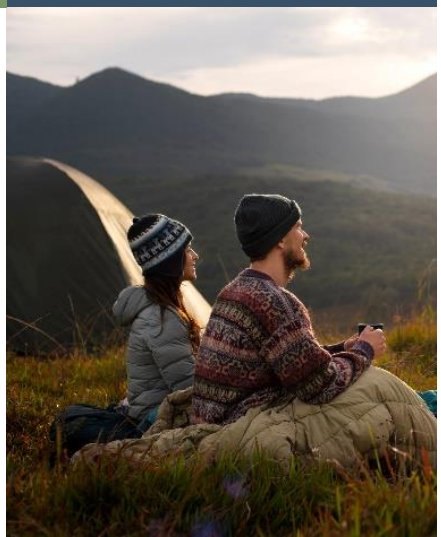


2026 LEWIS COUNTY BENEFIT GUIDE

January 1 – December 31, 2026

AFSCME & Non-Represented Employees

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 all benefits except Voluntary Long-Term Disability if you are hired to work 20 hours or more in a regular position, or if your extra-help / casual position extends beyond 6 months with at least 80 hours in each month, with no break in service per week and Voluntary Long-Term Disability if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your registered domestic partner (RDP) 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:** You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective on the 1st of the month coinciding with or following date of hire. If you fail to enroll on time, you will NOT have benefits coverage (except for County-paid life and AD&D insurance) until you enroll during our next annual Open Enrollment period, or you experience a qualifying life event (QLE).
- **Open Enrollment:** Changes made during Open Enrollment are effective 01/01/2026.

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

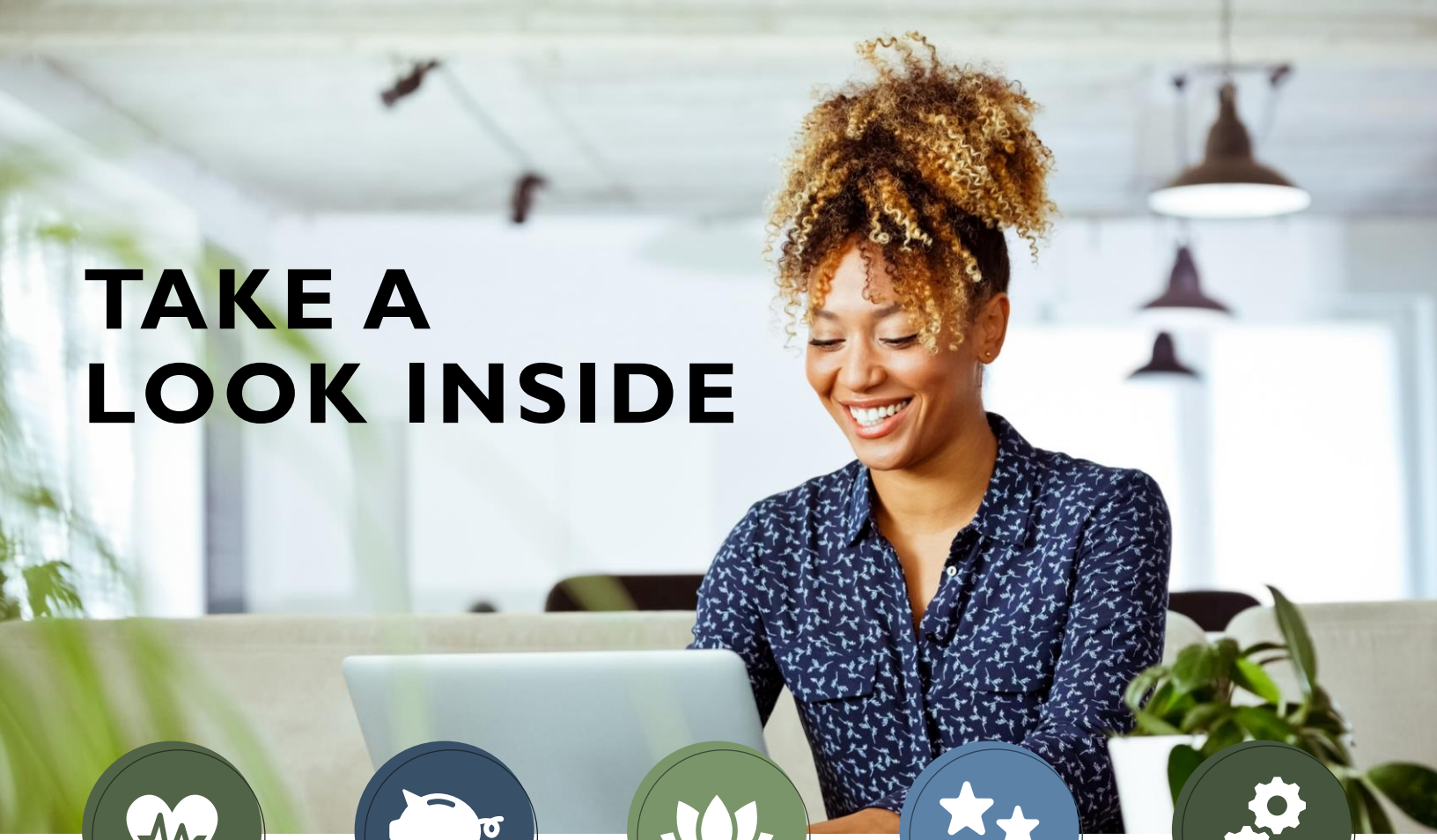
Making Changes

To change your benefit elections, you must contact Human Resources within 60 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.

ENROLLMENT

Click here to go the Employee Navigator portal. Enter the company identifier, **Lewis-County.** There you will find detailed information about the plans available to you and instructions for enrolling.

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 County 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.



TAKE A LOOK INSIDE

Health

- Medical Coverage
- Prescription Coverage
- Preventative Care
- Virtual Visits
- CVS Minute Clinics
- Dental Coverage
- Vision Coverage

Wealth

- Health Savings Account (HSA)
- Flexible Spending Accounts (FSA)
- Life & AD&D
- Disability Insurance
- Accident
- Critical Illness
- Hospital Indemnity
- State Mandated Disability & Leave

Wellbeing

- Choose the Right Place to Go for Care
- Mental Health Well-Being Services
- Employee Assistance Program
- Virtual Medical Services
- Aetna Health Your Way
- Aetna Reproductive Care

Perks

- Employee Discounts
- Medicare Guidance

Resources

- Find Aetna Provider
- Find a VSP Vision Provider
- Find a Dental Provider
- Aetna Online Account
- Aetna App
- Benefit Support
- Plan Contributions
- Important Contacts
- Benefit Terminology

BENEFIT ENROLLMENT

Enrollment Periods

Annual Open Enrollment

Each calendar year, Lewis County conducts an Open Enrollment. This is the time for you to re-evaluate your needs and elect benefit options for the new plan year.

New Hire and Newly Eligible Employee Enrollment

Newly hired or newly eligible employees must complete their online enrollment within 30 days of their date of hire or within 30 days of the date they become eligible.

Between Enrollment Periods

Generally, once you enroll, you cannot make changes to your enrollment selections until the next Open Enrollment period. You may make changes to your benefit elections outside of the annual Open Enrollment ONLY if you experience a Qualifying Life Event (QLE), as defined by the IRS. Benefit changes must also be consistent and made within 60 days of the QLE.

Qualifying life events (QLEs) that may allow you to make benefit changes:

Change in legal marital status

- Marriage
- Divorce, legal separation, annulment
- Death of your spouse

Change in your eligibility

- Taking or returning from a leave of absence
- Change in work schedule or status that causes a gain or loss of eligibility
- Change in family member's eligibility

Change in the number of eligible children

- Birth, adoption or death of a child
- Child gains or loses eligibility for coverage under the plan

They gain a benefit option or lose coverage

- New coverage choices made during their employer's annual enrollment
- You or your family member's COBRA coverage from another employer expires
- You or your family member becomes eligible for or loses Medicare or Medicaid
- You or your family member loses coverage under a government or educational institution's plan

Scan this code to watch a video about QLEs.

