





2027 LEWIS COUNTY BENEFIT GUIDE

January 1 – December 31, 2027

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 if you are hired to work 20 hours or more per week 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. 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 01/01/2027.

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

Scan the below QR Code 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
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
Regence Support Programs
Employee Assistance Program

Perks

Employee Discounts
Medicare Guidance

Resources

Find Regence Provider
Find a VSP Vision Provider
Find a Dental Provider
Regence App
Benefit Support
Plan Contributions
Important Contacts
Benefit Terminology

DISCLAIMER: The material in this benefits brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between your plan documents and this information, the plan documents will always govern. **Annual Notices:** ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The company will distribute all required notices annually.



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. Open Enrollment is November 9, 2026, through November 30, 2026, for the 2027 plan year, with benefits effective January 1, 2027.

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

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

HDHP + HSA

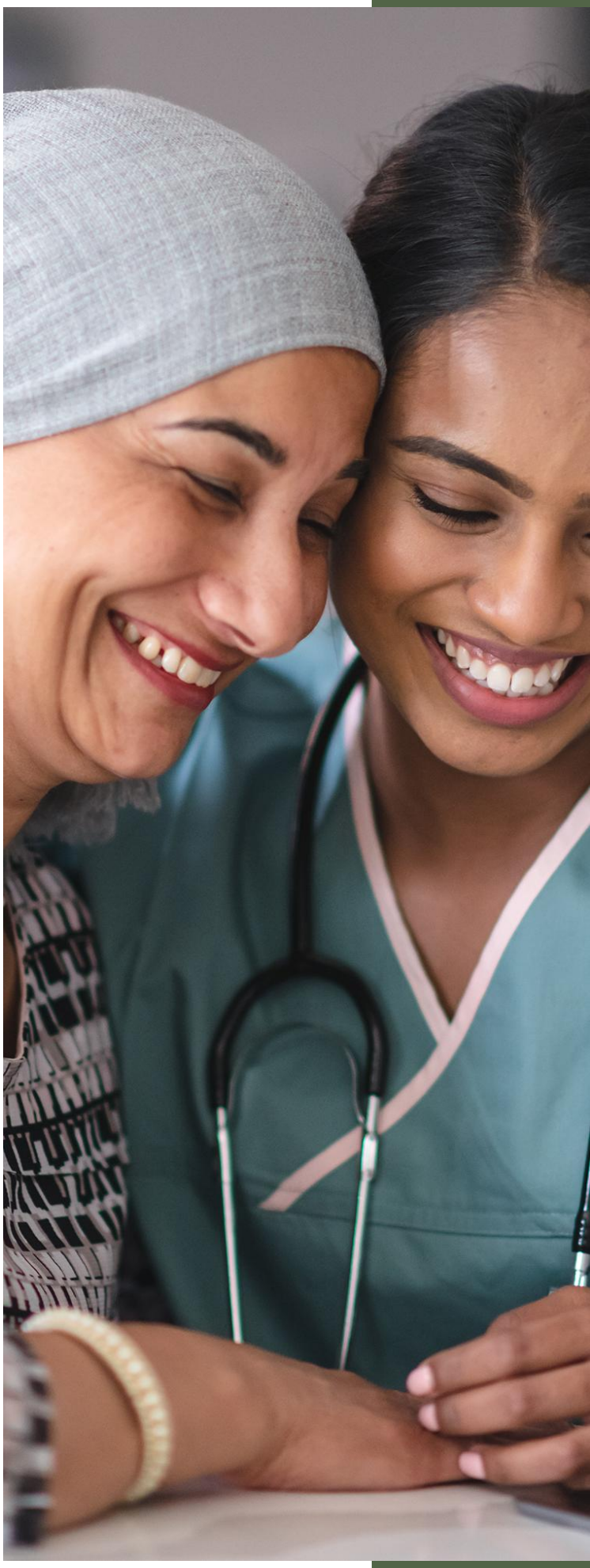
The HDHP + HSA (High-Deductible Health Plan + Health Savings Account), provided through Regence, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open an HSA, which is a tax-advantaged personal savings account that lets 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

The 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 36 in this benefit guide.

