined that the prescription drug coverage offered by **Washington Counties Insurance Fund** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is **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 15 to December 7. However, if you lose your 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 sign up for a Medicare prescription drug plan.

What Happens to your Current Coverage If You Decide to Join a Medicare Drug Plan?
You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you do decide to join a Medicare drug plan, your current coverage through the Trust will not be affected.

However, if you decide to join a Medicare drug plan and drop your current coverage through WCIF, please be aware that you and your dependents may not be able to get this coverage back until open enrollment. Contact the Administration office for more information if necessary.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?
You can continue your existing coverage and choose not to enroll in a Part D plan. However, please know that if you drop or lose your coverage with WCIF and don't enroll in a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay more (a penalty) to enroll in a Medicare prescription drug coverage 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 your did not have that coverage. For example, if you go nineteen months without coverage, your premium may be consistently at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For More Information about This Notice or Your Current Prescription Drug Coverage:
For further information, call the Customer Service number of the back of your ID card. You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare drug coverage and if your current coverage through WCIF should change. You also may request a paper 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. When you become Medicare eligible, you will be mailed a copy of the handbook every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

REQUIRED ANNUAL NOTIFICATIONS

For more information about Medicare prescription drug plans:

- Visit MEDICARE.gov
- Call your State Health Insurance Assistance Program (see 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

For peopled with limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more information about this extra help, visit Social Security online at SOCIALSECURITY.gov, or by phone 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).

Effective Date:	October 1, 2025 for Plan Year 2026
Name of Entity/Sender:	Washington Counties Insurance Fund
Contact—Position/Office	Vimly Administration Office
Address:	PO Box 6, Mukilteo, WA 98275
Phone Number:	1.855.623.6334

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- 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

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan. If you would like more information on WHCRA benefits, please call your Plan Administrator for more information.

HIPAA / GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

REQUIRED ANNUAL NOTIFICATIONS

Health Insurance Marketplace Coverage Options and Your Health Coverage

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2026 open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1, 2025, through January 15, 2026. From December 15, 2025 to January 15, 2026, coverage will be effective February 1,2026. After January 15, 2026, you can get coverage through the Marketplace for 2026 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

If the cost of our medical plan to cover yourself (and not any other members of your family) is more than 9.96 percent of your household income, or our coverage does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.) **All WCIF health plans currently meet the "minimum value standard".**

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, you lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

If you are not eligible for our Plan, you may want to look at the Health Insurance Marketplace as an option. In some cases you may qualify for a subsidy if you meet certain requirements. You will need to consult with an Insurance Navigator at the Health Insurance Marketplace to understand better your plan options as well as any subsidies which may apply to you.

How Can I Get More Information? Please visit WAHEALTHPLANFINDER.org or HEALTHCARE.gov for more information.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums. 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 HEALTHCARE.gov.

If you or your dependents are already enrolled in Medicaid or CHIP you can 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, you can contact your State Medicaid or CHIP office or dial **1.877.KIDS NOW (1.877.543.7669)** or INSUREKIDSNOW.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

To see if any more States have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, you can 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

REQUIRED ANNUAL NOTIFICATIONS

Notice of Special Enrollment Rights

If you acquire a new dependent, or if you decline WCIF health coverage for yourself or an eligible dependent (including your spouse*) while other coverage is in effect and later lost that other coverage for certain qualifying reasons, you have the right to enroll in a plan under its *Special Enrollment Provision*.

This notice also advises you of some of the other consequences of declining coverage, including your responsibility for any claims you might incur.

Loss of Other Coverage
If you decline enrollment for yourself or for an eligible dependent (including your spouse*) while other health insurance or health plan coverage is in effect, you may be able to enroll yourself and your dependents in a WCIF health plan if you or your dependents lost eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New Dependent
If you have a new dependent as a result of marriage, you may be able to enroll yourself or your new dependent if you request enrollment within 31 days after the marriage**. Step children may also be added within 31 days of the marriage**. You must request enrollment within 60 days after: Birth, Adoption / placement for adoption, Foster child placement, Grant of legal guardianship.

State Medical Assistance and Children's Health Insurance Program (CHIP)
If you meet any of the following scenarios, you and your dependents may be able to enroll in WCIF health plans within 60 days if:

- You become eligible for state medical assistance and the Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective to enroll you in this plan.
- You qualify for premium assistance under the state's medical assistance program of Children's Health Insurance Program (CHIP).
- You no longer qualify for health coverage under the state's medical assistance program or CHIP.

To request special enrollment or to obtain more information about WCIF health plans' *Special Enrollment Provisions*, contact your employer's Human Resources Department.

**or Qualified Domestic Partner*
***or Qualified Domestic Partnership*

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

NOTES

QUESTIONS?

Contact your Human Resource Department or visit WCIF.net

800.344.8570 (toll free)
info@wcif.net
2620 RW Johnson Blvd SW Suite 300, Tumwater, WA 98512

Benefits are what we do BEST!