BENEFIT ENROLLMENT

Employee Navigator – How to Login and Create an Account

Enrolling in benefits is easy. The Employee Portal is available 24 hours a day, seven days a week, so you can visit the site anytime and anywhere you have computer access.

Step 1:

Visit the Employee Navigator portal

Step 2:

To create an account, click in "Register as new user"

Step 3:

Enter your Information as requested in the relevant sections.

Your company identifier **Lewis-County**

Step 4:

On the next page you will be asked to create a username and password. It is recommended to use your County email for your email address.

Step 5:

Once you have completed the above steps, click "next" and you will then be brought to the Open Enrollment page.

Step 6:

Click "Begin Enrollment" to start your enrollment.

Evaluate Your Needs & Review Your Options

Be a smart health care shopper and ask yourself the following questions:

- Who should I cover? Evaluate your coverage options for all dependents who meet eligibility requirements.
- Are you having a baby? Considering a surgery? Currently in treatment for a chronic conditions.

Review this benefit guide or use the Brainshark video to view and learn about your health and wellness plan information.

Enroll Online

Step 1:

Visit your enrollment portal and complete the enrollment forms

Step 2:

Review and/or add/update your beneficiary and/or dependent information.

Step 3:

Follow the instruction prompts on each page to enroll or decline your benefit elections.

After You Enroll

Save Your Summary

Save or print a copy of your Enrollment Summary after making your coverage selections. Review it thoroughly to ensure that your benefit elections have been recorded correctly.

If there are any errors, contact the HR team at HR@lewiscountywa.gov so the necessary corrections can be made. Errors that are not reported by the communicated deadline cannot be corrected. Your next opportunity to correct any errors will be during the next annual Open Enrollment or within 60 days of experiencing a Qualifying Life Event.

Benefits Website

Our benefits website can be accessed anytime you want additional information on our benefit programs.

DOMESTIC PARTNER DISCLAIMER

Is My Domestic Partner Eligible?

Your domestic partner is eligible for coverage under the County's plans if you meet one of these requirements:

- You have an active registered domestic partnership with a governmental body, or
- You both meet all of the following:
    - Are age 18 or older and legally competent
    - Have cohabitated for at least six months
    - Are not married to anyone else (even if legally separated)
    - Are not related by blood
    - Have financial interdependence, as demonstrated by joint ownership of real estate, bank accounts, mortgage, credit obligations, mutual beneficiary designations or powers of attorney

Dependent children of your domestic partner are also eligible for coverage if they are:

- Unmarried
- Primarily dependent on you or your partner for support
- Living with you (unless waived for student status)
- Meet age, student and incapacity requirements for the plan

Imputed Income and Tax Implications

If you add a family member to your coverage who is not considered a dependent under federal income tax law, your share of the cost of coverage must be paid on an after-tax basis. Your employer's share of the cost of benefits is also treated as taxable income, which is known as imputed income. The IRS considers health coverage for a domestic partner and/or their children a taxable benefit with imputed income that is subject to federal income tax and any other required payroll taxes.

Changes in Domestic Partnerships

When enrolling your domestic partner in coverage, you agree that you will notify the County of any changes in your partnership status that would make your partner and/or their children ineligible for coverage. You must submit a Notice of Change in Domestic Partnership within 60 days of the change. Termination of coverage for domestic partners (and, in some cases, for children of domestic partners) is not a qualifying event for the purpose of continuing coverage under COBRA.

Required Documentation

Employees wishing to enroll a domestic partner for the first time will need to submit an Affidavit of Domestic Partnership to the Human Resources Department prior to completing their enrollment. Please contact HR at HR@lewiscountywa.gov for more information.

HEALTH

MEDICAL COVERAGE

Point of Service Plan

The Point of Service (POS) plan has features of HMO and PPO plans: You will need a referral from your primary care physician (PCP) in order to see a specialist. However, you can see the in- or out-of-network specialist of your choice, though you will pay more to see providers who aren't in your network.

To find an in-network provider, see page 38 in this benefit guide.

Scan this code to watch a video about comparing medical plan types.

MEDICAL COVERAGE

HDHP + HSA

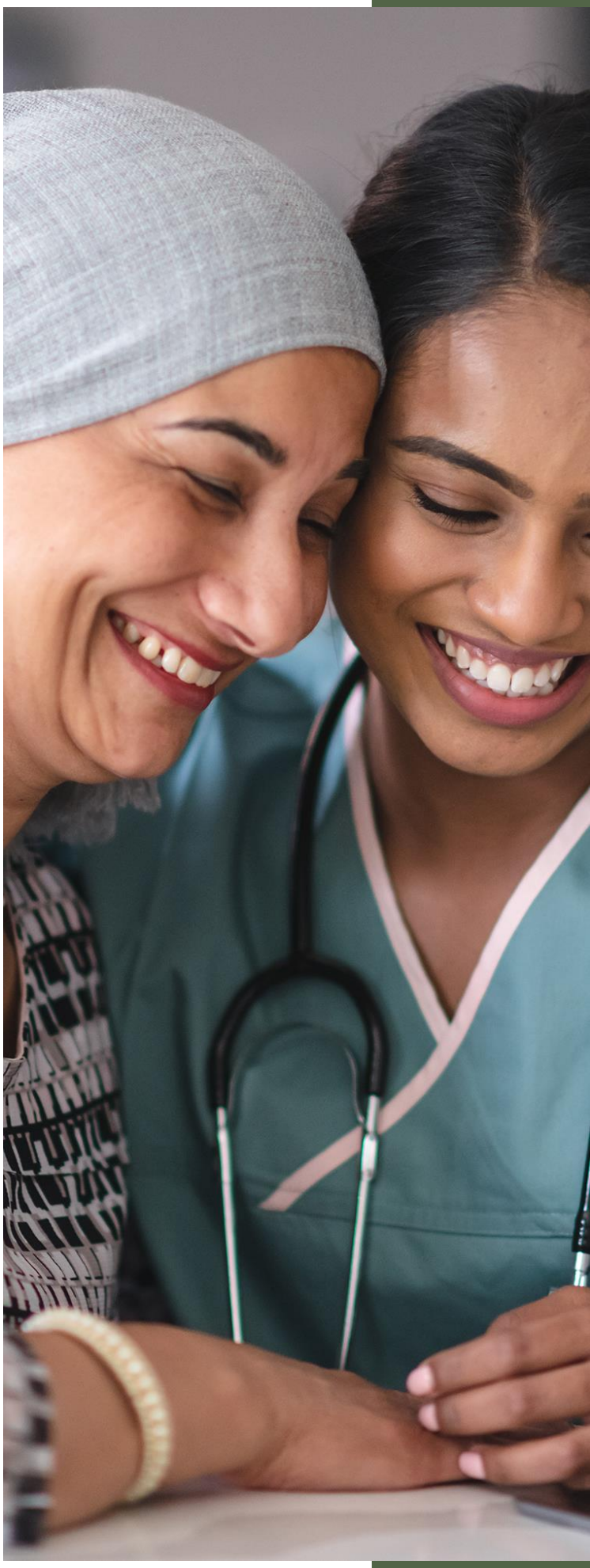
The HDHP + HSA (High-Deductible Health Plan + Health Savings Account), provided through Aetna, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open an HSA, which is a tax-advantaged personal savings account that lets 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 17-18 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.
- The HDHP includes copays for prescription drugs only. You must meet the annual deductible before prescription copays apply.
- 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.



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). **Note:** The deductibles and out-of-pocket maximums are per calendar year.

To find an in-network provider, see page 39 in this benefit guide.