Key Benefits	PPO $500		PPO $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[3]	
Office Visits (physician/specialist)	$25 / $50	40%*	$25 / $50	40%*	20%*	40%*
Mental Health Office Visits	$25	40%*	$25	40%*	20%*	40%*
Virtual Care - Telehealth	$10	40%*	$10	40%*	10%*	40%*
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%*
Outpatient Rehabilitation (60 PCY; speech, physical, occupational, massage)	$25	40%*	$25	40%*	20%*	40%*
Ambulance	20%*		20%*		20%*	
Emergency Room	$75 copay, then 20%*		$75 copay, then 20%*		20%*	
Urgent Care Facility (primary care/specialist)	$25 / $50		$25 / $50		20%*	
Inpatient Hospital Stay	20%*	40%*	20%*	40%*	20%*	40%*
Outpatient Surgery	20%*	40%*	20%*	40%*	20%*	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. HDDP Plan: The deductible is aggregate. With an aggregate deductible, the full family deductible must be met before coinsurance applies to any individual. PPO 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. HDHP: 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%. PPO 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 MEDICAL SERVICES

Doctor on Demand

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

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs. A call to our telehealth program will cost $10 for those on the PPO plans or 10% after the deductible has been met for those on the HDHP.

It's Convenient

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

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away! Scan the QR code or visit doctorondemand.com/regence-wa to register today. You'll want to create your online account in advance, so when you need care, you'll already be set up.

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

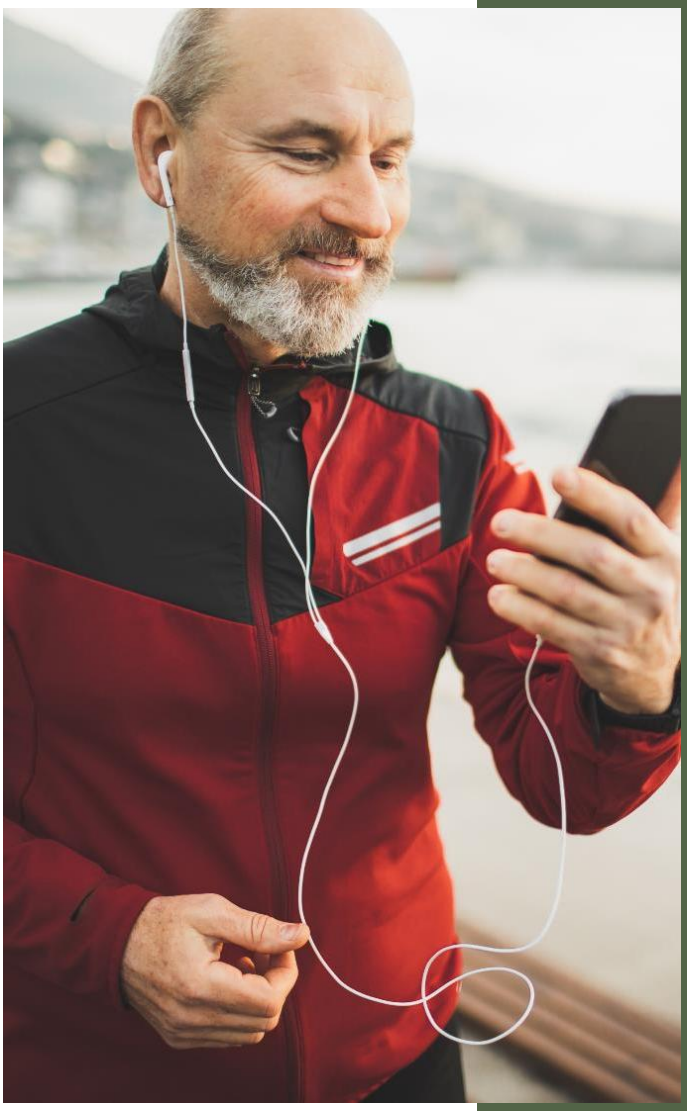
- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Ear infections
- Diarrhea or constipation
- Headaches and migraines
- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections

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

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 by accessing the number on the back of your member ID card or signing in to your online member account at Regence.com.

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.

Covered-Drug List

To see if your medication is covered and how much it will cost, visit regence.com/pharmacy, sign in or select your type of drug coverage, and click on **FIND A DRUG.**

90-Day Fills

You can pick up 90-day supplies of most long-term medication at one of the Extended Supply Network (ESN) retail pharmacies or have the Home Delivery program ship it to the location of your choice.