Key Benefits	POS $500		POS $1,000		HDHP $2,000	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$500 / $1,500		$1,000 / $3,000		$2,000 / $4,000[2]	
Out-of-Pocket Max (Individual/Family)	$2,500 / $5,000	Unlimited	$4,000 / $8,000	Unlimited	$4,500 / $9,000[2] $7,000 individual w/in a family[2]	
Office Visits (physician/specialist)	$25 / $50	40%*	$25 / $50	40%*	20%*	40%*
CVS Virtual Visits	Covered In Full	Not covered	Covered In Full	Not Covered	0%*	Not Covered
Routine Preventive Care	Covered In Full	40%*	Covered In Full	40%*	Covered In Full	40%*
Diagnostics (lab/X-ray)	20%*	40%*	20%*	40%*	20%*	40%*
Complex Imaging	20%*	40%*	20%*	40%*	20%*	40%*
Chiropractic/ Acupuncture (24 PCY)	$25	40%*	$25	40%*	20%*	40%*
Ambulance	20%		20%*		20%*	
Emergency Room	$75 Copay, 20%, Copay waived if admitted		$75 Copay, 20%, Copay waived if admitted		20%*	
Urgent Care Facility	$75 Copay	40%*	$75 Copay	40%*	15%*	40%*
Inpatient Hospital Stay	20%*	40%*	20%*	40%*	15%*	40%*
Outpatient Surgery	20%*	40%*	20%*	40%*	15%*	40%*

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.
2. CHDP Plan: The deductible is aggregate. With an aggregate deductible, the full family deductible must be met before coinsurance applies to any individual. POS Plans: The deductible is embedded. This means that once a family member meets their individual deductible, the plan will begin to pay coinsurance for that family member.
3. CDHP: The out-of-pocket maximum is aggregate. With an aggregate out-of-pocket maximum, the full family out-of-pocket maximum must be met before an individual's expenses are covered at 100%. POS Plans The out-of-pocket maximum is embedded. This means that, once an individual family member meets their out-of-pocket maximum, that individual's expenses are covered at 100%.

PREVENTIVE CARE

What is Preventive Care?

Regular preventive care can help you stay well, catch problems early on and may be potentially lifesaving. The ACA requires that certain preventive care services are provided for no cost, copayment or coinsurance. All medical plans cover preventive care services like screenings, immunizations and exams. When you visit in-network providers, you don't have to worry about any out-of-pocket costs for preventive care services. If you use an out-of-network provider, a deductible and out-of-network expenses may apply.

Preventive vs. Diagnostic Care

Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, this would be considered preventive care. But if your doctor recommends a colonoscopy to investigate symptoms you're having, this would be considered diagnostic care, and your plan cost share will apply.

Scan this code to watch a video about preventive care.

VIRTUAL VISITS

CVS Virtual Care

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 is covered in full 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.

24/ Care: For adults and children over 18 months

Mental Health Services available 8am – 7:30pm PST for adults and children 13 years and older. Most visits are available within 2 weeks.

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away! Call 866-211-5678, scan the QR code or visit CVS.com/virtual-care to register and schedule an appointment.

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.

PRESCRIPTION COVERAGE

Retail Pharmacy

When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network.

Specialty Program

With a rare or complex medical condition (e.g., cancer, hepatitis, hemophilia, rheumatoid arthritis or HIV), the appropriate use of specialty medications can be critical to maintaining or improving a patient's health and quality of life. We use the Aetna Advanced Control Plan program to make these medications accessible and cost effective for plan members. It provides focused, specialized support to individuals with complex medical conditions that often require multiple specialty medication therapies.

Save Money on Medications

Ask for Generic Drugs

You can save money by asking for generic drugs. The FDA requires that generic drugs have the same high quality, strength, purity and stability as brand-name drugs. The next time you need a prescription, ask your doctor to prescribe a generic drug if it is available and appropriate.

Use Mail Order

If you require regular medication for a long-term or chronic condition, such as arthritis or diabetes, you can save money by using your plan's mail-order service.

Key Benefits	POS $500 & $1,000		HDHP $2,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail Pharmacy				
Tier 1	$10	40%	20%	20%
Tier 2	$25	40%	20%	20%
Tier 3	$75	40%	20%	20%
Tier 4	30%	40%		
Mail Order Pharmacy				
Tier 1	$10	40%	20%	20%
Tier 2	$25	40%	20%	20%
Tier 3	$75	40%	20%	20%

Scan this code to watch a video about prescription drug coverage.

DENTAL COVERAGE

PPO

The dental Preferred Provider Organization (PPO) plan, provided through MetLife, 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 PDP Plus network.

To find an in-network provider, see page 41 in this benefit guide.

Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and annual benefit maximums are per calendar year.

Key Benefits	$2,500	
	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$50 / $150 (Type B & C Services Only)	
Annual Benefit Maximum (per person)	$2,500	
Preventive Services (Type A – Exams, X-Rays, Fluoride, Sealants))	Covered 100%	20%
Basic Services (Type B – Endodontics, Periodontics, Oral Surgery, General Anaesthesia))	20%*	30%
Major Services (Type C – Crowns, Bridges, Dentures, TMJ, Implants)	50%*	60%
Orthodontic Services (Type D) (Child & Adult)	50% $1750 per person Lifetime Max	
TMJ Lifetime Maximum	$500	

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.

DENTAL PLAN FACTS

- You may visit any dentist of your choice, but you'll receive the highest coverage when you visit in-network providers.
- If you visit an out-of-network provider, you will not benefit from discounted rates and will pay more for services.
- You may pay an annual deductible for select services.

VISION COVERAGE

Your eyesight is an integral part of your overall health and a key component of safety. The vision plan, provided through Vision Service Plan (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 VSP Choice 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, see page 40 in this benefit guide.

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

Key Benefits	Metlife / VSP	
	In-Network	Out-of-Network Reimbursement
Exam (1 Per 12 Months)	Covered in Full	Up to $45
Materials Copay	$0 Copay	Up to $70
Frames (1 Per 24 Months)	$200 Allowance	Up to $70
Lenses (1 Per 12 Months)		
Single Vision	$0	Up to $30
Bifocal	$0	Up to $50
Trifocal	$0	Up to $65
Contact Lenses (1 Per 12 Months) (in lieu of glasses)	$200 Allowance	Up to $105
Medically Necessary	Covered in Full	Up to $210
Elective	Up to $60 Copay	Up to $105

Second Pair Enhancement

- Two pairs of prescription eyeglasses, OR
- One pair of prescription eyeglasses AND an allowance towards contact lenses, OR
- Double your contact lens allowance.

*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

WEALTH

HEALTH SAVINGS ACCOUNT (HSA)

The HDHP $2000 Plan features an HSA provided through Inspira. 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.
- The County contributes the following amounts annually to your HSA account to help it grow:
    - **Employee only coverage: $700.08**
    - **Employee + dependent(s) coverage: $1400.16**
- 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	2025	2026
Individual	$4,300	$4,400
Family	$8,550	$8,750
Catch-up Contributions	$1,000	$1,000

Scan this code to watch a video about HSA limits.

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.

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

Preventive Medications List

If you are enrolled in an HSA-compatible medical plan, you may be able to access a range of preventive medications for a copay or coinsurance before meeting your deductible. These medications are contained in the HSA Preventive Drug List provided by your employer.

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)

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.

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 Healthy Equity , 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)	Dependent Care FSA (DCFSA)
Eligibility Requirements	You must be benefits eligible; enrollment in an HCFSA disqualifies you from making or receiving HSA contributions	Available to all eligible employees
Examples of Qualified Expenses	• Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions	• 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	$7,500 per family (or $2,500 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.

Submit an enrollment form to HR to confirm elections.

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

LIFE INSURANCE

Life insurance, provided through MetLife, 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)

Coverage Tier	Benefit Amount
Employee	$35,000

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 $10,000 up to $500,000	$200,000
Spouse	Increments of $5,000 up to $250,000.	$25,000
Child(ren)	$1,000, $2,000, $4,000, $5,000, or $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.

CHOOSING A BENEFICIARY

You may choose anyone to be the beneficiary of your Life and AD&D policy in the event of your death or serious injury. Review your beneficiary designation periodically to ensure if reflects your current wishes. You may change your beneficiary anytime on the employee portal.

EVIDENCE OF INSURABILITY (EOI)

If you elect above the guaranteed issue amount, you will be required to complete an evidence of insurability (EOI) for coverage to bind. Please note coverage will be pending until this has been completed to verify benefit amount eligible and confirmed.

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

DISABILITY INSURANCE

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

Voluntary Long-Term Disability

Provided at an affordable group rate.	
Benefit	60% of base salary
Maximum monthly benefit	$10,000
When benefit begins	After 90 days of disability
When disability end	SSNRA, Social Security Normal Retirement Age

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

GROUP ACCIDENT INSURANCE

Accident insurance, provided through MetLife, 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	$4,250

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

Benefit Type*	Low Plan	High Plan
Accidental Injury Benefits	**Pay Out**	**Pay Out**
Fracture Benefit	$100 - $8,000	$200 - $10,000
Concussion Benefit	$250	$500
Accident – Medical Services		
Ambulance Benefit	$300 - $1,000	$400 - $1,250
Emergency Care Benefit	$75 - $150	$100 - $200
Hospital Benefits		
Admission	$1,000	$1,500

* Please see your plan documentation for the full list of benefits

GROUP 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 MetLife, 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	$15,000

To help cover out-of-pocket health care expenses related to certain critical illnesses, you have the option to purchase critical illness insurance at discounted group rates. You and your covered spouse and dependents will receive a lump-sum payment to help cover out-of-pocket expenses related to cancer, heart attacks, strokes, benign brain tumors, major organ failure and certain childhood conditions. The lump-sum payment will vary depending on your condition. For more details, refer to the Summary Plan Description (SPD).

- Designed to complement your health care coverage
- Completely Voluntary
- Coverage also available for your spouse and dependents
- Provided through Met Life
- 100% Employee Paid (Premiums will vary dependent upon your coverage tier and age)

Covered Conditions	Initial Benefit	Recurrence Benefit
Autism Spectrum Disorder	25% of Benefit Amount	None
Benign Brain Tumor	100% of Benefit Amount	100% of Initial Amount
Cancer Category	5% - 100% of Benefit Amount	Varies
Coronary Artery Disease	50% of Benefit Amount	100% of Initial Amount
Heart Attack	50% - 100% of Benefit Amount	Varies
Infectious Disease	25% of Benefit Amount	Varies
Kidney Failure	100% of Benefit Amount	100% of Initial Amount
Stroke Category	10% - 100% of Benefit Amount	100% of Initial Amount

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.

GROUP 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 MetLife, 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
Total Benefit Paid Directly to Employee	$2,250

Category	Low Plan	High Plan
Hospital Benefits		
Admission Benefit	$500	$1,000
Confinement Benefit	$100	$200
Newborn Nursery Care Confinement	$100	$200
Inpatient Rehabilitation Benefit	$100	$200
Other Benefits		
Health Screening Benefit	$50	$50

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.

METLIFE VALUE ADD PROGRAMS

Will Preparation

Like life insurance, a carefully prepared Will is important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property. By enrolling for Supplemental Term Life coverage, you will have in person access to MetLife Legal Plans' network of 18,500+ participating attorneys for preparing or updating a will, living will and power of attorney. When you enroll in this plan, you may take advantage of this benefit at no additional cost to you if you use a participating plan attorney. To obtain the legal plan's toll-free number and the County's group access number, contact your employer or your plan administrator for this information.

Funeral Discounts & Planning Services

As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life - at no additional cost to you.

Dignity Memorial provides you and your loved ones access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States.

- When using the Dignity Memorial Network you have access to convenient planning services - either online at www.finalwishesplanning.com, by phone (1-866-853-0954), or by paper - to help make final wishes easier to manage. You also have access to assistance from compassionate funeral planning experts to help guide you and your family in making confident decisions when planning ahead as well as bereavement travel services - available 24 hours, 7 days a week, 365 days a year - to assist with time-sensitive travel arrangements to be with loved ones.

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MetLife Estate Resolutions Services (ERS)

ERS is a valuable service offered under the group policy. A MetLife Legal Plan attorney will consult with your beneficiaries by telephone or in person regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator. This can help alleviate the financial and administrative burden upon your loved ones in their time of need. .

Grief Counseling

You, your dependents, and your beneficiaries access to grief counseling sessions and funeral related concierge services to help cope with a loss – at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. At your time of need, you and your dependents have 24/7 access to a work/life counselor.

- Sessions can either take place in-person or by phone.
- Up to 5 face to face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to:
    - death, bankruptcy, divorce, terminal illness, or losing a pet.
- In addition, you have access to funeral assistance for locating funeral homes and cemetery options, obtaining funeral cost estimates and comparisons, and more.

You can access these services by calling 1-888-319-7819 or log on to one.telushealth.com

Username: metlifeassist
Password: support

STATE-MANDATED DISABILITY & PAID FAMILY LEAVE PROGRAMS

Employees who reside in one of the states or districts below may be eligible for statutory disability and/or family leave coverage provided by their state. State-provided benefits will be administered and paid out by the state in accordance with state laws and they may run concurrently with family medical leave (FMLA) and short-term disability (STD). Employees are responsible for applying to these programs with the applicable state agencies.

Note: The number of states that offer statutory disability and paid family leave coverage may change at any time.

- **Washington**: https://paidleave.wa.gov/

WELLBEING

CHOOSE THE RIGHT PLACE TO GO FOR CARE

Knowing where to go for care can save your time, money, and hassle. Our medical plan gives you a variety of care options for any medical issues you may face. Remember to save the Emergency Room for true emergencies.

PLEASE NOTE: The below information should be used for reference only. The is not a full or extensive list of treatment options or reasons to be seen at each care facility. If you have any questions on where to go for care, please consult your physician or medical care provider. In the event of a medical emergency, call 911.

Telehealth / Virtual Visit	Primary Care Provider (PCP)	Urgent Care Center	Emergency Room
Cost: $ | Time: 	Cost: $$ \| Time: 	Cost: $$$ | Time: 	Cost: $$$$ | Time: 
Benefit: • Lower cost • Speak to a doctor from anywhere • Reduced waiting room time	**Benefit:** • In-person examination • Reasonable price in-network • Familiarity with health history	**Benefit:** • Lower cost than an ER visit • Same-day visits are often available	**Benefit:** • Necessary for life-threatening conditions • Open 24/7, every single day of the year
Reasons to go: • Headaches • Fever & flu symptoms • Cough & sore throat • Skin irritations & rashes • Psychiatry services	**Reasons to go:** • Preventive care • Earaches & infections • Headaches • Skin irritations & rashes • Abdominal pain • Regular treatment for chronic conditions	**Reasons to go:** • Earaches & infections • Minor cuts, bumps, sprains, & burns • Allergic reactions • Animal bites • Mild asthma • Urinary tract infections • Back & join pain	**Reasons to go:** • Sudden numbness or weakness • Disorientation or difficulty speaking • Seizure or loss of consciousness • Severe cuts or burns • Overdoses • Uncontrolled bleeding • Coughing or vomiting blood • Heart attack or chest pain

MENTAL HEALTH WELL-BEING SERVICES

With telehealth and virtual mental well-being programs, you have another way to get the help you need from providers that are part of your network. And whatever you're facing, you have the same support for counseling or medications for mental health concerns. You can see them where and when it's convenient — you choose. One telehealth/virtual session will cost the same as an in-person office visit.

Depression, anxiety or those struggling with mental well-being concerns

Ages	Provider	Contact
5+	Array at Home	800-442-8938 / https://ArrayBC.com
5+	Telemynd	866-991-2103 / http://www.telemynd.com/aetna
5+	Alma Health	HelloAlma.com/aetna
13+ 18+	Talkspace	https://www.talkspace.com/aetna 13+ for therapy /18+ for medication management
18+	Meru Health	https://MeruHealth.com/sign-up/Aetna/
18+	Brightside	415-360-3348 / https://Brightside.com/

Specialty treatment for children & adolescents

Ages	Provider	Contact
6+	Valera Health	https://ValeraHealth.com
6-24	Equip Healh	855-387-4378 / https://Equip.Health
12+	Vita Health	844-866-8336 (1-844-866-TEEN) / https://VitaHealth.Care
12-28	Charlie Health	https://CharlieHealth.com/

Struggling with suicide

Ages	Provider	Contact
12+	Vita Health	844-866-8336 (1-844-866-TEEN) / https://VitaHealth.Care

Substance and alcohol use concerns

Ages	Provider	Contact
18+	Eleanor Health	866-972-0771 / https://EleanorHealth.com/

Scan this code to watch a video about mental health.