Visit regence.com/pharmacy, select your type of coverage or simply sign in, and click on **FIND A PHARMACY** to locate an ESN retail pharmacy or register for home delivery.

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	PPO $500 and PPO $1,000	HDHP $2,000
	In-Network	In-Network
Retail Pharmacy		
Tier 1	$10	20%*
Tier 2	$25	
Tier 3	$75	
Tier 4	30%	
Mail Order Pharmacy		
Tier 1	$10	20%*
Tier 2	$25	
Tier 3	$75	
Tier 4	N/A	

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

DENTAL COVERAGE

PPO

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

To find an in-network provider, see page 38 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	Delta Dental PPO Plus Premier™ Plan	
	Delta Dental PPO Plus Premier® Dentist	Non-Participating[1]
Deductible (Individual/Family)	$50 / $150 *only applies to basic and major services*	
Annual Benefit Maximum (per person)	$2,500	
Class 1 - Preventive Services (Exams, X-Rays, Fluoride (to age 14), Sealants)	Covered 100%	20%
Class 2 - Basic Services (Endodontics, Periodontics, Oral Surgery)	20%*	30%
Class 3 - Major Services (Crowns, Bridges, Dentures, TMJ, Implants)	50%*	60%
Orthodontic Services (Child & Adult)	50% $2,500 per person Lifetime Max	
Temporomandibular Join Disorder (TMJ) Lifetime Maximum (Per Person)	$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) via Delta Dental, 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 37 in this benefit guide.

Key Benefits	DeltaVision® / VSP®	
	In-Network	Out-of-Network Reimbursement
Exam (1 Per 12 Months)		
WellVision Exam®	$10 Copay	Up to $45
Essential Medical Eye Care (retinal imaging for members with diabetes covered-in-full. Additional exams & services beyond routine care, *Coordination with your medical coverage may apply.*	$20 Copay	Up to $45
Materials Copay	$10 Copay	Up to $70
Frames (1 Per 12 Months)	$200 Allowance $200 Walmart / Sam's Club $110 Costco Frame Allowance 20% savings on amount over allowance	Up to $70
Lenses (1 Per 12 Months)		
Single Vision	Included in materials copay	Up to $30
Bifocal	Included in materials copay	Up to $50
Trifocal	Included in materials copay	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
EasyOptions: Flexible Upgrade Choose one at no cost: (1) An additional $100 frame allowance, (2) Fully covered premium or custom progressive lenses, (3) fully covered anti-reflective coating, (4) additional $50 elective contact lens allowance.		N/A
Lens Enhancements: Premium Progressive: $95-$105; Custom Progressive: $150-$175; Anti-reflective coating: $41-$85; Photochromic: $75; Tines: $15-$17 (plastic only); Scratch resistance coating: $17		N/A



WEALTH

HEALTH SAVINGS ACCOUNT (HSA)

The HDHP $2,000 Plan features an HSA provided through Health Equity. 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: $708**
    - **Employee + dependent(s) coverage: $1,404**
- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Contribution Limits

Coverage Tier	2026	2027
Individual	$4,400	$4,500
Family	$8,750	$9,000
55+ 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 Health 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	2026: $3,400 2027*: $3,500 (estimate only, pending official IRS release)	$7,500 per family (or $3,750 each if you are married and file separate tax returns)

Important FSA Rules

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

- **You must enroll each year to participate.**
- **HCFSA:** Unused funds of up to 2026: $680; 2027: $700* 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 2026: $680; 2027: $700* will **not** be returned to you or carried over to the following year. NOTE: Those enrolled in a HDHP / HSA plan are NOT eligible to enroll in the HCFSA.
- **DCFSA:** Unused funds will NOT be returned to you or carried over to the following year.