MENTAL HEALTH WELL-BEING SERVICES (CONTINUED)

With telehealth and virtual mental well-being programs, you have another way to get the help you need from providers that are part of your network. And whatever you're facing, you have the same support for counseling or medications for mental health concerns. You can see them where and when it's convenient — you choose. One telehealth/virtual session will cost the same as an in-person office visit.

Chronic medical conditions and mental health

Ages	Provider	Contact
18+	AbleTo	844-330-3648 / Monday — Friday: 9 AM to 8 PM ET https://Member.AbleTo.com/Aetna/

Serious mental health conditions

Ages	Provider	Contact
6+	Valera Health	https://ValeraHealth.com
12-28	Charlie Health	https://CharlieHealth.com/

Eating Disorders

Ages	Provider	Contact
6-24	Equip Healh	855-387-4378 / https://Equip.Health

Scan this code to watch a video about mental health.

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 TELUS Health via Metlife.

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

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

EAP Benefits

- Assistance for you and your household members
- Up to 5 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 one.telushealth.com.

Username: metlifeeap

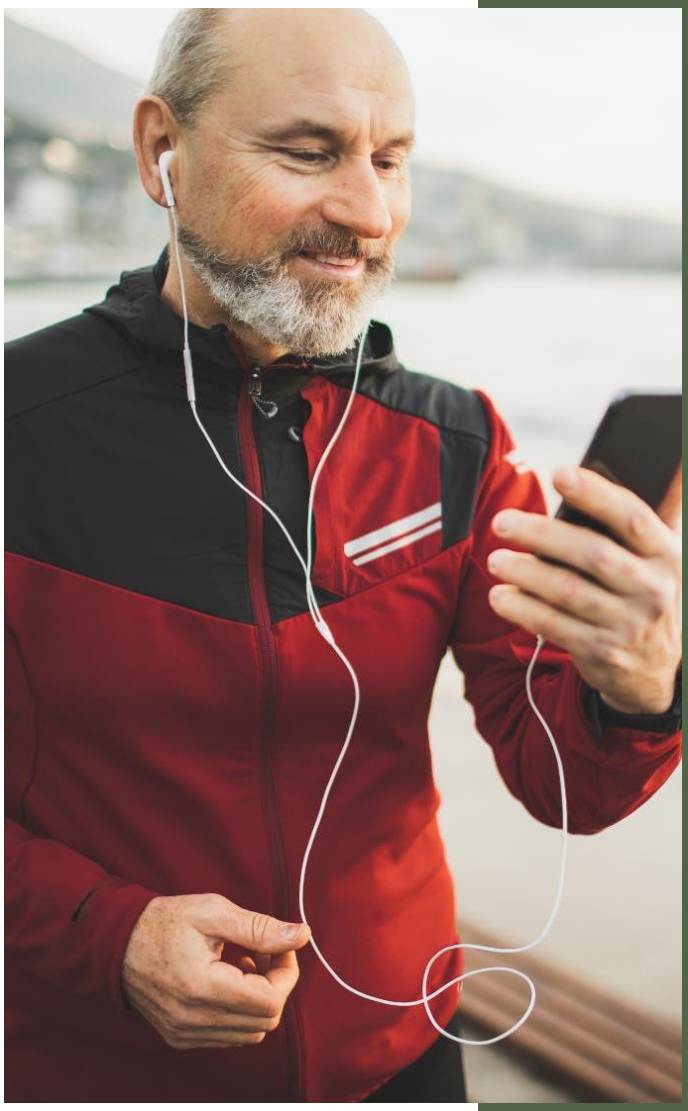
Password: eap

For questions, contact TELUS Health at 888.319.7819.

VIRTUAL MEDICAL SERVICES

24-Hour Nurse Line

Registered Nurses are available to consult with callers regarding health concerns, answer questions about diseases, medications, and medical tests, as well as discuss what to ask your doctor. This resource can help you become better educated about your health care decisions. The Nurse Line does not diagnose; however, having access to additional information can often put your mind at ease. The Nurse Line consultants specialize in helping you find resources that are right for you and your family



More reasons to use the 24-Hour Nurse Line

- Get information on a wide range of health and wellness topics
- Make better health care decisions
- Find out more about a medical test or procedure
- Get help preparing for a visit to your doctor
- Receive emails with links to videos that relate to your question or topic

Your online source for health information

Prefer to go online for health information? Check out the 24-Hour Nurse Line page on your member website.

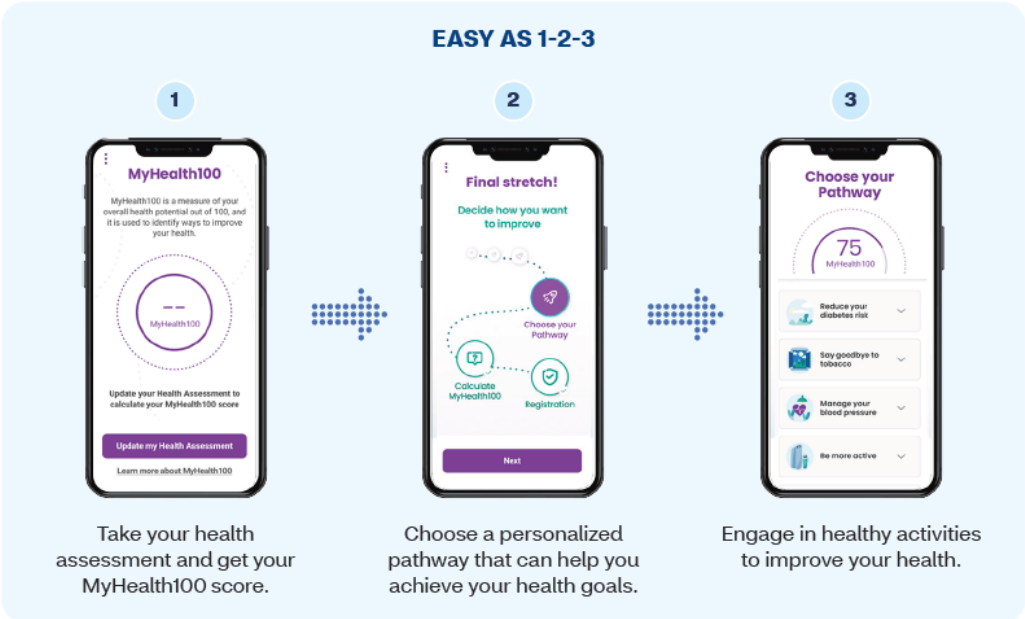
Here's what you can do:

- Send us an email.
- Use our symptom checker.
- Learn about treatment options and health risks.
- Research medications.
- It explains things in terms that are easy to understand.

Call 800-566-1555 or log in at AetnaStudentHealth.com

AETNA HEALTH YOUR WAY™

Now you can achieve your best health in a whole new way. As part of Aetna Health Your Way™, you can access a personalized digital health platform. It's the simpler way to stay on track in reaching your health goals.



Ready to explore Aetna Health Your Way™ today?
Just sign in at Health.Aetna.com. Or download the Aetna Health app today!

AETNA REPRODUCTIVE CARE

Support goes **beyond traditional maternity benefits** to deliver **complete reproductive care** — meeting your and your family's evolving needs across age and gender.

Reproductive care includes help with sexual health and birth control, support during fertility care and pregnancy, and guidance through midlife changes like menopause. Whether you're planning a family, looking for answers about your health, or managing changes in your body, we're here to support you

Enhanced support

- **Maternity and family-building support** includes one-to-one care team assistance for both men and women.
- **Expanded virtual care network** is available for both men and women.
- **24-hour dedicated women's health nurse line*** lets you call anytime to talk to a women's health nurse who can address maternity or other health concerns at no extra cost — so you can avoid a trip to the ER.

Family building and maternal health

- **Enhanced maternity support** helps keep parents and babies healthy by spotting risks early and providing extra support for those who need it most.
- **Personalized guidance from preconception to postpartum care** available from a team that explains your benefits, schedules appointments, and more.

Reproductive support

- **Reproductive resources** connect you to expert clinical teams and specialists who help with high-risk pregnancies, and conditions like polycystic ovarian syndrome (PCOS) and endometriosis.

Menopause and healthy aging

- **Midlife support** helps you navigate midlife transitions with care for changes like perimenopause, menopause, bone health, hearth health and mental well-being. Our new in-network specialty providers, Gennev and Midi Health, can help you on your menopause journey.

To navigate your care or for questions, visit your member website or call the number on the back of your member ID.

PERKS

EMPLOYEE DISCOUNTS

BenefitHub

Provide by HUB International, BenefitHub is an exclusive employee discount program that can help you save big on thousands of items daily such as travel, apparel, tickets, auto, electronics, insurance, education, restaurants and so much more!

To get started:

- Go to mypathperks.benefithub.com
- Enter Code **K7WEWL**
- Click on "Any Offer"
- Complete the Sign-Up Form

Questions? Call 813.675.2210

LifeMart Member Discount Program

LifeMart offers exclusive savings on major purchases and everyday essentials from brands you know and love, all in one convenient location. With discounts on travel, entertainment, child & senior care, wellness, home & auto, and so much more - LifeMart is the way to save.

- **Saving with LifeMart is easy:**
- Search for discounts by category
- Select an offer to review the details
- Simply follow the redemption instructions to access discounts

Plus, you can access LifeMart discounts anywhere, anytime, with the LifeMart mobile app*. Simply download the app and you can browse major savings on the go. Available for download in the Google Play Store and iTunes Store.

**Pre-registration is required.*

- Access via your Aetna Member Portal at www.aetna.com
- Click on the Health & Wellness Tab > Health & Wellness Discounts > Click on any of the Health & Wellness tiles to access the LifeMart Discount Website

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, call 833-482-7471 or email Senior.IFP@hubinternational.com.

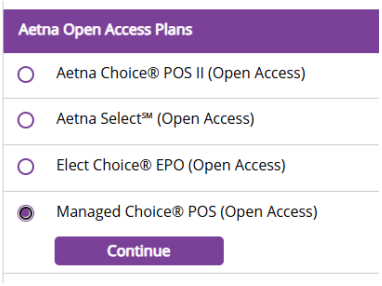
RESOURCES

FIND AN AETNA MEDICAL PROVIDER

Find an Aetna Provider

1. From the **Aetna.com** home page, log-in to your member website, or select "Find a Doctor"
2. Under "Don't have a member account?". Select "Plan from an employer"
3. Enter location under "Continue as Guest"
4. Select a plan to search the network in top right corner, this can be found on your ID card as well.

Medical: Open Access Point of Service Managed Care



- Three are two ways to search:
  - You can enter your providers name or specialty in the search bar.
  - You can also browse by category.

5. When you get your results, you can use the tool bar to narrow your search. Filter by specialty, area of expertise, gender, and spoken languages.

When you sign into your account, you will get a personalized search experience and information about procedure costs.

Scan this code to watch a video about choosing a provider.

FIND A VSP VISION PROVIDER

Find a VSP Vision Provider

1. From the **VSP.com** home page, select "Search Now" Under "Find a Doctor"
2. Enter Zip Code or Street Address, Search by Location, Office, or Doctor, Select "Search"
3. All VSP providers will populate based on your search parameters.

LOCATION OFFICE DOCTOR

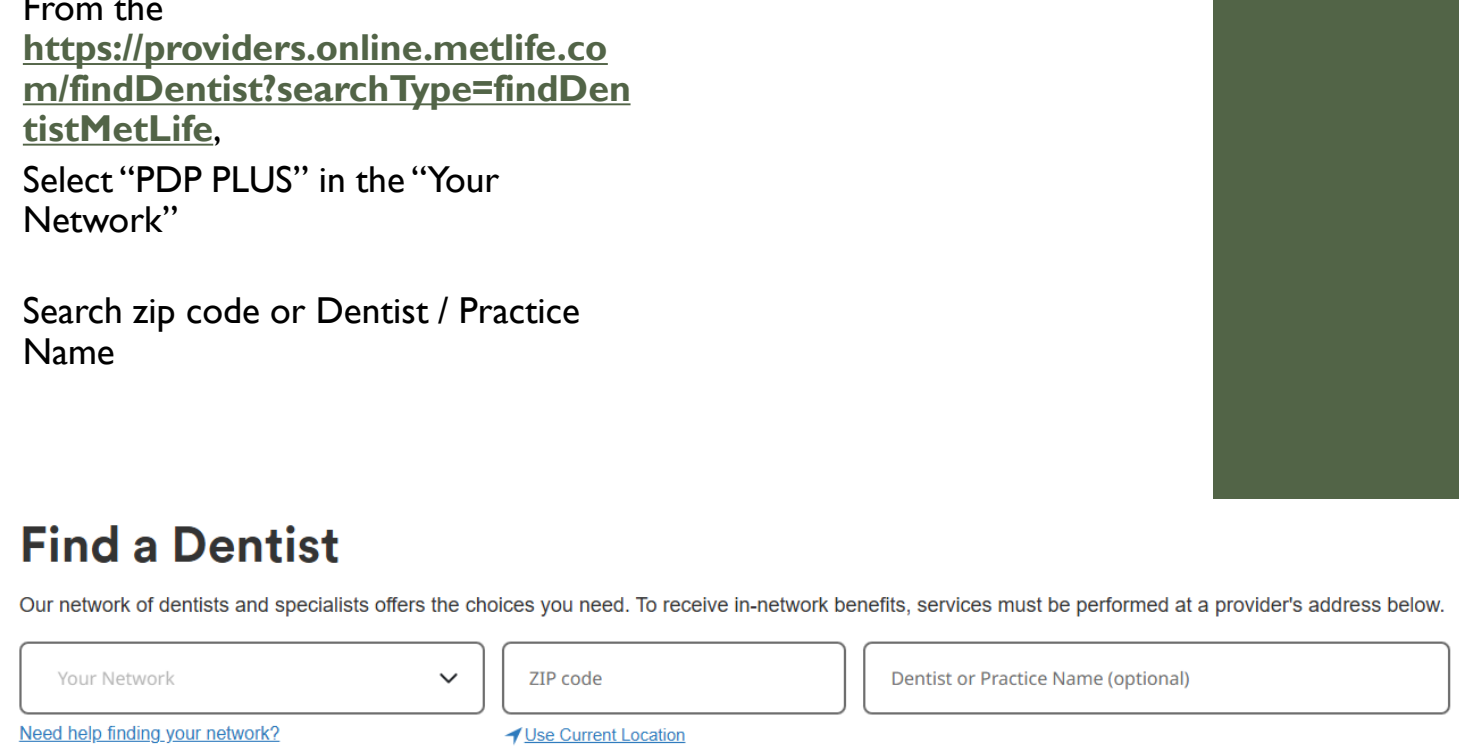
Zip OR Street Address (optional)

Scan this code to watch a video about choosing a provider.

FIND A METLIFE DENTIST

Find a MetLife Dentist

1. From the https://providers.online.metlife.com/findDentist?searchType=findDentistMetLife,
2. Select "PDP PLUS" in the "Your Network"
3. Search zip code or Dentist / Practice Name



Scan this code to watch a video about choosing a provider.