**** 2027 Estimate: Pending official IRS release.***

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 Mutual of Omaha, 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 $1,000,000	$250,000
Spouse	Increments of $5,000 up to $250,000	100% of the employee's election, up to $25,000
Child(ren)	$2,000 minimum $1,000 increments up to $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 it 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 Mutual of Omaha, 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 ends	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 Mutual of Omaha, 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	Employee: up to $6,000 Spouse: up to $3,000	Employee: up to $9,000 Spouse: up to $4,500
Concussion Benefit	$250	$500
Accident – Medical Services		
Ambulance Benefit	Up to $1,000	Up to $1,500
Emergency Care Benefit	$200	$300
Hospital Benefits		
Admission	$1,000	$1,500

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

GROUP CRITICAL ILLNESS INSURANCE

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 Mutual of Omaha
- 100% Employee Paid (Premiums will vary dependent upon your coverage tier and age)

	Minimum Amount	Maximum Amount	Increments	Guarantee Issue Amount
Employee	$5,000	$30,000	$5,000	$30,000
Spouse	$5,000	Up to 100% of employee amount, up to $30,000	$5,000	$30,000
Children	Up to 25% of employee/member benefit, up to $5,000			All child amounts are guaranteed

Covered Conditions	Initial Benefit	Recurrence Benefit
Inflammatory Bowel Disease	25% of Benefit Amount	None
Benign Brain Tumor	25% of Benefit Amount	100% of Initial Amount
Cancer Category	Up to 100% of Benefit Amount	Varies
Coronary Artery Disease	25% of Benefit Amount	100% of Initial Amount
Heart Attack	100% of Benefit Amount	100% of Initial Amount
Bone Marrow/Stem Cell Recipient	50% of Benefit Amount	100% of Initial Amount
Kidney Failure	100% of Benefit Amount	None
Stroke	100% of Benefit Amount	100% of Initial Amount

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



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 Mutual of Omaha, 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		
Hospital Admission Benefit	$500	$1,000
ICU Admission	$1,000	$2,000
Hospital Confinement Benefit	$100 per day, up to 30 days	$200 per day, up to 30 days
Newborn Nursery Care Confinement	$75 per day up, to two days	$75 per day, up to two days
Daily Rehabilitation Facility Confinement	$75 per day, up to 30 days	$175 per day up, to two days
Other Benefits		
Pet Boarding	$25 per day up to 15 days	$25 per day up to 15 days

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.

MUTUAL OF OMAHA VALUE ADD PROGRAMS

Will Preparation

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

- Log on to www.willprepservices.com and use the code **MUTUALWILLS** to register
- Answer the simple questions from any device and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requirements

Financial Wellness

The iGrad™ Enrich financial wellness tool is a convenient, one-stop shop that provides employees access to a variety of informational and educational resources to help them improve their financial stress and become more focused and productive at work.

Here are the resources you'll find in the financial wellness tool:

- Budget
- Managing Debt
- Behavioral Finance
- Money Personality
- Assessment
- Money Mindfulness
- Tools
- And more!

Go to mutualofomaha.com/eap to learn more about the Enrich financial wellness tool.

Travel Assistance

Take comfort in knowing that Travel Assistance travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

Emergency Travel Support Services include:

- Telephonic translation and interpreter services with 24/7 access to telephone translation services
- Locating legal services — referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- Baggage — assistance with lost, stolen or delayed baggage while traveling on a common carrier
- Emergency payment and cash — assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- Emergency messages — assistance with recording and retrieving messages between you, your family and/or business associates at any time
- Document replacement — coordination of credit card, airline ticket or other documentation replacement
- Vehicle return — if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

- **For inquiries within the U.S. call toll free:**
  - **1-800-856-9947**
- **Outside the U.S. call collect:**
  - **(312) 935-3658**



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/

If you are considering applying for these benefits through Washington State, please contact Human Resources so we can work together to discuss your need for leave, and ensure we answer any questions you may have. Contact information: HR@lewiscountywa.gov or (360)740-2737.



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



REGENCE SUPPORT PROGRAMS

Mental Health Support

Everyone could use a little help sometimes.

If you're feeling low or in need of support, we can help you find the right care. Many therapists and psychiatrists offer both in-person and virtual appointments, so you can get care just how you need it. Your plan may also include additional options for virtual therapy and virtual substance use disorder treatment.

Go to regence.com/member/behavioral-health and sign in to see all your options.

It can be challenging to find a mental health provider that fits. On top of that, wait times can be long. But we're here to help you find someone who can see you soon— just chat with us online or call the number on the back of your member ID card.

Scan this code to watch a video about mental health.

Health Insurance 101

Need help understanding health insurance? We'll start at the beginning.