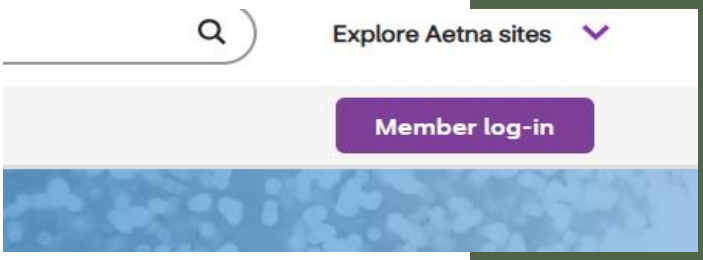
AETNA MEMBER WEBSITE

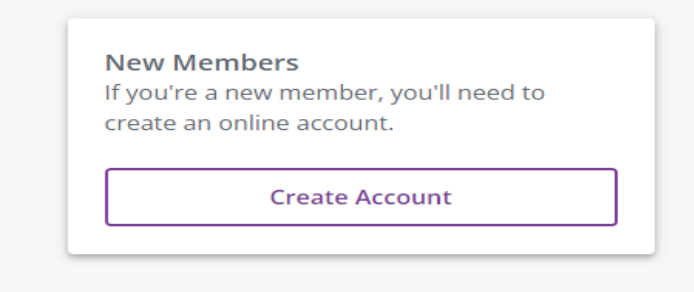
Create an Aetna Member Account

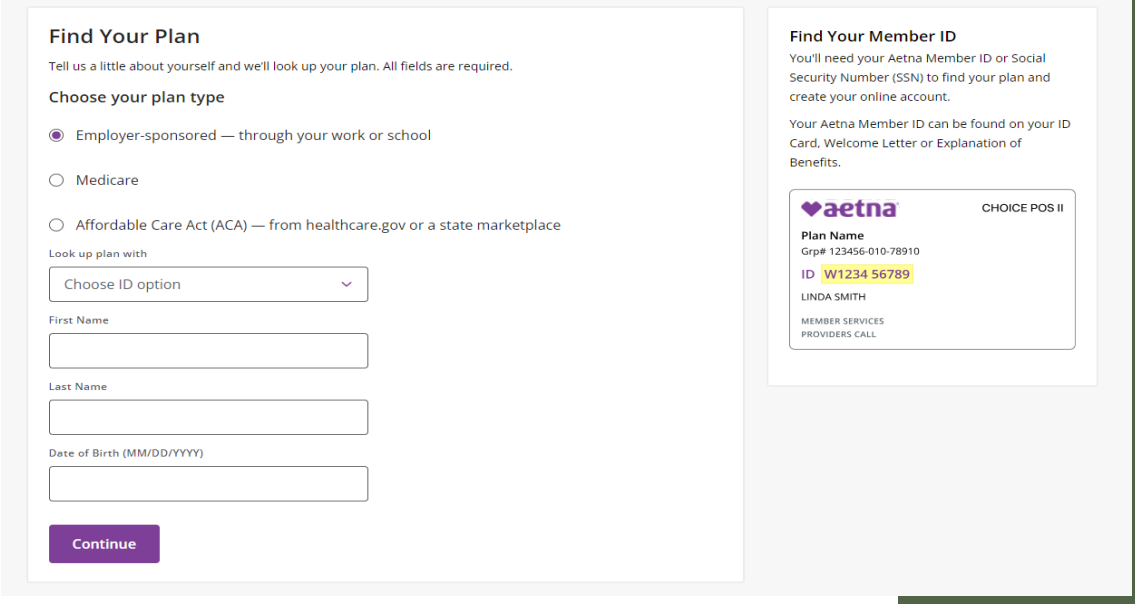
1. Go to **MyAetnaWebsite.com** and select "Login"
2. Click on "Register" under the "Don't have an account?" section
3. Fill in your Member ID number, name, date of birth, and zip code
4. Select your preferred method of communication (call, text, or email) and enter the provided 6-digit pin
5. Create a unique username and password

This account log-in information is also the same information to access your Aetna Mobile App.

Download from the app store today!







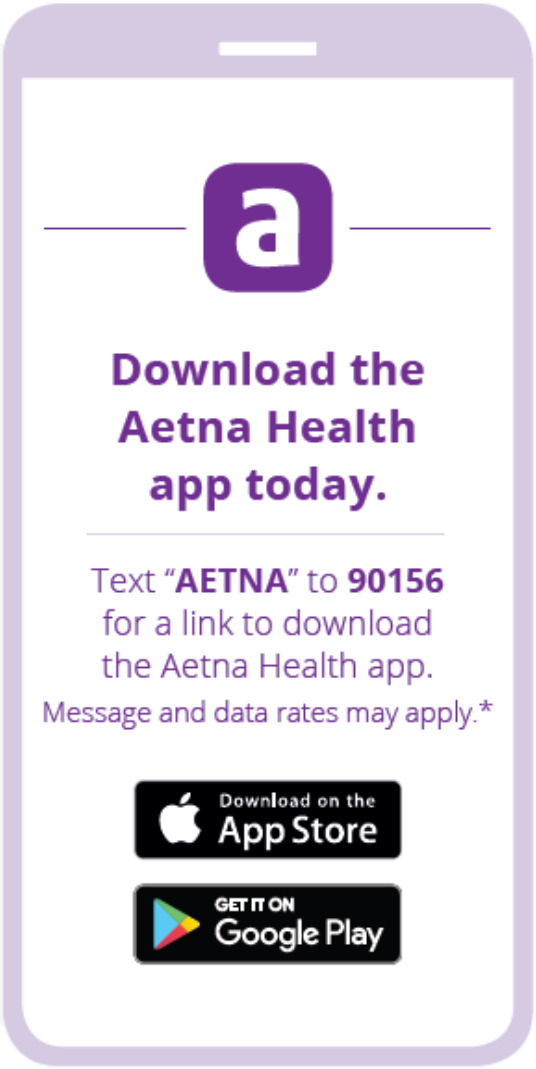
AETNA HEALTH MOBILE APP

Aetna Health Mobile App

You'll have convenient, anywhere access to your health plan information with Aetna's mobile app.

- View your health plan summary and get detailed information about what's covered.
- View claims details and pay claims for your whole family.
- Search for providers, procedures, and medications.
- Get cost estimates before you get care.
- Track spending and progress toward meeting your deductibles for you and your family.
- Speak with a doctor by phone or video 24/7 – from anywhere with Teledoc®
- Access your ID car whenever you need it.

Download the mobile app today, so it's ready when you need it!



BENEFITS SUPPORT

HUB Advocacy Call Center

Health Advocate provides support as you or your loved ones navigate the health care system. Your personal Health Advocate can help you with:

- Coordinating care with your providers
- Understanding all of your options and getting the most out of your benefits
- Finding in-network providers who are right for you
- Resolving issues with health care bills or insurance claims
- Preparing for a doctor's visit or hospital stay
- Getting second opinions
- Exploring treatment options, including medication, breakthrough therapies and trials
- Understanding if a recommended surgery is the right option for you

Health Advocate is available at no cost enrolled members, This service is completely confidential. Connect by phone or email, Within 24 hours of your initial call, The Employee Advocate Hotline will either have the issue resolved or update you on any further actions including the time frame for resolution.

COMING SOON!!!!

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.

POS 500 Medical + Dental + Vision

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$1024.65	$970	$54.65
Employee + Spouse	$1892.53	$1440	$452.53
Employee + Child(ren)	$1693.97	$1440	$253.97
Employee + Family	$2571.42	$1790	$781.42

POS 1000 Medical + Dental + Vision

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$995.20	$970	$25.20
Employee + Spouse	$1831.00	$1440	$391.00
Employee + Child(ren)	$1640.48	$1440	$200.48
Employee + Family	$2485.50	$1790	$695.50

HDHP $2000 Medical + Dental + Vision

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$954.04	$954.04	$0.00
Employee + Spouse	$1749.56	$1440	$309.56
Employee + Child(ren)	$1582.46	$1440	$142.46
Employee + Family	$2333.80	$1790	$543.80

Employees enrolled in the HDHP $2000 Medical plan and eligible, will receive a Health Savings Account with the following contributions.

Coverage	Lewis County HSA Contributions	
	Monthly	Annual
Employee Only	$58.34	$700.08
Employee + Family	$116.68	$1400.16

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.

Dental

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$33.98	$33.98	$0
Employee + Spouse	$67.58	$67.58	$0
Employee + Child(ren)	$78.21	$78.21	$0
Employee + Family	$120.01	$120.01	$0

Vision

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$10.66	$10.66	$0
Employee + Spouse	$21.38	$21.38	$0
Employee + Child(ren)	$18.10	$18.10	$0
Employee + Family	$29.84	$29.84	$0

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.