Learn everything you need to know about health insurance—including terminology, how insurance works, who pays what and the importance of networks. Get started at: regence.com/member/health-insurance-101

REGENCE SUPPORT PROGRAMS (CONTINUED)

Pregnancy Program

Get support from caring professionals throughout your pregnancy with our maternity management program. A nurse will reinforce your doctor's or midwife's care and answer questions 24/7. Learn more at: regence.com/member/programs/health-support-services/maternity

Care Management

If you have a difficult medical situation, our experienced care managers are here to give you the one-on-one support you need. They'll help you navigate the health care system and answer all your questions. Learn more at: regence.com/member/programs/health-support-services/regence-case-management

Utilization Management

Some care requires approval from Regence before you're covered. We'll help you understand options and related risks, avoid treatment that isn't necessary and save on out-of-pocket costs.

Virtual Muscle & Joint Support

Get help managing mobility and pain in joints, spine and muscles with a personalized virtual exercise program.

Regence Empower®

Your health plan includes Regence Empower®, an online well-being program and app that helps you take simple steps toward better health.

Whether you want to start a new fitness routine, improve your sleep habits or practice mindfulness, there's a program for you. And because working on your health is more fun together, your eligible spouse or domestic partner can earn the same incentives you do! Get going today—when you begin your well-being journey by taking the online Regence Empower Health Assessment, you'll earn your first reward.

Take Steps to better health and earn up to $100

To get started, sign in at **regence.com** or the app and find **Regence Empower**.

- **Step 1**
  - Take the online Health Assessment and earn a $15 electronic gift card
- **Step 2**
  - Explore and complete other healthy activities, like getting an annual checkup, to earn more rewards
- **Step 3**
  - Claim your rewards in electronic gift cards





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 Mutual of Omaha.

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

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

EAP Benefits

- Assistance for you and your household members
- Up to 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: mutualofomaha.com/eap

Call: 1-800-316-2796

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



PERKS

EMPLOYEE DISCOUNTS

BenefitHub

Provided 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

Regence Members-Only Discounts

With Regence Advantages, you can save on alternative care, fitness devices, LASIK, hearing aids, healthy meals and more, plus get 20% off eligible Walgreens-branded health and wellness items. Learn more at: regence.com/member/resources/advantages-discounts



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 A MEDICAL PROVIDER

Find a Regence Provider:

1. Sign in to regence.com.
2. Click on "Care" on the left navigation bar. Select "Find a provider". Then choose "Medical"
3. Choose a search category and enter your search term.

You can also search as a guest by:

1. Visiting regence.com.
2. Entering your location and network name

Network: Preferred

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/ DELTA DENTAL 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 DENTAL PROVIDER

Find a Dental Provider

1. From the deltadental.com home page, select "Member Tools" then "Dentist Finder"
2. Search as a member (PREFERRED) or by network.
3. Choose your dental plan network in the drop down:
    - **Delta Dental PPO Plus Premier**

When you sign into your account, you will get a personalized search experience.

If you don't have an online account, it's easy to set one up!

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



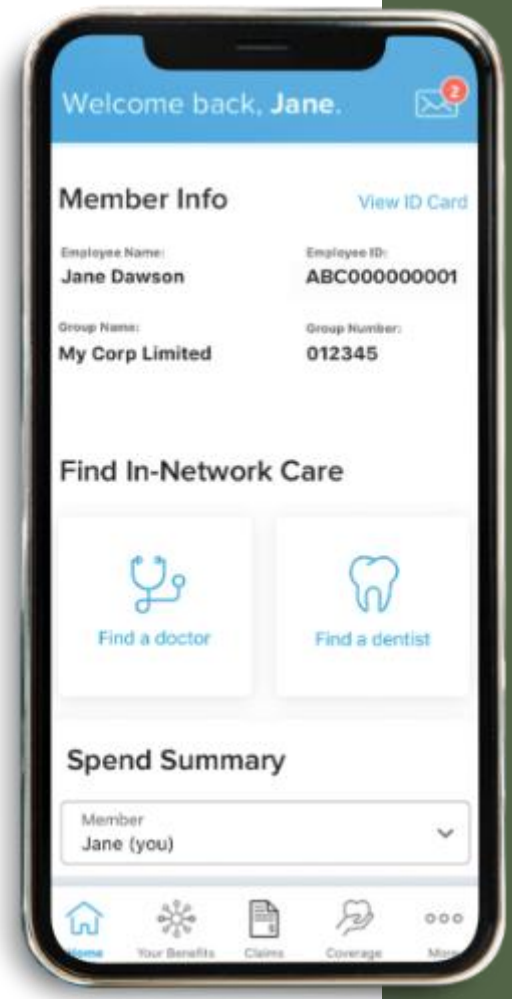
REGENCE MOBILE APP

Stay Connected with the Mobile App

Once you register for your account on the web, you can access your account using the mobile app.

Through the app you can:

- View your digital member ID cards
- Find an in-network provider or hospital
- Securely access your claims and benefits at home or on the go
- Get connected to our Customer Care team at the touch of a button



Download on the App Store

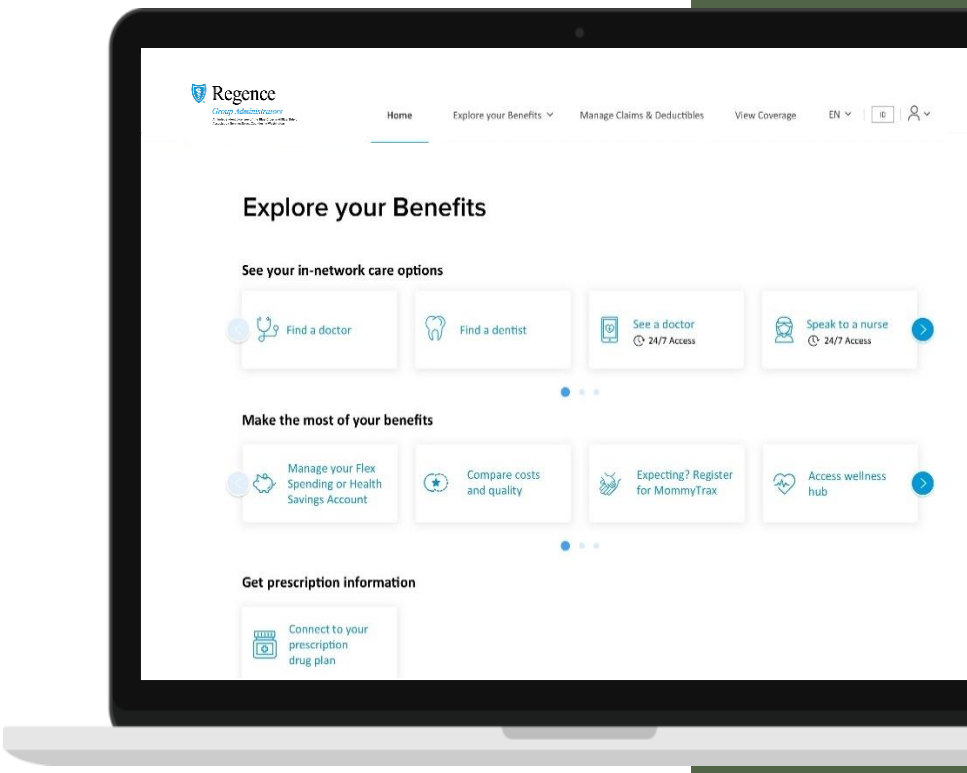
GET IT ON Google Play

REGENCE MEMBER PORTAL

After receiving your member ID number, you can create a member portal account on our website to easily and securely manage your healthcare benefits.

Through the member portal you can:

- View your Claims status
- View your benefits and coverage
- Get help with your questions
- Connect to RGA programs and services



Create your account at regence.com

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 to 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.



CONTACT

Phone: 877-838-4779
Email: advocates@hubinternational.com
Fax: 855.204.7146

Monday – Friday
7:00 am – 5:00 pm PST

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.

Regence Classic PPO $500 Medical

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$1,075.08	$975.16	$99.92
Employee + Spouse	$1,978.54	$1,440.89	$537.65
Employee + Child(ren)	$1,752.65	$1,413.16	$339.49
Employee + Family	$2,656.49	$1,751.62	$904.87

Regence Classic PPO $1,000 Medical

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$1,042.87	$973.16	$69.71
Employee + Spouse	$1,911.22	$1,438.89	$472.33
Employee + Child(ren)	$1,694.13	$1,411.16	$282.97
Employee + Family	$2,562.47	$1,747.62	$814.85

Regence HDHP $2,000 Medical

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$996.25	$970.16	$26.09
Employee + Spouse	$1,819.19	$1,432.89	$386.30
Employee + Child(ren)	$1,628.08	$1,407.16	$220.92
Employee + Family	$2,392.52	$1,738.62	$653.90

Employees enrolled in the HDHP $2,000 Medical plan and eligible, will receive a Health Savings Account with the following contributions.