Voluntary Life and AD&D – Monthly Premium

Age	Cost (Per $1000 of Insurance)	$10,000	$20,000	$40,000	$50,000	$100,000
	Employee & Spouse	Employee & Spouse	Employee & Spouse	Employee & Spouse	Employee & Spouse	Employee & Spouse
0 – 29	$0.12	$1.18	$2.36	$4.72	$5.90	$11.80
30-34	$0.12	$1.25	$2.50	$5.00	$6.25	$12.50
35-39	$0.16	$1.58	$3.16	$6.32	$7.90	$15.80
40-44	$0.22	$2.2	$4.4	$8.80	$11.00	$22.00
45-49	$0.34	$3.38	$6.76	$13.52	$16.90	$33.80
50-54	$0.53	$5.27	$10.54	$21.08	$26.35	$52.70
55-59	$0.80	$7.99	$15.98	$31.96	$39.95	$79.90
60-64	$1.18	$11.79	$23.58	$47.16	$58.95	$117.70
65-69	$1.94	$19.36	$38.72	$77.44	$96.80	$193.6
70 & over	$3.28	$32.79	$65.58	$131.16	$163.95	$327.90

**Due to rounding, your actual payroll deduction amount may vary slightly.*

How to Calculate Premiums

1. Choose the amount of employee coverage that you want to buy.
2. Look up the premium costs for your age group for the coverage amount you are selecting on the chart above.
3. Choose the amount of coverage you want to buy for your spouse. Again, find the premium costs on the chart above.
   Note: Premiums are based on your age, not your spouse's.
4. Choose the amount of coverage you want to buy for your dependent children. The premium costs for each coverage option are shown above.

Dependent Child Coverage Monthly Premium	
$1,000	$0.23
$2,000	$0.45
$4,000	$0.91
$5,000	$1.14
$10,000	$2.27

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.

Voluntary Long-Term Disability

Age	Premium Rates for LTD
	Employee
Under 30	$0.142
30-39	$0.303
40-44	$0.415
45-49	$0.564
50-54	$0.755
55-59	$0.863
60-64	$0.673
65+	$0.253

How to Calculate Premiums

1. To determine your premium, refer to the chart above that shows the rates for ages per $100 of covered salary.
2. Select the age banded rate that applies to you.
3. Complete the following premium calculation worksheet.

Premium Calculation Worksheet	
Annual Earnings = ***PLEASE NOTE:*** *If your annual earnings exceed $200,000 the premium is based on $200,000 due to the maximum benefit cap. Use $200,000 in this calculation.*	$
B. monthly Earnings = (A divided by 12)	$
C. Your monthly Earnings divided by 100 = (B *divided by 100*)	$
D. Estimated monthly Premium you will pay = (*C multiplied by the applicable age-banded rate*)	$

Premiums are based on your current age as of the effective date of coverage. At each policy anniversary, future costs will change as your age increases. Due to rounding, your actual payroll deducted premium may vary slightly.

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.

Voluntary Group Accident Insurance

Benefit Tier	Low Plan	High Plan
Employee Only	$6.60	$9.65
Employee + Spouse	$6.42	$9.30
Employee + Child(ren)	$9.10	$13.10
Employee + Family	$11.91	$17.20

Voluntary Group Hospital Indemnity

Benefit Tier	Low Plan	High Plan
Employee Only	$11.21	$20.55
Employee + Spouse	$23.21	$42.55
Employee + Child(ren)	$17.41	$31.92
Employee + Family	$29.41	$53.92

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.

Voluntary Critical Illness

Attained Age	$15,000 Elected Benefit			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Less than 25	$3.00	$5.25	$6.90	$9.15
30 – 34	$3.60	$6.15	$7.50	$10.05
30 – 34	$5.25	$8.55	$9.15	$12.45
35 – 39	$7.80	$12.30	$11.70	$16.20
40 – 44	$11.40	$17.85	$15.30	$21.75
45 – 49	$16.95	$25.95	$20.85	$29.85
50 – 54	$24.90	$37.95	$28.80	$41.85
55 – 59	$35.70	$53.85	$39.60	$57.60
60 – 64	$52.50	$78.90	$56.40	$82.80
65 – 69	$76.65	$114.75	$80.55	$118.65
70 – 74	$109.35	$163.95	$113.25	$167.85
75+	$150.75	$226.05	$154.65	$229.95

Attained Age	$30,000 Elected Benefit			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Less than 25	$6.00	$10.50	$13.80	$18.30
30 – 34	$7.20	$12.30	$15.00	$20.10
30 – 34	$10.50	$17.10	$18.30	$24.90
35 – 39	$15.60	$24.60	$23.40	$32.40
40 – 44	$22.80	$35.70	$30.60	$43.50
45 – 49	$33.90	$51.90	$41.70	$59.70
50 – 54	$49.80	$75.90	$57.60	$83.70
55 – 59	$71.40	$107.70	$79.20	$115.20
60 – 64	$105.00	$157.80	$112.80	$165.60
65 – 69	$153.30	$229.50	$161.10	$237.30
70 – 74	$218.70	$327.90	$226.50	$335.70
75+	$301.50	$452.10	$309.30	$459.90

IMPORTANT CONTACTS

Benefit	Carrier	Group Number	Phone Number	Website/Email
Human Resources	Lewis County	N/A	360.740.2737	HR@lewiscountywa.gov
Medical	Aetna	TBD	800.238.6299	www.aetna.com
Dental	MetLife	5780810	800.300.4296	www.metlife.com
Vision	MetLife/VSP	5780810	800.300.4296	www.metlife.com/vision
Life & AD&D	MetLife	5780810	800.300.4296	www.metlife.com
Vol. Life & AD&D	MetLife	5780810	800.300.4296	www.metlife.com
Supplemental Benefits	MetLife	5780810	800.300.4296	www.metlife.com
Employee Assistance Program (EAP)	TELUS via Metlife	5780810	888.319.7819	One.telushealth.com UN: metlifeeap PW: eap
Health Savings Account (HSA) Administration	Inspira	TBD	888.678.8242	Inspirafinancial.com
Health Care & Dependent Care Flexible Spending Accounts (FSA)	Health Equity		877.924.3967	

ANNUAL NOTICES & BENEFIT SUMMARIES

See your Human Resources department or Employee Navigator for annual notices and benefit summaries.

BENEFIT TERMINOLOGY

Aggregate deductible

All covered family members work together to meet the family deductible. Once any collection of family members meets the deductible through their combined medical expenses, the plan's benefits will begin to pay for all family members at the coinsurance amount for the rest of the plan year.

For example, HDHP $2000 features an in-network family deductible of $4000. If three members of the family satisfy the $4000 family deductible, the medical carrier will pay 100% of the remaining in-network expenses for all family members.

Aggregate out-of-pocket maximum

All covered family members work together to meet the family out-of-pocket-maximum. Once any collection of family members meets the out-of-pocket maximum through their combined medical expenses, all covered expenses for all family members will be paid at 100%.

For example, HDHP $2000 features a family out-of-pocket maximum of $9000. If three members of the family satisfy the family out-of-pocket maximum of $9000 the medical carrier will pay 100% of remaining in-network expenses for all family members.

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. The County also allows domestic/civil union partners to be listed as dependents.

Dependent care FSA

A flexible spending account (FSA) is designed to provide tax-exempt funds that can be used to offset qualifying expenses for children and elderly dependents. Eligible dependent care expenses include daycare, before- and after-school care, summer day camps and eldercare for dependents claimed on your income taxes. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as "use it or lose it."

BENEFIT TERMINOLOGY

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.

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.

Emergency Room

You should visit an emergency room if you are experiencing any life-threatening condition, such as chest pain, shortness of breath, serious bodily injury, severe abdominal pain or loss of consciousness.

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, POS 500 features an in-network family deductible of $1500. If one member of the family satisfies the individual $500 deductible, the medical carrier will pay 80% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining $1000, 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 POS 500, features a family out-of-pocket maximum of $5000. If one member of the family satisfies the individual out-of-pocket maximum of $2500, 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.

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. (These are typically "Tier 1" drugs in the County's medical plans.)

BENEFIT TERMINOLOGY

Health care FSA

Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

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 County's 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").

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.

BENEFIT TERMINOLOGY

Non-preferred 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. (These are typically ["Tier 3"] drugs in the County's medical plans.)

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 County 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.

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. (These are typically ["Tier 2"] drugs in the County's medical plans.)

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.

BENEFIT TERMINOLOGY

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 County, though there are insurance benefits the County 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 the County 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.

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.

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.

BENEFIT TERMINOLOGY

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.

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.

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.

Scan this code to watch a video about benefit terms.

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