Coverage	Lewis County HSA Contributions	
	Monthly	Annual
Employee Only	$59	$708
Employee + Family	$117	$1,404

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	$35.09	$35.09	$0
Employee + Spouse	$69.81	$69.81	$0
Employee + Child(ren)	$86.79	$86.79	$0
Employee + Family	$129.78	$129.78	$0

Vision

Coverage	Monthly Contributions		
	Total Cost	Employer Contribution	Employee Cost
Employee Only	$7.75	$7.75	$0
Employee + Spouse	$16.30	$16.30	$0
Employee + Child(ren)	$17.05	$17.05	$0
Employee + Family	$25.60	$25.60	$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	$0.118	$1.18	$2.36	$4.72	$5.90	$11.80
30-34	$0.125	$1.25	$2.50	$5.00	$6.25	$12.50
35-39	$0.158	$1.58	$3.16	$6.32	$7.90	$15.80
40-44	$0.220	$2.20	$4.40	$8.80	$11.00	$22.00
45-49	$0.338	$3.38	$6.76	$13.52	$16.90	$33.80
50-54	$0.527	$5.27	$10.54	$21.08	$26.35	$52.70
55-59	$0.799	$7.99	$15.98	$31.96	$39.95	$79.90
60-64	$1.179	$11.79	$23.58	$47.16	$58.95	$117.90
65-69	$1.936	$19.36	$38.72	$77.44	$96.80	$193.60
70 & over	$3.279	$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	$0.227
$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	$4.14	$6.42
Employee + Spouse	$6.49	$10.20
Employee + Child(ren)	$9.51	$14.30
Employee + Family	$11.46	$18.11

Voluntary Group Hospital Indemnity

Benefit Tier	Low Plan	High Plan
Employee Only	$9.39	$19.56
Employee + Spouse	$21.61	$44.82
Employee + Child(ren)	$12.96	$26.89
Employee + Family	$25.93	$53.78

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

Age Band	Monthly Rate per $1,000		$5,000 Elected Benefit		$30,000 Elected Benefit	
	Employee	Spouse	Employee	Spouse	Employee	Spouse
Less than 30	$0.29	$0.29	$1.45	$1.45	$8.70	$8.70
30 - 39	$0.39	$0.39	$1.95	$1.95	$11.70	$11.70
40 - 49	$0.74	$0.74	$3.70	$3.70	$22.20	$22.20
50 - 59	$1.64	$1.64	$8.20	$8.20	$49.20	$49.20
60 - 69	$3.59	$3.59	$17.95	$17.95	$107.70	$107.70
70 - 79	$6.64	$6.64	$33.20	$33.20	$199.20	$199.20
80 - 99	$9.79	$9.79	$48.95	$48.95	$293.70	$293.70

If elected, child insurance is automatic. A separate premium is not required.

IMPORTANT CONTACTS

Benefit	Carrier	Group Number	Phone Number	Website/Email
Human Resources	Lewis County	N/A	360.740.2737	HR@lewiscountywa.gov
Medical	Regence	202701	888.734.3623	Regence.com
Dental	Delta Dental	06482	800.554.1907	DeltaDentalWA.com
Vision	Delta Dental/VSP	76482	800.877.7195	Vsp.com
Life and AD&D	Mutual of Omaha	G000D3GW	800.775.8805	mutualofomaha.com
Vol. Life and AD&D	Mutual of Omaha	G000D3GW	800.775.8805	mutualofomaha.com
Vol. Long Term Disability	Mutual of Omaha	G000D3GW	800.775.8805	mutualofomaha.com
Supplemental Benefits	Mutual of Omaha	G000D3GW	800.775.8805	mutualofomaha.com
Employee Assistance Program (EAP)	Mutual of Omaha	G000D3GW	800.775.8805	mutualofomaha.com
Health Savings Account (HSA) Administration	Health Equity via Regence	Lewis County	TBD	TBD
Health Care & Dependent Care Flexible Spending Accounts (FSA)	Health Equity	Lewis County	877.924.3967	healthequity.com/contact
Advocacy Call Center	HUB	Lewis County	877.838.4779	advocates@hubinternational.com

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.

NOTES